S B
36

Mel — 2-28-89

Please see pg 3, bottom of pg 5, pg 6 and pg 11

The other material outlines the D. Min requirements.

Please call for more information - if needed -

Allen Ross
for 344 6078
563-4325

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: SB 36
PUBLISH DATE: _____

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: An Act relating to insurance coverage for treatment of a mental or nervous condition
Sponsor: Faiks
Requestor: Senate HESS

Agency Affected: Commerce & Economic Dev.
BRU: Insurance
Components: Operations

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
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	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary) No fiscal impact in FY 90.

No direct impact on the division's operations.

Prepared by: Joan Brown, Administrative Officer
Division: Insurance
Phone: 465-2597
Date: _____

Approved by Commissioner: Larry Merculieff
Agency: Department of Commerce & Economic Development
Date: 5/2

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

6152D-3/011990a

JAN 23 1989

STATE OF ALASKA
1989 LEGISLATIVE SESSION

BILL VERSION: SB 36
PUBLISH DATE: 1-9-89

FISCAL NOTE

REQUEST:

Revision Date:
Title: An Act relating to ins. coverage for treatment of a mental or nervous condition.
Sponsor: Faiks
Requestor: Senate HESS

Agency Affected: Commerce & Econ. Dev.
BRU: Insurance
Components: Operations

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
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	-0-	-0-	-0-	-0-	-0-	-0-
PART-TIME						
TEMPORARY						

ANALYSIS : (Attach a separate page if necessary)

No direct impact on the division's operations.

Prepared by: Joan Brown
Division: Insurance
Phone: 465-2597
Date: 1-17-89

Approved by Commissioner: [signature]
Agency: Commerce and Economic Development
Date: 1/20/89

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)
mm0599t
011789a

FEB 01 1989

STATE OF ALASKA
1989 LEGISLATIVE SESSION

Bill Version: SB 36
Publish Date:

FISCAL NOTE

REQUEST:

Revision Date:
Title: An Act relating to insurance coverage for mental/nervous conditions
Sponsor: Faiks
Requestor:

Agency Affected: Department of Administration
BRU: Retirement and Benefits
Components: Retirement and Benefits

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

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

POSITIONS:

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

ANALYSIS: (Attach a separate page if necessary)

This bill will not result in additional operations cost for the Division of Retirement and Benefits.
THIS BILL IS ESTIMATED TO COST ALL STATE AGENCIES $2,696.2 IN INCREASED PERSONAL SERVICES COSTS. THIS BILL IS ESTIMATED TO COST SCHOOL DISTRICTS AND OTHER PARTICIPATING POLITICAL SUBDIVISIONS $2121.2 IN FY 90. See pages 2 and 3 for a detailed analysis.

Prepared By: Sally Smith, Director Sally Smith Phone: 465-4470
Division: Retirement and Benefits Date: 1-31-89

Approved by Commissioner: John M. Andrews Date: 2/1/89
Agency: Department of Administration

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

8/6K2/012603-9

Rev: 12/16/88

STATE OF ALASKA
1989 LEGISLATIVE SESSION

Bill Version: SB 36
Publish Date:

FISCAL NOTE

REQUEST: FEB 22 1989

Revision Date: February 15, 1989
Title: An Act relating to insurance coverage for mental/nervous conditions
Sponsor: Faiks
Requestor:

Agency Affected: Department of Administration
BRU: Retirement and Benefits
Components: Retirement and Benefits

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

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

POSITIONS:

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

ANALYSIS: (Attach a separate page if necessary)

This bill will not result in additional operations cost for the Division of Retirement and Benefits.

THIS BILL IS ESTIMATED TO COST ALL STATE AGENCIES $2,453.3 IN INCREASED PERSONAL SERVICES COSTS. THIS BILL IS ESTIMATED TO COST SCHOOL DISTRICTS AND OTHER PARTICIPATING POLITICAL SUBDIVISIONS $1,957.7 IN FY 90. See pages 2 through 4 for a detailed analysis.

Prepared By: Sally Smith, Director Sally Smith Phone: 465-4470
Division: Retirement and Benefits Date: Feb. 17, 1989

Approved by Commissioner: John M. Andrews Date: 2/21/89
Agency: Department of Administration

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

8/6K2/012603-9

Rev: 12/16/88

This analysis assumes a continuation of the full coverage of unlimited inpatient treatment rather than imposing the 45 days per year minimum as outlined in the bill. It also assumes the imposition of a $2500 annual maximum on outpatient treatment as a "reasonable" contract limitation. There is currently no limitation on the number of hours of outpatient treatment or office visits. This is more liberal than the minimum of 50 hours outlined in the bill. We have also assumed no additional increase in the future since the plans' experience will dictate any changes.

The analysis consists of three separate components. There is a summary of costs at the end of the analysis. The first component addresses the direct increase to health insurance premiums for active State employees for an increased level of coverage. The second addresses the increased costs to the State due to increased contributions to the retirement systems. The third component addresses the increased costs to school districts and political subdivisions due to the increase in their contributions to the retirement systems and the direct increase to health insurance premiums for those entities participating in the State sponsored health plan.

Contributions to the retirement systems from employers would increase in order to actuarially fund the enhanced benefits in the retirees' health plan.

1. Active State Employee Program. Health insurance premiums for active State employees are estimated to increase $4.97 per month per employee, effective February 1, 1990. For purposes of this analysis we have assumed no additional increase in the future. The total FY 90 increase in costs for active State employees is estimated to be $323.1. This is calculated by multiplying the estimated number of employees each month times $4.97 times 5 months. The full year equivalent (FY 91) of this increase is $775.3.

   Total full year equivalent increase for
   active employee health insurance $775.3

2. Retiree Program. This bill is estimated to result in an increase to the State's cost by .297% of the PERS payroll and .236% in the TRS payroll. The FY 90 State PERS payroll, including the University of Alaska is estimated to be $521,208,708 (State $463,907,093; and University of Alaska, $57,302,615.) It is assumed to remain level each year thereafter.

   The FY 90 State TRS payroll, including the University of Alaska, is estimated to be $55,085,786 (Department of Education, $5,025,700; and the University of Alaska, $50,060,086). TRS salaries are also assumed to remain level each year thereafter.

The FY 90 increase in costs to the State due to retirement contributions of $1,678.0 is calculated as follows:

Estimated State PERS FY 90 payroll	$463,907,093	
PERS contribution rate increase	.297%	
FY 90 State Total PERS cost		$1,377.8
Estimated University of Alaska PERS FY 90 payroll	$57,301,615	
Pers contribution rate increase	.297%	
FY 90 University of Alaska Total PERS cost		$ 170.2
Estimated Department of Education TRS FY 90 payroll	$ 5,025,700	
TRS contribution rate increase	.236%	
FY 90 Department of Education Total TRS cost		$ 11.9
Estimated University of Alaska TRS FY 90 payroll	$ 50,060,086	
TRS contributions rate increase	.236%	
FY 90 University of Alaska Total TRS cost		$ 118.1
Total estimated State cost increase for FY 90 for retirement system contributions		$ 1678.0

3. Political Subdivision Active and Retiree Programs. In addition to the State cost there would also be an increase in political subdivisions' contribution rate to the PERS by .297% of PERS payroll and school districts' contribution rate to the TRS by .236% of TRS payroll. The FY 90 PERS payroll for political subdivisions is estimated to be $354,521,366. The FY 90 TRS payroll for school districts is estimated to be $339,201,043. Salaries for both systems are assumed to remain level each year thereafter. The FY 90 increase in costs to these entities due to retirement contributions of $1853.4 is calculated as follows:

Estimated political subdivision FY 90 payroll	$354,521,366	
PERS contribution rate increase	.297%	
FY 90 political subdivision Total PERS cost		$ 1052.9
Estimated school district FY 90 payroll	$339,201,043	
TRS contribution rate increase	.236%	
FY 90 School district Total TRS cost		$ 800.5
Total estimated FY 90 political subdivision and school district cost increase for retirement system contributions		$ 1853.4

There would also be an increase to the health insurance premiums for active employees of political subdivisions and school districts that participate in the State sponsored health plan. This increase would not take effect until FY 91 since the health contract is not renewed until that date. The estimated FY 91 costs for these employees will increase by $104.3. This is calculated as follows by multiplying the estimated monthly increase per employee ($4.97) times the estimated number of employees (1750) times 12 months.

Total health insurance increase for political subdivisions and school districts in FY 91	$ 104.3

Increase in FY 90 Costs Due to Expanded Health Insurance

	Active Employees	Retirees	Total
State	$775.3*	$1678.0	$2453.3
Political Subdivisions and School Districts	104.3**	1853.4	1957.7

* Shown as full year equivalent
** Shown as full year equivalent. No increase for FY 90

If this bill becomes law, the unfunded liability will increase by $4.6 million and the funding ratio will decrease by .35% in the TRS.

The unfunded liability will increase by $13.83 million and the funding ratio will decrease by .6% in the PERS.

STATE OF ALASKA
1990 LEGISLATIVE SESSION

Bill Version: SB 36
Publish Date:

FISCAL NOTE

REQUEST:

Revision Date: December 12, 1989
Title: An Act relating to insurance coverage for mental/nervous conditions
Sponsor: Faiks
Requestor:

Agency Affected: Department of Administration
BRU: Retirement and Benefits
Components: Retirement and Benefits

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

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

POSITIONS:

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

ANALYSIS: (Attach a separate page if necessary)

This bill will not result in additional operating costs for the Division of Retirement and Benefits.
THIS BILL IS ESTIMATED TO COST ALL STATE AGENCIES $2,564.9 IN INCREASED PERSONAL SERVICES COSTS.
THIS BILL IS ESTIMATED TO COST SCHOOL DISTRICTS AND OTHER PARTICIPATING POLITICAL SUBDIVISIONS $1,951.5 IN FY 91. See pages 2 through 4 for a detailed analysis.

Prepared by: Sally Smith, Director Phone: 465-4470
Division: Retirement and Benefits Date: 10 Jan 90
Approved by Commissioner: Frank S. Baxter Date: 1/25/90
Agency: Department of Administration

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

8/6K3701020I-072

Rev: 11/89

This analysis assumes a continuation of the full coverage of unlimited inpatient treatment rather than imposing the 45 days per year minimum as outlined in the bill. It also assumes the imposition of a $2,500 annual maximum on outpatient treatment as a "reasonable" contract limitation. There is currently no limitation on the number of hours of outpatient treatment or office visits. This is more liberal than the minimum of 50 hours outlined in the bill. We have also assumed no additional increase in the future since the plans' experience will dictate any changes.

The analysis consists of three separate components. There is a summary of costs at the end of the analysis. The first component addresses the direct increase to health insurance premiums for active State employees for an increased level of coverage. The second addresses the increased costs to the State due to increased contributions to the retirement systems. The third component addresses the increased costs to school districts and political subdivisions due to the increase in their contributions to the retirement systems and the direct increase to health insurance premiums for those entities participating in the State sponsored health plan.

Contributions to the retirement systems from employers would increase in order to actuarially fund the enhanced benefits in the retiree's health plan.

1. Active State Employee Program. Health insurance premiums for active State employees are estimated to increase $4.97 per month per employee, effective February 1, 1990. For purposes of this analysis, we have assumed no additional increase in the future. The total possible FY 90 increase in costs for active State employees is estimated to be $323.1. This is calculated by multiplying the estimated number of employees each month (13,000) times $4.97 times five months. The full year equivalent (FY 91) of this increase is $775.3.

   Total full year equivalent increase for
   active employee health insurance . . . . . $ 775.3

2. Retiree Program. This bill is estimated to result in an increase to the State's cost by .297 percent of the Public Employees' Retirement System (PERS) payroll and .236 percent in the Teachers' Retirement System (TRS) payroll. The FY 91 State PERS payroll, including the University of Alaska, is estimated to be $556,310,861 (State $492,656,834, and University of Alaska $63,654,027). It is assumed to remain level each year thereafter.

   The FY 91 State TRS payroll, including the University of Alaska, is estimated to be $58,159,258 (Department of Education and Legislature

$5,673,729, and the University of Alaska $52,485,529). TRS salaries are also assumed to remain level each year thereafter.

The FY 91 increases in costs to the State due to retirement contributions of $1,789.6 is calculated as follows:

Estimated State PERS FY 91 payroll . .	$492,656,834	
PERS contribution rate increase . . .	.297%	
FY 91 State Total PERS cost		$1,463.2
Estimated University of Alaska PERS FY 91 payroll	$ 63,654,027	
PERS contribution rate increase . . .	.297%	
FY 91 University of Alaska Total PERS cost		$ 189.1
Estimated Department of Education/ Legislature TRS FY 91 payroll . . .	$ 5,673,729	
TRS contribution rate increase	.236%	
FY 91 Department of Education Total TRS cost		$ 13.4
Estimated University of Alaska TRS FY 91 payroll	$ 52,485,529	
TRS contributions rate increase . . .	.236%	
FY 91 University of Alaska Total TRS cost		$ 123.9
Total estimated State cost increase for FY 91 for retirement system contributions		$1,789.6

3. Political Subdivisior Active and Retiree Programs. In addition to the State cost, there would also be an increase in political subdivisions' contribution rate to the PERS by .297 percent of PERS payroll and school districts' contribution rate to the TRS by .236 percent of TRS payroll. The FY 91 PERS payroll for political subdivisions is estimated to be $358,420,788. The FY 91 TRS payroll for school districts is estimated to be $344,238,828. Salaries for both systems are assumed to remain level each year thereafter. The FY 91 increase in costs to these entities due to retirement contributions of $1,876.9 is calculated as follows:

Estimated political subdivision FY 91 payroll	$358,420,788	
PERS contribution rate increase . . .	.297%	
FY 91 political subdivision Total PERS cost		$1,064.5
Estimated school district FY 91 payroll	$344,238,828	
TRS contribution rate increase	.236%	
FY 91 school district Total TRS cost		$ 812.4
Total estimated FY 91 political subdivision and school district cost increase for retirement system contributions		$1,876.9

There would also be an increase to the health insurance premiums for active employees of political subdivisions and school districts that participate in the State sponsored health plan. The estimated FY 91 costs for these employees will increase by $74.6. This is calculated as follows by multiplying the estimated monthly increase per employee ($4.97) times the estimated number of employees (1,250) times 12 months.

Total health insurance increase for political subdivisions and school districts in FY 91 . . . . . $ 74.6

Increase in FY 91 Costs Due to Expanded Health Insurance

	Active Employees	Retirees	Total
State	$775.3*	$1,789.6	$2,564.9
Political Subdivisions and School Districts	$ 74.6*	$1,876.9	$1,951.5

* Shown as full year equivalent.

If this bill becomes law, the unfunded liability will increase by $4.6 million and the funding ratio will decrease by .3 percent in the TRS.

The unfunded liability will increase by $13.83 million and the funding ratio will decrease by .6 percent in the PERS.

STATE OF ALASKA
1989 LEGISLATIVE SESSION

FEB 0 1 1989

Bill Version: SB 36
Publish Date:

FISCAL NOTE

REQUEST:

Revision Date:
Title: An Act relating to insurance coverage for mental/nervous conditions
Sponsor: Faiks
Requestor:

Agency Affected: Department of Administration
BRU: Retirement and Benefits
Components: Retirement and Benefits

EXPENDITURES/REVENUES: (Thousands of Dollars) + 20% year 1

OPERATING	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

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

POSITIONS:

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

ANALYSIS: (Attach a separate page if necessary)

This bill will not result in additional operations cost for the Division of Retirement and Benefits.
THIS BILL IS ESTIMATED TO COST ALL STATE AGENCIES $2,696.2 IN INCREASED PERSONAL SERVICES COSTS. THIS BILL IS ESTIMATED TO COST SCHOOL DISTRICTS AND OTHER PARTICIPATING POLITICAL SUBDIVISIONS $2121.2 IN FY 90. See pages 2 and 3 for a detailed analysis.

Prepared By: Sally Smith, Director Sally Smith Phone: 465-4470
Division: Retirement and Benefits Date: 1-31-89

Approved by Commissioner: John M. Andrews Date: 2/1/89
Agency: Department of Administration

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

Fiscal Note/ Analysis
Dept. of Administration

8/6K2/012603-9

Rev: 12/16/88

This analysis assumes a continuation of the full coverage of unlimited inpatient treatment rather than imposing the 45 days per year minimum as outlined in the bill. It also assumes the imposition of a $2500 annual maximum on outpatient treatment as a "reasonable" contract limitation. There is currently no limitation on the number of hours of outpatient treatment or office visits. This is more liberal than the minimum of 50 hours outlined in the bill. We have also assumed no additional increase in the future since the plans' experience will dictate any changes.

The analysis consists of three separate components. There is a summary of costs at the end of the analysis. The first component addresses the direct increase to health insurance premiums for active State employees for an increased level of coverage. The second addresses the increased costs to the State due to increased contributions to the retirement systems. The third component addresses the increased costs to school districts and political subdivisions due to the increase in their contributions to the retirement systems and the direct increase to health insurance premiums for those entities participating in the State sponsored health plan.

Contributions to the retirement systems from employers would increase in order to actuarially fund the enhanced benefits in the retirees' health plan.

1. Active State Employee Program. Health insurance premiums for active State employees are estimated to increase $4.97 per month per employee, effective February 1, 1990. For purposes of this analysis we have assumed no additional increase in the future. The total FY 90 increase in costs for active State employees is estimated to be $323.1. This is calculated by multiplying the estimated number of employees each month times $4.97 times 5 months. The full year equivalent (FY 91) of this increase is $775.3.

   Total full year equivalent increase for
   active employee health insurance $775.3

2. Retiree Program. This bill is estimated to result in an increase to the State's cost by .34% of the PERS payroll and .27% in the TRS payroll. The FY 90 State PERS payroll, including the University of Alaska is estimated to be $521,208,708 (State $463,907,093; and University of Alaska, $57,302,615.) It is assumed to remain level each year thereafter.

   The FY 90 State TRS payroll, including the University of Alaska, is estimated to be $55,085,786 (Department of Education, $5,025,700; and the University of Alaska, $50,060,086). TRS salaries are also assumed to remain level each year thereafter.

The FY 90 increase in costs to the State due to retirement contributions of $1,920.9 is calculated as follows:

Estimated State PERS FY 90 payroll	$463,907,093	
PERS contribution rate increase	.34%	
FY 90 State Total PERS cost		$1,577.3
Estimated University of Alaska PERS FY 90 payroll	$57,301,615	
Pers contribution rate increase	.34%	
FY 90 University of Alaska Total PERS cost		$ 194.8
Estimated Department of Education TRS FY 90 payroll	$ 5,025,700	
TRS contribution rate increase	.27%	
FY 90 Department of Education Total TRS cost		$ 13.6
Estimated University of Alaska TRS FY 90 payroll	$ 50,060,086	
TRS contributions rate increase	.27%	
FY 90 University of Alaska Total TRS cost		$ 135.2
Total estimated State cost increase for FY 90 for retirement system contributions		$ 1920.9

3. Political Subdivision Active and Retiree Programs. In addition to the State cost there would also be an increase in political subdivisions' contribution rate to the PERS by .34% of PERS payroll and school districts' contribution rate to the TRS by .27% of TRS payroll. The FY 90 PERS payroll for political subdivisions is estimated to be $354,521,366. The FY 90 TRS payroll for school districts is estimated to be $339,201,043. Salaries for both systems are assumed to remain level each year thereafter. The FY 90 increase in costs to these entities due to retirement contributions of $2121.2 is calculated as follows:

Estimated political subdivision FY 90 payroll	$354,521,366	
PERS contribution rate increase	.34%	
FY 90 political subdivision Total PERS cost		$ 1205.4
Estimated school district FY 90 payroll	$339,201,043	
TRS contribution rate increase	.27%	
FY 90 School district Total TRS cost		$ 915.8
Total estimated FY 90 political subdivision and school district cost increase for retirement system contributions		$ 2121.2

There would also be an increase to the health insurance premiums for active employees of political subdivisions and school districts that participate in the State sponsored health plan. This increase would not take effect until FY 91 since the health contract is not renewed until that date. The estimated FY 91 costs for these employees will increase by $104.3. This is calculated as follows by multiplying the estimated monthly increase per employee ($4.97) times the estimated number of employees (1750) times 12 months.

Total health insurance increase for political subdivisions and school districts in FY 91	$ 104.3

Increase in FY 90 Costs Due to Expanded Health Insurance

	Active Employees	Retirees	Total
State	$775.3*	$1920.9	$2696.2
Political Subdivisions and School Districts	104.3**	2121.2	2225.5

* Shown as full year equivalent
** Shown as full year equivalent. No increase for FY 90

If this bill becomes law, the unfunded liability will increase by $5.3 million and the funding ratio will decrease by .4% in the TRS.

The unfunded liability will increase by $15.8 million and the funding ratio will decrease by .7% in the PERS.

Allen Price
3661 Hazen Circle
Anchorage, Alaska 99515

MAR 0 9 1989

March 5, 1989

Senator Paul Fischer
Chairperson, HESS
Post Office Box V
Juneau, Alaska 99811

Re:S.B. 36

Dear Senator Fischer,

This letter concerns S.B. No. 36. and the possible inclusion of Pastoral Counselors in that bill. Representative Barnes' office may have sent material to you concerning Doctor's degrees in Pastoral Counseling and Psychotherapy and how this is of interest to the consumer in Alaska.

Pastoral Counselors are listed in the Bill on page 3, line 21. I would like to see (9) (F) added after (9) (E) (ii) which would read: "a person certified as a member of the American Association of Pastoral Counselors and who has a masters or doctors degree in pastoral counseling. There would also be an addition after (10) (B) (v) which would be (10) (B) (vi) which would read: "a person certified as a member of the American Association of Pastoral Counselors and who has a masters or doctors degree in pastoral counseling and psychotherapy.

I appreciate your help in this matter. If your office needs additional information or clarification, please contact me at (907) 563-4325 or at my home, 344-6078

My name may ring a bell with you as I worked with you and your wife in your shop in Soldotna when I worked for Community and Regional Affairs of the State.

Cordially Yours,

Allen Price

Dave:
Put with bill
If it comes up again we can discuss this.

TO: Sen. Paul Fischer

FROM: Mel Krogseng, Professional Assistant
Rep. Ramona Barnes

DATE: 3/17/89

RE: SB 36 "An Act relating to insurance coverage for the treatment of a mental or nervous condition."

It has been brought to Rep. Barnes' attention that "pastoral counselors" have not been included in SB36. We have received correspondence requesting an amendment to the bill to include pastoral counselors. Since this is a Senate Bill and is in the Senate HESS Committee, Rep. Barnes request that you address this issue when the bill comes up before the committee.

Attached you will find a letter from Allen Price outlining the changes requested. Mr. Price has stated to me he would like to see members of the American Association of Pastoral Counselors included.

In reading the General Information Brochure from the American Association of Pastoral Counselors, it appears that adequate training is required for membership.

If you have any questions, please call me or call Mr. Price at 344-6078 or 563-4325. Thanks for you help.

Allen & Nancy Price
3661 Hazen Circle
Anchorage, Alaska 99515

February 16, 1989
Honorable Ramona Barnes
Post Office Box V
Juneau, Alaska 99811

Dear Representative Barnes,

I am writing this letter as a follow up of a conversation by phone that I had with your office yesterday. It concerned S.B. 36 and the American Association of Pastoral Counselors as sighted in (8) of that bill.

I would also like to see "pastoral counseling" added to (9) (D) of S B. 36 after "or doctoral degree in..." Also, "pastoral counseling" could be added to (10) (B) (iv) after "doctoral degree in..."

As I discussed with one of your staff last year, pastoral counselors, members of AAPC, must have a bachelor's degree, a three years master's degree, and hundreds of hours of supervision in individual, couple, family and group counseling. They are also required to have continued supervision by qualified professionals. This insures the public of quality service delivery. It also gives the consumer the option of getting service with a person who will respect and often use faith as an adjunct to therapy. As you might imagine, this is particularly important when it comes to the healing of a parent's children in stress.

I appreciate your help, and wisdom, in the matter. If your office needs additional information or clarification, please contact me at (907) 563-4325 or 344-6078.

Cordially yours,

Allen Price

AMERICAN ASSOCIATION

OF PASTORAL COUNSELORS

General Information Brochure

on

Individual Membership & Affiliation

SPRING 1988

AVAILABLE AAPC MATERIALS

Copies of the following materials can be obtained prior to membership application; however, these materials are included in the application kit requested below:

(CHECK ONLY IF NOT REQUESTING APPLICATION KIT)

[ ]	Handbook	$ 3.00
[ ]	Directory.	$10.00
[ ]	Annual Newsletter Subscription . .	$10.00
[ ]	Membership Committee Operational Manual	$ 5.00

To obtain application materials for membership or affiliation in the American Association of Pastoral Counselors, complete the following form and mail with a check for $30.00 to:

American Association of Pastoral Counselors
9508A Lee Highway
Fairfax, VA 22031

(CHECK ONLY ONE)

Certified: [ ] Member [ ] Fellow [ ] Diplomate

Affiliates: [ ] Pastoral [ ] Professional

[ ] Pastoral Counselor-in-Training

[ ] International

(PLEASE TYPE OR PRINT CLEARLY)

NAME _____

ADDRESS _____

_____

_____

PHONE (____)_____

PROCESSING FEES AND DUES*

Processing Fees must accompany completed applications as follows:

Diplomate	$300**
Fellow	$150
Member	$150
Pastoral Counselors-in-Training	$ 50
Pastoral Affiliate	$ 50
Professional Affiliate	$ 50
International Affiliate	$ 25

Annual Dues

Diplomate	$190
Fellow	$150
Member	$110
Pastoral Counselors-in-Training	$ 36
Pastoral Affiliate	$ 36
Professional Affiliate	$ 58
International Affiliate	$ 18

*Processing fees and dues change periodically. It is suggested you write/call the Association Office if this booklet is more than one year old.

**This may be paid in two installments; $150 at time application is submitted and $150 prior to meeting with the Association Membership Committee.

CONTENTS

INTRODUCTION

The American Association of Pastoral Counselors was formally organized in 1963 to advance the purposes of pastoral counseling within the religious communities and the field of mental health in the United States and Canada. Setting standards, establishing criteria and providing certification for pastoral counselors were the first major tasks of the Association.

What follows is general information about AAPC in an abbreviated form. The Handbook and Membership Committee Operational Manual contain more detailed information and are included with the application kit.

PURPOSES AND ORGANIZATION OF AAPC

The AAPC Constitution promotes the following purposes:

(1) Ministry of pastoral counseling;
(2) Exploration, clarification and guidance of human life through a theological perspective;
(3) Professional competence, support and growth among pastoral counselors;
(4) Improved pastoral care by ministers;
(5) Relationships with ecclesiastical and interprofessional groups.

To fulfill these purposes the AAPC is organized into the following nine Standing Committees:

Centers and Training Committee	Ethics Committee
Legal Concerns Committee	Finance Committee
Nominating Committee	Membership Committee
Professional Concerns Committee	Research Committee
Theological and Social Concerns	

The AAPC is organized into ten regions:

NORTHEAST

Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut, Nova Scotia, New Brunswick, Prince Edward Island, New Foundland, Quebec

DEADLINES

Applications are reviewed twice a year. Completed applications **must be** received **in the Association Office** by:

July 1 - Processed in the Fall (September to November)

December 1 - Processed in the Spring (March to April)

Notification of decisions made on applications are forwarded in December after the fall processing and review and May after the spring processing and review.

CONSULTATIVE INTERVIEWS

Upon request, consultative interviews with the Regional Membership Committee may be provided for a fee of $150.00. (Submit payment to Association Office payable to AAPC.)

person may have the formal requirements for Fallow category but lacks the seasoning qualities that come from extended practice and experience.

Pastoral Affiliate level is for persons whose primary ministry is in the parish and who do not desire more formal training in pastoral counseling. These persons usually are looking for a means to be part of the mainstream of pastoral counseling, benefit from consultative support of experienced pastoral counselors and wish to participate in the meetings and committees of AAPC.

Persons who are uncertain for which category of membership/affiliation to apply, may consult with their Regional Membership Chairperson.

APPLICATION PROCESS AND PROCEDURES

1. Obtain the full application kit by completing the form contained in this pamphlet. The kit contains application forms, Membership Manual, Directory, Handbook, religious endorsement information, Newsletter and other pertinent information. **A $30 payment must accompany the request.**

2. Consult with the appropriate Regional Membership Committee Chairperson IF you require additional assistance with your application. (A list of Regional Membership Committee Chairpersons is enclosed.)

3. Send **ONE ORIGINAL and ONE COPY OF:** completed application, **REQUIRED** transcripts, current religious body endorsement, supervisor's reports, and any other supporting documents **AND APPROPRIATE PROCESSING FEE** as stated on page 11 to the Association Office.

4. Appear before the Regional Membership Committee for review (required for Certified Membership; optional for Affiliates except where required by particular regions).

EASTERN
New York, New Jersey, Ontario

ATLANTIC
Delaware, Pennsylvania, Maryland, Virginia, West Virginia, District of Columbia

SOUTHEAST
North Carolina, South Carolina, Georgia, Florida, Alabama, Mississippi, Tennessee

MIDWEST
Ohio, Kentucky, Indiana, Michigan

CENTRAL
Missouri, Kansas, Illinois, Wisconsin, Iowa, Minnesota, Manitoba

ROCKY MOUNTAIN-PLAINS
North Dakota, South Dakota, Nebraska, Montana, Wyoming, Colorado, Utah, Saskatchewan

SOUTHWEST
Arkansas, Louisiana, Oklahoma, Texas, New Mexico

PACIFIC
Arizona, Nevada, California, Hawaii

NORTHWEST
Idaho, Oregon, Washington, Alaska, Alberta, British Columbia, Yukon, Northwest Territories

ASSOCIATION OFFICE

The Association Office provides leadership and coordination for the AAPC. In 1979 it was relocated in the Washington Metropolitan Area and a full-time Executive Director employed. All inquiries may be directed to the **Association Office, AAPC, 9508A Lee Highway, Fairfax, VA 22031; telephone 703-385-6967.**

MEMBERSHIP AND AFFILIATION CATEGORIES AND REQUIREMENTS

Individual membership has three certified categories: Member, Fellow and Diplomate.

There are four categories of affiliates: Pastoral, Professional, International and Pastoral Counselor-in-Training.

Each membership and affiliate category has its own standards and criteria. This booklet briefly summarizes the purpose, criteria and benefits of each category.

