ALASKA LEGISLATURE COMMITTEE BILL FILES - 1987 - 1988 8879

SB 66 cont., SB 67 Leg. Finance 32 32

cash 66

ALASKA STUDENT LOAN PROGRAM
STUDENT LOAN ACTIVITY
Projected to 2010-11

Year	Loan Awards	Loan Volume	Loan Collections	Loan Forgiveness	General Fund	G.F. with Bonding
87-88	17,204	$ 80,000,000	$23,298,455	$ 3,786,944	$56,701,545	$20,000,000
88-89	16,738	80,345,504	27,587,414	4,441,374	52,758,090	25,000,000
89-90	16,381	80,676,052	33,387,487	5,326,377	47,288,565	25,000,000
90-91	16,044	81,024,565	40,624,030	6,430,564	50,400,535*	25,000,000
91-92	16,248	82,865,042	44,721,848	7,584,355	53,143,194*	25,000,000
92-93	16,491	85,341,434	52,739,315	8,745,092	52,602,119*	25,000,000
93-94	16,708	87,298,990	56,381,286	9,831,303	45,917,704*	25,000,000
94-95	16,675	88,375,670	59,929,106	10,789,747	28,446,564	25,000,000
95-96	16,653	88,261,738	63,349,462	11,571,828	24,912,276	25,000,000
96-97	16,416	87,007,173	66,563,505	12,187,296	20,443,668	25,000,000
97-98	16,018	84,895,801	69,475,575	12,679,094	15,420,226	25,000,000
98-99	16,745	88,748,536	71,991,794	13,069,109	16,756,742	25,000,000
99-00	17,201	91,166,845	74,056,739	13,360,407	17,110,106	25,000,000
00-01	17,546	92,991,621	76,271,198	13,587,333	16,720,423	25,000,000
01-02	17,765	94,155,886	78,537,715	13,750,923	15,618,171	25,000,000
02-03	17,949	95,130,963	80,787,019	13,899,705	14,343,944	25,000,000
03-04	18,154	96,214,236	82,951,870	14,064,996	13,262,366	25,000,000
04-05	18,368	97,349,392	85,015,769	14,238,204	12,333,623	25,000,000
05-06	18,578	98,462,230	86,996,273	14,408,006	11,465,957	25,000,000
06-07	18,773	99,498,206	88,906,992	14,566,080	10,591,214	25,000,000
07-08	18,960	100,489,383	90,752,988	14,717,319	9,736,395	25,000,000
08-09	18,965	101,518,364	92,532,964	14,874,404	8,985,400	25,000,000
09-10	19,375	102,687,093	94,248,233	15,052,656	8,438,860	25,000,000
10-11	19,621	103,992,073	95,908,070	15,251,776	8,084,003	25,000,000

*90-91 includes $10.0 million to accommodate cash flow
*91-92 includes $15.0 million to accommodate cash flow
*92-93 includes $20.0 million to accommodate cash flow
*93-94 includes $15.0 million to accommodate cash flow