CERTIFIED MEMBERSHIP

Each category of certified membership has explicit educational and training requirements,* an examination process for demonstration of competence and endorsement from the recognized religious body. Certified membership entitles a person to a vote on the policies, procedures, programs and business of the AAPC.

These requirements are set by the Bylaws of the Association, as follows:

Member

B.A. and M.Div. degrees from accredited schools; endorsement as a minister in good standing in a recognized religious body; continuing responsible relationship to local religious community; one unit of clinical pastoral education in an accredited center; three years as a minister, 375 hours of pastoral counseling together with 125 hours of supervision of that counseling, one-third of such supervision to have been with an AAPC approved Center for Training in Pastoral Counseling or from a Diplomate of the Association.

* Equivalencies for membership and affiliation have been established and are included in the Membership Committee Manual as part of application materials.

10. Participation in the international dimensions of pastoral care and counseling.

Certified pastoral counselors are increasingly recognized as professional mental health providers by governmental agencies and public and private health insurance carriers. The AAPC actively works with the complex issues surrounding such recognition. Both the right to practice as mental health professionals and the preservation of the unique integrity of pastoral counselors are under constant vigilance by the AAPC.

Above all, the benefit of membership and affiliation in AAPC is participation in the mainstream development and guidance of pastoral counseling as a field of religious ministry and mental health care.

SELECTING APPROPRIATE CATEGORY OF MEMBERSHIP/AFFILIATION

For persons who have no previous relationship with the AAPC, the usual entering categories are Pastoral Counselor-in-Training, Member or Pastoral Affiliate.

The Pastoral Counselor-in-Training is designed for persons who are in the process of supervision and course work in a pastoral counseling educational program, either in a center or in a school. This person may have some previous clinical experience but whose hours of focused work in pastoral counseling are just beginning. This category of affiliation gives the person access to the Membership Committee for consultation, support and information during the course of training as well as enjoyment of the activities and resources of the AAPC.

Member category is the usual entry point for persons seeking certification of pastoral counseling. A person applying for Member level needs the minimum formal requirements outlined above and is usually in continuing supervision and training. Those applying for Member category are persons who have recently completed a training program in Pastoral Counseling. Often a

BENEFITS OF MEMBERSHIP AND AFFILIATION

Each person entering membership or affiliation in the AAPC has some particular professional and personal motivation or objective. Beyond such particular personal desires, the following benefits are provided:

1. Subscription to the Journal of Pastoral Care, published quarterly in conjunction with the Association for Clinical Pastoral Education, Canadian Association for Pastoral Education, Association of Mental Health Clergy, College of Chaplains, National Institute of Business and Industrial Chaplains, Inc., Correctional Chaplain's Association and the AAPC.

2. Receipt of the Newsletter, published quarterly.

3. Information on employment and training opportunities throughout the United States and Canada.

4. Attendance at the Annual AAPC Convention, held in the spring.

5. Regional Conferences, usually held in the fall of each year.

6. Workshops and special interest meetings.

7. Optional--Professional Liability Insurance coverage for additional fee for all Association member/affiliate levels with exceptions of Canadian residents and Professional and International Affiliates--currently not eligible. Individuals not affiliated with the Association are ineligible. Information current as of 12/87.

8. Participation in the overall issues and purposes of the AAPC through Association and Regional Committees.

9. Ongoing involvement with professional relationships in the religious communities and mental health professions.

Fellow

All the requirements for Member plus: M.A., S.T.M., D.Min. or Ph.D. in pastoral counseling, demonstrated ability to work as a pastoral counselor at an advanced level of competency; 1,000 hours of pastoral counseling while receiving at least 125 hours of supervision (totaling 250 hours of supervision, 1,375 hours of counseling).

Diplomate

All the requirements for Fellow plus significant performance in at least three of the following -- academic achievement (Ph.D. or equivalent), research, publication, leadership in AAPC, teaching and/or supervising pastoral care and counseling or contributions to church and community; supervision of at least five candidates for membership for a minimum of 30 hours each, while receiving 50 hours of personal supervision for the 150 cumulative hours supervised.

The examination process for all levels of certified membership is a face-to-face appearance with a Regional Membership Committee. These committees request submission of clinical materials in preparation for the examination.

AFFILIATES

Pastoral Affiliate

B.A. and M.Div. degrees; religious body endorsement; three years as a minister; active in one's local religious community; consultative relationship with an AAPC Fellow or Diplomate or other consultant approved by the Association.

Professional Affiliate

Member of one of the helping professions and certification by that profession; an interest in pastoral counseling or pastoral counseling centers.

International Affiliate

Post-seminary training in pastoral counseling plus active involvement in a ministry of counseling; submission of a plan for professional development including pastoral consultation and professional affiliation.

Pastoral Counselor-in-Training

Persons beginning the educational process for certified pastoral counselor. Minimum requirements are: college undergraduate degree; minister in good standing or in process; endorsement from religious endorsing body; submission of a plan for completing certified membership requirements.

Affiliates are entitled to participate in the programs of AAPC but without vote in business matters.

ENDORSEMENT BY RELIGIOUS BODY

Religious body endorsement is a specialized process conducted by the applicant's religious body in which the applicant holds membership. The specific qualifications and procedures for endorsement vary with each religious body. The definition for minister is made by the applicant's religious body and may or may not include ordination. **NOTE:** Religious body endorsements may take a few months to obtain and in some cases require meeting with a committee. It is recommended that requests for endorsements be made well in advance of the due date for application to AAPC.

STANDARDS FOR CERTIFIED MEMBERSHIP

Evaluation of readiness for certified membership in AAPC is based upon two kinds of judgments. The first depends upon formal and technical requirements and can be demonstrated by academic degrees, hours of supervision, experience, supervisory evaluations, etc. The second is based upon the evaluations of one's professional peers joined in a committee interview and

involves assessment and affirmation of professional competence not measurable by formal requirements.

Educational preparation for certified membership should contribute to the pastoral counselor's training and develop a broad experience-related understanding of people. This should take place in a setting in which the pastor can relate theoretical knowledge to, and derive from, pastoral work with people, i.e., a setting in which both the school and practical situation are in mutual relation.

The following areas of study are considered important for the achievement of the educational objectives: Theories of Personality and Personality Development; Interpersonal Relations; Marriage and Family Dynamics; Group Dynamics; Personality and Culture; Psychopathology; The Psychology of Religious Experience; Theories of Counseling and Psychotherapy; Theories of the Pastoral Office including the History and Theory of Pastoral Care; Research Methods; Orientation to the Helping Professions. These studies are aimed toward the integration of theological and religious dimensions with the psychological understanding of persons.

CONTINUATION OF MEMBERSHIP AND AFFILIATION

The AAPC is committed to the continued growth and development of its members and affiliates. Continuing education and peer support are the major functions of the Professional Concerns Committee. Each year certified members are required to submit a written self-report on the educational and training activities which enhance his or her professional growth.

Certified members are expected to maintain an active pastoral counseling practice, participate in a responsible program of continuing education and maintain a consultative relationship with peers.

Membership and affiliation must be renewed annually by the payment of dues for the new fiscal year and by submission of required reports.

Individual Membership:

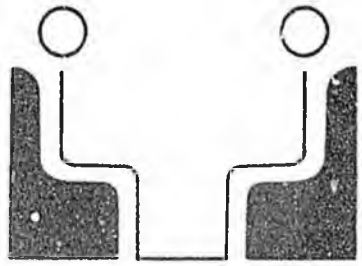
- Persons become members of AAPC through a process of consultation and review of academic and clinical education which leads to competent professional ministry. Categories of individual membership are:
  - Membership — Member, Fellow, Diplomate
  - Affiliation — Pastoral Counselor-in-Training, Pastoral Affiliate, Professional Affiliate, International Affiliate
- All individual members are held accountable to their faith group and to AAPC through:
  - The guidelines of continuing education
  - The Code of Ethics of the AAPC

Institutional Membership:

- Institutions which provide pastoral counseling service and education can become and remain members through regular review and adherence to the AAPC Code of Ethics as:
  - Pastoral Counseling Service Centers
  - Pastoral Counseling Training Programs
  - Pastoral Counseling Affiliate Centers
- All Institutional Members are held accountable to the sponsoring religious bodies.

AMERICAN ASSOCIATION OF PASTORAL COUNSELORS:
9508 A Lee Highway, Fairfax, Virginia 22031 • 703-385-6967

AMERICAN ASSOCIATION OF PASTORAL COUNSELORS



AMERICAN ASSOCIATION OF PASTORAL COUNSELORS:

- is an international organization of clergy and other religious-oriented professionals whose ministry is helping persons grow in times of life crises.
- is a membership organization of pastors, professional pastoral counselors, other helping professionals and the institutions which train and employ them.
- establishes standards for training and supervision in pastoral counseling which leads to certification of persons for competent practice as pastoral counselors and accreditation of institutions which provide counseling service and education.
- supports its members with opportunities for continuing education, professional dialogue and on-going consultation for growth in professional competency.
- represents its members in relationships with other professional organizations, denominations and faith groups, mental health associations and agencies of government.
- serves the public by ensuring consistent quality in counseling and psychotherapy which enhances personal and social growth toward wholeness.

The American Association of Pastoral Counselors was formally organized in 1963 in response to the need for leadership and standards for the involvement of religious organizations in mental health care. Since that time, the Association has provided clarity in pastoral counseling practice and training, criteria for religious institutions in pastoral counseling ministry and coordination with other mental health professions.

Today's **Pastoral Counselor** walks in the centuries old tradition of **shepherding.** The work of **Pastoral Care and Counseling** has been a vital heritage and today is of increasing importance.

The **age of anxiety** and mankind's **search for meaning** has given new impetus and urgency for training with a spiritual dimension to respond to these unfolding human crises. Two national studies within the past two decades have indicated that more people turn to the minister for help when facing personal problems than to any other professional.

The American Association of Pastoral Counselors welcomes inquiry from persons and institutions seeking information related to certification, accreditation, standards and the extensive work of the Association in the religious and mental health fields.

Major business of the organization is conducted through a Board of Governors composed of the officers, regional chairpersons and standing committee chairpersons.

Annual and Regional Conferences are held as are occasions for professional growth through major addresses, workshops, colleague dialogue and policy decision making.

Financing relies primarily on annual dues of the membership. The AAPC welcomes gifts and grants to further its work as a not-for-profit corporation.

The Association Office is administered through the **Executive Director** and staff at the **Fairfax, Virginia** location. **Inquiries about AAPC are welcome.** A directory, handbook and other additional materials are available at a nominal cost.

AAPC is at work in Local Communities. . .

- Helping persons discover and claim new opportunities and growth in the midst of personal, marital, family, religious, vocational or health crises.
- Serving persons in varied settings including pastoral counseling centers, local churches and synagogues, hospitals, seminaries and community mental health centers.
- Consulting with congregations and secular organizations which seek to become more authentic and humane.
- Providing both specialized in-service training and supervision in pastoral counseling.
- Developing constructive relationships with other helping professionals.

AAPC is at Work in Ten Regions

Nationally and Internationally. . .

- Offering vital continuing educational opportunities.
- Certifying ministers trained in pastoral counseling and participating in the certification of service centers and the approval of training programs.
- Encouraging networks of members for professional support and enrichment.
- Facilitating growth and innovation in the ministry of pastoral counseling throughout the United States and Canada and other countries.
- Promoting research in religion and mental health.

DOCTOR OF MINISTRY PROGRAM

Pastoral Counseling/Psychotherapy Track

A HANDBOOK

Office of Ministry Programs
Garrett-Evangelical Theological Seminary
2121 Sheridan Road
Evanston, IL 60201
312/866-3930

Allen D Price
B6 has a work.

HANDBOOK FOR
THE DOCTOR OF MINISTRY PROGRAM
PASTORAL COUNSELING TRACK
GARRETT-EVANGELICAL THEOLOGICAL SEMINARY

I. INTRODUCTION

The Doctor of Ministry is a professional degree program designed to facilitate a high level of competence in the practice of ministry, with special emphasis on pastoral counseling. The goals of the program are:

(1) To provide training leading to a growing understanding of and high level of competence in the theory and practice of pastoral counseling.

(2) To integrate the Biblical, theological and historical resources of the Christian tradition with current theory from the behavioral sciences as basis for improved performance in the practical skills of pastoral counseling.

(3) To encourage fraternal collaboration, conjoint leadership, and mutual accountability of learning through a climate of collegiality and partnership in learning.

(4) To make possible personal assessment and growth in the areas of clarification of vocational identity, renewal of personal faith, self-understanding, and self-directed learning.

The degree is an "in-ministry" program, with applicants to have a minimum of three years of post-M.Div., full-time experience in the field prior to entering the program. It is conducted on a contractual basis with selected Pastoral Counseling Centers, which provide supervised training in clinical skills and the context and structures for support, practice, and evaluation. These Centers are:

Pastoral Psychotherapy Institute
Parkside Human Services Corporation, Lutheran General Medical Center
1580 North Northwest Highway, #111
Park Ridge, IL 60068 Phone: 312/696-6023
Bonnie Niswander, D.Min., Director of Psychotherapy Training

The Pastoral Counseling and Consultation Centers of Greater Washington
3000 Connecticut Avenue, N.W.
Washington, DC 20008 Phone: 703/281-1870
H. Rodney Landes, Ph.D., Director of Professional Training

Indiana Counseling and Pastoral Care Center, Inc.
1717 West 86th Street, Suite 130
Indianapolis, IN 46260 Phone: 317/872-3141
Brian W. Grant, Ph.D., Training Director

Interfaith Counseling Service, Inc.
3421 North Hayden Road
Scottsdale, AZ 85251 Phone: 602/994-1329
H. Terry Kriesel, Ph.D., Executive Director

Ecumenical Center for Religion and Health
4507 Medical Drive
San Antonio, TX 78229 Phone: 512/696-9966
Homer A. Bain. Ph.D., Director of Training

Texas Research Institute for Mental Sciences
Pastoral Counseling Training Program
1300 Moursund
Houston, TX 77030 Phone: 713/797-1976 ext. 368
William D. Tallevast, Th.M., Morris Taggert, Ph.D.

Virginia Institute of Pastoral Care
Box 5184, 507 N. Lombardy Street
Richmond, VA 23220 Phone: 804/359-4321
W. Victor Maloy, D.Min., Director of Education

Des Moines Pastoral Counseling Center
632 Woodland Terrace
Des Moines, IA 50309 Phone: 515/288-6728
J. Jeffrey Means, Ph.D., Director of Training and Education

Illinois Pastoral Services Institute
702 North East Street
Bloomington, IL 61701 Phone: 309/827-5051
Clyde Getman, D.Min., Director of Training

Participants are to be staff counselors in one of these centers and will receive supervised clinical training and some didactic course work in that context. The remainder of the course work in pastoral psychology and counseling and all their study in the classical fields, as well as the ultimate guidance of the research project is done through the Seminary, in a combination of on-campus seminars, directed studies by correspondence, and individual consultations with faculty. Although the program design has a set structure, sufficient flexibility is allowed for each participant to build some aspects of his/her program around personal and professional needs and goals.

The program must be completed in no less than two and one-half years and no more than five and one-half years from the time of attendance at the first seminar. Any participant who withdraws, is asked to leave, or does not complete the program within this time, may be given a Certificate for Pastoral Leadership Development, in recognition of the amount and nature of work completed satisfactorily. This Certificate is granted only to persons who have completed at least two three-week seminars, one Directed Study (two papers), and one full year of clinical and didactic training in a cooperating Pastoral Counseling Center.

This is a competency-based degree program, with growth in competence measured by Seminary faculty, Center supervisors, and fellow participants, as a means of assessing progress toward and readiness for admission to candidacy and the granting of the degree. The high level of competence expected of a Doctor of Ministry in pastoral counseling is defined as: satisfactory completion of all components of the program, as determined by Seminary faculty, and qualification to make application for at least the Fellow level of the American Association of Pastoral Counselors, as determined by Seminary faculty and Center supervisors.

II. EDUCATIONAL PHILOSOPHY

A. Holistic Approach. The program makes full use of the biblical, theological, and historical resources of the Christian tradition, as well as current theory from the behavioral sciences. Such theoretical studies are utilized in an integrative, inter-disciplinary approach to the practice of ministry, which balances an understanding of foundations with the development of counseling skills. Each of the learning experiences which make up the program is guided by leadership teams made up of persons representing both the theoretical and the practical competence necessary to insure such an holistic approach.

B. Areas of Competence. As a competency-based program correlated with the standards for professional practice, the Doctor of Ministry takes into account the qualifications established by the American Association of Pastoral Counselors, and has expanded upon these as follows:

1. Personal Identity and Interpersonal Competence--awareness of self, of internal dynamics and interpersonal relationships, and capacity for flexible and effective relatedness to others.

2. Academic and Theoretical Competence--knowledge of theological and behavioral sciences and their integration at both theoretical and operational levels. This includes knowledge of theories and perspectives in the following areas: Bible, theology, church history, ethics and society, personality and personality development, interpersonal relations, marriage and family dynamics, group dynamics, personality and culture, psychology of religious experience, counseling and psychotherapy, pastoral care, and personality assessment.

3. Pastoral Identity--ability to see one's pastoral role in its ecclesiastical and interprofessional contexts, and to function with integrity in that role.

4. Therapeutic Competence--ability to assess a client's therapeutic need, to establish a therapeutic relationship, and to conduct, complete, and evaluate that therapy.

5. Ethical Commitment--understanding of and assent to standards of professional ethics, as well as commitment to such basic values as respect for the worth and rights of persons as creatures of God.

6. Research Design and Methodology--ability to understand research reports, to apply research conclusions to one's practice of pastoral counseling, and to design, carry out, and evaluate an empirical research project of limited scope and complexity.

C. Collegiality and Accountability. Assuming that a professional style of ministry involves mutual collaboration, reciprocal accountability, and shared learning, the program structures these elements into the process at every step of the way. Specifically, the participant is responsible to the Seminary, the Pastoral Counseling Center, and peers in the profession. These various agencies are also accountable to the participant to contribute to his/her learning, growth,

and professional development. These accountabilities are expressed through the D.Min. Committee, Core Faculty Team, Colleague Group, and Advisory Team.

D. Contextual Focus. The locus for learning in this program is the actual place of the participant's ministry--the Pastoral Counseling Center, which provides opportunity for clinical practice and supervision, didactic training, and peer support and accountability.

E. Conjoint Leadership. Seminary, clinical, and other academic faculty, as well as the participants themselves, are all seen as resources for learning. Each has knowledge and expertise that the others lack, and is utilized at appropriate points in the learning process. Serving as Faculty Adviser or Consultant, as Adjunct Faculty, as teachers of seminars and directed studies, as members of the Colleague Group and Advisory Team, or as special resource persons, each contributes from his/her vantage point or area of competence to one or more of the following stages of the program: assessment, goal-setting, design, coordination, training, supervision, consultation, leadership of seminars, development of Research Project, evaluation. All are both teachers and learners in the program, with the result that not only do participants develop in professional competence, but others on the leadership teams also experience growth and the Centers themselves are enriched.

F. Personal Formation. A strong emphasis is placed on the minister as person. The program is designed no merely to facilitate acquisition of knowledge and skills, but also to contribute significantly to personal growth. One aspect of this is the renewal of faith. Once the participant's needs and desired directions of growth in this area have been assessed, a program of reading, journal reflection, consultation with faculty, and exposure to other resources and experiences, is developed accordingly. Another aspect is the stress on self-understanding, vocational identity, and the utilization of oneself as a resource for ministry. A third aspect is the effort to enable the participant to become a self-directed learner. The program asserts that ministers can and should become self-reliant learners who are not dependent on schools for their continuing education, but rather can identify their needs, set learning goals, and find the resources to achieve them. Hence, the participant is the key person in designing and implementing a program tailor-made to his/her own beginning level of competence, desired directions of growth, needs and goals, and particular context for ministry. Personal growth is thus achieved as participants are empowered to become perpetual self-initiated learners.

G. Flexibility. The design of this program is predicated on the principle that form should follow function in the learning process. The participant's awareness of need for knowledge, skills, or personal growth in faith, self-understanding and competence, becomes the organizing principle around which the specific design of his/her program is shaped. Hence, although certain aspects of the program structure--such as the intensive seminars, the papers and Research Projects and Directed Studies--are fixed for all participants, there is ample flexibility within each of these components and within the program as a whole for developing an individualized program to meet the specific needs and goals of each participant.

H. Practice-Reflection. Learning in this program takes place as participants carry on their counseling practice under supervision, and engage

in regular theological reflection on their experience. Reflection on practice takes place through the writing and discussion of case studies, Colleague Group meetings, Advisory Team meetings, consultations with faculty, and the carrying out and reporting of the Research Project. The mid-program Identity Paper, describing the participant's developing theology and style of ministry, provides a major opportunity for theological reflection on one's practice of ministry. By inter-relating Biblical and theological themes with professional practice through a process of disciplined reflection, the program encourages the participant to incorporate this approach as a permanent aspect of his/her style of ministry.

III. THE ADMISSIONS PROCESS

A. Objectives. The admissions process is designed to:
1. Assist the applicant in thinking through and clarifying his/her own personal and professional goals and in developing plans and procedures for achieving them.
2. Determine whether the applicant has the capability, resources, and motivation to learn and achieve his/her goals through this program.
3. Determine whether and how Seminary resources may be utilized to assist the applicant in achieving his/her goals, within the limits of the program format.
4. Determine whether the applicant has the personal and professional capability for developing the clinical skills expected in the program, and whether s/he possesses the personal, interpersonal, clinical, and intellectual resources to do doctoral level work in pastoral counseling.
5. Link the applicant with appropriate faculty and other resources in the Seminary and a competent and supportive Advisory Team, and to begin building a working relationship among these key actors in his/her program.
6. Generate data from the applicant's participation in the entry phases of the program on which the D.Min. Committee may base a final decision on admission.

B. Criteria. Decisions on admission are based on the following criteria:
1. Academic/cognitive.
   a. Capacity to integrate theological and behavioral understandings with the practice of ministry.
   b. Capacity for clear articulation of goals.
   c. Capacity for self-directed learning.
   d. The minimum standard for admission is the M.Div. degree or equivalent from an accredited seminary with a Grade Point Average of 3.0 or equivalent, or a satisfactory score on the Weschler Adult Intelligence Scale (WAIS). The Minnesota Multiphasic Personality Inventory (MMPI), or other relevant data may be required.
2. Professional and performance.
   a. Degree of competence, capacity for growth, and openness to learning in both theoretical and clinical dimensions of training in pastoral counseling.
   b. A minimum of three years of full-time, post-M.Div. experience in ministry.
   c. Extent of openness to and participation in continuing education experience since seminary.
   d. Capacity for peer accountability.
      1) Ability to learn from colleagues in a peer setting.
      2) Ability to give and receive criticism and support from peers.
   e. A clear and growing sense of pastoral identity.
   f. A minimum of two quarters of Clinical Pastoral Education (or clinical equivalency).
   g. Ability to meet the standards for membership in the American Association of Pastoral Counselors in the following areas:
      (1) Educational Requirements
      (2) Requirements for Clinical Work Under Supervision
      (3) Requirements for Personal Therapeutic Experience
      (See AAPC Handbook, pages 29-31, for the detailed aspects of this criterion.)

3. Personal and psychological.
   a. Trainability, teachability, capacity for studenthood, capacity to learn and grow.
      1) Is the timing right? Is the person able at this juncture to assimilate new learning and growth?
      2) Is s/he integrated enough to be able to devote his/her energies to meet the demands of the program?
   b. Affective capacity; extent of being in contact with one's own emotionality.
   c. Degree of awareness of one's strengths and weaknesses.
   d. Capacity to work within the parameters of the program - to be "back in school," meet the additional time demands, benefit from clinical training.
   e. Capacity to think theologically about one's self and work; ability to reflect on, make meaning of, and communicate one's own experience.
   f. Capacity to "be with" other persons, to establish and maintain growing relationships.
   g. Degree of intentionality, sense of direction and purpose.
   h. Degree of being in touch with one's own struggles with life issues, ultimate questions, and personal and Christian identity.
   i. Capacity for self-evaluation.

C. Procedure. Admission to the program is granted to a prospective participant upon satisfactory completion of the following application steps and requirements:

1. The applicant seeks admission to the training and service delivery program at one of the cooperating Pastoral Counseling Centers and becomes accepted for clinical training, which includes the delivery of pastoral counseling services as a counseling staff member at that center.
2. The applicant submits an application form secured from the Seminary accompanied by the following supporting information and documents:
   a. All college, seminary, and graduate school transcripts.
   b. The names of three references:
      1) A seminary professor who knows the applicant's academic work and potential well;
      2) A denominational judicatory official (District Superintendent, Board of Ministry member, executive of endorsing body, etc.) who knows the applicant's present parish work and professional competence well;
      3) The Director of Training of the Center to which application is being made, who can certify that the applicant meets the standards for membership in the AAPC, report on the applicant's acceptance into that training and service delivery program, and communicate the Center's recommendation regarding the applicant's participation in the D.Min. program.
   c. A $25 application fee, which is non-refundable.*
   d. A Statement of Purpose indicating the applicant's reasons for wishing to enroll in the program, projected vocational and learning goals, and possible Research Project.

e. A Professional Identity Paper of 1500-3000 words, including the following:
   1) Applicant's present understanding of him/herself as a person, a Christian, and a clergyperson;
   2) Formative experiences which have shaped applicant's development;
   3) Case material from applicant's practice of ministry with theological reflection on this;
   4) Theological themes of special meaning to applicant;
   5) A statement regarding the fundamental theological and social issues which the applicant feels are crucial to ministry in today's church and world;
   6) Current areas of significant growth, searching, and needed development;
   7) Crises in faith and living;
   8) Satisfying and frustrating experiences in ministry;
   9) Assessment of personal strengths and shortcomings;
   10) Significant characteristics which make the applicant who s/he is.

f. A sermon or detailed outline of a Bible study course developed by the applicant, which deals responsibly with the exposition of a Biblical text.

g. An annotated bibliography of books or resources which the applicant has found stimulating in ministry since seminary.

3. On the basis of these written data, action on "Preliminary Admission" is taken by the D.Min. Committee, on recommendation of the pastoral psychology faculty. The deadline for receiving the completed application is April 15, and the applicant is notified by the Director of Admissions by June 1.

4. The Coordinator of the Pastoral Counseling track and/or a faculty member of the Pastoral Psychology faculty of Garrett-Evangelical visit the Center where the applicant is in training for an extensive interview and consultation with the applicant and the Director of Training/ Adjunct Faculty member there. The purposes of this consultation are to: a) interpret and clarify the D.Min. program and the interface of the Center and Seminary in its implementation; b) clarify the roles and responsibilities of the applicant's program; c) organize the applicant's Advisory Team; d) identify the applicant's learning goals and how s/he intends to pursue these through the components of the program, particularly the Research Project; e) develop a Learning Contract to which all present can agree.

5. On the basis of this consultation, the Coordinator of the Pastoral Counseling track: a) makes a recommendation to the D.Min. Committee regarding Final Admission, and b) enlists a Faculty Advisor for the applicant.

6. Final admission is contingent upon the acceptance of the Learning Contract by the D.Min. Committee and the agreement of the Faculty Advisor and the Coordinator of the Pastoral Counseling track, which may require personal conferences on campus between the applicant and the faculty involved.

IV. STRUCTURE

In recognition of the fundamental corporate nature of Christian existence, as well as the empirical evidence that personal growth and learning are best facilitated and sustained in and through support systems, this program involves the Participant in a network of learning and support communities. The following groups are involved in the ways specified:

1. DOCTOR OF MINISTRY COMMITTEE

This Committee has general oversight of the program, and is responsible to the Seminary faculty. It is made up of: President (ex officio), Dean (ex officio), Director, Coordinators of the tracks, three faculty members appointed by the President; Participants elected from each of the tracks, a representative of the D.Min. alumni (chosen by the Committee), and a United Methodist layperson (chosen by the Committee).

The Committee meets at least once a quarter to make policy decisions, advise on administrative matters, review applications for admission, and make recommendation of Participants to the faculty for Admission to Candidacy and the granting of degrees. Only faculty members vote on matters of admission, Admission to Candidacy and granting of degrees. The faculty members of the Committee may meet on call between quarterly meetings to act on necessary business. Minutes of these meetings are submitted to the full Committee for confirmation at regular meetings.

2. FACULTY MEMBERS

During the Admissions Process, the Participant, in consultation with the Coordinator, selects a Faculty Advisor to resource his/her learning goals, in cooperation with the Adjunct Faculty/Training Director of the Pastoral Counseling Center.

The Faculty Advisor is a member of the Pastoral Psychology department of the Seminary faculty. S/he normally attends Advisory Team meetings on site, when possible, reads and evaluates all major papers including the Mid-Program Professional Identity Paper, chairs the Mid-Program Evaluation Conference, serves as primary resource person on the Research Project, reads and evaluates the Research Project Report and chairs the Oral Defense, and oversees the Participant's progress in development of clinical skills in consultation with the Training Director of the Center.

The Coordinator of the Pastoral Counseling track is also a member of the Pastoral Psychology faculty, who is responsible to administer this aspect of the D.Min. program.

The Director of Training at the Pastoral Counseling Center serves as an Adjunct Faculty member of the Seminary and gives direct and continuous oversight to the Participant in the clinical aspects of the program, providing linkage to the Seminary through frequent consultation with the Faculty Advisor. S/He also reads and evaluates the Mid-Program Professional Identity Paper and Research Project Report, participates in the Mid-Program Evaluation Conference and the Research Project Oral Defense, and monitors the Participant's progress in all aspects of the program.

3. ADVISORY TEAM

The Advisory Team is made up of the Faculty Advisor, the Pastoral Counseling Track Coordinator, the Adjunct Faculty/Training Director of the Center who normally serves as chairperson, other Center staff related to the Participant in a supervisory or training capacity, and such other persons as may be considered by the Participant and Team to have a useful contribution to make to his/her learning. The function of the Team is to guide, oversee, support, and evaluate the Participant's performance and progress in the program. The Team meets at least once per year. The agenda is made up of some or all of the following components: (1) sharing of personal and program concerns and progress; (2) consideration of faculty evaluation sheets from the previous seminar; and (3) a review of each Participant's progress in the program, including work at the Center, work at the Seminary, and the Research Project. The Track Coordinator (and whenever possible the Faculty Advisor) will attend a minimum of one Team meeting a year to provide linkage between Seminary and Center.

V. CURRICULUM

The program consists of the following prescribed components, in most of which there is latitude for participants to negotiate with the faculty responsible in order that the experience may contribute directly to their individual program goals and learning objectives as far as is possible within the mandatory parameters of requirements for the degree.

1. Two three-week on campus thematic seminars, normally held in January. The themes on alternate years are "Faith Resources for Ministry" and "The Nature and Practice of Ministry." Preparatory readings are assigned in advance for these seminars. (Shared jointly with participants in the other tracks.)

2. Directed Studies in each of these two thematic areas, which are reading and research courses normally completed at home in the five months immediately following each January seminar, and sent to the Seminary for evaluation by the faculty teaching team. (Shared jointly with participants in the other tracks.)

3. Four functional seminars, held on campus, focusing on the theory and practice of pastoral counseling. Two of these are offered as intensive workshops during the January seminars. The other two are given over a three-week span in late June and early July during each of two consecutive years. The themes and rotation of these seminars are as follows:

Year A.	January -	Pastoral Theology: Theory and Practice (historical and systematic with case applications)
Year A.	June-July -	Religious Issues in Pastoral Diagnosis and Psychopathology Pastoral Assessment Pastoral Psychotherapy Delivery Systems
Year B.	January -	Psychology of Religious Experience (theories of personality)
Year B.	June-July -	Pastoral Psychotherapy and Value Systems (culture and personality) History of Pastoral Care and Counseling

The seminar on Research Design and Methodology is offered annually. It is open to all students in this track, including those wishing to repeat it, and to participation by the Directors of Training in the cooperating Centers.

4. Directed Studies for each of these functional seminars, with readings, research, and papers to be assigned by the faculty involved, to be completed either before or after the seminar by target dates to be set by faculty and class.

5. Ongoing Journal reflections (optional) in preparation for writing the Mid-Program Professional Identity paper.

6. Participation in the ongoing didactic and clinical training program of the Center, as specified in the Learning Contract. Normally, didactic course work is offered by the Center in the following areas: Theories of Personality and Personality Development, Marriage and Family Dynamics, Group Therapy, Psychopathology, and Theories of Counseling and Psychotherapy. The clinical program of the Center will meet the requirements of the American Association of Pastoral Counseling for clinical work under supervision, personal therapeutic experience, and orientation to the helping professions.

7. A Mid-Program Professional Identity Paper, which is a major integrative paper combining learnings gained from participation in all aspects of the program to date, case material from the Participant's pastoral counseling ministry, an update on all elements of the first Professional Identity Paper submitted during the application process, a description and rationale for one's style and approach to pastoral counseling, and a systematic theological reflection on one's current practice of pastoral counseling. This paper is read and evaluated by the Adjunct Faculty/Training Director, the Track Coordinator, the Faculty Advisor, and one other faculty member.

8. Participation in the Mid-Program Evaluation Conference, which is normally held after the participant has completed two three-week on-campus Seminars and the corresponding Directed Studies, and one year of clinical and didactic training at the Center. In this Conference, the Participant's Mid-Program Professional Identity Paper, Research Project Proposal, and overall progress in the program at both Center and Seminary are discussed and evaluated. This Conference is held at the Seminary, and is attended by the Participant, the Adjunct Faculty/Training Director of the Center, the Coordinator of the Pastoral Counseling track, the Faculty Advisor, and one other faculty member enlisted by the Coordinator in consultation with the Participant.

9. Admission to Candidacy is granted by the faculty after successful completion of the Mid-Program Evaluation Conference, upon recommendation of the Evaluation Conference Committee (see #8 above) and the D.Min. Committee. Steps leading to Admission to Candidacy must be initiated within two and one-half years of attendance at the first seminar.

10. An empirical Research Project in some area of pastoral psychology and counseling, with adequate grounding in relevant theory and theology, to be developed and carried out in consultation with the Adjunct Faculty/Training Director, Track Coordinator, and Faculty Advisor. This project is to be evaluated, written up in a Research Project Report, and defended before the Advisory Team and a faculty committee. Guidelines for the Research Project and Report are found in Section VI of this Handbook.

11. Regular meetings with one's Advisory Team.

VI. THE RESEARCH PROJECT (AND RESEARCH PROJECT REPORT)

A. Nature and Purpose. The Research Project is conceived as an effort in creative ministry, to be developed and carried out in relation to the Participant's context of ministry, and taking a significant approach to a problem or area of study related to the theory and/or practice of pastoral counseling. It is a demonstration of the Participant's ability to relate his or her own practice of ministry to fundamental theory in the classical disciplines and behavioral science studies found in the seminary curriculum.

It involves the application of a theology of ministry and data from research to a particular aspect of professional practice, in such a way as to develop, implement and evaluate an original, investigative program which promises to make a significant contribution to the profession. The purpose is to demonstrate professional excellence in the ability to contribute to the practice of ministry through original research, design, implementation, data-analysis and evaluation.

The design and completion of the Research Project shall demonstrate the following:

1) The ability to identify and appropriately investigate a problem, issue, or area of study in pastoral counseling;

2) The ability to engage in quality research of some aspect of pastoral counseling and derive from that research some generalizable contribution to the profession;

3) The ability to complete a written research report which reflects a depth of theological and psychological insight;

4) The successful completion of oral consultations with the Track Coordinator, Faculty Advisor and Adjunct Faculty/Training Director during the project and an oral defense at the conclusion of the project (see paragraph B-5 below) which are both designed to examine it critically in the light of the several disciplines and perspectives represented and their relation to the practice of ministry.

B. Sequence. The following steps show the normal progression in developing and reporting the project. Variations must be negotiated with the Faculty Advisor and Track Coordinator as part of the Learning Contract.

1) A Prospectus is developed by the Participant, in consultation with the Faculty Advisor, Track Coordinator and Training Director/Adjunct Faculty in the process of negotiating the Learning Contract. This consists of preliminary identification of:

   a) The objective
   b) Area of investigation
   c) Resources to be consulted
   d) Overall plan
   e) Proposed steps for implementation
   f) Means of evaluation
   g) Format of reporting

This is completed no later than the end of the first Seminar after admission.

2) A Project Proposal is drafted and submitted within two months after completi the seminar on research design and methodology. This is to be prepared in accordance with the outline indicated in section C, below. It is submitted first to the instructor of the Research Seminar and then the Advisory Team and faculty committee and must receive the approval of all these parties. This approval forms part of the basis upon which the Participant is recommended for Admission to Candidacy.

3) The Project Proposal, together with the Mid-Program Professional Identity Paper and the Report of Work Completed in Pastoral Counseling Center, are presented and discussed in the Mid-Program Evaluation Conference (see page 22, item 5).

4) The Project is carried out.

5) The first draft of the Research Project Report is prepared in accordance with the guidelines indicated in sections D and E, below. It is submitted to the Training Director/Adjunct Faculty, Faculty Advisor, and Track Coordinator, and must receive their approval. The Evaluation Conference Committee makes one of the following recommendations on the basis of their reading of the first draft: acceptable without revision; acceptable with revisions specified; not acceptable with no bar to rewriting; not acceptable with bar to rewriting. If not acceptable with no bar to rewriting, the Participant may resubmit his/her work within a year of the rejection.

6) After revisions, the final draft of the Research Project Report is submitted first to the Training Director/Adjunct Faculty and Advisory Team and then to the Faculty Advisor, Track Coordinator and such other faculty members as have agreed to read and evaluate it.

7) The Participant will engage in an oral defense of the Project and Report before a faculty committee consisting of the Faculty Advisor, Track Coordinator, Adjunct Faculty/Training Director, and another faculty member enlisted by the Coordinator in consultation with the Participant. Approval of the Field Project itself and the written Report, and a successful defense, together form the basis upon which this committee makes its recommendation to the D.Min. Committee. For participants planning to graduate in June, this must be completed by the date specified in the current G-ETS catalog.

8) The D.Min. Committee hears the reports and recommendations from the Oral Defense Committee, submitted by the Faculty Advisor, and makes a recommendation to the entire faculty regarding the awarding of the degree.

C. The Proposal

1) The purpose of the proposal is to define clearly and concisely the area of study (problem, hypothesis, need-situation or proposition) to be explored. Secondarily, the proposal offers a description of the methodology by which the investigation, design, implementation, and evaluation are to be done. Thirdly, the proposal defines the boundaries of the study - the areas for which the Participant will be held responsible in the presentation of the Project and the subsequent oral defense. Clarity of focus is to be sought, both to limit the amount of extraneous labor and to facilitate adequate coverage of the designated area of study.

2) The format of the proposal, while it may be adapted to the nature of a particular project, normally should contain the following elements:

a) The statement of the area of study, including a concise statement of purpose, a clear description of the problem or area to be explored or hypothesis being advanced, a clarification of the presuppositions (biblical, theological, historical, and behavioral science) which underlie the thesis, a delineation of the scope of the Project, a rationale for selecting this area for investigation or experimentation (including one's interest, previous and present involvement, training, background, and skills relevant to the project), written evidence of the agreement of the institution(s) concerned to participate in the proposed Project, and a statement on the originality of the Project and its potential contribution to the profession.

b) A statement of available resources - printed, human and organizational - which the Participant has researched, intends to make use of, and for which s/he wishes to be held responsible in the final written product and subsequent defense. These would include books, monographs, articles, reports of other research or experimentation in the area, consultants, agencies, etc.

c) A description of the Project design, including an explanation of the methodology to be followed, an account of the biblical, historical, theological and psychological resources to be utilized, a description of the process by which the conclusions will be reached and verified, an outline of the form of the final written report, and a provisional statement of the conclusion which the Participant thinks will eventuate from the study.

d) A tentative schedule for completing the various elements of the Project design.

e) A cover page of the Project Proposal, including the Participant's name, titles of the Research Project, date of proposal, and a one-paragraph summary statement of the goal and methodology of the Project.

D. Components of the Research Project Report. While creativity and originality are encouraged in the development and presentation of the Research Project, the following elements normally would be expected:

1) An introduction, in which the purpose of the Project is stated, the area of study described, the rationale for selection of this project developed, and the thesis advanced.

2) A section of theoretical foundations, in which the relevance to the Project of biblical, theological, historical, psychological and sociological resources is developed.

3) A report of one's review of previous thought, investigation, and experimentation relevant to the area of study.

4) An account of the Project itself, including the preliminary design, research population, methodology, and implementation.

5) An evaluation of the Project, in terms of how well the purpose was accomplished and design carried out, with reasons as to why or why not.

6) The conclusions drawn from the Project.

7) The bibliography of resources used.

8) Any appendices relevant to the Project or supporting the conclusions.

9) A title page, which appears in the very front of the volume. This is worded as follows:

Garrett-Evangelical Theological Seminary
(title of project)
A Research Project Report
Submitted to the Faculty
in Partial Fulfillment of Requirements
for the Degree of
Doctor of Ministry
by
(name of candidate)
(city and state)
(date)

10) An approval page, which appears just after the title page. This is headed "Approved By" and has four lines for signatures, with "Advisory Team Chairperson," "Faculty Advisor," "Faculty Consultant," and "Coordinator, Pastoral Counseling Track," typed under them.

11) A 100-word abstract of the Research Project Report which is a concise summary of the development and conclusions and appears just after the approval page.

E. Form. The Research Project Report should be adequately documented, and normally will be presented in written form, unless an alternative form more appropriate to communicating the nature and results of the project is approved by the Faculty Advisor. Creativity and originality are encouraged in all phases of the Project including style of communication. The length of the Report will be commensurate with the nature and demands of the project. The Report should be submitted in a form suitable for publication in a professional journal. A Manual for Writers of Term Papers, Theses and Dissertations by Kate L. Turabian, Phoenix Books, University of Chicago Press should be used in determining form, and the form must be consistent throughout. Approval of the Track Coordinator and/or Faculty Advisor on matters of form and style should be secured in advance. Two copies must be submitted, one for the G-ETS library and one for the D.Min. Office. Additional copies may be submitted if the Participant wishes them for him/herself. The Participant will be billed for the binding fee for these copies.

F. Criteria for Evaluating the Project Proposal, the Research Project itself, and the Project Report

1) Theological relevance and grounding. The Project should be significantly informed by one or more of the classical theological disciplines (Bible, Theology, Church History), bringing into constructive encounter both theological reflection and professional practice.

2) Evidence of learnings. The Project should be a means of facilitating the growth of the Participant in the understandings and skills of the pastoral counseling ministry, and the Report should describe and demonstrate these new insights and increased competencies.

3) Contribution to the pastoral counseling profession. The Project should contribute in some observable way to the enhancement of the practice and/or delivery of pastoral counseling.

4) Originality. An effort should be made to determine what other investigation and experimentation has already been done in the area of study, and then to develop an innovative approach to the Project. While there is no intention of assuring the absolute originality assumed for academic doctoral dissertations, it is not sufficient simply to replicate or report work done by others.

5) Clarity. There must be evidence that the Participant has a thorough grasp of the area to be explored, demonstrates the capacity to utilize the necessary methodology, and can communicate the design and conclusions of the Project clearly, concisely and with continuity.

6) Coherence. The Project Report should represent a solid integration of theory and practice, with the conclusions clearly and verifiably related both to the theoretical foundations and to the data generated by the carrying out of the Project.

G. Examples of Titles of Research Projects

1) Pastoral Counseling Centers: Their Theology, Theory of Personality and Modality of Therapy
2) The Unique and Definable Needs of Blended Families
3) The Relationship Between God Image and Personality Style
4) A Longitudinal Study of Pastoral Counseling as a Component in Wholistic Health Care
5) Dream Work: A Means of Change in Self-Perception and of Subsequent Growth
6) Middle-Age Daughter–Elderly Mother: Intergenerational Individuation in a Christian Perspective

DISTINCTIONS BETWEEN PH.D. DISSERTATION AND D.MIN. PROJECT

Ph.D. Dissertation	D.Min. Field Project (Parish Ministry Track)	D.Min. Research Project (Pastoral Counseling Track)
1. Puts emphasis on adding to the body of knowledge, coming up with new facts or interpretations.	1. Puts emphasis on developing a program or project and on evaluating its effectiveness.	1. Puts emphasis on developing a program or project and on evaluating its effectiveness.
2. Strives to make an original contribution by researching an area that has not been explored or tested in the same way before.	2. Stresses innovativeness in the sense of doing something in ministry in a specific context that has never been done before.	2. Stresses innovativeness in the sense of doing or investigating something in the pastoral counseling ministry which is new to a specific context.
3. Begins with theory, and investigates or explores that theory to the cutting edge of what is known. Sometimes uses theory as a basis for elaborating and refining theoretical understandings.	3. Develops the dialectic between theory and practice, action and reflection, by testing a new way of doing something and then, as a theologian, asking what does it mean. Expects integration of theory and practice.	3. Begins with theory, and investigates or explores that theory in the context of the pastoral counseling ministry. Expects integration of theory and practice in the context of theological perspectives.
4. Tests and/or proves an hypothesis.	4. Tests and evaluates creative, new ways of doing ministry.	4. Tests and/or investigates an hypothesis.
5. Is written in the style and format expected by the academic community.	5. Is written in a style and format acceptable to the academic community, but is addressed primarily to ministry and the church.	5. Is written in a style and format acceptable to the academic community and the pastoral counseling profession.
6. Requires sophisticated research skills.	6. Requires existential involvement in the project in a leadership role, plus baseline skill in doing credible evaluation.	6. Requires the basic research skills needed for doing credible evaluation.
7. Demands a high level of expertise in a narrowly-defined area of investigation.	7. Demands a respectable level of knowledge of theory in the area of the project, plus a high level of competence in the practice of ministry in this area.	7. Demands a respectable level of knowledge of theory in the area of the project, plus a high level of competence in analyzing the delivery of pastoral counseling to the target population.
8. Expects a thorough mastery of international scholarship concerning a particular issue, often including a history of research.	8. Expects mastery of selected viewpoints concerning a particular issue.	8. Expects a general mastery of scholarship concerning a particular issue, sometimes including a history of research.

VII. EVALUATION

The program lays heavy stress on evaluation, in order both to provide ample feedback to Participants on their performance and growth in and through the various aspects of the program, and also to assess their growth toward the high level of competence expected of a Doctor of Ministry. Each Participant receives a written faculty evaluation of his/her performance in each aspect of the program, based on both his/her own learning objectives, on the specific competency criteria established for that component, and on the general criteria listed below in relation to each element of the program.

A. THE CRITERIA

1. In the second phase of the admissions process, each Participant develops learning objectives and a Learning Contract that become the first set of criteria against which his/her performance and progress are measured. The effectiveness of the program thus in part can be determined by how well it enables the Participant to grow from where s/he is at entry to where s/he wants to be.

2. A second set of criteria for evaluating both the program and the Participant are those specifically relating to the several components of the program. These are used by faculty in writing evaluations of the work of Participants and by Center staff and Advisory Teams in doing peer evaluation and assessing the performance of Participants in the clinical aspects of the program. Criteria for the several program components are given below.

a. Criteria for Feedback on Participation in Seminars

(1) Attendance.
(2) Extent and quality of participation in discussions.
(3) Evidence of having done and assimilated the reading.
(4) Capacity to integrate theory and practice.
(5) Degree of mastery of the concepts and principles basic to the theme of the seminar.
(6) Degree of competence in using the skills being taught in the seminar.
(7) Capacity for openness and depth in relationships with others in the group.
(8) Degree of self-awareness, self-acceptance, self-esteem, and self-direction.
(9) Degree of intentionality in pursuing one's own learning goals and objectives.
(10) Willingness to risk by trying out new ideas, approaches, and behavior.

b. Criteria for Evaluation of Directed Study Papers

(1) Evidence of having explored the study area in sufficient depth and scope.
(2) Evidence of comprehension of materials read.
(3) Evidence of ability to integrate concepts and principles from both the seminar and the reading into an organization of ideas which is clearly one's own.
(4) Capacity to relate the conceptual material to one's own approach to ministry.
(5) Capacity to maintain the integrity of the Directed Study assignment while at the same time achieving one's own learning goals.
(6) Capacity to write in a clear, concise, communicative style.

(7) Capacity to relate this paper to the larger framework of the Directed Study, to other elements in the program, and to the program as a whole.
(8) Evidence of a willingness to enter wholeheartedly into the study, within reasonable limits of time and energy.

c. Criteria for Evaluation of Clinical Counseling Performance

(1) The Seminary holds Participants in all Centers accountable to the AAPC criteria for clinical progress beginning at the Member level and moving up to the Fellow level. (See AAPC Handbook, pages 6-8.)
(2) Each Center may supplement these criteria with such other criteria as relate specifically to its clinical training program.

d. Criteria for Evaluation of Didactic Training Taken Under the Auspices of Pastoral Counseling Centers

(1) The staff of each Center will carry out a formal written evaluation of each Participant's performance in didactic course work. This evaluation is to be informed by, but not limited to, the Seminary criteria for academic work specified in sections a and b on pages 19-20 of this Handbook. In cases where letter grades are given, only grades of B or above are acceptable.
(2) Each Center may supplement these with such other criteria as are directly related to its didactic training program.

e. Criteria for Evaluation of Mid-Program Professional Identity Paper

(1) Evidence of having comprehended and assimilated concepts and principles from all of the program components completed to date.
(2) Evidence of growth in self-understanding, self-acceptance, self-esteem, and self-direction since writing the first Professional Identity Paper at the time of application.
(3) Evidence of ability to integrate learnings from the program into a comprehensive, coherent theory of ministry.
(4) Evidence of ability to reflect theologically on case material from one's own practice of ministry.
(5) Capacity to write in a clear, concise, communicative style.

f. Criteria for Evaluation of Research Project and Research Project Report
(See Part VI, section F)

g. Criteria for Evaluation of Performance in Mid-Program Evaluation Conference and Research Project Oral Defense

(1) Evidence of capacity to defend and interpret adequately what one has written.
(2) Familiarity with the sources one has used.
(3) Ability to articulate verbally the same concepts and principles about which one has written.
(4) Capacity to perceive and accept shortcomings in one's written or oral presentations when discovered and pointed up in the group interchange.
(5) Capacity to criticize one's own theory, practice, and project from at least one other theoretical perspective.
(6) Capacity to ground one's practice of ministry biblically and theologically.
(7) Willingness to fulfill reasonable requests for revision or rewriting of inadequate sections of either paper.
(8) Capacity and willingness to enter into dialogue with faculty on substantive issues in the theology and practice of ministry.

B. THE PROCESS

1. Evaluation of Participation in Seminars

a. Written comments on each Participant are solicited by the Director from all members of the seminar teaching team who have had extended contact with the Participants (i.e. more than two sessions). These comments are based on the above criteria.
b. These comments are shared with the student and the Advisory Team by the Track Coordinator. Each member's feedback sheet is read and discussed by the Advisory Team, with members supplying data from their perceptions of his/her behavior which either support or refute the faculty feedback.
c. Copies of the feedback sheet are also sent to each Participant's Faculty Advisor and Adjunct Faculty/Training Director, and placed in his/her folder in the D.Min. Office and sent to the Registrar's Office.

2. Evaluation of Directed Study Papers

a. Participants send their papers as they complete them to the D.Min. Office.
b. After their reception is recorded, they are sent to the faculty responsible for grading them together with an evaluation form. This form has space for comments and suggestions for revision, and asks that the paper be marked "acceptable," "returned for revision," or "returned for a complete re-write."
c. The paper and evaluation sheet are returned by the faculty to the D.Min. Office; copies are kept on file; and the originals are returned to the Participant.
d. If the paper is returned for revision this process is repeated until it is acceptable.
e. The policy and procedure on papers returned for revision is as follows:
   (1) After the second paper is returned, or one paper is returned for the secend time, the Faculty Advisor is notified and asked to bring the matter up at the next meeting of the Participant's Advisory Team.
   (2) After the fourth paper is returned, or two papers have been returned twice, or any combination of these, the Participant is invited to the campus for a consultation with his/her Faculty Advisor.
   (3) After the sixth paper is returned, or three papers have been returned twice, or any combination of these, the matter is brought to the D.Min. Committee for a decision of the Participant's continuation or termination with the program.

3. Evaluation of Clinical Counseling Performance

The procedure here varies from Center to Center. Each Participant should check with the Director of Training at his/her Center to secure information regarding that Center's evaluation procedures. Quarterly evaluation of each Participant's clinical progress and course work at the Center is recommended. Semi-annual evaluation is required.

After the evaluation has been done by the Center staff, the report is transmitted by the Training Director to the Coordinator of the Pastoral Counseling track at the Seminary, to be entered on the Participant's permanent record in the Registrar's Office.

4. Evaluation of Mid-Program Professional Identity Paper

a. The Participant sends copies of the paper to all members of the Advisory Team to read.
b. The Advisory Team meets to discuss and evaluate the paper, using the above criteria, and the chairperson sends a written report of their evaluation and their recommendation on Admission to Candidacy to the D.Min. Office. If they have suggestions for revision, these are made by the Participant before going any further.
c. The revised paper is sent to the D.Min. Office, which transmits copies to the Faculty Advisor and Track Coordinator, who read and evaluate it.
d. The Participant comes to the campus for a Mid-Program Evaluation Conference, at which:
   (1) the Professional Identity Paper is thoroughly discussed and evaluated;
   (2) the Research Project Proposal is reviewed and evaluated;
   (3) the Participant's performance and progress in the program to date is reviewed;
   (4) the Participant's growth in the general and functional competencies of the program is assessed; and
   (5) a recommendation is made on Admission to Candidacy and transmitted to the Registrar's Office on the form provided.

   If Admission to Candidacy is not recommended at this time, suggestions are made to the Participant as to what s/he needs to do to qualify for Admission to Candidacy, or what alternative steps s/he might take.

5. Admission to Candidacy

a. Data on Which to Base a Recommendation for Admission to Candidacy:
   (1) Satisfactory completion of at least two Seminars, and evaluations of these.
   (2) Satisfactory completion of at least the first year of clinical and didactic training in one's Pastoral Counseling Center and written evaluation of this work.
   (3) Satisfactory completion of both Directed Studies, and evaluations of these.
   (4) Submission of an acceptable Research Project Proposal.
   (5) A written report of work completed at the Pastoral Counseling Center (on the form supplied by the Seminary), including assurance from the Training Director of satisfactory completion of the first year's clinical and didactic training.
   (6) Satisfactory completion of the Mid-Program Professional Identity Paper and the Mid-Program Evaluation Conference.
   (7) A written recommendation from the Evaluation Conference Committee (on the form provided) after a review of all of the above data.

b. The Process of Admission to Candidacy
   (1) The Participant makes known his/her desire and readiness for this step to the Faculty Advisor and/or Track Coordinator and submits his/her Mid-Program Professional Identity Paper and Research Project Proposal.
   (2) The Mid-Program Evaluation Conference, involving the Track Coordinator, Faculty Advisor, Adjunct Faculty/Training Director, and another faculty member enlisted by the Coordinator in consultation with the Participant, is held either on campus or at the Center. This committee makes a recommendation to the D.Min. Committee on the form provided.
   (3) The D.Min. Committee considers the report from the Mid-Program Evaluation Conference and makes a recommendation to the Faculty.
   (4) The recommendation of the D.Min. Committee is presented to the Faculty for final action on Admission to Candidacy.

6. Evaluation of Research Project and Research Project Report

a. The Adjunct Faculty/Training Director makes regular in-process evaluations of the progress of the Research Project, as do the Faculty Advisor and Track Coordinator on the basis of consultation with the Participant and the Adjunct Faculty during and between field visits. These are made directly to the Participant and influence the course of the project.

b. The first draft of the Report is submitted for reading by members of the Advisory Team at the Center.

c. The Team meets to discuss and evaluate the Report using the criteria in Part VII, section F, and makes suggestions for revision to the Participant.

d. The Participant incorporates these suggestions into a second draft, copies of which are sent to the Registrar's Office for distribution to the Track Coordinator, Faculty Advisor, and one other faculty member enlisted by the Coordinator in consultation with the Participant. These all read the Report and make evaluative notes.

e. The Participant comes to the campus for the Oral Defense, chaired by the Faculty Advisor, during which:
   (1) the Participant summarizes the rationale, design, results, and conclusions of the Project;
   (2) each member of the committee raises issues and concerns for dialogue with the Participant;
   (3) suggestions for revision of the Report are made and agreed to by consensus;
   (4) the procedure is worked out for submission of the final draft and granting of final approval, usually with the Faculty Advisor; and
   (5) a recommendation is made on approval of the Research Project and readiness for graduation, with committee members signing the form provided, and the Advisor transmitting this to the D.Min. Office.

   If approval is not granted at this time, suggestions are made to the Participant as to what s/he needs to do to qualify for the degree, or what alternative steps might be taken.

f. If it is decided that the Research Project is inadequate and cannot be revised or re-written to become acceptable, then the Participant is terminated from the program, and is granted a Certificate for Pastoral Leadership Development in recognition of the amount and nature of work completed.

g. The Director or Dean submits a recommendation for the granting of the degree to the Faculty, who in turn make a recommendation to the Board of Trustees.

7. Graduation

a. When all requirements are completed satisfactorily, and the Participant has been recommended to receive the D.Min. degree, his/her name and the title of his/her Research Project Report are sent to the Registrar's Office to be printed in the Commencement program in May of the year in which the work is all completed.

b. The Participant is thus eligible to participate in that May Commencement and to receive the degree at that time.

VIII. TUITION AND FEES

1. The tuition is $3,800, with $1,900 payable in each of the first two years, normally by January 15 and June 30. If necessary, alternative arrangements may be made with the Business Office.
2. A non-refundable application fee of $25 is required at the time a application is submitted.
3. A continuation fee of $200 is charged for each six months or portion thereof the Participant remains in the program after completing the first two and one-half years.
4. A $35 graduation fee is required at the time the D.Min. Committee votes to recommend the granting of the degree.
5. The above tuition and fee structure covers the administrative and instructional expenses of the program, and entitles the Participants to engage in all components of the D.Min. curriculum, to enroll in other Seminary courses or Continuing Education events which contribute to his/her learning objectives and are part of his/her Learning Contract, and to make use of all the learning resources of the Seminary without additional cost.
6. Besides tuition and fees paid to the Seminary, the Participant also pays the Pastoral Counseling Center its regular tuition rate for the clinical and didactic training program taken there. The Seminary will compensate the Center, however, for any services rendered to the Participant as required by the D.Min. program (Advisory Team meetings, reading and evaluation of the Mid-Program Professional Identity Paper and the Research Project Report, etc.), as distinguished from the requirements of the Center-sponsored ongoing training program.
7. In addition to tuition and fees, the Participant is expected to bear the cost of his/her travel to and from the Seminary, board and room while on campus, fees for specialized training experiences, and fees and expenses for the services of non-faculty consultants which s/he engages as resources for aspects of his/her program.
8. The Seminary will pay all costs for the Faculty Advisor and Track Coordinator to visit the Participant's Center for periodic supervision, consultation, and attendance at Advisory Team meetings. However, any services rendered by the Faculty should be compensated with suitable honoraria.
9. Garrett-Evangelical Theological Seminary provides no financial aid for Participants in the Doctor of Ministry program. A portion of the tuition fees may sometimes be earned from counseling fees at the Center.
10. The tuition and fee amounts specified above are subject to change.

Office of Ministry Programs
Garrett-Evangelical Theological Seminary
2121 Sheridan Road
Evanston, Illinois 60201
312/866-3930

JAN 2 3 1989

Alaska State Legislature

Chairman
(907) 465-4523

Jan Faiks
Post Office Box V
Juneau, Alaska 99811

Senate Judiciary Committee

January 23, 1989

MEMORANDUM

TO: Senator Paul Fischer, Chairman
Senate HESS Committee

FROM: Senator Jan Faiks, Chairman
Senate Judiciary Committee

SUBJECT: SB 36 "An Act relating to insurance coverage for the treatment of a mental or nervous condition."

Senate Bill 36 has been referred to the Senate HESS Committee for consideration. This bill is identical to HCS SCSB 67 (Jud), which passed the legislature last session by a vote of 26 - 14 in the House and 15 - 3 in the Senate. It was subsequently vetoed by Governor Cowper.

This bill requires insurers to include minimum mental health coverage in group insurance policies sold to businesses with 20 or more permanent, full-time employees. It further requires insurers to offer as an option minimum mental health coverage in group policies sold to businesses with fewer than 20 permanent, full-time employees. In so doing, the bill will eliminate the discrimination which currently exists between mental health and other medical insurance benefits.

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

Most states that require mental health coverage also define the minimum coverage that must be offered. Senate Bill 36

requires a minimum of 45 days of inpatient treatment and 50 equivalent hours of outpatient treatment per year.

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

50/50

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

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

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

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

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

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

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

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

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

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

ok. costs

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

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

In a 1983 study, a moderate amount of psychotherapy was shown to significantly reduce hospital costs for persons suffering from four different types of chronic disease. Another study that same year showed that patients who received outpatient psychotherapy treatment used 56% fewer medical services than those who had not been treated.