*This builds up a float of $60.0 million to allow for fall loan processing

1/8/87

oosh66

ALASKA COMMISSION ON POSTSECONDARY EDUCATION
ALASKA STUDENT LOAN PROGRAM
SUMMARY OF NEW LOAN ORIGINATION

YEAR ENDING 6/30	STATE APPROPRIATIONS 1 +	SYSTEM EQUITY (a) 2 +	BOND PROCEEDS 3 =	TOTAL FUNDS AVAILABLE 4 -	EXPENSES (b) 5 -	DEBT SERVICE (c) 6 =	NEW LOANS 7
1987	0	0	0	0	0	0	0
1988	20,000,000	20,152,279	49,810,000	89,962,279	6,475,300	3,486,700	80,000,279
1989	25,000,000	26,828,204	43,875,000	95,703,204	5,359,750	9,997,950	80,345,504
1990	25,000,000	34,019,202	42,550,000	101,569,202	4,857,500	16,035,650	80,676,052
1991	25,000,000	41,506,415	40,675,000	107,181,415	4,265,750	21,891,100	81,024,565
1992	25,000,000	49,281,242	40,000,000	114,281,242	3,815,500	27,600,700	82,865,042
1993	25,000,000	57,071,484	40,000,000	122,071,484	3,428,500	33,301,550	85,341,434
1994	25,000,000	64,346,490	40,000,000	129,346,490	3,011,000	39,036,500	87,298,990
1995	25,000,000	70,754,370	40,000,000	135,754,370	2,559,500	44,819,200	88,375,670
1996	25,000,000	75,975,088	40,000,000	140,975,088	2,072,500	50,640,850	88,261,738
1997	25,000,000	80,069,773	40,000,000	145,069,773	1,546,000	56,516,600	87,007,173
1998	25,000,000	83,317,101	40,000,000	148,317,101	977,500	62,443,800	84,895,801
1999	25,000,000	85,857,586	40,000,000	150,857,586	1,106,000	61,003,050	88,748,536
2000	25,000,000	87,760,095	40,000,000	152,760,095	1,156,000	60,437,250	91,166,845
2001	25,000,000	89,243,571	40,000,000	154,243,571	1,190,500	60,061,450	92,991,621
2002	25,000,000	90,315,686	40,000,000	155,315,686	1,200,000	59,959,800	94,155,886
2003	25,000,000	91,290,763	40,000,000	156,290,763	1,200,000	59,959,800	95,130,963
2004	25,000,000	92,374,036	40,000,000	157,374,036	1,200,000	59,959,800	96,214,236
2005	25,000,000	93,509,192	40,000,000	158,509,192	1,200,000	59,959,800	97,349,392
2006	25,000,000	94,622,030	40,000,000	159,622,030	1,200,000	59,959,800	98,462,230
2007	25,000,000	95,658,006	40,000,000	160,658,006	1,200,000	59,959,800	99,498,206
2008	25,000,000	96,649,183	40,000,000	161,649,183	1,200,000	59,959,800	100,489,383
2009	25,000,000	97,678,164	40,000,000	162,678,164	1,200,000	59,959,800	101,518,364
2010	25,000,000	98,846,893	40,000,000	163,846,893	1,200,000	59,959,800	102,687,093
2011	25,000,000	100,151,873	40,000,000	165,151,873	1,200,000	59,959,800	103,992,073

NOTES:

(a) System Equity consists of recycling of repayments on old loans plus earnings on Debt Service Reserve.

(b) Expenses consist of funding of a Debt Service Reserve (10% of Bond Issue) and Costs of Issuance (3% of Bond Issue), plus $0 to the state.

(c) Bond interest rate of: 7.00%
Principal amortization matches loan repayments.

SB 66 CREATING THE ALASKA STUDENT LOAN CORPORATION

(General Position Statement)

The Alaska Commission on Postsecondary Education, at its December 12-13, 1986 meeting formally endorsed the use of an alternate funding source, such as tax exempt bonds, if full funding from the General Fund were unavailable for Alaska Student Loans. After exploring a wide variety of options (reported in the Legislative Report, "The Alaska Student Loan Program: (5 Years of Helping Alaskans"), the Commission feels that tax exempt bonding is a viable source of revenue for student loans.

In the long run, it will cost the State more to bond than to fund directly from the General Fund; but in the short run, when compared to direct General Fund support it saves over $150 million.

<u>The Commission endorses the establishment of the Student Loan Corporation, which will provide this bonding capability.</u>

There is a controversial section which should be carefully examined. Section 5 has serious implications for a number of schools particulary within Alaska.

BACK UP

SB 66

SECTIONAL ANALYSIS OF THE ALASKA STUDENT LOAN CORPORATION

*Section 1.

Sec. 14.42.100. ALASKA STUDENT LOAN CORPORATION. This paragraph creates the Alaska Student Loan Corporation. The corporation cannot be terminated while debt obligations are outstanding.

Sec. 14.42.110 PURPOSE OF CORPORATION. This paragraph establishes the purpose of the corporation to provide higher education opportunities for residents of Alaska.

Sec. 14.42.120. CORPORATION GOVERNING BODY. The Corporation shall be governed by an executive committee of five members made up from the thirteen members of the Alaska Commission on Postsecondary Education Board. The board members are made up of one member of the State Board of Education and four members are from the rest of the board excluding the two legislative members. Board members shall receive travel and per diem. A majority of the board constitutes a quorum for the organization.

Sec. 14. 42.130. MEETING OF THE BOARD. The board meetings will meet at the call of the chairman and any meeting at which corporate bonds are authorized at least twenty-four hours notice shall be given to the public.

Sec. 14.42.140. MINUTES OF MEETINGS. The board shall keep minutes of every meeting and shall send copies to the governor and Legislative Budget and Audit committee.

Sec. 14.42.150. ADMINISTRATION OF AFFAIRS. The board shall manage the business of the corporation and adopt by-laws and regulations in accord with the Administrative and Procedures Act. The board shall delegate supervision and administration to the Executive officer.