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

be shifted from the State to the private sector.

Senate Bill 36 may indirectly reduce the dependency of the community mental health centers in Alaska on State funds. These facilities currently receive matching grants from the State and charge their patients a sliding fee base upon their ability to pay. After the grant is matched, all additional fees are devoted to enhance the programs and expand their facilities. Division of Mental Health personnel report that because of a lack of funds, these centers can only provide 25-30% of the communities' mental health needs. They predict that the passage of a mental health insurance bill will allow them to serve up to one-half of this need.

Specifically, this bill proposes the following:

Section 1. COVERAGE FOR TREATMENT OF A MENTAL OR NERVOUS CONDITION. AS 21.42 is amended to add a new section (21.42.375) which will require coverage for treatment of a mental or nervous condition.

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

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

(c) Notwithstanding (a), an insurer is not required to provide minimum coverage for mental or nervous disorders if the insured is an employer who employs fewer than 20 permanent, full-time employees. However, insurers must offer such employers the option to purchase this coverage.

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

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

Section 3. AS 21.87.340 is amended to add additional chapters

and provisions which apply to service corporations.

Section 4. Provides an effective date for this act for policies entered into on or after January 1, 1990.

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

Thank you.

STEVE COWPER
GOVERNOR

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

June 17, 1988

The Honorable Dan Faiks
President of the Senate
Alaska State Legislature
P.O. Box V
Juneau, AK 99811

Dear Senator Faiks:

Under the authority of art. II, sec. 15 of the Alaska Constitution, I have vetoed HCS CSSB 67(Jud), relating to insurance coverage for the treatment of a mental or nervous condition. The proposed Act would have required all providers of group medical insurance in Alaska to include coverage for treatment of mental or nervous conditions.

My decision to veto this bill is not based on an unwillingness to make medical care available to those who suffer from a serious mental illness. Every family who has suffered the heartbreak and cost of mental illness well understands the need for help to reduce that emotional and financial anguish. The intent of this bill is well-meaning, but it goes one step too far. It mandates, rather than makes optional, this extended health coverage.

This legislation would raise premium costs for all group major medical policies issued in the state. The initial rise in premium costs may not be significant. However, studies have shown that as usage of the coverage increases, so will premiums. Increased premiums will serve as a disincentive for smaller employers to choose to provide major medical insurance. It does not serve the interests of the small employers and their employees who would like to have major medical coverage, but who cannot afford it because of this mandated coverage.

We must also expect that employers will want to work to keep the overall costs of health care coverage at the same rate. As we add mandated coverages to their policies, it can be expected that other coverages will have to be dropped. The trade-off for increased mental health coverage may come at the expense of dependent coverage or other popular coverages.

VETO MESSAGE - SB 67

The estimated yearly cost to the State of Alaska for adding this level of coverage to the health policy now offered the employees is $532,500. An additional $1,334,000 would be required to add this to the health care policy for certain state employees. Over $1.3 million of new costs to the state was identified and yet the bill did not receive a hearing in the House Finance Committee and was passed with a zero fiscal note. It is not clear that legislators understood that the bill increases costs to state and local government and to small businesses.

The State of Alaska will continue to support funding for the many community health centers across the state and to be sensitive to the needs of those suffering from mental illness. I am not ready, however, to force all health insurance programs in Alaska to include this type of coverage.

Prior to and during the next Legislature, I will be glad to discuss the possibility of requiring major expenses related to mental illness to be covered under policies written in Alaska. But in my opinion, HCS CSSB 61(Fin) is too comprehensive to be acceptable without a cost analysis.

Sincerely,

Steve Cowper
Governor

Department of Commerce & Economic Development / POSITION PAPER

SB 36 An Act relating to insurance coverage for the treatment of a mental or nervous condition.

The bill mandates coverage for the treatment of a mental or nervous condition on group policies up to 45 days per year of inpatient treatment and a total of 50 hours of outpatient treatment or office visits per year. If the insured or subscriber is an employer with less than 20 employees, the coverage is not mandated but must be offered.

Even though this bill does not directly affect the Division of Insurance, excepting rates, forms and compliance capacity, the bill does have some potential adverse effects upon the insuring public.

There are two main issues of concern raised by the legislation. The first issue is one of public policy, i.e., the propriety of mandating coverage as opposed to mandating the offer of coverage. The second is the issue of increased costs and market availability.

A. Propriety of Mandated Coverage:

If this bill is enacted, Alaska will be one of 14 states which mandate that mental and nervous disorders be included in major medical policies. This bill will take the voluntary aspect of the selection of the coverage away from both the insurer and the employer or insured.

One argument is that the Legislature should be encouraging more small to medium employers to provide group major medical coverage to their employees. Making this coverage mandatory for all group major medical policies, either offered or sold in the state, could end up being a deterrent to those employers who would like to provide major medical coverage but simply choose not to because of the added cost that results from the mandated coverage for mental or nervous conditions. Even exempting those employers with 20 or fewer employees, the large employers would not be affected as much as would a small employer who finds that because of the small size of the employers' "group" of employees, a proportionally larger premium must be paid. This added coverage mandate could be just enough to push the small employer over the threshold of that which is affordable.

The cost of mandated coverage could be of such consequence as to discourage purchase at all, or force exclusion of more popular coverage such as dental or vision care. To the degree that dollars available for health care are fixed or limited, this bill has the effect of decreasing funds for conditions or services now covered.

B. Costs and Availability Effects:

This bill would raise premium costs for all group major medical policies issued in the state.

The initial rise in premium costs may not be significant. However, studies have shown that, as usage of the coverage increases, so will premiums. Also, as medical costs have done in the past, the associated costs of providing the type of care as mandated by this bill will most likely increase at a more rapid rate as the availability and usage of the benefit increases. Costs are inseparable from usage. The proposed legislation places no dollar cap on benefits, although there is a time limit on treatment, and, thus, it might encourage insureds to "piggy back" covered conditions.

The Spring 1986 issue of Perspective, the periodical for Blue Cross, cites a University of Wisconsin study involving 4,200 students who used the benefit in 1985. The usage was enough to more than double the student health insurance premium. Of those claims for psychiatric, alcoholism and drug abuse services, 90 percent were for psychiatric treatment.

The potential for cost increases in the field of mental health will adversely affect premiums, which will serve as a disincentive for smaller employers to choose to provide major medical insurance. It does not serve the interests of the small employer/employee who would like to have major medical coverage without the frills, but who cannot afford it in the future because of this mandated coverage.

HB 92 would tend to force the small to medium-sized insurer from the marketplace for lack of underwriting expertise relating to the coverage or ability to write it economically. This is at a time when the number of insurers willing to write health insurance is already declining.

Other issues to be considered include the effect of mandatory insurance on collective bargaining agreements, health and welfare plans regulated under Employee Retirement Income Security Act (ERISA), self-insureds, and those employed by companies whose headquarters are out of state; all of which may result in uneven application of the law.

Enactment of CSSB 363 (Fin) last year which mandated coverage for the treatment of alcoholism and drug abuse has, however, set a precedent for mandated coverage in Alaska.

The division is against mandated coverage but would support a mandated offer of coverage.

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Larry Merculieff, Commissioner
Date: 2/1/89

TESTIMONY BY GORDON E. EVANS
ON BEHALF OF HEALTH INSURANCE ASSOCIATION OF AMERICA
BEFORE SENATE HESS COMMITTEE
ON SB36
February 1, 1989

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

HIAA is opposed to SB36 in its present form. This legislation would require insurers doing business in Alaska -- and that includes both those companies selling disability (health) insurance policies, and hospital or medical service corporations providing subscriber contracts -- to include coverage for the treatment of a mental or nervous condition in their policies and/or contracts.

SB36 is similar to HCS CSSB67 (Judiciary), which passed the Legislature last year and was vetoed by Governor Cowper because, in his words, "The intent of this bill is well-meaning, but it goes one step too far. It mandates, rather than makes optional, this extended health coverage." While HIAA does not oppose insurance coverage for the treatment of a mental or nervous condition, the Association does -- for reasons which I will set out -- oppose any legislation which mandates, that is,

requires insurers to provide particular benefits in their health insurance policies.

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

First, mandated health benefit laws erode the ability of insurers 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.

Secondly, health insurance is expensive, but mandated benefit laws only serve to artificially raise the cost of such benefits, thus contributing to the rapidly escalating cost of health insurance. The net effect of mandating the level of the benefits coverage called for by SB36 would be to increase the cost of benefit coverage to insurers and in turn to drive up the price of health insurance premiums to the Alaska consumer. Incidentally, mental health benefits are among the most costly, if not THE most costly, of benefit coverages. This could result in increasing th cost of doing business for employers who offer group coverage their employees. It is even conceivable that affordable premium rates could NOT be established for individual policies so as to make coverage feasible.

Finally, state-mandated health benefit laws often cause larger employers to choose to self insure in order to circumvent the added cost of these required benefits. This legislation would not apply to self insurers or those with employee welfare benefit plans which are exempted under the federal ERISA.

In summary, HIAA's opposition to SB36 is based solely on the fact that HIAA favors the preservation of a system that allows the prospective purchaser of health insurance a free choice of which risks he or she wishes to cover from among the various coverages offered by competing insurance carriers. Since individuals and employers have differing health needs, the HIAA also believes that the choice of how the policyholder spends what funds he or she has available for health insurance should be free of any governmental decree.

Department of Commerce & Economic Development / POSITION PAPER

SB 36 An Act relating to insurance coverage for the treatment of a mental or nervous condition.

The bill mandates coverage for the treatment of a mental or nervous condition on group policies up to 45 days per year of inpatient treatment and a total of 50 hours of outpatient treatment or office visits per year. If the insured or subscriber is an employer with less than 20 employees, the coverage is not mandated but must be offered.

Even though this bill does not directly affect the Division of Insurance, excepting rates, forms and compliance capacity, the bill does have some potential adverse effects upon the insuring public.

There are two main issues of concern raised by the legislation. The first issue is one of public policy, i.e., the propriety of mandating coverage as opposed to mandating the offer of coverage. The second is the issue of increased costs and market availability.

A. Propriety of Mandated Coverage:

If this bill is enacted, Alaska will be one of 14 states which mandate that mental and nervous disorders be included in major medical policies. This bill will take the voluntary aspect of the selection of the coverage away from both the insurer and the employer or insured.

One argument is that the Legislature should be encouraging more small to medium employers to provide group major medical coverage to their employees. Making this coverage mandatory for all group major medical policies, either offered or sold in the state, could end up being a deterrent to those employers who would like to provide major medical coverage but simply choose not to because of the added cost that results from the mandated coverage for mental or nervous conditions. Even exempting those employers with 20 or fewer employees, the large employers would not be affected as much as would a small employer who finds that because of the small size of the employers' "group" of employees, a proportionally larger premium must be paid. This added coverage mandate could be just enough to push the small employer over the threshold of that which is affordable.

The cost of mandated coverage could be of such consequence as to discourage purchase at all, or force exclusion of more popular coverage such as dental or vision care. To the degree that dollars available for health care are fixed or limited, this bill has the effect of decreasing funds for conditions or services now covered.

B. Costs and Availability Effects:

This bill would raise premium costs for all group major medical policies issued in the state.

The initial rise in premium costs may not be significant. However, studies have shown that, as usage of the coverage increases, so will premiums. Also, as medical costs have done in the past, the associated costs of providing the type of care as mandated by this bill will most likely increase at a more rapid rate as the availability and usage of the benefit increases. Costs are inseparable from usage. The proposed legislation places no dollar cap on benefits, although there is a time limit on treatment, and, thus, it might encourage insureds to "piggy back" covered conditions.

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The potential for cost increases in the field of mental health will adversely affect premiums, which will serve as a disincentive for smaller employers to choose to provide major medical insurance. It does not serve the interests of the small employer/employee who would like to have major medical coverage without the frills, but who cannot afford it in the future because of this mandated coverage.

SB 36 would tend to force the small to medium-sized insurer from the marketplace for lack of underwriting expertise relating to the coverage or ability to write it economically. This is at a time when the number of insurers willing to write health insurance is already declining.

Other issues to be considered include the effect of mandatory insurance on collective bargaining agreements, health and welfare plans regulated under Employee Retirement Income Security Act (ERISA), self-insureds, and those employed by companies whose headquarters are out of state; all of which may result in uneven application of the law.

The division is against mandated coverage but would support a mandated offer of coverage.

Larry Merculiett, Commissioner

Date: 2/1/89

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This analysis assumes a continuation of the full coverage of unlimited inpatient treatment rather than imposing the 45 days per year minimum as outlined in the bill. It also assumes the imposition of a $2500 annual maximum on outpatient treatment as a "reasonable" contract limitation. There is currently no limitation on the number of hours of outpatient treatment or office visits. This is more liberal than the minimum of 50 hours outlined in the bill. We have also assumed no additional increase in the future since the plans' experience will dictate any changes.

The analysis consists of three separate components. There is a summary of costs at the end of the analysis. The first component addresses the direct increase to health insurance premiums for active State employees for an increased level of coverage. The second addresses the increased costs to the State due to increased contributions to the retirement systems. The third component addresses the increased costs to school districts and political subdivisions due to the increase in their contributions to the retirement systems and the direct increase to health insurance premiums for those entities participating in the State sponsored health plan.

Contributions to the retirement systems from employers would increase in order to actuarially fund the enhanced benefits in the retirees' health plan.

1. Active State Employee Program. Health insurance premiums for active State employees are estimated to increase $4.97 per month per employee, effective February 1, 1990. For purposes of this analysis we have assumed no additional increase in the future. The total FY 90 increase in costs for active State employees is estimated to be $323.1. This is calculated by multiplying the estimated number of employees each month times $4.97 times 5 months. The full year equivalent (FY 91) of this increase is $775.3.

   Total full year equivalent increase for
   active employee health insurance $775.3

2. Retiree Program. This bill is estimated to result in an increase to the State's cost by .34% of the PERS payroll and .27% in the TRS payroll. The FY 90 State PERS payroll, including the University of Alaska is estimated to be $521,208,708 (State $463,907,093; and University of Alaska, $57,302,615.) It is assumed to remain level each year thereafter.

   The FY 90 State TRS payroll, including the University of Alaska, is estimated to be $55,085,786 (Department of Education, $5,025,700; and the University of Alaska, $50,060,086). TRS salaries are also assumed to remain level each year thereafter.

The FY 90 increase in costs to the State due to retirement contributions of $1,920.9 is calculated as follows:

Estimated State PERS FY 90 payroll	$463,907,093	
PERS contribution rate increase	.34%	
FY 90 State Total PERS cost		$1,577.3
Estimated University of Alaska PERS FY 90 payroll	$57,301,615	
Pers contribution rate increase	.34%	
FY 90 University of Alaska Total PERS cost		$ 194.8
Estimated Department of Education TRS FY 90 payroll	$ 5,025,700	
TRS contribution rate increase	.27%	
FY 90 Department of Education Total TRS cost		$ 13.6
Estimated University of Alaska TRS FY 90 payroll	$ 50,060,086	
TRS contributions rate increase	.27%	
FY 90 University of Alaska Total TRS cost		$ 135.2
Total estimated State cost increase for FY 90 for retirement system contributions		$ 1920.9

3. Political Subdivision Active and Retiree Programs. In addition to the State cost there would also be an increase in political subdivisions' contribution rate to the PERS by .34% of PERS payroll and school districts' contribution rate to the TRS by .27% of TRS payroll. The FY 90 PERS payroll for political subdivisions is estimated to be $354,521,366. The FY 90 TRS payroll for school districts is estimated to be $339,201,043. Salaries for both systems are assumed to remain level each year thereafter. The FY 90 increase in costs to these entities due to retirement contributions of $2121.2 is calculated as follows:

Estimated political subdivision FY 90 payroll	$354,521,366	
PERS contribution rate increase	.34%	
FY 90 political subdivision Total PERS cost		$ 1205.4
Estimated school district FY 90 payroll	$339,201,043	
TRS contribution rate increase	.27%	
FY 90 School district Total TRS cost		$ 915.8
Total estimated FY 90 political subdivision and school district cost increase for retirement system contributions		$ 2121.2

There would also be an increase to the health insurance premiums for active employees of political subdivisions and school districts that participate in the State sponsored health plan. This increase would not take effect until FY 91 since the health contract is not renewed until that date. The estimated FY 91 costs for these employees will increase by $104.3. This is calculated as follows by multiplying the estimated monthly increase per employee ($4.97) times the estimated number of employees (1750) times 12 months.

Total health insurance increase for political subdivisions and school districts in FY 91	$ 104.3

Increase in FY 90 Costs Due to Expanded Health Insurance

	Active Employees	Retirees	Total
State	$775.3*	$1920.9	$2696.2
Political Subdivisions and School Districts	104.3**	2121.2	2225.5

* Shown as full year equivalent
** Shown as full year equivalent. No increase for FY 90

If this bill becomes law, the unfunded liability will increase by $5.3 million and the funding ratio will decrease by .4% in the TRS.

The unfunded liability will increase by $15.8 million and the funding ratio will decrease by .7% in the PERS.

Department of Commerce & Economic Development / POSITION PAPER

SB 36 An Act relating to insurance coverage for the treatment of a mental or nervous condition.

The bill mandates coverage for the treatment of a mental or nervous condition on group policies up to 45 days per year of inpatient treatment and a total of 50 hours of outpatient treatment or office visits per year. If the insured or subscriber is an employer with less than 20 employees, the coverage is not mandated but must be offered.

Even though this bill does not directly affect the Division of Insurance, excepting rates, forms and compliance capacity, the bill does have some potential adverse effects upon the insuring public.

There are two main issues of concern raised by the legislation. The first issue is one of public policy, i.e., the propriety of mandating coverage as opposed to mandating the offer of coverage. The second is the issue of increased costs and market availability.

A. Propriety of Mandated Coverage:

If this bill is enacted, Alaska will be one of 14 states which mandate that mental and nervous disorders be included in major medical policies. This bill will take the voluntary aspect of the selection of the coverage away from both the insurer and the employer or insured.

One argument is that the Legislature should be encouraging more small to medium employers to provide group major medical coverage to their employees. Making this coverage mandatory for all group major medical policies, either offered or sold in the state, could end up being a deterrent to those employers who would like to provide major medical coverage but simply choose not to because of the added cost that results from the mandated coverage for mental or nervous conditions. Even exempting those employers with 20 or fewer employees, the large employers would not be affected as much as would a small employer who finds that because of the small size of the employers' "group" of employees, a proportionally larger premium must be paid. This added coverage mandate could be just enough to push the small employer over the threshold of that which is affordable.

The cost of mandated coverage could be of such consequence as to discourage purchase at all, or force exclusion of more popular coverage such as dental or vision care. To the degree that dollars available for health care are fixed or limited, this bill has the effect of decreasing funds for conditions or services now covered.

Option

B. Costs and Availability Effects:

This bill would raise premium costs for all group major medical policies issued in the state.

The initial rise in premium costs may not be significant. However, studies have shown that, as usage of the coverage increases, so will premiums. Also, as medical costs have done in the past, the associated costs of providing the type of care as mandated by this bill will most likely increase at a more rapid rate as the availability and usage of the benefit increases. Costs are inseparable from usage. The proposed legislation places no dollar cap on benefits, although there is a time limit on treatment, and, thus, it might encourage insureds to "piggy back" covered conditions.

The Spring 1986 issue of Perspective, the periodical for Blue Cross, cites a University of Wisconsin study involving 4,200 students who used the benefit in 1985. The usage was enough to more than double the student health insurance premium. Of those claims for psychiatric, alcoholism and drug abuse services, 90 percent were for psychiatric treatment.

The potential for cost increases in the field of mental health will adversely affect premiums, which will serve as a disincentive for smaller employers to choose to provide major medical insurance. It does not serve the interests of the small employer/employee who would like to have major medical coverage without the frills, but who cannot afford it in the future because of this mandated coverage.

SB 36 would tend to force the small to medium-sized insurer from the marketplace for lack of underwriting expertise relating to the coverage or ability to write it economically. This is at a time when the number of insurers willing to write health insurance is already declining.

Other issues to be considered include the effect of mandatory insurance on collective bargaining agreements, health and welfare plans regulated under Employee Retirement Income Security Act (ERISA), self-insureds, and those employed by companies whose headquarters are out of state; all of which may result in uneven application of the law.

The division is against mandated coverage but would support a mandated offer of coverage.

Larry Merculieff, Commissioner

Date: 2/1/89

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020189b

STATE OF ALASKA
1989 LEGISLATIVE SESSION

BILL VERSION: SB 36
PUBLISH DATE: 1-9-89

FISCAL NOTE

REQUEST:

Revision Date:
Title: An Act relating to ins. coverage for treatment of a mental or nervous condition.
Sponsor: Faiks
Requestor: Senate HES

Agency Affected: Commerce & Econ. Dev.
BRU: Insurance
Components: Operations

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
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	-0-	-0-	-0-	-0-	-0-	-0-
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

No direct impact on the division's operations.

Prepared by: Joan Brown
Division: Insurance
Phone: 465-2597
Date: 1-17-89

Approved by Commissioner: [signature]
Agency: Commerce and Economic Development
Date: 1/25/89

Distribution (by preparer):
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Times 1/22/89

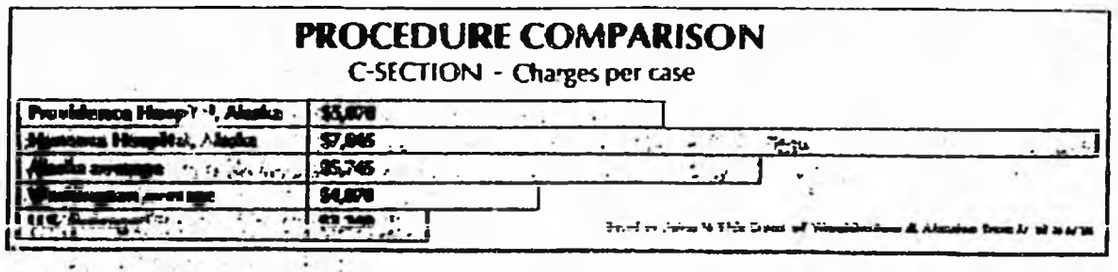
Good health carries hefty price tag

By JOE HUNT
Times Writer

Karen Jordan, like many business owners throughout Alaska, is caught in the insurance trap.

Faced with skyrocketing insurance costs, Jordan and her partner at Alaska Pension Services, Ltd., are making choices about their employees' benefits that go against their business philosophy. They believe in providing the best health care benefits for their employees as well as deserved pay raises, Jordan said, but this year neither is likely to happen.

Insurance premiums for Jordan's 10 employees jumped by 109 percent last year, just three months after she cut back health benefits to avoid another 40 percent increase. The small company swallowed hard and absorbed the increase even though it represented a boost of 5.5 percent in the entire payroll.



In the end, however, the cost of the insurance has to be passed on somewhere and during a down economy, it can't be made up in increased fees, she said. Ultimately and unfortunately, she said, the cost will fall on the employees, either in the form of reduced benefits or through the loss of their annual pay raise.

Jordan's frustration with unexpected and seemingly undeserved insurance increases is being echoed by business owners, union representatives, company managers, govern-

See Insurance, page A-5

Insurance: High cost of health

Continued from page A-1

ment officials, individual policy holders, and even insurance brokers who are dealing with the increases every day.

"The insurers are frustrated by the system and the brokers are definitely frustrated," said Joe Grove, an Anchorage insurance broker. "It's no picnic having to deliver increases year after year to your clients."

The nation's top 300 insurance companies lost more than $3.2 billion on their health coverage in 1987, the last year in which complete information was available. That has translated into major increases in premiums for employers and, often, reduced benefits for Alaskans.

It will cost the state of Alaska an extra $20 million to cover the 33 percent increase it received last fall in the cost of health benefits. The state will be hit with another five percent increase on Feb. 1.

Health Insurance for the International Brotherhood of Electrical Workers went up 33 percent last year and will go up another 15.7 percent this year. That cost and who pays for it has become the biggest factor in modern labor negotiations.

A relatively small group, the Laundry and Drycleaning Union opted to go with a $1,000 deductible in their policy rather than face a 57 percent increase under their old policy that had a $100 deductible.

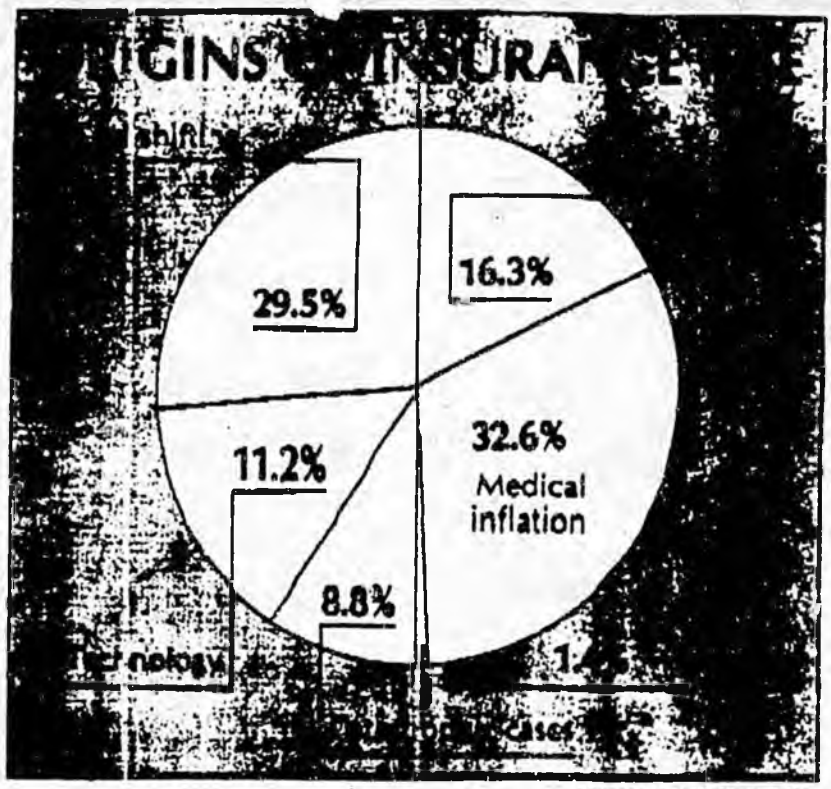
If the Anchorage School District had not renegotiated its health care benefits, it would have seen increases totalling 98 percent in the last two years with another 35-40 percent increase expected this year.

Blue Cross of Washington and Alaska has requested to raise rates for their 3,500 individual policy holders in Alaska by 19 and 72 percent. Policy holders with $1,000 deductibles would have the 72 percent increase while anyone with a $2,500 deductible would see a 19 percent increase.

A public hearing on the Blue Cross rate increase will be held Jan. 27 at the Wilda Marston Room in the Z.J. Loussac Public Library from 9 a.m.-4:30 p.m.

Though there are no specific figures available, most experts in the industry say that the overall cost of health insurance is rising by a vague 20-60 percent this year after a similar boost in costs last year. On an individual basis over the last two years, health insurance has risen as little as 16 percent for health coverage on city employees to as much as 200 percent for insurance at The Anchorage Times.

The rising cost of health insurance is a phenomenon that is feeding on itself. It's the epitome of the old chicken-and-egg question. No one really knows which rose first, the cost of health insurance or the cost of health care.



Source: Hewitt Associates

According to figures presented by the Governor's Interim Commission on Health Care, Alaska is seeing an ever-growing populace that falls through the cracks of health care coverage. In the report, the commission estimated 40,000 working Alaskans and their dependents are currently uninsured and do not qualify for public assistance programs such as Medicaid.

That doesn't keep those people from getting sick or having accidents, however. Providence Hospital reports that it provided $10.5 million worth of medical care in 1989 that went to people who were either uninsured or unable to pay their portion of the bill.

Humana Hospital-Alaska wrote off more than $15 million last year for treatment that was chalked up either to charity or bad debt. That represented 21 percent of its total business in 1988.

It's a growing problem. Three years earlier, Humana had $5 million in unpaid medical care, representing nine percent of its business.

The problem is self-perpetuating. Rising health insurance premiums, the number of people who cannot afford them, and the associated expense of charity health care are inexorably tied together in a cycle of ever-increasing cost.

It's a pattern both hospitals expect to continue. "A lot more people are becoming sick who don't have the ability to pay or can't afford to pay the full rate," said Sharon Anderson, director of marketing and planning for Humana.

"As the cost of health insurance goes up, it will impact the individual and small business owner and I'm sure the (bad debt and charity cases) will go up," said Kaaren Johnson, associate administrator at Providence.

To blame the rising cost of health insurance on medical inflation is too simplistic, say insurance experts. Medical inflation only represents one piece of a complicated, multi-dimensional puzzle that paints a bleak picture for the future of health benefits for workers.

Insurers also point to:

- Malpractice paranoia, in which frequent lawsuits, inflated court settlements, and rising liability insurance force doctors and hospitals to protect themselves as best they can. Higher liability premiums not only force higher medical costs, but to protect themselves, doctors often order unnecessary tests to double and triple check their work.
- Shrinking government health care programs that are forcing a shift in costs to the private sector. If programs such as Medicaid cover only part of the hospitalization costs, for example, the remaining cost must be made up somewhere else.
- Advancements in technology, which saves lives, but usually with a hefty pricetag. Modern technology takes years to develop and millions of dollars in research. That means it is expensive to purchase, maintain, and use.
- Catastrophic illnesses and accidents are being successfully treated through modern technology and technique. Organ transplant patients and premature infants are two examples in which lives are saved, but extended hospitalization results in huge insurance claims. AIDS, as a relatively new and growing medical problem, has also had its effect on insurers.

Perhaps most importantly, insurance experts say, is that Americans refuse to get involved in the dollars and cents of their own health care.

Alaskans are not wise shoppers when it comes to their medical care, said Grove. Why should they be, he asks? Someone else is paying the bill.

"The bulk of health care is

coverage can make you sick

Times photo by ALICE PUSTER

Blue Cross vice president Steven Clark discusses the cost of health insurance in Anchorage.

paid by a third party," Grove said. "The recipient of health care doesn't care what it costs and the doctor doesn't care. The patient is not challenging the doctor or hospital so you have a situation where the two most important players don't care about the costs."

Alaskans are slowly being forced to accept more responsibility for their health care through higher deductibles and by paying a larger share of their remaining medical bills.

"Most of us can go out and drop $100 on an evening and think nothing about it," Grove said. "But, we still want a $100 deductible, don't we?"

Stephen Clark, vice president of Blue Cross of Washington and Alaska, admits that the higher deductible is part of a system-wide strategy to get consumers to recognize the costs of health care. "The more I get you involved in the consumption of health care, the more you modify your habits," Clark said.

Clark flew to Anchorage last week to discuss the ills of the health insurance business, a problem that is multiplied when speaking about Alaska.

"Unfortunately, I am the harbinger of the problem," Clark said. "The problem is here. The costs are going up. We have to work together as a community to solve the problem."

Alaska has problems unique to the state that result in even higher insurance costs, Clark said. Alaska's relatively young population has a high rate of alcoholism and drug abuse requiring expensive treatment. There is also a higher percentage of smokers in the state leading to more smoker-related health problems, he said.

The younger residents tend to be risk takers in a harsh environment, he said, leading to a high rate of accidents. Also, the rate of infant mortality and incidents of premature birth are abnormally high. All of those factors work against the state, he said.

Combined with the state's comparatively higher cost for general hospital or physicians fees, Alaska becomes a difficult state to do business in, Clark argues.

According to claims filed with Blue Cross, Alaska's general medical care runs 46 percent higher than the same care in Washington state. Surgery averages 28 percent higher, lab fees run 72 percent higher, and X-rays are 35 percent higher in Alaska, Clark claims.

In the future, insurance companies expect to take a more commanding role in the health care of their policy holders, Clark said.

Prior insurance company approval would be sought for major medical treatment except under emergency conditions. The insurers may ask the policy holder to undergo surgery in Outside hospitals, he said.

■ **MONEY MARKETS:** Weekly listings / B-4 ■ **MALLWATCH:** Merchants join forces / B-5 ■ **PLASTIC POWER:** Holiday bills / B-6

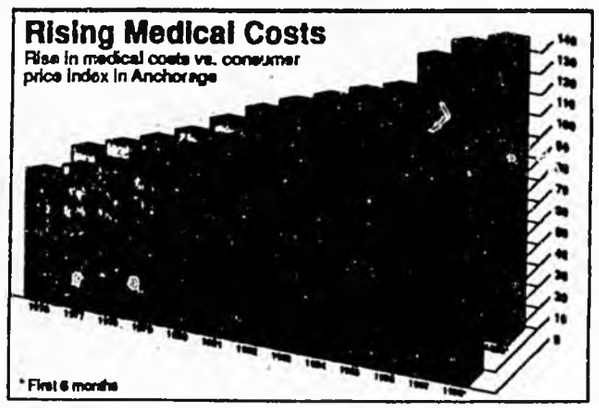
Anch Daily News

BUSINESS

SUNDAY
SECTION B Jan. 22, 1989

Health insurance costs rise feverishly

Workers at a loss as employers cut back on benefits



BY HAL BERNTON
Daily News reporter

Lester Snow has worked as an Alaska disc jockey for 19 years, and one benefit he always counted on was health insurance. That meant a lot to Snow because his wife, Jennifer, has a serious heart condition that requires medication and close monitoring.

Then last February, Snow got bad news from his employer, Sourdough Broadcasters Inc. Owner Patty Harpel said she couldn't afford the 70 percent price increase demanded by the company's insurer, and couldn't find a cheaper alternative. Group insurance for the station's 15 employees would be dropped.

Snow fell back on a Veterans Administration policy to cover his own ailments but he also needed a family policy for his wife and two teen-age children. He found Jennifer's heart condition drove the cost of that policy out of sight. "My family has nothing," Snow says. "If we have a catastrophic accident or illness, I will be up against a wall."

Snow is experiencing the harsh edge of a new Alaska business trend — the slashing of employee health-care benefits.

Throughout the state — and particularly in Anchorage — employers already reeling from several years of recession are being shell-shocked by huge annual increases in the cost of health-care benefits.

They're responding by cutting back on these benefits and forcing employees to share more of the costs, and in some cases dropping such coverage altogether. And they're joining a debate already in progress among insurers, those who offer medical services and state officials about why rates are skyrocketing and just what can be done to control them.

Often hit hardest by increases are small employers already operating on thin profit margins.

Anchorage Daily News/Jim Lavrakas

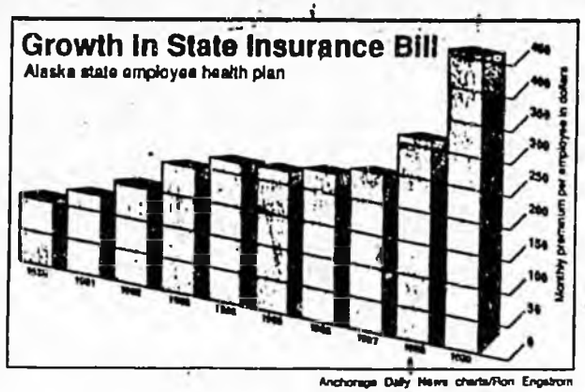
Disc jockey Lester Snow was left scrambling when his employer was forced to drop health benefits for employees.

"You just don't get good rates if you have anyone with medical problems," says Harpel, the station manager. "And you never know how long you will be able to keep a policy before it's canceled and you're out on the big wide ocean looking for another lifesaver."

A state survey estimated that 40,000 working Alaskans and their dependents lack any type of health insurance — either from private or public sources.

The state's shrinking health-care coverage represents a sharp reversal from the boom years of the early '80s, when Alaska employers — both public and private — developed some of the nation's best health benefits to help recruit workers from the Lower 48. Many policies were what insurance agents call "cadillacs," featuring minimal out-of-the pocket expenses for employees.

But many of the "cadillacs" are turning into humble Fords and Chevys, or worse, as employers struggle to cope with the rising insurance costs. That has made health insurance a major issue in state, municipal and private sector union negotiations, and in Juneau, where politicians already have drafted bills to create a new state health insurance corporation.



Anchorage Daily News charts/Ron Engstrom

"It's a serious problem, and one that we're going to face for the rest of our lives," says Bill Quinn, a union leader who serves on an Alaska Railroad Corp. health insurance committee. "Those of us in the baby boom may not be faced with what kind of health insurance we want when we retire, but whether we'll be able to afford it."

The Alaska health-care inflation parallels a nationwide surge in benefit costs, but premium inflation here appears to be particularly acute.

Three nationwide surveys reported by Business Insurance, The Wall Street Journal and Health Week cited average 1989 increases of 11 to 25 percent for group health plans.

In Alaska, a few companies contacted by the Daily News report they've managed to hold the line on health costs. Alaska Commercial Co., for example, an Anchorage-based merchandising chain employing 450 people, this year reports no increase in its policy premium.

"We manage the benefits very carefully," says Sam Salkin, Alaska Commercial's president. "We have (medical) authorization procedures, second opinions."

But Alaska Commercial is the exception, not the norm.

Three major Alaska insurance brokers indicated average 1989 increases of 30 to 60 percent are the norm.

And some increases top 100 percent, according to brokers Walt Baldwin, Bill Purrington and Dave Stratton.

Those rate increases have pushed the cost of many Alaska policies far above the national average. For an Alaska Railroad union worker and family, for example, the total cost of annual insurance is $5,845, more than double the national average.

In years past, employers tried to dodge rate increases by changing to another insurer. But this year, the market's tightened and finding another insurer is much harder to do, says Baldwin.

Employee exams often are required before new insurers agree to write the policies, and if they don't like what they find, then they back away or refuse to insure already existing conditions.

The cost of individual policies — a fall-back for those whose employers don't offer insurance — also is soaring. Blue Cross of Washington and Alaska, a major state insurer, is seeking an average 70 percent jump in the cost of individual insurance policies.

"The point is not just that it's expensive, but whether it will even be available," said Paul Roller, director of the state Division of Insurance. "People just cannot afford those rates."

□

The debate over Alaska's rising health costs is often dominated by discord.

Doctors say their Alaska costs are high, because overhead is much higher, and they point the finger at insurance companies.

"I think a lot of the problems, from the physician's perspective, are generated by the insurance companies," says Richard Neubauer, an Anchorage internist. "They set up a lot of obstacles for prompt payment of bills, and maximize the amount of paperwork.

Please see Page B-3, HEALTH

HEALTH INSURANCE: Employers cut be

Continued from Page B-1

"They set up quality insurance programs, review types of things, and call for justification."

Broker Purrington accuses Blue Cross, a major — and non-profit — Alaska insurer, of predatory pricing — cutting rates when major competition shows up, then jacking them up once that competition's gone. In 1985, for example, Blue Cross cut many of its group rates to help fend off an unsuccessful attempt by Humana Care Plus to grab a pice of the Alaska market.

Stephen Clark, executive vice president of Blue Cross, says the problem doesn't lie with the insurance companies. He says Alaska doctors and hospitals charge much more than in the Lower 48, and their company just passes through the ever-inflating costs. Alaska laboratory tests, for example, averaged 72 percent higher in Alaska than Washington, according to Blue Cross data.

'If we are to contain the excessive costs of health care in Alaska, we've got to work in unison with the physicians, hospitals, employers and individual subscribers," Clark says.

State officials don't keep detailed financial data on all of the more than 30 insurers selling health insurance in Alaska. But they do monitor Blue Cross, due to its special status as a non-profit medical service corporation. And in 1987, the last year in which financial information is available, state records indicate Blue Cross roughly broke even in Alaska, paying out $61 million in claims and administrative costs and taking in the same amount in premiums.

Aetna Life & Casualty, in a report to a state task force, indicated that since 1985, the insurance plan covering state employees lost more than $10 million.

State insurance division officials cite several major national trends forcing up the cost of Alaska health insurance. They include:

• The use of ever-more-costly technology to examine, treat and prolong the life of patients, including victims of AIDS and other terminally ill patients.

"Our society hasn't reached the point yet where we say we can't afford to absorb the cost of a heart transplant for a 60-year-old guy who's been smoking six packs of cigarettes all his life," says Warren Dvorak, benefits manager for the Anchorage School District.

• Increased salaries to help hospitals and other institutions deal with an ever more severe shortage of nurses and other medical personnel.

• Cost shifting. As the federal government cuts back on Medicare and other medical payments, hospitals are trying to compensate by raising rates for patients with private insurance.

• Recent federal laws requiring employers to extend temporary health benefits to former employees and full benefits to some seasonal and temporary employees.

Regional trends also fuel the inflation, according to the state insurance division, industry officials and a draft report of the Governor's Interim Commission on Health Care:

• Huge increases in the cost of Alaska malpractice insurance — both for doctors and hospitals — have been passed on to health care consumers. And the threat of damage suits has prompted more defensive medicine. Doctors order additional, at times unnecessary, tests and exams to help protect them from patients who might later decide to sue.

• With the past three years, a major increase in the use of an ever-expanding array of Alaska health care services. Last year, for example, Charter North Medical Corp. opened an expensive new facility for in-patient treatment of disturbed children. That prompted a more than doubling of admissions from state employees and their families. And hospital charges to the state's insurance program soared from $320,446 in fiscal year 1987 to $1.2 million in fiscal year 1988.

The increased use, industry officials say, also results from skittish workers who — in a down economy — fear for job security, and want to make sure any health problems are dealt with while they still have coverage.

• The sagging economy also has caused a big increase in free medicine by the hospitals. Within the past three years, Providence Hospital's unreimbursed medical services jumped from $7 million to $17 million. During that same time period, Humana's jumped from $5 million to $12 million, the hospitals say.

That tends to drive up the cost of services for those who can afford to pay, state officials say.

□

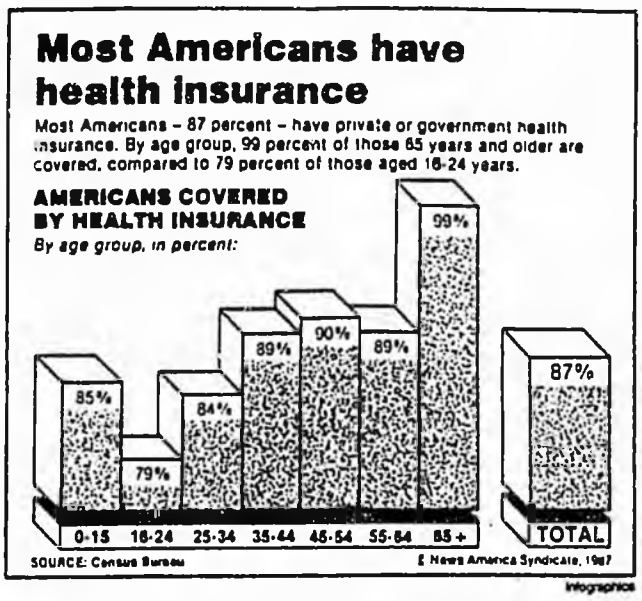
In the Lower 48, the struggle to gain control of health care costs — and often intense competition for patient dollars — has triggered a revolution in health care delivery. In many major urban areas, employers can choose from a wide range of programs, such as pre-paid health-care plans in which doctors and hospitals guarantee services for a fixed fee. Other programs involve doctors and hospitals who team up to offer employers discount services in exchange for large volumes of business.

In the health-care industry, such programs are known as "managed care," and many view them as the wave of the future.

"An increasingly high percentage of people who are insured receive some sort of managed care," says Doug Hastings, a Washington, D.C., attorney specializing in hospital and health care issues. "And most experts predict that growth will continue."

But in Alaska, such programs are in their infancy. That's due, in part, to the state's isolation and sparse population, which make it difficult to organize large-volume health care programs profitably.

Another obstacle to their development is the state's doctors, many of whom view such programs with distrust and outright hostility. "I'm extremely happy that those things have not come here,"



nefits in face of rising costs

"You just don't get good rates if you have anyone with medical problems. And you never know how long you will be able to keep a policy before it's canceled."

— Patty Harpel

said Neubauer, the internist.. "... Maybe the cost of insurance will go down, but so will the quality of care and I'm not sure it's worth it."

Neubauer said the managed care systems tend to screen out those who are really sick, since they may need lots of expensive treatment that will cut away the profits from a pre-paid or discount plan.

Other Alaska doctors say managed care means more insurance company bureaucracy and inferior care for everyone: Doctors withholding treatment for fear the next test — or the next operation — will erode the profit from a pre-determined fee.

Insurance companies disagree and are frustrated by the Alaska doctors' reluctance to embrace the new systems. "You're opening a very interesting and very sensitive area," says Robert Simons, a physician employed as Aetna's medical director. Simons said he sent letters to state physicians asking them to join in new managed care program with Aetna, and found "no real interest."

Blue Cross says it will attempt to impose healthcare management on physicians by drafting new discount policies that only reimburse patients for the average cost of a physician's service. The average broken arm, for example, costs $67 to set in Alaska, but some doctors charge $150.

If a doctor's cost is way over the average — and there are no special complications to justify that, then the new policy would prod the patient to a cheaper doctor, said Clark, the Blue Cross vice president.

Aetna and Blue Cross have had more success dealing with hospitals.

Aetna has convinced Humana to offer a 30 percent discount in services, according to Simons, in return for helping fill the hospital's beds with a steady stream of its insured.

Blue Cross has teamed up with Providence in a similar program. And Providence recently struck out on its own to offer such discounts directly to Alyeska Pipeline Service Co. and several other large employers.

The employers who purchase such discounted services use an economic hammer to insure their employees go to the right hospital. Employees pay a low deductible if they attend the preferred hospital, a much higher deductible if they attend the competition.

Such plans were first introduced to Anchorage in the mid '80s, and as rates rise, their appeal grows, both to employers and employees.

The Alaska Railroad, for example, after months of tough bargaining reached a 1987 union agreement that included a three-year freeze on employer payments toward health benefits. At the time, it looked like a good settlement because those payments covered all the costs of a gilt-edged medical plan jointly insured through the railroad and Aetna.

But last year, Aetna hit the railroad with a 40 percent rate increase for the standard plan. Then they offered a more modest alternative, a 14 percent rate increase for those employees who would join a "preferred hospital" plan with Humana.

Under that plan, employees who chose Providence would have to pocket 40 percent — rather than the standard 20 percent — of initial hospital costs.

Other cost management efforts included insurance company approval of nonemergency surgery and a financial penalty for not obtaining a second opinion on prospective surgery.

Non-union railroad employees chose to sign up for the preferred plan, but union workers opted against it. Then this year, facing another 32 percent increase, the unions decided to go with the preferred option.

Even with the preferred plan, the new insurance doesn't come cheap. A family policy will cost each union member $2,049 out of pocket.

Quinn, the union leader, said he's talked with the rank and file About cutting benefits to try to bring that expense down farther. But for the moment, his members say no. "The employees still want the plan they have. They aren't willing to downscale it — yet."

Trading suspects sought

Los Angeles Times

CHICAGO — A key prosecutor in the government's investigation of alleged fraud in Chicago's multi-billion-dollar commodities futures industry went door-to-door Saturday, trying to pressure suspects to cooperate with federal agents.

Department of Justice veteran Ira H. Raphaelson, who is heading the investigation, and FBI agents pressed traders to agree to provide evidence against others who worked in the trading pits of the Chicago Board of Trade and the Chicago Mercantile Exchange.

Sources in the legal community said the tactic indicated that the government was still trying to obtain critical cooperation. The investigation is the most sweeping ever into the arcane industry that is as much a cornerstone of Chicago's economy as entertainment is to the Hollywood economy or Wall Street to New York.

But its success, legal observers said, may depend more on what happens in the next several weeks than on what went on during the last three years of undercover work.

The need for cooperation — and the government's leverage for obtaining it — has been underscored by lawyers and commodities exchange officials monitoring the investigation.

For example, traders and brokers who were observed — and in some instances electronically recorded — by five undercover FBI agents posing as traders at the two markets have been accused of relatively minor infractions, but infractions that carry relatively major penalties.

They were confronted, for the most part, in late night and early morning by FBI agents and assistant U.S. attorneys in a series of subpoena-serving visits that began last Monday. The beginning of the public part of the investigation last week coincided with a major conference for commodity law attorneys on the Caribbean island of St. Martin.

"If you are ever going to break open a major undercover investigation and go door to door, the time to do it is when most of the good lawyers in the area are out of town," said a former Department of Justice attorney who is representing suspects.

SB36

REVIEW & OUTLOOK

Mandated Health Costs

Ground zero in the emerging federal budget debate is health-care costs. The Reagan-Bush budgets are presumably targeting Medicare outlays, which surely will set off howls of unfairness from the program's protectors. Simultaneously, congressional liberals want increasingly to move the health burden "off budget" by enacting federal mandated-benefit laws. Before this great Washington debate gets too far down the track, it might be useful to take a hard look at the train that's already left the station—mandated health benefits at the state level.

The states' programs have relentlessly inflated the cost of basic health care. Generally, these laws require private health insurance to cover specific diseases and disabilities and specific services. In 1970, there were only 30 such laws in the United States. This year the number will exceed 700. Maryland alone has 32. Not surprisingly, the percentage of Americans covered by hospital policies has dropped from a high of 83% in 1978 down to 79% today.

States variously compel insurers to provide coverage for maladies ranging from AIDS to drug abuse, and for services ranging from acupuncture to *in vitro* fertilization. Low-income people often must buy an expensive smorgasbord health-insurance policy covering services they don't want or need. Leaner, cafeteria-type plans are often unavailable.

The range of medical treatment required by some states is staggering:

• Ten states require insurers to cover outpatient care, even though such care can be significantly more expensive. Another 10 states require home health-care coverage.

• At least 37 states mandate coverage for chiropractors, and some insist they be reimbursed at the same rate as physicians.

• In Arkansas and Connecticut, insurers must cover the services of naturopaths (herb specialists). Florida and Nevada require that acupuncturists be reimbursed.

A study by the National Center for Policy Analysis, a Dallas-based think tank, estimates that as many as 25% of the uninsured lack health coverage because mandated benefits such as the above make it too expensive.

Even a single mandate can greatly increase insurance-premium costs. Golden Rule Insurance—the largest seller of family policies—says that because Georgia allows someone with coverage by more than one insurer to fully collect benefits from each, Golden Rule must charge 15% more there. Massachusetts has strict price controls on premiums; it tells insurers to make up losses it incurs there in other states. Golden Rule recently announced it wouldn't sell insurance in Massachusetts and six other states with similar laws.

Four states now require a financial-impact report before any new mandates are approved. Hawaii learned that mandating coverage for chiropractors would raise insurance costs by as much as $8.1 million.

Many large- and medium-size firms have reacted to the explosion in mandated benefits by no longer buying insurance. They self-insure their health plans instead. In 1976, such self-insurance accounted for only 5% of all health insurance; today it is over 40%. The major reason is that federal law exempts self-insured plans from most state regulations. Self-insurance is fine for employees of those firms, but the result is that the full burden of costly regulations is borne by the rest of the population: employees of small business, the self-employed and the unemployed.

Innovative alternatives are under way at the local level. In Tulsa, Okla., small, uninsured companies can join with large companies in one, large health plan. Montgomery County, Md., has contracted with Blue Cross to offer all of its 700,000 residents a voluntary catastrophic health policy for an annual premium of $26 for an individual and $54 for a family. The county has no financial or legal obligations.

Liberals seem to have little patience for such solutions. A bill by Senator Ted Kennedy would require all employers to provide a government-designed insurance policy for their workers. Former Treasury economists Gary and Aldona Robbins estimate that in its first year the Kennedy plan could cost as much as $100 billion and destroy one million jobs. Lobbyists would soon try to open up federal insurance reimbursement to a variety of special interests. "There are 142 health-related professions," says NCPA president John Goodman. "Everyone would want to be reimbursed and costs would skyrocket."

Medical outlays don't just happen; they flow mainly from conscious decisions by politicians to create a market for health care. The states' experience will be worth remembering as Washington starts trying to shove back into the bottle the health-care genie it released years ago.

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

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June 3, 1987

MEMORANDUM

TO: Representative Niilo Koponen

ATTN: Lisa McLaren

FROM: Jay Livey
Legislative Analyst

RE: **Mental Health Insurance Laws in Other States**
Research Request 87.307

You asked that we: 1) determine the extent to which other states regulate the coverage of mental health services under health insurance policies sold within the state; 2) identify the types of mental health providers that are eligible to be reimbursed under the mental health coverage in other states; and 3) discuss the impact to mental health services in Alaska associated with designating specific mental health providers to be eligible for reimbursement from insurance claims.

Mental Health Insurance in Other States

The attached chart identifies the states which regulate mental health benefits in private health insurance policies. Thirteen states (Colorado, Connecticut, Maryland, Maine, Massachusetts, Minnesota, Montana, New Hampshire, North Dakota, Ohio, Oregon, Virginia and Wisconsin) have laws which require insurers to include mental health services as part of certain insurance policies sold in the state. Thirteen states (Arkansas, California, Florida, Georgia, Illinois, Kansas, Louisiana, Missouri, New York, Tennessee, Vermont, Washington and West Virginia) require only that insurance policies "offer" mental health coverage at the policy holder's option.

Mandated Coverage. Of the states which mandate mental health coverage, four states (Connecticut, Maryland, Massachusetts and Virginia) require coverage for individual as well as group policies. The type of mandated coverage specified in state insurance laws varies considerably. Colorado, Connecticut, Maine, Maryland, New Hampshire and Oregon specify coverage of inpatient services, partial hospitalization and outpatient services. Massachusetts, Montana, Virginia and Wisconsin specify inpatient and outpatient coverage only while Ohio and Minnesota specify only outpatient coverage. North Dakota specifies coverage for inpatient services and partial hospitalization but not for outpatient services.

Mental health providers eligible to receive insurance reimbursement under mandated coverage include psychiatrists in all thirteen states, psychologists in 12 states and social workers in six states. It should be noted, however, that the licensing requirements vary among states with regard to the qualifications required of these mental health providers. In virtually all of these states, mental health services offered in a licensed hospital or community mental health center are covered under mandated insurance policies.

Mandated Availability. Of the thirteen states which mandate availability of mental health coverage as a policy option, nine states specify that only inpatient and outpatient coverage be offered. Two states, Florida and Vermont, specify that in addition to inpatient and outpatient coverage, partial hospitalization should also be offered. Tennessee offers only outpatient coverage while Washington statutes do not specify services to be offered.

In twelve of these thirteen states--Georgia does not specify the types of providers eligible for insurance reimbursement--psychiatrists and psychologists are designated as professionals eligible for insurance reimbursement. In addition, five states specify social workers or other counseling professionals as eligible providers.

Provision of Mental Health Services in Alaska

Under Alaska law, three types of mental health professionals are licensed by the State: psychiatrists (AS 08.64), psychologists and psychological associates (AS 08.86). It is unlawful for an individual who is not so licensed to practice psychiatry or psychology or to generally advertise his or her services as relating to psychiatry or psychology. However, this does not preclude other types of health professionals from providing counseling services, e.g., drug and alcohol counsellors and family counselors.

Any hospital other than federal hospitals must be licensed by the State. A hospital is defined as any "institution or establishment, public or private, devoted primarily to providing diagnosis, treatment, or care over a continuous period of 24 hours each day for two or more unrelated individuals suffering from illness, physical or mental disease, injury or deformity, or any other condition for which medical or surgical services would be appropriate." Alaska has two hospitals licensed as psychiatric hospitals, Alaska Psychiatric Institute (API) and Charter North. In addition, Fairbanks Memorial, Providence and Mt. Edgecumbe are licensed to provide psychiatric services.

Community mental health centers established under AS 47.30 do not require a State license, but their operations must conform to State law and department regulations. Currently, there are 27 community mental health centers in Alaska. (See Table 1 for a summary of the community mental health centers in the state.)

Table 1 also includes the staffing characteristics of the community mental health centers as of October 1986. As the table indicates, eight mental health centers have medical doctors on staff. Of the centers without an M.D., eight have a PhD psychologist on staff (although two of these individuals were not licensed by the State) and 11 centers were staffed by an individual with a Masters degree. Within this latter group, one individual with a Masters degree was licensed as a psychological associate.

TABLE 1
COMMUNITY MENTAL HEALTH CENTERS IN ALASKA

		---------STAFFING INFORMATION---------		
LOCATION	NUMBER OF COMMUNITIES SERVED	MEDICAL DOCTOR	PSYCHOLOGIST	PSYCHOLOGICAL ASSOCIATE
Anchorage	3	yes	yes	yes
Fairbanks	8	yes	no	no
Wasilla	6	yes	yes	yes
Juneau	7	no	yes	yes
Kenai	4	yes	yes	no
Ketchikan	6	no	yes	no
Bethel	35	yes	no	no
Kodiak	6	no	yes	yes
Nome	16	no	no	no
Homer	8	yes	yes	yes
Sitka	2	no	yes	no
Barrow	7	no	no	no
Dillingham	26	yes	no	no
Kotzebue	12	no	no	no
Dutch Harbor	11	no	yes	no
Valdez	1	no	no	yes
Seward	5	yes	yes	yes
Prince of Wales	4	no	no	no
Galena	7	no	yes	no
Cordova	2	no	yes	no
Tok	7	no	no	no
Haines	3	no	no	no
Copper Center	10	no	no	no
McGrath	8	no	yes	no
Aniak	9	no	no	no
Fort Yukon	7	no	no	no
Tanana	8	no	no	no

Notes: Staff information provided as of October 1986.
Source: Alaska Department of Health and Social Services, Division of Mental Health.

Prepared by the House Research Agency, June 1987.

Table 2 provides a geographical distribution of licensed mental health providers in the state. As the table indicates, the licensed mental health providers are located predominantly in the larger communities in the state although Homer, Dutch Harbor, Seward, Petersburg and Glenallen all have a licensed provider.

TABLE 2
GEOGRAPHIC DISTRIBUTION OF LICENSED MENTAL HEALTH PROVIDERS IN ALASKA

COMMUNITY	PSYCHIATRISTS	PSYCHOLOGISTS	PSYCHOLOGICAL ASSOCIATES
Anchorage	30	44	7
Fairbanks	4	19	1
Wasilla	0	2	2
Homer	0	2	0
Cordova	0	1	0
Kodiak	0	1	0
Juneau	2	5	1
Ketchikan	0	4	0
Kenai/Soldotna	0	4	0
Sitka	0	3	0
Dutch Harbor	0	1	0
Seward	0	1	0
Kodiak	0	2	1
Petersburg	0	0	1
Glenallen	0	0	1
Out of State		13	0
Total	36	102	14

Source: Psychiatrist information from personal communication with the Alaska State Medical Association. Other data from Department of Commerce and Economic Development, Division of Occupational Licensing.

Prepared by the House Research Agency, June 1987.

Mental Health Insurance in Alaska

As Tables 1 and 2 indicate, there are areas of the state in which no providers could be reimbursed by insurance companies if reimbursement were restricted to licensed psychiatrists and psychologists. (Although psychological associates are licensed by the State, they must work under the direct supervision of a psychologist or psychiatrist.) Based on staffing patterns present in October of 1986, nine community mental health centers serving 84 rural communities do not have a licensed mental health provider on staff. As Table 2 indicates, these same communities have no private practitioners who could provide reimbursable services.

Expanding the definition of reimbursable providers to include master level practitioners would allow all community mental health centers to provide reimbursable services. According to the Division of Mental Health, as of October of 1986, all community mental health centers were staffed by an individual with at least a Master in Social Work (MSW) degree or Master of Arts (MA) degree in psychology.

One suggestion that has been made with regard to expanding the scope of reimbursable services in the state is to license mental health programs rather than mental health providers. Under this licensing format, community mental health centers which provide the required standards of service would be licensed by the State and be eligible for insurance reimbursement. Depending upon the licensing standards adopted, a community mental health center could be eligible for reimbursement even if the staff did not include a provider eligible to offer reimbursable services. The Division of Mental Health is currently investigating this approach.

It has also been suggested that although many rural areas do not currently have eligible providers, the market incentives created by mental health insurance legislation would cause providers to move into the underserved areas. This scenario assumes that there are a significant number of individuals in the underserved areas who would be covered by insurance policies and who would seek mental health services. Steve Caverly, acting director of the mental program at the Yukon-Kuskokwim Health Corporation (YKHC), noted that in the Bethel area, this assumption was not necessarily accurate.

Mr. Caverly noted that, in Bethel, there are a significant number of individuals who are covered under group insurance plans. However, this is not true in the villages that are within the YKHC service unit. He doubts that the YKHC program could collect sufficient revenue from insurance companies to offset the expense of hiring a psychiatrist or psychologist if the employment of these providers were necessary to bill insurance companies. However, he did note that the program currently bills for medicaid and some private insurance so that a billing procedure already exists.

Mr. Caverly identified two technical problems with regard to the types of practitioners eligible for insurance company reimbursement. First, he noted that it is very difficult for the mental health programs in the rural areas to attract and retain psychiatrists and psychologists, even if sufficient funds are available to pay them. Turnover of these professionals is high in the rural areas and recruitment is a time-consuming process. Consequently, it is likely that for significant periods of time a community mental health center may not have either a psychiatrist or psychologist on staff even if this were the desired staffing level. If insurance coverage is discontinued during the time that one of these providers is not on staff, clients may choose to discontinue services rather than make higher out-of-pocket payments.

A second problem is associated with determining the appropriate level of service for the client. Mr. Caverly noted that, in some cases, clients are better served within their home communities. Many community services can be most efficiently provided by practitioners other than psychiatrists and psychologists. However, if these services are not reimbursable because they are not offered by an eligible provider, a client may choose an inappropriate level of service (such as inpatient treatment in Anchorage) because it is covered by his or her insurance policy.

If you have any questions or want additional information, please contact this agency.

Attachments

SUMMARY OF STATE MANDATES OF
MENTAL HEALTH INSURANCE COVERAGE

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

MAs Mandated Availability
MBPs Mandated Minimum Benefit Package

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

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

MA: Mandated Availability
MBP: Mandated Minimum Benefit Package

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

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

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STATE	TYPE OF MANDATE	DATE	INPATIENT	PARTIAL HOSPITALIZATION	OUTPATIENT	POLICIES COVERED	ELIGIBLE PROVIDERS
Tennessee	MA	1974	Not mandated	Not mandated	30 visits per year copays and deductibles on par with physical illnesses.	Group, Individual	Psychiatrist, psychologist, community health center with an approved plan for quality assurance, accredited hospitals.
Vermont	MA	1975	45 days per year in a general or mental hospital.	45 day equivalents of active care per year.	100% of the first 5 visits and 80% thereafter up to $500 per year.	Group	Psychiatrist, psychologist, licensed mental health professional, licensed general or mental hospital or community mental health centers.
Virginia	MBP/MA	1975	MBP: 30 days per year in a mental or general general hospital includes benefits for drug and alcohol rehabilitation and treatment with respect to drug and alcohol rehabilitation only. There is an $80 per day indemnity benefit and a lifetime coverage of 90 days.	Not specified	MA: $500 per year with reasonable deductibles and coinsurance that are not less favorable than physical illnesses, except that the copayment not exceed 50% up to $1,000 per benefit period.	Group, Individual	Psychiatrist, psychologist, licensed clinical social worker, mental health treatment center.
Washington	MA	1983					
West Virginia	MA	1977	45 days per year in a mental or general hospital; on par with illnesses in a general hospital.	Not specified	50% copayment up to $500 per year, sessions cannot exceed 50 per year.	Group, Individual	Psychiatrist, psychologist, licensed or accredited general mental hospital, comprehensive health service organization, community center or clinic.
Wisconsin	MBP	1975	Not less than the lesser of either the expenses of the first 30 days as an inpatient in a hospital, or the first $7000 minus a copayment of up to 10%.	Not specified	Up to $1000 minus a copayment of up to 10%.		Psychiatrist, psychologist, hospital, residential facility, outpatient treatment facility.

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

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MBP: Mandated Minimum Benefit Package

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

Source: State Health Reports, Intergovernmental Health Policy Project, No. 20 (Special Feature), January 1986.

THE AMERICAN JOURNAL OF PSYCHIATRY

A New Look at Evidence About Reduced Cost of Medical Utilization Following Mental Health Treatment

Emily Mumford, Ph.D., Herbert J. Schlesinger, Ph.D., Gene V. Glass, Ph.D., Cathleen Patrick, Ph.D., and Timothy Cuerdon, B.A.

Meta-analysis of 58 controlled studies and analysis of the claims files for the Blue Cross and Blue Shield Federal Employees Plan for 1974–1978 provide mutually supporting evidence of the cost-offset effects of outpatient mental health treatment. These two complementary resources provide a powerful tool for investigating the nature of associations between mental health services and subsequent reductions in the use of other medical services. The authors found that the reductions in use of medical services are associated with inpatient rather than with outpatient utilization and tend to be larger for persons over 55 years of age.

(Am J Psychiatry 141:1145–1158, 1984)

The literature on the phenomenon that the cost of outpatient psychotherapy may be offset by savings in medical expenditures began with a West German study of persons who had psychoanalysis or psychoanalytic psychotherapy and whose use of hospitalization for a 5-year period was less than that of a control group (1). This study and the subsequent literature were reviewed by Jones and Vischi, who concluded that the effect of psychotherapy was to reduce use of medical services by about 20% (2). A meta-analysis of 15 controlled offset studies up to 1978 that included some reviewed by Jones and Vischi yielded an estimate of the cost-offset effect between 0% and 14% (3). The range of estimates reflects methodologic flaws in many studies.

A meta-analysis of controlled studies of the effect of "psychologically-informed intervention" on patients following heart attack or facing surgery showed that patients provided with information—about their condition, what to expect, and how to further recovery—or who were given emotional support did better than control subjects on most outcome indicators (4). Thirteen of these experimental studies included days in hospital as an outcome indicator, and their combined results showed that psychologically treated patients were discharged about 2 days sooner than were persons not so treated. Devine and Cook, from a meta-analysis of 49 controlled experiments of the effects of psychoeducational interventions with surgical patients, reported 1.31 fewer hospital days for patients receiving mental health services than for patients provided only the usual medical management (5).

Since our last review of the cost-offset literature in 1978, the number of controlled studies has increased to 58 suitable for meta-analysis (1, 6–62). It is feasible now to study the variables associated with reduced medical utilization following mental health treatment. A second resource, the massive fee-for-service research data base derived from the health insurance claims files of the Blue Cross and Blue Shield Federal Employees Program (FEP), provides a complementary perspective for studying the same variables. When we use these two large sets of data, each with special strengths that may compensate for weaknesses in the other, we can attempt to answer the same questions from two distinctly different perspectives.

METHOD 1: META-ANALYSIS OF THE COST-OFFSET LITERATURE

Meta-analysis is a quantitative procedure for summarizing findings across studies (4, 63). It makes use of any of several summary statistics that convert diverse

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TABLE 1. The Characteristics and Findings of 58 Studies of Effects of Outpatient Psychotherapy on Subsequent Medical Care Utilization

	Patient Data					Outcome Measure	
	Age (years)[b]						
Study[a]	Range	Mean	Sex	Setting	Intervention	Outpatient	Inpatient
Andrew (6)[c]	24–75	54	M	Inpatient surgery	Instruction		Days
Archuleta et al. (7)[f]	15–70	45	M/F	All inpatient sites	Instruction		Days
Budd et al. (8)[f]	23–63	49	M/F	Inpatient surgery	Instruction		Intensive care days Hospital days
Budman et al. (9)[g]	—	21+	M/F	Health maintenance organization (HMO)	Short-term group therapy	Cost Visits[h]	
Budman et al. (10)[g,i]	21–56	31	M/F	HMO	Short-term group therapy Therapy drop-outs	Cost Visits[h] Cost Visits[h]	
Christopherson et al. (11)[f]	34–71	55	M	Inpatient surgery	Instruction		Intensive care days Hospital days
Cohen (12)[f]	21–65	—	M/F	Inpatient surgery	3 types of instruction		Days
Davis (13)[c]	—	—	M/F	Inpatient surgery	Crisis intervention		Days
Delong (14)[f]	23–64	44	F	Inpatient surgery	Instruction		Days
Duehrssen et al. (1)[g]	—	25+	M/F	Outpatient clinic	Psychoanalysis		Days
Edwards et al. (15)[g]	17–40	29	M	Navy alcohol rehabilitation center	Alcohol counseling	Sick days	Hospital days
Egbert et al. (16)[c]	—	52	M/F	Inpatient surgery	Instruction		Days
Felitti (17)[g]	—	—	M/F	HMO	Psychiatric consultation	Visits[h]	
Felton et al. (18)[c]	19–71	—	M/F	Inpatient surgery	Instruction Emotional support		Days
Florell (19)[c]	—	—	M/F	Inpatient surgery	Emotional support Emotional support plus instruction		Days
Follette et al. (20)[g] (1st- and 5th-year results only)	24–62	38.1	M/F	HMO	Psychotherapy: 1 visit 2–8 9+ 1 visit 2–8 9+	Visits[h]	 Days
Fortin et al. (21)[c]	20–59	—	M/F	Inpatient surgery	Instruction		Days
Goldberg et al. (22)[g]	All ages	—	M/F	HMO	Short-term psychotherapy	Doctor visits Lab and X-ray visits	
Goldberg et al. (23)[g]	6–65+	—	M/F	HMO	Short-term psychotherapy	Visits[h]	Days
Goldensohn et al. (24)[g]	0–65	—	M/F	HMO	Short-term psychotherapy	Doctor visits Specialist visits Lab and X-ray visits	
Graves et al. (25)[g]	0–21	—	M/F	Health clinic	Short-term family therapy	Visits[h]	
Gruen (26)[c]	40–69	—	M/F	Inpatient cardiology	Short-term counseling		Days
Hankin et al. (27)[g] (average of 1st and 2nd years versus 4th and 5th years)	All ages	—	M/F	HMO	Diagnostic visit	Doctor visits Lab and X-ray visits	

Psychotherapy Group				Control Group[c]				
	Mean (±SD)		%		Mean (±SD)		%	%
N	Pre	Post	Change	N	Pre	Post	Change	Difference[d]
22		6.32		18		6.78		−6.8
248		7.49 (±5.70)		267		6.90 (±3.91)		+8.6
16		4.1		15		6.0		−31.7
16		9.3		15		11.2		−17.0
93	59.61	71.95	+20.7	93	35.42	54.39	+53.6	−32.9
93	3.9	6.7	+71.8	93	2.6	4.7	+80.8	−9.0
43	$6.86	$6.55	−4.5					−4.5
	2.94	2.41	−18.0					−18.0
24	$12.70	$7.29	−42.6					−42.6
	4.10	2.38	−42.0					−42.0
29		3.2		12		4.7		−31.9
29		11.1		12		13.3		−16.5
40		3.93		37		4.05		−3.2
37		3.72						−8.1
39		3.82						−5.7
13		5.0 (±4.7)		13		6.5 (±3.8)		−23.1
31		6.17		33		7.18		−14.1
125	5.2	1.2	−77	100	5.1	4.8	−5.9	−71.1
148	28.0	15.1	−46.1					−46.1
	13.0	7.0	−46.2					−46.2
46		3.8		51		6.5		−41.5
134								−50
25		11		25		14		−21.4
12		14						0
30		4.90 (±1.71)		50		6.10 (±2.3)		−19.7
70		4.33 (±1.11)						−29.0
80	11.4	4.4	−61.4	152	11.4	12.9	+13.2	−74.6
41	19.0	5.7	−70.0					−83.2
31	11.6	5.7	−50.9					−64.1
80	1.46	0.63	−56.8	152	2.13	2.01	−5.6	−51.2
41	1.61	0.85	−47.2					−41.6
31	4.94	0.68	−86.2					−80.6
37		6.35		32		6.44		−1.4
256	4.94	3.42	−30.7					−30.7
	3.11	2.18	−29.8					−29.8
483	5.27 (±3.12)	5.23 (±3.12)	−.7	483	4.67 (±4.92)	5.03 (±4.92)	+7.7	−8.4
	0.99	0.38	−61.6		0.46	0.62	+34.8	−96.4
169	3.8	3.4	−10.5	141	4.6	4.8	+4.3	−14.8
	2.0	1.7	−15.0		1.3	1.6	+23.1	−38.1
	10.3	7.7	−25.2		8.9	11.4	+28.1	−53.3
21	5.8	3.7	−36.2	21	4.7	6.1	+29.8	−66.0
35		22.5 (±3.44)		35		24.9 (±10.65)		−9.6
378	5.23	5.14	−1.7	8,562	3.82	3.89	+1.8	−3.5
	4.75	5.43	+14.3		3.51	3.89	+10.8	+3.5

TABLE 1 (continued)

Study[a]	Patient Data: Age (years)[b] Range	Mean	Sex	Setting	Intervention	Outcome Measure: Outpatient	Inpatient
Hart (28)[c]	43–65	—	M/F	Inpatient surgery	Hypnotism		Days
Hill (29)[c]	50–91	—	F	Inpatient surgery	3 types of instruction		Days
Hitchcock (30)[c]	18–70	39	M/F	Inpatient surgery: Cholecystectomy	Instruction Emotional support		Days
	—	—		Herniorraphy	Instruction Emotional support		Days
Jacobson et al. (31)[g]	—	—	M/F	Air Force hospital	Instruction		Admissions
Jameson et al. (32)[g]	—	40+	M/F	Fee-for-service psychiatry (Blue Cross)	Short-term psychotherapy	Cost/month[h]	
Johnson et al. (33)[c]	21–70	44	M/F	Inpatient surgery: cholecystectomy	5 types of instruction		Days
Johnson et al. (34)[c] (replication study with former sample as controls)	21–70	46	M/F	Inpatient surgery: cholecystectomy	5 types of instruction		Days
Kennecott (35)[g]	—	21+	M/F	Counseling center	Counseling	Costs[h]	
Kessler (36)[g]	All ages	—	M/F	HMO	Short-term psychotherapy	Visits[h]	
Kogan et al. (37)[f] (2 years pre versus 2 years post)	—	—	M/F	HMO	Short-term psychotherapy	Visits[i]	
Langer et al. (38)[c]	—	—	M/F	Inpatient surgery	Emotional support Instruction Both		Days
Levitan et al. (39)[f]	—	65+	F	Inpatient surgery	Liaison psychiatry		Days
Lindeman et al. (40)[c]	16–60+ 5–15	— —	M/F	Inpatient surgery	Instruction		Days
Lindeman et al. (41)[f]	15+	50	M/F	Inpatient surgery	Instruction		Days
Longobardi (42)[g]	—	23.6	M/F	Military health clinic	Short-term psychotherapy	Visits[h]	
Lucas (43)[c]	26–60	52.2	M	Inpatient surgery	3 types of emotional support		Days
Lunn (44)[g]	—	—	M/F	Fee-for-service health clinic	Alcohol counseling	Days lost Sick claims Cost of claims	
McHugh et al. (45)[g]	—	—	M/F	Mental health center	Short-term psychotherapy	Visits[k]	
Mechanic et al. (46)[g]	—	18+	M/F	Fee-for-service psychotherapy	Short-term psychotherapy	Visits[k]	Admissions
Olbrisch (47)[c]	18–25	—	M/F	College health clinic	Instruction	Visits[h]	

Psychotherapy Group				Control Group[c]				
	Mean (±SD)		%		Mean (±SD)		%	%
N	Pre	Post	Change	N	Pre	Post	Change	Difference[d]
20		12.5 (±1.47)		20		12.3 (±1.66)		+1.6
10		3.37 (±0.92)		10		3.19 (±0.79)		+5.6
10		3.31 (±0.59)						+3.8
10		3.13 (±0.71)						−1.9
13		4.9 (±1.1)		14		5.5 (±0.9)		−10.9
13		5.4 (±1.6)						−1.8
13		3.6 (±0.8)		14		3.9 (±0.9)		−7.7
13		3.6 (±0.9)						−7.7
—	72	66	−8.3					−8.3
136	$16.47	$7.06	−57.1	4,398	—	—	—	−57.1
14		6.20		10		6.36		−2.5
14		5.97						−6.1
12		5.78						−9.1
14		5.84						−8.2
13		5.29						−16.8
11		5.23		10		6.39		−18.2
8		5.33						−16.6
9		5.24						−18.0
10		5.24						−18.0
13		5.55						−13.2
150	$93.22	$41.62	−55.4	150	$36.25	$36.79	+1.5	−56.9
1155	6.25	5.75	−8.1					−8.1
148	7.85	6.74	−14.1	148	4.39	4.31	−1.8	−12.3
14		5.64		15		7.6		−25.8
15		7.2						−5.3
15		6.2						−18.4
23		30		23		42		−28.6
90		6.70		86		6.65		+0.8
19		2.11 (±0.74)		11		3.0 (±3.0)		−29.7
107		6.5 (±3.8)		132		8.4 (±7.5)		−22.6
17	7.47	2.71	−63.7	17	6.94	7.12	+2.6	−66.3
9		10.56 (±1.13)		9		12.78 (±2.05)		−17.4
9		12.22 (±2.17)						−4.4
9		12.78 (±4.66)						0.0
104	33.1	17.1	−48.3	48	14.33	31.69	+121.1	−169.4
104	1.75	0.95	−45.6	48	1.19	1.42	+19.3	−64.9
104	$899.56	$468.18	−48.0	48	$397.54	$904.44	+127.5	−175.5
119	6.7	11.6	+72.4					+72.4
91	5.2 (±5.0)	4.4 (±5.0)	−15.4	842	2.6 (±3.5)	2.4 (±3.5)	−7.7	−7.7
	0.23	0.15	−34.8		0.10	0.11	+10	−44.8
44	2.5	1.11	−55.5	38	1.5	0.88	−41.3	−14.2

TABLE 1 (continued)

Study[a]	Patient Data: Age (years)[b] Range	Mean	Sex	Setting	Intervention	Outcome Measure: Outpatient	Inpatient
Olendzki (48)[g]	5–65	—	M/F	Fee-for-service health clinic	Short-term psychotherapy	Visits[k] Costs[h]	
Ormeyer (49)[e]	16–65	—		Inpatient surgery	Instruction plus emotional support Emotional support		Days
Patterson et al. (50)[g]	All ages	33	M/F	HMO	Short-term psychotherapy	Doctor visits Lab visits X-ray visits	
Pickett (51)[e]	20–68	—	M/F	Inpatient surgery	2 types of instruction		Days
Plomick et al. (52)[g]	15–69	43.2	M/F	3 HMOs	Alcohol counseling	Visits[h]	
Regier et al. (53)[g]	—	—	M/F	Four health care settings	Short-term psychotherapy	Visits[h]	
Risser et al. (54)[f]	40–75	56.8	M	VA inpatient surgery	Instruction		Days
Rosen et al. (55)[f]	—	20.0	M/F	Health science center	Short-term psychotherapy	Doctor visits Diagnostic visits Prescriptions	
							Days
Schmitt et al. (56)[e]	20–70	—	M	VA inpatient surgery	Group discussion		Days
Sherman et al. (57)[g]	25–77	47.4	M/F	HMO	Alcohol counseling	Cost/year per patient[h]	
							Cost/year per patient
Smith (58)[g]	16–23	—	M/F	College health service	Short-term psychotherapy	Visits[k]	
Surman et al. (59)[e]	—	50	M/F	Inpatient surgery	Emotional support		Days
Uris (60)[g]	—	—	M/F	HMO	Short-term psychotherapy	Visits[k]	
Van Steenhouse (61)[e]	29–65	—	M	Inpatient surgery	Emotional support Instruction		Days
Wilson (62)[e]	—	42	M/F	Inpatient surgery: Cholecystectomy	Instruction Relaxation training Both		Days
	—	43.1	F	Hysterectomy	Instruction Relaxation training Both		Days

[a]Studies by the following authors were reviewed but not included in this analysis because insufficient data were available for computation or study design did not al. (67), Harrington (68), Hayami et al. (69), Healy (70), Hegyvary et al. (71), Hoeper (72), Holder et al. (73), Johns et al. (74), Johnson et al. (75–77), Kogan et
[b]We report mean ages and age ranges only when they are provided by the authors.
[c]Some studies report multiple control groups. We have reported the control group that best approximates usual and customary care.
[d]Plus sign favors control group.
[e]Experimental design with random assignment.
[f]Experimental design with nonrandom assignment.
[g]Time-series study.
[h]Includes visits for X-rays and lab tests.
[i]Budman et al. called the dropouts a control group. However, since they received some mental health treatment, we consider them another treatment group.
[j]Includes visits for X-rays, lab tests, and mental health treatment.
[k]Excludes visits for X-rays and lab tests.

Psychotherapy Group				Control Group[c]				
	Mean (±SD)		%		Mean (±SD)		%	%
N	Pre	Post	Change	N	Pre	Post	Change	Difference[d]
401	3.0	3.5	+16.7	7,018	1.9	2.05	+7.9	+8.8
	126.5	109.5	−13.4		74.0	66.0	−10.8	−2.6
27		6.0		26		6.6		−9.1
26		5.8						−12.1
426	6.02	5.72	−5.0	—	—	—	—	−5.0
	1.86	1.59	−14.6		—	—	—	−14.6
	0.33	0.24	−29.4		—	—	—	−29.4
16		7.44		11		7.45		−.1
16		7.33						−1.6
367	1.01	0.68	−32.7	314	0.14	0.20	+42.9	−75.6
	(±0.67)	(±0.67)			(±0.29)	(±0.29)		
987		6.7		172		7.1		−5.6
541		6.1		379		8.7		−29.9
258		4.8		555		6.7		−28.4
957		4.9		491		6.2		−21.0
8		11.6		12		14.3		−18.9
103	5.69	3.37	−40.8	100	2.73	2.63	−3.7	−37.1
	2.82	2.11	−25.2		2.16	2.32	+7.4	−32.6
	3.86	2.22	−42.5		2.47	2.51	+1.6	−44.1
	2.13	1.16	−45.5		1.88	1.90	+1.1	−46.6
25		9.7		25		11.8		−17.8
64	293	263	−10.2	85	336	339	+0.9	−11.1
64	278	151	−45.7	85	209	493	+135.9	−181.6
49	1.41	1.52	+7.8	49	1.30	1.10	−15.4	+23.2
20		13.4		20		17		−21.2
45	4.18	3.71	−11.2	45	4.00	2.86	−28.5	+17.3
18		11.1		18		10.3		+7.8
18		11.6						+12.6
8		6.50		8		7.38		−11.9
		(±0.76)				(±1.41)		
8		6.63						−10.2
		(±0.92)						
11		6.27						−15.0
		(±1.27)						
9		7.22		10		8.40		−14.1
		(±1.20)				(±1.35)		
10		7.50						−10.7
		(±1.67)						
8		7.75						−6.9
		(±1.67)						

conform to specifications or did not permit assessment of the impact of mental health services on medical utilization: Abbott (65), Diehr et al. (66), Godbole et al. (78), Koulouch (79), Lindeman (80), Norfleet et al. (81), Patterson et al. (82), and Sclare et al. (83).

findings from individual studies to a common base that is free of scale.

To update our literature search we began with the comprehensive list of references provided by Jones (64). We called Medlars and Index Medicus searches for January 1979 through July 1982, reviewed *Excerpta Medica* from January 1979 to July 1982, and obtained Automated Subject Citation Alert and PsycSCAN searches for cost-offset topics and key authors. We also searched *Dissertation Abstracts* and obtained microfilms of relevant entries. Finally, we surveyed reports from published lists of grants and contracts of government agencies and checked usable studies through *Citation Index* from 1979 to 1982. By May 1983 we had located 58 cost-offset studies suitable for meta-analysis (see table 1). Of these, 27 were doctoral dissertations, unpublished government grant or contract reports, or reports from private industry. The relatively large portion of unpublished studies should alleviate the fear that meta-analysis of published studies may be biased by the generally positive results of studies that are published. Eighteen additional cost-offset studies were not included in the meta-analysis because the data provided were insufficient or the design was inadequate to assess the impact of mental health treatment on utilization of medical services (65–83).

RESULTS 1

General Cost-Offset Effects

Table 1 displays the characteristics and findings of the 58 studies of effects of outpatient psychotherapy on subsequent medical care utilization. The outcomes of all of the studies ranged from a 72.4% increase to −181.6% (decrease) in use of medical services following psychotherapy. Eighty-five percent of all of these studies reported a decrease in medical utilization following psychotherapy.

Twenty-six of these studies were naturalistic, time-series studies that compared persons' medical care utilization before and after psychotherapy. Each person served as his or her own control. Some of the studies also used comparison groups of persons who did not have psychotherapy. These studies did not assign patients to treatment groups randomly. Of the 26 time-series studies, all but six were conducted in prepaid clinic settings. This subset of studies yielded an average effect size of −33.10% (95% confidence interval is −57% to −20%). The weight of the findings from these 26 studies might be thought impressive considering that such naturalistic studies avoid the confounding problems of Hawthorne effects (84). On the other hand, the studies are open to other challenges.

First, the meaning of results from most such time-series studies has been challenged because experimental and comparison groups were selected differently. The medical care utilization of experimental subjects was recorded on "relative time" before and after the time of first mental health treatment. But the utilization data of comparison subjects were collected before and after an arbitrarily selected date. We expect that utilization of medical services may rise before the individual's entry into mental health treatment as a function of the same sense of distress that eventuated in his or her seeking mental health care. Thus the pre-psychotherapy utilization of the experimental groups might represent a peak or near peak. The medical care utilization of the mental health-treated group would be expected to fall from its peak regardless of benefits from the psychotherapy, since what goes up, in statistics as in nature, must come down. In contrast, for the control group there would be no such expectation either for a rise or fall. Thus results favoring the experimental group over the control group might be explainable in terms of statistical regression to the mean.

Self-selection for psychotherapy is also frequently invoked as a reason to question the findings of naturalistic studies. Random assignment to treatments is a cornerstone of methods developed in the biological sciences. But since self-selection for psychotherapy might well be regarded as part of that treatment, new methods to provide a functional equivalent of random assignment are called for. In the meantime, rather than simply dismissing the results of such a large number of studies, one can view the potential biasing effects of self-selection as an empirical matter to be settled by data.

Thirty-two studies were experimental in design, assigning patients to treatment conditions either randomly or through some matching scheme. Of these, 22 experiments determined the effects of psychological intervention on patients hospitalized for medical crises, with patients assigned randomly to a group receiving relevant information, emotional support, or both or to a comparison group receiving only the standard medical regimen.

Analyzing only these 22 studies that are not vulnerable to bias resulting from self-selection or misinterpretation of the phenomenon regarding regression to the mean, we find that on the average these modest psychological interventions reduced inpatient hospitalization approximately 1.5 days below the control groups' average of 8.7 days. This effect is in the same direction as, although slightly smaller than, our earlier finding of about 2 days on the basis of 13 studies (4).

In a comparison of the outcome measures of these 22 experimental studies that used random assignment to treatments with the 26 time-series studies in which patients had selected psychotherapy, the studies using random assignment yielded an average percent change of −10.4%. The 26 studies relying on self-selection yielded an average percent change of −33.1%. The offset effect is smaller when self-selection is ruled out by random assignment, but it appears both under conditions of random assignment and with self-selec-

tion of treatment. Devine and Cook (5) performed a similar test in their meta-analysis of cost-offset effects of mental health treatment among surgical patients and concluded that the method of subject assignment was not systematically related to the size of estimates of effect.

Outcome Indicators: Outpatient Versus Inpatient Medical Utilization

Of the 48 estimates of the effects of mental health treatment on outpatient medical utilization, only five came from experimental studies. Of the 71 estimates of the effect of mental health treatment on inpatient utilization, 62 came from experimental studies. The question is hopelessly confounded with study methodology and must be approached in a different way.

Five studies (20, 23, 46, 55, 57) provided data that permit an unconfounded examination of the effects of psychotherapy on inpatient as well as outpatient medical care utilization. In all but one, the reduction in inpatient medical utilization exceeded the reduction in outpatient utilization. The average change was −73.4% for inpatient utilization and −22.6% for outpatient utilization. Only one study (20) was an exception to this pattern. If one assumes that these five studies were drawn from a population of studies for which it is hypothesized that there is a .50 probability of inpatient utilization being reduced more than outpatient utilization, then the four "successes" (inpatient reduction greater than outpatient) in five "trials" have a probability less than .10 of being equaled or exceeded under the hypothesis.

These five studies have strengths and weaknesses that are complementary. On balance they permit the conclusion that the offset effect is likely to be greater for inpatient medical care utilization than for outpatient utilization. As we shall see, analysis of insurance claims will strengthen this impression.

Age of Patients as a Mediating Factor in Cost-Offset Effects

Most of the cost-offset studies did not report findings by age of patient; we found only two cost-offset studies of older people that were suitable for meta-analysis (29, 39). Neither of these dealt with outpatient psychotherapy, possibly reflecting a misleading bias that older patients do not profit from outpatient psychotherapy. There are, of course, many case reports and studies of positive benefits of mental health treatment for geriatric patients. For example, Godbole and Verinis (67) compared the effects of two forms of psychotherapy in a study of 61 hospitalized patients and reported benefits for both treatment groups as assessed by improvement in rating forms completed by nursing staff and author/therapists.

National statistics show the same trend as the research literature. In 1980 persons age 65 years and older constituted 11% of the population and accounted for 29% of all health expenditures (85). Yet they received a disproportionately small portion (2%–4%) of outpatient mental health services (86). These figures suggest underutilization of mental health services by this age group. Older people may be less likely than other age groups to be referred for mental health treatment, although their needs may be greater and benefits would seem to be significant.

Levitan and Kornfeld (39) provided psychiatric consultation to 24 elderly patients hospitalized for fractured femur and compared their hospital stays with those of a comparison group of 26 patients hospitalized for the same reason without psychiatric intervention in the same months of the previous year in the same hospital. Length of stay for the intervention group was 12 days shorter than the mean of 42 days for the control group, and twice as many of the patients who had been provided consultation returned home rather than being discharged to a nursing home or other institution.

Hill (29) studied 40 cataract surgery patients between the ages of 50 and 91 years. They were randomly assigned to a behavioral training group, a sensory information training group, a combined behavioral and sensory training group, or a comparison group that received no special preparation. We would not expect important differences in length of stay, since the mean hospital stay for all four groups of patients was only a little over 3 days. However, a second outcome variable—first venture from home after discharge—did show significant differences in the expected direction. The "combined" group ventured out soonest from home, and both other treatment groups ventured out sooner than the comparison group.

Since we could find only two studies that directly addressed the impact of age on the offset effect, we measured its impact indirectly through meta-analysis of the 23 studies that did report the mean age of subjects. In 15 inpatient studies the mean age of the patients was 48.14 years, and the correlation between the mean age listed in each study and the effect size was −.44, indicating that older subjects benefit more. In four outpatient studies that used visits to the doctor as the outcome measure, the mean age of the patients was 30.53 years, and the correlation between mean age and effect size was −.31. In four alcohol outpatient studies the mean age of the clients was 35.8 years, and the correlation between mean age and effect size was −.78. Thus in three different settings with three different populations a consistent finding emerges: Older people tend to have greater offset effects following mental health treatment.

METHOD 2: ANALYSIS OF HEALTH INSURANCE CLAIMS FILES

The claims files of the Blue Cross and Blue Shield FEP from 1974 through 1978 contain the medical care charges for a national sample of 6.7 million federal

employees, retirees, survivors, and family members. About 53% of all federal employees were insured by FEP during these years, providing the largest fee-for service data base available. The procedures for transforming the claims files to research files are described elsewhere (87). About 1.5% of persons covered received some form of mental health services in any 1 year during the 5-year period, or about 3.9% during the 5 years. This proportion is consistent with other reports that 1% to 1.8% of general medical patients receive psychiatric treatment in a 1-year period (88, 89).

Previous work (87) has shown a dose-response relationship for psychotherapy and medical care utilization, with a cost-offset effect becoming clear after about six psychotherapy visits. In the present study, therefore, we examined the medical utilization of a group of persons who had at least seven outpatient mental health treatment visits beginning in 1975 but no psychiatric inpatient claims at any time. We compared their medical care utilization with that of a randomly selected subset of persons who filed no mental health claims throughout the 5 years of the data base. Each person in both groups was drawn from a contract that was active from 1974 through 1978 and was required to have at least one medical claim of any size in 1975 to enter the study. The data thus represent persons who made at least minimal use of medical care services. About 19% of contracts filed no claims during the 5 years. To ensure that differences in death rates would not bias the results, each person over age 55 had to have at least one claim of any kind in 1978, the last year of the data base.

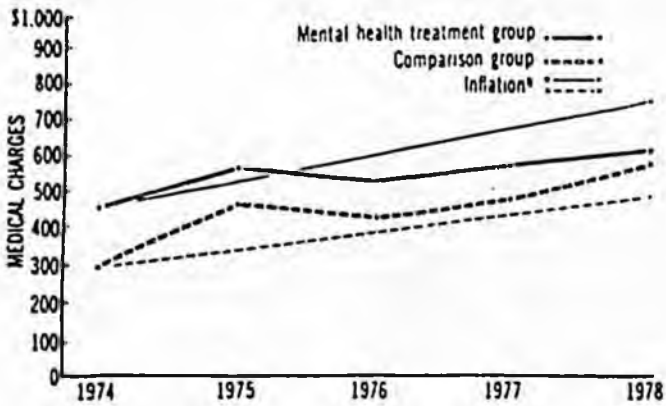
This method of comparison avoids capitalizing on statistical regression to the mean, since both groups were compared on calendar time and had the same requirement to enter the study, a medical claim in 1975. We were thus able to compare the medical care utilization of the two groups for 1 year before the year of the entry requirement and for 3 years following it, which is also the year in which each person in the treatment group began a first episode of outpatient psychotherapy with or without drugs.

RESULTS 2

Evidence of General Cost-Offset Effects

Figure 1 shows that in 1974, the year before the start of mental health treatment, the medical charges for the treatment group were markedly higher than those for the comparison group, a finding consistent with the literature that suggests excess morbidity from physical disease among the mentally ill (90, 91) and our earlier findings (87). The medical charges of both groups rose in 1975 in part as an artifact of selection—each person was required to have at least one medical claim in that year. The medical care charges of both groups then fell in 1976 and rose again at a slower rate from 1976 to

FIGURE 1. Total Medical Charges of Persons With Seven or More Outpatient Mental Health Treatment Visits From 1974 Through 1978 But No Inpatient Psychiatric Claims (N=6,629) and a Random Sample of Persons With No Mental Health Treatment Claims (N=32,450)[a]



[a]All persons were required to have at least one medical claim in 1975, and those over age 55 at least one claim in 1978.
[b]The inflation rate was 13.6%/year.

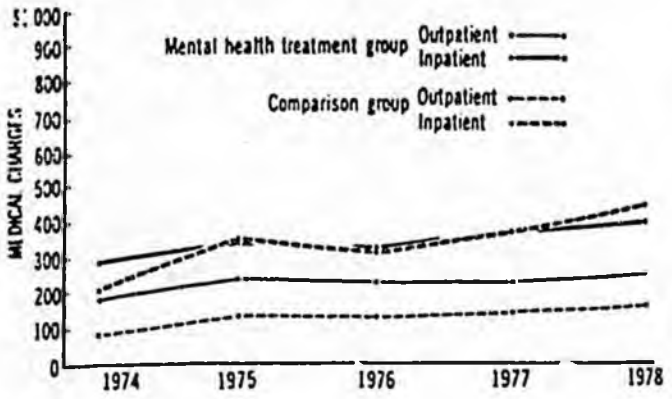
1978. Following mental health treatment, the medical care charges of the treatment group increased more slowly than the average inflation rate of 13.6% per year. In contrast, the charges of the comparison group increased faster than the inflation rate. If we adjust the means for 1975–1978 for the difference between the groups in 1974, the adjusted means of the treatment group were significantly lower than those of the comparison group during each of these 4 years ($r=-3.21$, -2.44, -2.69, and -3.77, respectively, $p<.05$).

The treatment group was younger than the comparison group (33.6 years versus 39.4 years) and contained more females (59.6% versus 53.2%). Since use of medical services increases with age, is higher for females, and varies geographically, it is possible that differences in utilization favoring the mental health group could be explained by these variables. Therefore we adjusted the means of the mental health treatment and comparison groups for age, sex, and regional differences by the method of unweighted means analysis (92). Removing the "nuisance variables" in this way did not alter the general form of the findings. The adjusted means were different, but the pattern of differences was not affected. Therefore the following analyses will be based on actual means whose meanings are perhaps intuitively easier to grasp.

Cost-Offset Effects in Claims Files: Outpatient Versus Inpatient Medical Utilization

Figure 2 compares the outpatient and inpatient medical care charges of the persons whose total medical charges were graphed in figure 1. Outpatient charges include physician office visits, outpatient laboratory charges, and prescription drugs. Inpatient charges include all medical charges incurred while the patient was hospitalized, e.g., hospital bed, physician

FIGURE 2. Inpatient and Outpatient Medical Charges for Persons With at Least Seven Outpatient Mental Health Treatment Visits From 1975 Through 1978 But No Inpatient Psychiatric Claims (N=6,629) and a Random Sample of Persons With No Mental Health Treatment Claims (N=32,450)[a]



[a]See footnote a in figure 1.

fees, and other charges billed separately during the hospitalization.

It is clear that in every year the mental health group spent more in outpatient charges than the comparison group. The curves are nearly parallel. After adjustment of the means for 1975 through 1978 for differences between the two groups in 1974, the only significant difference between them occurred in 1975 and favored the comparison group. The mean inpatient medical care charges of the mental health group were also higher than those of the comparison group in 1974. But in 1978 they were lower, and in the intervening years they were nearly indistinguishable. After adjustment of the means for differences in 1974, the mental health group had significantly lower inpatient medical care charges in every subsequent year. The cost-offset effect that we saw in adjusted total medical charges was primarily the result of a lowering of inpatient medical charges for the mental health group.

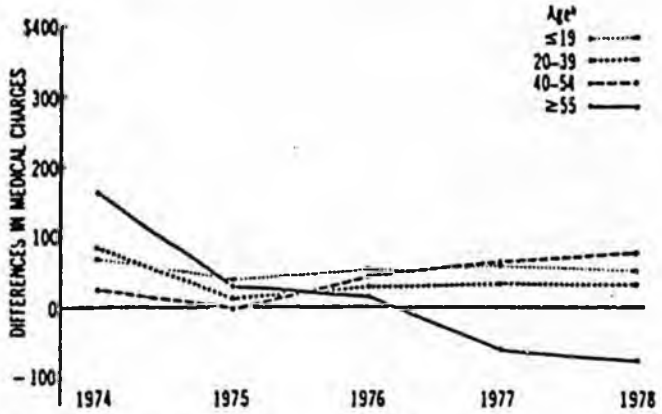
Cost-Offset Effects in Claims Files as Mediated by Patients' Age

An examination of the cost-offset effect for narrow age subsets is complicated by the necessarily small sizes of these groups and the high variances characteristic of medical claims data. Since most persons obtain medical care only occasionally, claims data consist mostly of zero entries. Claims generally range from a few dollars to several hundred dollars, with a few much larger entries. In small groups, a single person with extraordinarily high medical claims can increase the variance considerably and complicate the interpretation of differences among group means. We can avoid this problem by removing the extreme cases, defined as persons with total medical charges over $20,000 in a single year, from both the mental health and comparison groups.

Removing the extreme cases from both groups lowered the mean of each group by only a few dollars and reduced the size of both groups by only 0.4%. Thus variance and standard errors were minimized without altering the general form of the findings.

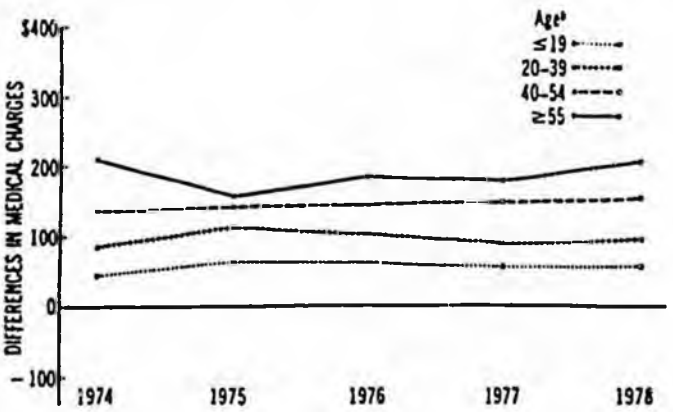
To emphasize the relative differences in medical care utilization of age subsets, figure 3 displays differences between the mean inpatient medical charges of the treatment group and the comparison group for four age groups. Figure 4 presents the same differences for outpatient medical utilization. Negative differences (below the zero line) indicate that the treatment group had lower charges than the comparison group. A

FIGURE 3. Differences in Mean Inpatient Charges for Four Age Groups of Persons With at Least Seven Mental Health Treatment Visits From 1974 Through 1978 But No Inpatient Psychiatric Claims and a Random Sample of Persons With No Mental Health Treatment Claims[a]



[a]See footnote a in figure 1. Persons with total medical charges exceeding $20,000 in any one year were excluded.
[b]The sample sizes for the mental health treatment and comparison groups were as follows: 19 years or younger, 1,746 and 8,183, respectively; 20–39 years, 2,387 and 7,521; 40–54 years, 1,871 and 10,363; and 55 or older, 595 and 6,252.

FIGURE 4. Differences in Mean Outpatient Medical Charges for Four Age Groups of Persons With at Least Seven Mental Health Treatment Visits From 1974 Through 1978 But No Inpatient Psychiatric Claims and a Random Sample of Persons With No Mental Health Treatment Claims[a]



[a]See footnote a in figure 1. Persons with total medical charges exceeding $20,000 in any one year were excluded.
[b]See footnote b in figure 3.

falling curve, whether above or below the zero difference line, indicates a cost-offset effect. Graphing differences in this way removes the inflation component, since it affects both groups equally.

A comparison of figures 3 and 4 shows that the cost-offset effects seen for total medical charges resulted largely from lowered inpatient medical charges. Further, the oldest age group among the mental health treatment persons, those over 55, clearly showed the most dramatic decrease in hospital charges; in 1974 they had average inpatient medical charges more than $160 higher than those of the comparison group. In 1978 they were spending $70 less. This finding cannot be explained by selective dropout, since all persons in the oldest age groups were required to have at least one claim in 1978.

Figure 4 shows that the differences in outpatient medical charges of all the age groups remained fairly constant over the 5 years and that the expenditures of the mental health group were higher in every year than those of the comparison group. The slight dips in the curve of the oldest age group reflect the fact that those over age 55 in the mental health treatment group had significantly lower outpatient charges in 1975 and 1977 ($t=-4.31$ and -1.99, respectively, $p<.05$).

These findings for fee-for-service health insurance subscribers are generally in accord with findings derived from our meta-analyses of studies done in organized medical care settings and hospitals using both experimental and time-series methods.

DISCUSSION

Retrospective analysis of health insurance claims data and meta-analyses of time-series studies and prospective controlled experimental studies converge to provide evidence of a general cost-offset effect following outpatient psychotherapy. The widespread and persistent evidence of reduced rate of increase of medical expense following mental health treatment argues for the inseparability of mind and body in health care, and it also argues specifically for the likelihood that mental health treatment may improve patients' ability to stay healthy enough to avoid hospital admission for physical illness.

The clearest cost-offset effect appears largely in the reduction of inpatient rather than outpatient costs. As we noted in an earlier study (87), inpatient charges account for 75% of total medical charges and substantial savings would have to result from reduced hospitalization. Older patients show larger cost-offset effects than younger ones. These findings could be surprising to anyone believing that mental health treatment is necessarily more effective for younger than older people. The findings could also be surprising if one had assumed that reduction of medical services associated with psychotherapy is a function of keeping "the worried well" from "cluttering outpatient services." We have presented more detailed evidence elsewhere to show that recipients of mental health services suffer more chronic disease and are physically sicker than people who do not use psychiatric services (3, 87, 93). The effects of outpatient mental health treatment cannot be explained as simple substitution of one outpatient service for another.

Older people generally use more medical services and more expensive inpatient services, leaving more room for cost reductions. But other factors may also contribute. Many older people have special mental health needs following emotionally distressing events such as suffering physical disease; experiencing loss of friends, spouse, social status, or income; being victims of crime; or being forced to relocate. The 1975 Harris survey showed that 8% of the respondents 65 and older said they had no close person to talk to, compared with 5% of the respondents under 65 (94). Older men and women often have multiple social problems and more than one chronic disease or disability. Yet on average they are seen for a shorter period of time by their doctors during outpatient visits (95). Older people may also be in jeopardy because their lives lack the structure of a daily work routine and the supportive social networks associated with employment. The older patient—even if voluble about physical symptoms or peeves—may not volunteer much about emotional distress to a much younger physician, who also may not inquire about such problems when examining an elderly patient. Such a situation is not promising for early detection of need for mental health intervention, nor is it optimal for active cooperation between patient and physician in the effective management of chronic illness that would minimize need for hospitalization.

In view of the needs of the older population, planned psychological intervention may have special advantages. Provision of mental health services to older people could serve to shore up flagging determination to follow medical advice and to stay healthy and socially engaged. Evidence from one study of patient education and support for hypertensive patients reported that the special program had a more positive influence on compliance among elderly than among young patients (96).

In view of the evidence from the literature and from our studies of health insurance claims, underutilization of mental health services by the elderly may result in needless suffering among the elderly and needless cost to society.

REFERENCES

1. Duehrssen A, Jorswiek E: An empirical and statistical inquiry into the therapeutic potential of psychoanalytic treatment. Der Nervenarzt 36:166–169, 1965
2. Jones KR, Vischi TR: Impact of Alcohol, Drug Abuse and Mental Health Treatment on Medical Care Utilization. Med Care 17 (Dec Supplement), 1979
3. Mumfo[illegible] E, Schlesinger HJ, Glass GV: A Critical Review and Indexed Bibliography of the Literature up to 1978 on the Effects of Psychotherapy on Medical Utilization. Report to NIMH, Contract NIMH-MH-77-0049. Rockville, Md, NIMH, 1978

4. Mumford E, Schlesinger HJ, Glass GV: The effects of psychological intervention on recovery from surgery and heart attacks: an analysis of the literature. Am J Public Health 72:141–151, 1982
5. Devine EL, Cook TD: A meta-analytic analysis of effects of psychoeducational interventions on length of post-surgical hospital stay. Nurs Res 32:267–274, 1983
6. Andrew JM: Recovery from surgery, with and without preparatory instruction, for three coping styles. J Pers Soc Psychol 15:223–226, 1970
7. Archuleta V, Plummer OB, Hopkins KD: A Demonstration Model for Patient Education: A Model for the Project "Training Nurses to Improve Patient Education": Project Report. Boulder, Colo, Western Interstate Commission for Higher Education, June 1977
8. Budd S, Brown W: Effect of a reorientation technique on post-cardiotomy delirium. Nurs Res 23:341–348, 1974
9. Budman SH, Wertlieb D, Budman S, et al: Maximizing the offset of medical utilization via psychological services: a strategy for intervention. Cambridge, Mass, Harvard Community Health Plan, 1979
10. Budman SH, Demby A, Randall M: Psychotherapeutic Outcome and Reduction in Medical Utilization: A Cautionary Tale. Cambridge, Mass, Harvard Community Health Plan, 1980
11. Christopherson B, Pfeiffer C: Varying the timing of information to alter pre-operative anxiety and post-operative recovery in cardiac surgery patients. Heart Lung 9:854–861, 1980
12. Cohen F: Psychological preparation, coping and recovery from surgery (doctoral dissertation). Dissertation Abstracts International 37:454B, 1976
13. Davis HS: The role of a crisis intervention treatment in the patient's recovery from elective surgery (doctoral dissertation). Dissertation Abstracts International 36:3490B, 1973
14. Delong RD: Individual differences in patterns of anxiety arousal, stress-relevant information and recovery from surgery (doctoral dissertation). Dissertation Abstracts International 32:554B, 1971
15. Edwards D, Bucky S, Coben P, et al: Primary and secondary benefits from treatment for alcoholism. Am J Psychiatry 134: 682–683, 1977
16. Egbert LD, Battit GE, Welch CE, et al: Reduction of postoperative pain by encouragement and instruction of patients. N Engl J Med 270:825–827, 1964
17. Felitti VJ: Diagnosis in Large Populations. San Diego, Calif, Kaiser Permanente, 1980
18. Felton G, Huss K, Payne EA, et al: Preoperative nursing intervention with the patient for surgery: outcomes of three alternative approaches. Int J Nurs Stud 13:83–96, 1976
19. Florell JL: Crisis intervention in orthopedic surgery (doctoral dissertation). Dissertation Abstracts International 32:3633B, 1971
20. Follette WT, Cummings NA: Psychiatric services and medical utilization in a prepaid health plan setting. Med Care 5:25–35, 1967
21. Fortin F, Kirouac S: A randomized controlled trial of preoperative patient education. Int J Nurs Stud 13:11–24, 1976
22. Goldberg ID, Krantz G, Locke BZ: Effect of a short-term outpatient psychiatric therapy benefit on the utilization of medical services in a pre-paid group practice medical program. Med Care 8:419–428, 1970
23. Goldberg ID, Allen G, Kessler L, et al: Utilization of medical services after short-term psychiatric therapy in a pre-paid health plan setting. Med Care 19:272–286, 1981
24. Goldensohn SS, Fink R: Mental health services for Medicaid enrollees in a prepaid group practice plan. Am J Psychiatry 136:160–164, 1979
25. Graves RL, Hastrup J: Effects of psychological treatment on medical utilization in a multi-disciplinary health clinic for low income minority children. Dallas, University of Texas Health Science Center, 1978
26. Gruen W: Effects of brief psychotherapy during the hospitalization period on the recovery process in heart attacks. J Consult Clin Psychol 43:223–232, 1975
27. Hankin JR, Steinwachs DM, Elkes C: The impact on utilization of a copayment increase for ambulatory psychiatric care. Med Care 18:807–815, 1980
28. Hart RR: Recovery of open heart surgery patients as a function of a taped hypnotic induction procedure (doctoral dissertation). Dissertation Abstracts International 36:5259B, 1975
29. Hill BJ: Sensory information, behavioral instructions and coping with sensory alteration surgery (doctoral dissertation). Dissertation Abstracts International 40:2381B, 1979
30. Hitchcock LS: Improving recovery from surgery: the interaction of preoperative interventions, coping processes and personality variables (doctoral dissertation). Austin, University of Texas Department of Psychology, 1982
31. Jacobson JM, O'Rourke PJ, Wolf AE: Impact of a diabetes teaching program on health care trends in an Air Force medical center. Milit Med 148:46–47, 1983
32. Jameson J, Shuman LJ, Young WW: The effects of outpatient psychiatric utilization on the costs of providing third-party coverage. Med Care 16:383–399, 1978
33. Johnson JE, Rice VH, Fuller SS, et al: Sensory information, instruction in a coping strategy and recovery from surgery. Res Nurs Health 1:4–17, 1978
34. Johnson JE, Fuller SS, Endress MP, et al: Altering patients' responses to surgery: an extension and replication. Res Nurs Health 1:111–121, 1978
35. Kennecott Copper Corporation: Insight: A Program for Troubled People. Salt Lake City, Utah Copper Division, 1970
36. Kessler L: Episodes of psychiatric care and medical utilization (doctoral dissertation). Baltimore, Johns Hopkins University School of Hygiene and Public Health, 1978
37. Kogan WS, Thompson DJ, Brown JR, et al: Impact on integration of mental health service and comprehensive medical care. Med Care 13:934–942, 1975
38. Langer EJ, Janis IL, Wolfer JA: Reduction of psychological stress in surgical patients. Journal of Experimental Social Psychology 11:155–165, 1975
39. Levitan SJ, Kornfeld DS: Clinical and cost benefits of liaison psychiatry. Am J Psychiatry 138:790–793, 1981
40. Lindeman CA, Stetzer SL: Effects of preoperative visits by operating room nurses. Nurs Res 22:4–16, 1973
41. Lindeman CA, Van Aernam B: Nursing intervention with the presurgical patient: the effects of structured and unstructured preoperative teaching. Nurs Res 20:319–332, 1971
42. Longobardi PG: The impact of a brief psychological intervention on medical care utilization in an army health care setting. Med Care 19:665–671, 1981
43. Lucas RH: The affective and medical effects of different preoperative interventions with heart surgery patients (doctoral dissertation). Dissertation Abstracts International 36:5763B, 1976
44. Lunn CR: Remarks at the Ontario Blue Cross Symposium on Alcoholism in Industry. Toronto, Ontario Blue Cross, 1976
45. McHugh JP, Kahn MW, Heiman E: Relationships between mental health treatment and medical utilization among low-income Mexican-American patients: some preliminary findings. Med Care 15:439–444, 1977
46. Mechanic D, Cleary PD, Greenley JR: Distress syndromes, illness behavior, access to care and medical utilization in a defined population. Med Care 20:361–372, 1982
47. Olbrisch ME: Evaluation of a stress management program for high utilizers of a pre-paid university health service. Med Care 19:153–159, 1981
48. Olendzki MC: Health Services Utilization and Cost Pre- and Post-Mental Health Treatment in Organized Fee-For-Service Health Care Settings. Report to NIMH, Contract 278-80-0010(DB). Rockville, Md, NIMH, 1982
49. Ortmeyer JA: Anxiety and repression coping styles and treatment approaches in the integration of elective orthopedic surgical stress (doctoral dissertation). Dissertation Abstracts International 36:5536A, 1978
50. Patterson DY, Bise B: Report Pursuant to Contract 282-77-0219-MS. Report to NIMH. Rockville, Md, NIMH, 1978
51. Pickett C: Locus of control and intervention strategies with surgical patients (doctoral dissertation). Dissertation Abstracts

International 40:2381B, 1979
52. Plotnick DE, Adams KM, Hunter HR, et al: Alcoholism Treatment Programs Within Prepaid Group Practice HMO's: A Final Report. Rockville, Md, National Institute on Alcohol Abuse and Alcoholism, 1982
53. Regier DA, Goldberg ID, Burns BJ, et al: Epidemiological and health services research findings in four organized health/mental health settings. Presented at the ADAMHA Health Maintenance Organization Conference. Rockville, Md, ADAMHA, 1977
54. Risser NL, Strong A, Bither S: The effect of an experimental teaching program on post-operative ventilatory function: a self-critique. Western J Nursing Research 2:484–500, 1980
55. Rosen JC, Wiens AN: Changes in medical problems and utilization of medical services following psychological intervention. Am Psychol 34:420–431, 1979
56. Schmitt FE, Woolridge PJ: Psychological preparation of surgical patients. Nurs Res 22:108–115, 1973
57. Sherman RM, Reiff S, Forsythe AB: Utilization of medical services by alcoholics participating in an outpatient treatment program. Alcoholism 3:115–120, 1979
58. Smith JC: The effects of the provision of psychotherapy on medical utilization in a pre-paid student health center (doctoral dissertation). Boulder, University of Colorado Department of Education, 1980
59. Surman OS, Hackett TP, Silverberg EL, et al: Usefulness of psychiatric intervention in patients undergoing cardiac surgery. Arch Gen Psychiatry 30:830–835, 1974
60. Uris JS: Effects of Mental Health Utilization and Diagnosis on General Medical Care Utilization in a Prepaid Clinic Setting. Boulder, Colo, Western Interstate Commission for Higher Education, 1974
61. Van Steenhouse AL: A comparison of three types of pre-surgical psychological intervention with male open heart surgery patients (doctoral dissertation). Dissertation Abstracts International 39:1449A, 1978
62. Wilson JF: Determinants of recovery from surgery: pre-operative instruction, relaxation training and defensive structure (doctoral dissertation). Dissertation Abstracts International 38:1476B, 1977
63. Glass GV, McCaw B, Smith ML: Meta-analysis in Social Research. Beverly Hills, Calif, Sage Publications, 1981
64. Jones KR (ed): Report of a Conference on the Impact of Alcohol, Drug Abuse and Mental Health Treatment on Medical Care Utilization: Publication (ADM) 81-1180. Bethesda, Md, Department of Health and Human Services, 1980
65. Abbott MM: Consequences of short term psychotherapy with wives of first myocardial infarction patients (doctoral dissertation). San Diego, California School of Professional Psychology, 1979
66. Diehr P, Williams SJ, Shortell SM, et al: The relationship between utilization of mental health and somatic health services among low income enrollees in two provider plans. Med Care 17:932–952, 1979
67. Godbole A, Verinis JS: Brief psychotherapy in the treatment of emotional disorders in physically ill geriatric patients. Gerontologist 14:143–148, 1974
68. Harrington RL: Systems Approach to Mental Health Care in a HMO Model. NIMH Grant MH-24109, Final Report. Rockville, Md, NIMH, 1981
69. Hayami DE, Freeborn DK: Effect of coverage on use of an HMO alcoholism treatment program, outcome, and medical care utilization. Am J Public Health 71:1133–1143, 1981
70. Healy KM: Does preoperative instruction make a difference? Am J Nurs 68:62–67, 1968
71. Hegyvary ST, Chamings PA: The hospital setting and patient care outcomes. J Nurs Adm 5:29–32, 36–42, 1975
72. Hoeper E: Observations on the impact of psychiatric disorder upon primary medical care, in Mental Health Services in General Health Care, vol 1: Institute of Medicine Publication 70-004. Washington, DC, National Academy of Sciences, 19[illegible]
73. Holder HD, Hallen JB: A Study of Health Insurance Coverage for Alcoholism for California State Employees: Third Year Experience Summary: Report RP0228. Rockville, Md, National Institute on Alcohol Abuse and Alcoholism, 19[illegible]
74. Johns M, Boras KW, Harrison J, et al: Benefit-Cost Analysis of Alcoholism Treatment Centers. Prepared by the JWK International Corporation, Annandale, Va, for the National Institute on Alcohol Abuse and Alcoholism, Contract ADM 281-75-0031. Rockville, Md, NIAAA, 1976
75. Johnson BA, Johnson JE, Dumas RG: Research in nursing practice: the problem of uncontrolled situational variables. Nurs Res 19:337–342, 1970
76. Johnson JE, Dobbs JM, Leventhal H: Psychosocial factors in the welfare of surgical patients. Nurs Res 19:18–29, 1970
77. Johnson JE, Hill VH: Sensory and distress components of pain. Nurs Res 23:203–209, 1974
78. Korgan WS, Thompson DJ, Brown JR, et al: Impact of integration of mental health service and comprehensive medical care. Med Care 13:936–942, 1975
79. Koulouch FT: Role of suggestion in surgical convalescence. Arch Surg 85:144–155, 1962
80. Lindeman CA: Nursing intervention with the presurgical patient. Nurs Res 21:196–208, 1972
81. Norfleet MA, Burnell GM: Utilization of medical services by psychiatric patients. Hosp Community Psychiatry 32:198–200, 1981
82. Patterson V, Levene H, Breger L: A one-year follow-up of two forms of brief psychotherapy. Am J Psychother 21:76–82, 1977
83. Sclare AB, Balfour MB, Crocket JA: Group psychotherapy in bronchial asthma. J Psychosom Res 2:157–171, 1957
84. Roethlisberger F, Dickson W: Management and the Worker. Cambridge, Mass, Harvard University Press, 1939
85. Department of Health and Human Services: Health, United States, 1981. Hyattsville, Md, Office of Health Research, Statistics and Technology, 1981
86. Glasscote RM, Gudeman JE, Mills DG: Creative Mental Health Services for the Elderly. Washington, DC, Joint Information Service of the American Psychiatric Association and the Mental Health Association, 1977
87. Schlesinger HJ, Mumford E, Glass GV, et al: Mental health treatment and medical care utilization in a fee-for-service system: outpatient mental health treatment following the onset of a chronic disease. Am J Public Health 73:422–429, 1983
88. Locke B, Krantz G, Kramer M: Psychiatric need and demand in a pre-paid group practice program. Am J Public Health 56:895–904, 1966
89. Fink R, Goldensohn S, Shapiro S, et al: Treatment of patients designated by family doctors as having emotional problems. Am J Public Health 57:1550–1564, 1967
90. Innes G, Millar WM: Mortality among psychiatric patients. Scott Med J 15:143–148, 1970
91. Babigian HM, Odoroff CL: The mortality experience of a population with psychiatric illness. Am J Psychiatry 126:470–480, 1969
92. Glass GV, Stanley JC: Statistical Methods in Education and Psychology. Englewood Cliffs, NJ, Prentice-Hall, 19[illegible]
93. Schlesinger HJ, Mumford E, Glass GV: Mental health services and medical utilization, in Psychotherapy: From Practice to Research to Policy. Edited by Vandenbos G. Beverly Hills, Calif, Sage Publications, 1980
94. Harris L and Associates: The Myths and Reality of Aging in America. Washington, DC, National Council on Aging, 1975
95. Keeler EB, Solomon DH, Beck JL, et al: Effect of patients age on duration of medical encounters with doctors. Med Care 20: 1101–1108, 1982
96. Morisky DE, Levine DM, Green LW, et al: Health education program effects on the management of hypertension in the elderly. Arch Intern Med 142:1835–1838, 1982

Mental Health Services:
The Case for Insurance Coverage

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

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

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

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

S.A.M.

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1

Executive Summary

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

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

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

Myth #1:

The problems of behavior-related illnesses are not serious.

Reality

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

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

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

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

Myth #2:

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

Reality

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

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

Myth #3:

The costs of mental health care usually exceed the benefits.

Reality

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

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

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

Myth #4:

Mental health services are substantially overused and misused.

Reality

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

Summary

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

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

2

Insurer Concerns

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

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

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

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

Finally, insurers are concerned that there is vast misuse

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

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

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

3

Prevalence and Cost of Mental Illness

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

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

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

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

★ ★ ★ ★

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

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

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

EXHIBIT ONE

PREVALENCE OF MENTAL ILLNESS WITHIN A SIX-MONTH PERIOD

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

*highest rate of treatment

Source: National Institute of Mental Health

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

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

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

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

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

EXHIBIT TWO

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

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

Totals may not add due to rounding.

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

b. Components are indicated in parentheses.

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

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

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

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

EXHIBIT THREE

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

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

Totals may not add due to rounding.

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

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

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

4

What is Mental Health Care?

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

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

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

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

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

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

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

4. OTA, p. 13.

5

Is Mental Health Care Effective?

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

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

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

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

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

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

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

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

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

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

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

6. OTA, p. 44.

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

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

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

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

When is mental health care effective?

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

8. OTA, p. 46.

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

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

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

10. Parloff, p. 43.

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

6

Comparison of the Costs and Outcomes of Different Treatment Settings

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

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

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

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

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

Key findings from the 28-month study period were:

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

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

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

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

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

EXHIBIT FOUR

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

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

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

EXHIBIT FIVE

CLINICAL OUTCOMES OF REVIEWED RANDOMIZED CONTROL TRIALS[a]

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

a. Berk, p. 21.

EXHIBIT SIX

ECONOMIC OUTCOMES OF REVIEWED SIMULTANEOUS CONTROL STUDIES[a]

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

a. Berk, p. 22.

EXHIBIT SEVEN

ECONOMIC OUTCOMES OF REVIEWED RANDOMIZED CONTROL STUDIES[a]

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

a. Berk, p. 23.

EXHIBIT EIGHT

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

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

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

*Significant at the .10 level.
**Significant at the .05 level.
†Signifcance not tested, as the number is a sum of means.
[a]These data were derived from agency or patient reports on the number of contacts, patient reports being used only when it was not possible (or was excessively costly) to obtain the relevant information from the agency. Estimates of the costs per contact were obtained from the agency.
[b]Data from the Department of Vocational Rehabilitation (DVR) were available only for the 28-month study period as a whole, which included the follow-up period after the experiment. The per patient costs presented in Exhibit Eight are 12/28, or 43 percent of the 28-month data, reflecting average cost for one year. The figures reflect double counting because much of the DVR expenditures go for payments to other agencies that are included in cost section 2 of the exhibit. We have been able to account for, and to exclude, DVR payments to the sheltered workshops but not, for example, to hospitals. The $24 difference is biased upward by the omission of counselling expenses attributable only to C-group members.
[c]These figures include fees for physicians, psychologists, and nurses but exclude any associated laboratory fees.
[d]These data were derived from patient reports and as such subject to misreporting. Patient reports were used only when it was not possible (or was excessively costly) to obtain the relevant information from an independent source. In some cases, when an interviewer suspected faulty reporting, individual spot-checks were made with the agency in question; agencies that were not able to provide us with information on all patients were sometimes able to provide it on this spot-check basis.
[e]These figures are derived from interviews conducted four months after admission with 22 families of E group patients and 18 families of C group patients (34% of the E group, 27% of the C group). The other families were not interviewed because: (1) they lived outside of Dane County (23% of each group); (2) the subject or the family refused to cooperate (12% of the E group, 22% of the C group); or (3) the relative could not be contacted (31% of the E group, 28% of the C group). The questionnaire examined the families' experience in the two weeks preceding the interview only, and, with some trepidation, these figures have been inflated to an annual average. The reduced sample size and the single interview yielded data which must be interpreted with caution.
[f]These figures were derived by multiplying the number of days of work the family members missed because of the patient by a daily wage of $24 ($3 an hour).
[g]Our judgments, based on examination of patient reports.
[h]Earnings do not include value of fringe benefits, if there were any.
[i]Interviewers' assessments.
[j]Includes Madison Opportunity Center, Inc., and Goodwill Industries.

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

EXHIBIT NINE

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

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

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

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

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

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

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

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

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

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

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

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

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

7

The Benefits of Psychiatric Care Relative to Cost

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

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

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

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

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

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

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

Study Description

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

Results

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

Comment

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

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

Study Description

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

Results

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

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

Study Description

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

Results

Benefits exceeded costs by a 2.5 to 1 margin.

Comment

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

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

Study Description

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

Results

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

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

Study Description

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

substitution (methadone) to the therapeutic community approach.

Results

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

Comment

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

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

Study Description

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

Results

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

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

How cost beneficial is psychotherapy for people who are:

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

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

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

Major findings of the meta-analysis were:

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

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

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

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

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

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

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

5. People over 65 received proportionately less mental

13. Mumford et al., p. 1152.

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

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

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

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

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

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

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

15. Mumford et al., p. 1156.

16. Mumford et al., p. 1154.

8

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18. Manning et al.

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

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Official Business

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HEALTH, EDUCATION, AND SOCIAL SERVICES

DATE: FEBRUARY 1, 1989

Subject of meeting:

SB 36 - INSURANCE FOR MENTAL/NERVOUS CONDITION

SIGN-IN

PLEASE PRINT!

NAME	ADDRESS	PHONE	REPRESENTING	DO YOU WANT TO TESTIFY?
Dr Noia				
GORDON EVANS	318 4TH ST., JUNEAU	586-3210	HIAA	YES
D.M. Scholl, Ph.D	Alaska Mental Health Board 419 6th St #1108 Juneau AK 99801	465-3071	Alaska Mental Health Board	yes
SALLY SMITH	Div. Ret Iben DOIT	465-4470	DEPT ADMIN	YES
ROB SHOAF	240 Main St, #800 Juneau Alyeska Pipeline	586-3340	Alyeska Pipeline	yes
PAUL ROLLER	Pouch D Juneau	465-2515	Div. of Insurance	YES

Public sector employees - no to paid

Evans - objects in present form
Mental - most expensive

(1) Self insurers - No

Who must insure →

→ Mandatory offering -

Mental Health Act
Dr Shell

Jones - 29.47 -

E Note

Schobb — M. Health Bd.

1) Mandatory Requirement /
2) Employer pay — "employer may
unless employer volunteers.

Rob Shoaf — Alaska.

($70)

Self insured — managed by Actna
Employee
Employer } shared costs

Q - Empl. all

Paul Roller —

State = teenage preg. 94 Million / yr.

Inclusion

1. Mandatory [illegible] or Offer
2. Effect on political subdivisions

SPRING 1986

PERSPECTIVE

THE BLUE CROSS AND BLUE SHIELD MAGAZINE

SEVEN QUESTIONS READERS ASK ...

including the cost of high-tech baby care

QUESTION #2:

Why Are Mental Health Benefits So Troublesome For Health Insurers?

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

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

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

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

Rep. Merkt

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

CONGRESS FEARFUL

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

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

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

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

But insurers find it nearly impossible to identify displaced costs.

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

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

1973	California 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	K nsas
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

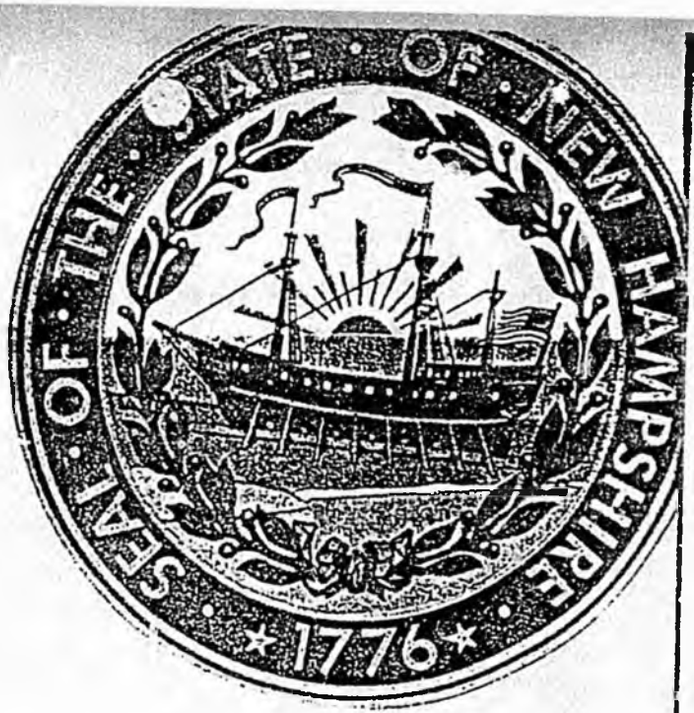
That's another 7 states already in the 1980s.

---

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

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

**not counting mentally handicapped (32 states)*



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

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

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

California, Maryland and Oregon were in that maiden group.

But it is Massachusetts which sums up the 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:

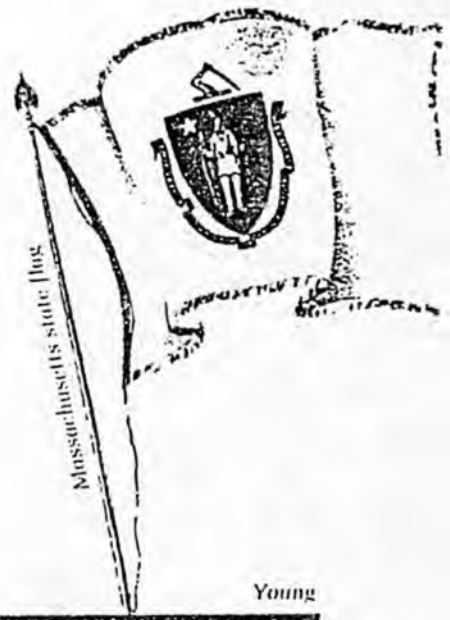
- $6 extra family fees per month in Massachusetts,
- "nearly $5" in Kansas, and
- "between $2 and $3" in Maryland.

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

The Effects of State-Mandated Insurance Benefits on Employers: Preliminary Findings from Research in Progress

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1. Introduction

One of the fastest growing areas of regulation affecting most businesses are state-mandated provisions for group health insurance benefits. Since 1970 over 600 state-mandated benefit laws have been newly enacted in the 50 states (Scandlen 1987). These include laws imposing requirements on: (1) the particular services or providers covered in insurance plans, (2) the rules governing entitlement for participation in an employer's plan, and (3) the capability of separated workers to convert their group coverage to self-paid individual coverage, regardless of health status. In 1986 Congress followed the states' lead by implementing the first federal mandate on the terms of job-based health insurance coverage. The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires that employers allow former workers and family members to participate in the company plan for a period of up to three years in some circumstances.

Mandates apply only if insurance is offered. Like other regulations that dictate the terms of compensation, they raise labor costs. In competitive markets, employers are likely to respond by rearranging the wage-benefit package and/or the mix of labor and capital employed in ways to deflect those higher costs. For example, they might reduce wages and/or other fringe benefits, forgo a health insurance benefit altogether, or hire more of those workers who are ineligible for fringe benefits. If sufficient offset effects occur then workers might in fact lose more than they gain from a mandated insurance standard.

Little is known about the actual effects of mandated health insurance benefits. A few recent studies, however, suggest that mandates may substantially raise the cost of providing group insurance. Mellman (1985), for example, estimated that Maryland's state-mandated coverages raised

employers' cost for employee-only coverage by 12 percent, and raised the cost of family coverage by 17 percent. State-mandated coverages may be especially burdensome for employers with plans covering employees in different states; their insured plans must satisfy all applicable mandates. State insurance taxes, which total four percent of premiums for commercial coverage in some states (e.g. in Alabama, Hawaii, and Oklahoma), also increase the cost of offering health insurance.

Many insurance industry experts believe that the growth in state mandates is a major factor in the recent decisions of many employers to self-insure. Section 514 of the Employee Retirement Income and Security Act of 1974 (ERISA) grants self-insured benefit plans exemption from state insurance laws and taxation by not allowing these plans to be classified as insurance (Demkovich 1986). In 1981 only 21 percent of employees in medium and large-sized firms were covered by a self-funded plan but by 1985 the percentage had doubled (Jensen and Gabel, in press). Over the same period the states collectively enacted over 200 mandated coverage requirements (Blue Cross and Blue Shield Association 1986).

The dramatic growth in self-insurance raises both efficiency and equity issues for regulators. First, self-insurance arrangements tend to be more costly to administer than purchased plans containing the same coverage (Jensen and Gabel, in press). Second, since only relatively large firms can self-insure, the exemption of such plans creates a two-tier regulatory environment; plans in large firms escape state scrutiny and taxation while those in small firms do not.

While self-insurance may be a viable response to regulation for a large sized firm it is simly not an option for small employers. A few unexpected catastrophic claims could easily threaten the financial solvency of a small or mid-sized firm which self-insured. The smaller firm has far

fewer avenues open to lessen the burden of mandated benefits.

Since smaller firms find it more difficult to deflect the costs of mandates, they are probably more likely to respond by dropping coverage entirely. Their decision to offer insurance is known to be highly sensitive to the price of coverage (Dennis 1985 and Jensen 1986), and it may well be that the increased premium due to mandates drives some smaller firms from the market entirely. Recent growth in the number of uninsured in the U.S., who are mostly employed in small businesses (Chollet 1987), may in part be due to the growth of mandated coverages.

This report summarizes several findings from my current research on the issue of how firms respond to state insurance regulation. The questions I address are the following:

(1) Have state mandates encouraged firms to self-insure?

(2) Do self-insured firms avoid mandated coverages?

(3) By how much do mandates raise premiums?

(4) How many more small firms in 1985 would have offered insurance, were it not for the presence of state-mandated coverages?

(5) How would the picture of insurance coverage among small firms change if all states had mandates identical to those in Minnesota?

Using several available secondary data sets on the fringe benefit offerings of employers between 1981 and 1985, I have attempted to address these questions empirically. Much of this research has not yet been reported in manuscript form, however by September 1988 I expect to have written three papers which fully document the analyses and findings. This paper should therefore be interpreted as very abridged and preliminary.

2. Data Sources

My analyses use data from two sources. The first is the Bureau of

Labor Statistics' Annual Employee Benefit Survey (EBS) of medium and large-sized firms throughout the U.S. (generally firms with 250 or more workers). Roughly 43,000 firms, collectively employing 23 million workers, are within the scope of this recurrent annual survey. It provides nationally representative, detailed information on the funding media for insurance plans offered by larger firms in the private sector and the specific provisions of their plans.

The second data set is a 1985 survey of some 1500 firms, mostly smaller sized, conducted by the National Federation of Independent Businesses (NFIB). It gathered information on which fringe benefits were offered, including health insurance, and the characteristics of the firm and its workers. As Table 1 shows, the size and industry distribution of respondents to the NFIB survey resonably reflects the firm population in Minnesota, as well as the nation.

3. Findings

(1) Have state mandates encouraged firms to self-insure?

Among large firms, a small part of the growth in self-insurance since 1980 is due to recently introduced coverage mandates in the areas of alcohol, drug abuse, and/or mental illness. The movement to self-insurance is, in large measure however, attributable to state continuation-of-coverage mandates for terminated workers, which many states have recently enacted, the new state risk pool programs which are financed by a tax on insured plans, also increasingly common, and the new requirements in many states that psychologists' services be covered.

Table 2 shows the estimated incremental effects of various state insurance regulations on the large firm's probability of having newly elected self-insurance between 1981 and 1985. These estimates are based on

a logit model of the firm's decision to self-insure, which was estimated using the BLS data. A continuation-of-coverage requirement for terminated workers was found to raise the firm's probability of converting to self-insurance by 0.312 (on a scale of 0 to 1), and a mandate for the coverage of psychologists' services was found to raise it by 0.127. Other entries in Table 2 can be interpreted similarly.

Since the self-insurance model on which these calculated incremental effects are based was estimated on a sample of fairly large firms (their average size being 437 employees), they may not reflect the self-insurance decisions of smaller firms. Mandates would probably have an even greater effect on the decision of a smaller firm, provided it was "large enough" for self-insurance to be an option. Since smaller firms pay higher loading charges, mandates are more costly for them. Indeed, in a recent survey of Minnesota employers, small firms which self-insured more often rated "avoidance of state-mandated coverages" as an important reason for their choice of self-funding (Office of the Legislative Auditor 1988).

(2) Do self-insured firms avoid mandated coverages?

In medium and large-sized firms, employees who are covered by self-funded plans are slightly less likely to have coverage in areas that tend to be mandated. Among medium and large-sized firms in 1985, 64.5 percent of subscribers in self-funded plans had coverage for alcoholism treatment, as compared to 71.6 percent among subscribers in conventional BCBS and commercial plans (Table 3). The same pattern held for drug abuse treatment coverage (56.4 percent versus 62.5 percent), for coverage of home health care services (48.4 percent versus 56.4 percent), for coverage of clinical psychologists' services (52.8 percent versus 55.2 percent), and for coverage of a stay in a psychiatric hospital (23.2 percent versus 32.2

percent).

Also, despite the lower incidence of the special mental health coverages just noted, enrollees in self-funded plans were just as likely to have some coverage for a hospital confinement due to a nervous or mental disorder (99.8 percent in each group), and within self-funded plans, the hospital psychiatric coverage was more often identical to the coverage for other inpatient confinements. Forty-five percent of enrollees in self-funded plans had psychiatric inpatient coverage comparable to that for other conditions, compared to 34.5 percent of enrollees in purchased plans.

There are no nationally representative studies which look at the content of self-funded plans in small firms. A recent study of such plans in Minnesota, however, found that they were much less likely to contain coverages mandated under that state's laws (Office of the Legislative Auditor 1988).

(3) By how much do mandates raise premiums?

The incremental cost of covering a particular category of care can be determined by comparing the premiums of plans which contain the coverage to the premiums of plans which do not, while holding constant other provisions of coverage. A method for making such a comparison would be to estimate a regression model relating premiums to the content of coverage in a plan. For a given coverage included in the model, the coefficient corresponding to that coverage would estimate the marginal cost due to the presense of the coverage. Jensen, Feldman, and Dowd (1984) used just such a method in their premium analysis for Twin Cities employers.

Using the BLS data described earlier, I estimated a premium model for 1,865 fee-for-service plans offered in the private sector between 1981 and 1984, and used it to assertain the incremental premium cost of including

the following coverages: chemical dependency treatment, the services of a clinical psychologist, a stay in a psychiatric hospital, and home health care services, among others.

In 1983 constant dollars, the coverage of chemical dependency treatments, which usually meant coverage of both alcohol and drug abuse treatments, raised the monthly premiums for individual and family coverage by $2.88 and $9.80, respectively. The coverage of psychologists' services raised the individual premium by $7.87 per month and the family plan premium by $23.07 per month. The coverage of a stay in a psychiatric hospital increased the family plan premium by $19.70 per month, but decreased the premium for individual coverage by $2.19 per month. The presense of coverage for home health care services decreased both individual and family plan monthly premiums, by $2.61 and $7.37, respectively. Most of these findings were statistically significant.

(4) How many more small firms in 1985 would have offered insurance were it not for the presence of state-mandated coverages?

To address this question I first estimated a probit model of the small firm's decision to offer health insurance in 1985, using the NFIB data described earlier. I then used that econometric model to simulate changes in the insurance offerings of the surveyed firms that would have occured had the "most complained about" mandates not been present. The probit model was estimated on 1320 useable observations, and incorporated 19 explanatory variables. It fit the data quite well, correctly predicting the "offer insurance" decision of 1053 firms (80 percent of the sample).

The model was used to predict the purchase decision of each firm under the assumption that, in states where present, the following were eliminated: coverage mandates for alcohol and drug abuse treatments, mental

illness, and psychotherapy, continuation-of-coverage requirements for terminated workers, and insurance risk pool taxes. The resultant distribution of insurance across sample firms was then compared to the real distribution.

Table 4 summarizes the findings of this simulation analysis. Of the 1320 firms in the sample, 397 actually did not offer health insurance in 1985. The simulation predicted that 71 of the 397 (18 percent) would have offered insurance were it not for the presense of mandates. Had the mandates been absent, 75 percent of the sample would have offered insurance, whereas in actuality 70 percent offered insurance. Gains in coverage would have been made across all size classes and industries. In relative terms, however, the classes of firms most able to afford insurance would see the largest gains: mid-sized firms that did not already offer coverage, industries employing somewhat higher paid labor (transportation, utilities, manufacturing, and mining), and firms that were providing life but not health insurance.

(5) How would the picture of insurance coverage among small firms change if all states had mandates identical to those in Minnesota?

This question was answered in a manner similar to that used to answer question (4). For each of the 1320 firms in the sample, I used the probit model to predict the firm's purchase decision under the assumption that its state had insurance regulation identical to that in Minnesota, both in terms of content and dates of enactment. Of the 923 sample firms that actually offered insurance in 1985, 109 would not have if they were subject to Minnesota statutes. Overall, the percentage of firms offering coverage would have declined from 70 to 62 percent. The largest relative losses in coverage would have occured among very small firms (those with fewer than 10 employees) that offer health insurance, those in agriculture,

nonprofessional services, and retail trade, sole proprietorships, firms in the western U.S., and firms providing health but not life insurance. Most of these categories describe either firms for which new mandates would be relatively expensive for one or more reasons, or firms with low paid workers unable to pay for all the new coverages.

4. Summary

From the preliminary analyses reported here, I draw the following conclusions. First, among firms with 250 or more workers, a small part of the growth in self-insurance between 1981 and 1985 was due to coverage mandates for alcohol and drug abuse treatments, and mental illness. However, state continuation-of-coverage requirements for terminated workers, and mandates for the coverage of psychologists' services significantly spurred conversions to self-insurance.

Second, the presense of a large number of mandates discouraged the provision of insurance among firms which were very small and/or in low-paying industries. Minnesota's mandates were found to be particularly burdensome; if exported to the other 49 states, the percentage of all firms offering insurance would likely have dropped from 0.7 to 0.62. If the goals of public policy include expanding the base of privately provided insurance, then policies should be developed which make coverage more affordable and simple to administer for firms which otherwise would have difficulty offering the benefit. Imposing the same set of mandates and taxes on these firms (as on other firms) seriously risks increasing the number of uninsured.

State regulations which especially hindered the offering of insurance by small firms included a continuation-of-coverage requirement for terminated workers, a coverage mandate for psychologists' services, and the

presense of a risk pool program when financed by taxes on purchased plans. Not surprisingly, it was found that these regulations also encouraged self-insurance among larger firms.

The administrative costs associated with coverge continuation rules was apparantly quite high for employers. This must have been especially true in small firms where mean job tenure historically has been roughly half that of much larger firms. The coverage of psychologists' care was found to be particularly expensive. Plans containing such coverage cost 14 percent more than plans without it. Evidently, this amount was too large for some firms to afford. Under risk pools programs that raised revenue through a tax on insured plans, the burden of the tax fell mainly on small employers, since they comprised the bulk of purchased plans. If the number of self-insured plans keeps increasing, then the smaller will be the number of employers who must bear the cost of subsidizing these pools, thereby exacerbating the advantages of self-insurance. Unless state governments can find a method for financing risk pools that does not discriminate against fully insured plans, both the number of small firms declining to offer coverage at all, and the number of larger firms opting to self-insu[illegible]ikely continue to grow.

References

Blue Cross and Blue Shield Association of America, Mandated Coverage Laws Enacted through 1986, Office of Government Relations, Chicago IL, Feburary 1987.

Chollet, Deborah J., "A Profile of the Nonelderly Population Without Health Insurance," in Government Mandating of Employee Benefits. Washington, DC: Employee Benefit Research Institute, 1987.

Demkovich, Linda. "ERISA and the States," Intergovernmental Health Policy Project: Focus On. George Washington University, March 1986.

Dennis, William J. Jr., Small Business Employee Benefits. Washington, DC: National Federation of Independent Businesses, 1985.

Jensen, Gail A., Roger Feldman, and Bryan Dowd. "Corporate Benefit Policies and Health Insurance Costs," Journal of Health Economics 3 (3): 275-296, 1984.

Jensen, Gail A. Employer Choice of Health Insurance Benefits. Unpublished Ph.D. Dissertation, University of Minnesota, 1986.

Jensen, Gail A. and Jon R. Gabel. "The Erosion of Purchased Health Insurance," Inquiry. in press.

Mellman, R.J., Maryland Mandated Benefits Report. Washington DC: Health Insurance Association of America, 1985.

Scandlen, Greg. "The Changing Environment of Mandated Benefits," in Government Mandating of Employee Benefits." Washington, DC: Employee Benefit Research Institute, 1987.

Office of the Legislative Auditor, State of Minnesota, Health Plan Regulation. St. Paul Minnesota, Feburary 1988.

Table 1

Comparison of NFIB Survey Respondents to the Population of Firms in Minnesota and throughout the United States

(Size and Industry Distributions in Percent)

	NFIB Sample	Minnesota Firms	All U.S. Firms
A. Size Distribution:			
Fewer than 10 Employees	61%	71%	78%
10-19 Employees	18	14	11
20-49 Employees	12	9	7
50 or More Employees	8	6	4
Total	100%	100%	100%
B. Industry Distribution:			
Transportation	4%	5%	4%
Agriculture	6	2	4
Manufacturing and Mining	14	11	9
Construction	13	7	14
Financial Services	9	7	8
Trade and Services	54	68	61
Total	100%	100%	100%

Table 2

Marginal Effects of State Regulations on the Firm's Probability of Converting to Self-Insurance[a]

Description	Estimate
Change[b] in the Probability of Self-Insurance Due to the Presence of:	
Mental Illness Coverage Mandate	-0.041
Psychologists' Services Coverage Mandate	0.127**
Alcoholism Treatment Coverage Mandate	0.010
Drug Abuse Treatment Coverage Mandate	0.100
Employer Risk Pool Tax Program	0.074
Continuation of Coverage Mandate	0.312***
A Mandate Other than Those Listed Above	-0.016**
A Unit Increase in the Premium Tax	0.015

Notes: [a]These calculations are for medium and large-sized firms only and are based on an estimated logit model of the firm's decision to newly elect self-funding between 1981 and 1985.

[b]The change was calculated at the sample mean of characteristics other than the regulation indicated

***Statistically significant at the 0.01 level
**Statistically significant at the 0.05 level
*Statistically significant at the 0.10 level

Table 3

Do Self-Funded Plans Avoid Mandated Coverages?

Comparison of Selected Characteristics of Self-Funded and Purchased Plans, 1985

Trait	Percentage of Participants with the Trait Within:	
	Self-Insured	Comm/FCBS
Alcoholism Treatment Coverage	64.5	71.6
Drug Abuse Treatment Coverage	56.4	62.5
Home Health Care Coverage	48.4	56.4
Hospital Confinements Due to a Nervous or Mental Disorder Covered	99.8	99.8
Hospital Psychiatric Coverage Identical to Other Inpatient Hospital Confinements	54.7	34.5
Stay in a Psychiatric Hospital Covered	23.2	32.2
Coverage for Psychologists' Services	52.8	55.2

Note: These tabulations are were made on fee-for-service plans offered by medium and large-sized private sector firms throughout the U.S. The data may not be representative of the coverage in firms which employ fewer than 250 workers.

Table 4

Potential New Insurance Plans Among 1320 Small Firms if the Most Contentious State Mandates were Eliminated

(Specifically, coverage mandates for alcohol and drug abuse treatments, mental illness, and psychotheraphy, continuation of coverage requirements, and insurance risk pool taxes.)

Group or Subgroup	Number of Firms	Number Without Insurance	Proportion Without Insurance	Number that Would Newly Adopt Ins.	Proportion Among those Without Ins.
Entire Sample	1320	397	0.30	71	0.18
By Size Class:					
Fewer than 10 Employees	812	349	0.42	57	0.16
10-19 Employees	239	37	0.15	10	0.27
20-49 Employees	156	9	0.06	4	0.44
50 or More Employees	113	2	0.02	1	0.50
By Industry:					
Agriculture	75	33	0.44	5	0.15
Non Professional Services	173	74	0.43	10	0.13
Retail Trade	390	145	0.37	25	0.17
Financial, Insurance, and Real Estate	124	37	0.30	7	0.19
Construction	177	47	0.27	9	0.19
Wholesale Trade	141	29	0.21	6	0.21
Transportation and Utilities	52	8	0.15	2	0.25
Manufacturing & Mining	188	24	0.12	7	0.29
By Region:					
West	325	115	0.35	18	0.16
North Central	431	130	0.30	30	0.23
South	382	108	0.28	13	0.12
Northeast	182	44	0.24	11	0.25
By Ownership:					
Proprietorships	421	254	0.60	30	0.12
Partnerships	80	18	0.23	5	0.27
Corporations	819	125	0.15	36	0.29
By Life Insurance Offering:					
Not Provided	410	218	0.53	28	0.13
Provided to Some or All Emp.	910	179	0.20	43	0.24
By Pension Plan Offering:					
Not Provided	589	211	0.36	35	0.16
Provided to Some of All Emp.	731	336	0.45	36	0.11

Table 5

The Decrease in Insurance Coverage Among 1320 Small Firms If

All the States had Coverage Mandates Identical to those in Minnesota

Group or Subgroup	Number of Firms	Number With Insurance	Proportion With Insurance	Number that Would Drop Insurance	Proportion Among those With Ins.
Entire Sample	1320	923	0.70	109	0.12
By Size Class:					
Fewer than 10 Employees	812	463	0.58	82	0.18
10-19 Employees	239	202	0.85	18	0.09
20-49 Employees	156	147	0.94	7	0.05
50 or More Employees	113	111	0.98	2	0.02
By Industry:					
Agriculture	75	42	0.56	7	0.17
Non Professional Services	173	99	0.57	15	0.15
Retail Trade	390	245	0.63	37	0.15
Financial, Insurance, and Real Estate	124	87	0.70	11	0.13
Construction	177	130	0.73	15	0.12
Wholesale Trade	141	112	0.89	10	0.09
Transportation and Utilities	52	44	0.85	4	0.09
Manufacturing & Mining	188	164	0.88	10	0.06
By Region:					
West	325	210	0.65	31	0.15
North Central	431	301	0.70	27	0.09
South	382	274	0.72	34	0.12
Northeast	182	138	0.76	17	0.12
By Ownership:					
Proprietorships	421	167	0.40	43	0.26
Partnerships	80	62	0.77	6	0.10
Corporations	819	694	0.85	60	0.09
By Life Insurance Offering:					
Not Provided	410	192	0.47	38	0.20
Provided to Some or All Emp.	910	731	0.80	71	0.10
By Pension Plan Offering:					
Not Provided	589	378	0.64	52	0.14
Provided to Some of All Emp.	731	395	0.54	57	0.14