Sec. 14.42.160. EXECUTIVE OFFICER. The corporation shall employ an executive officer who is the executive officer of the Commission on Postsecondary Education.

Sec. 14.42.170. EMPLOYMENT OF PERSONNEL. The executive officer may hire employees in the exempt service. The board may appoint other officers and engage professionals.

Sec. 14.41.190. EXECUTIVE BUDGET ACT. The ope
the corporation is subject to the Executive Budget A

Sec. 14.41.200. GENERAL POWERS. The corporatio
to sue and be sued, adopt an official seal, enter int
receive and administer gifts or grants according to t
conditions of gift or grant, borrow money, pay finance

Backup

Senate Bill 66

SECTIONAL ANALYSIS

interest, invest money, collect from borrowers, gather information on loans, require an elegible institution to file reports, service student loans, obtain information about students applying for loans, contract for purchase of student loans, sell or participate in the sale of student loans, modify interest terms and conditions of student loans based on contracts with bondholders, collect and pay reasonable fees as well as charges in connection with student loans, enter into agreements on student loans concerning federal student loans, enter into contracts with lenders, administer federal money, consent to the modification of terms of the student loans, enter into agreements with Alaska Commission on Postsecondary Education, procure insurance against losses, provide advisory services to borrowers, enter into credit facilitiy agreements and make pleges, covenants, and agreements with respect to the repayment of borrowings of the credit facility agreements, do all acts necessary to carry out the powers implied in this chapter.

Sec. 14.42.210. STUDENT LOAN FUND. Creates a student loan fund inside the corporation to make student loans and secure bond issues the proceeds of which are used to make student loans. The student loan fund shall be administered by the Alaska Commission on Postsecondary Education.

Sec. 14.42.220. BONDS OF THE CORPORATION. The Corporation may borrow money and issue bonds secured by the income and receipts from student loans and other assets. The bonds are issued by resolutions of the board. Each bond issue shall have a maturity of thirty years or less and be subject to the Uniform Commercial Code. The corporation may not issue bonds, other than refunding bonds, during any two consecutive fiscal years in an aggregate amount greater than $150,000,000 unless the legislature, by law, approves issuance of a greater amount.

Sec. 14.42.230. TRUST INDENTURES AND TRUST AGREEMENTS. Issues of bonds may be secured by trust indenture or agreement between the corporation and may be a trust company, bank or national banking association inside or outside the state by secured loan agreement or other instrument giving powers to a corporate trustee by which means the corporation may enter into agreements with the holders of the bonds that the board decides desirable as to the disposition of the proceeds of the bonds, collection of loan payments, assignment of its rights in security interest created to a trustee for the benefit of bondholders, conditions which bonds may be issued, vesting in trustee of rights and powers. Pledge and mortgage assets. Provide for security of the bonds.

Sec. 14.42.240. CAPITAL RESERVE FUNDS AND CAPITAL RESERVE FUND REQUIREMENTS. This section creates the Capital Reserve Fund. These paragraphs create what is commonly know as the moral obligation of the State to repay these bonds.

Sec. 14.42.250. VALIDITY OF PLEDGE. Bonds issued under this chapter shall be valid and binding against all parties having claim of any kind from the corporation.

Sec. 14.42.260. NONLIABILITY OF BONDS. Members of the corporation are not subject to personal liability for issuance of the bonds. The bonds issued do not constitute liability for the State but are payable solely from the income and receipts of the corporation.

Sec. 14.42.265. UNDERWRITERS. The State Purchasing Act (AS 36.30) does not apply to the selection of an underwriter by the board.

Sec. 14.42.270. PLEDGE OF STATE. The State pledges not to alter or limit the rights of bond holders interest when the bonds are outstanding.

Sec. 14.42.280.. EXEMPTION FROM TAXATION. The real and personal property of the corporation are not subject to state or local tax.

Sec. 14.42.290. BONDS LEGAL INVESTMENTS FOR FIDUCIARIES. Bonds are legal investments for all fiduciaries and municipalities in the State.

Sec. 14.42.300. OPERATION OF CERTAIN STATUTES EXCEPTED. The corporation may not be considered or constitute a political subdivision for the purpose of lending it's credit. The corporation is not considered a municipal corporation under Title 29. The funds and real estate of the corporation are not considered property of the State.

Sec. 14.42.310. ANNUAL AUDIT. The coporation shall have an annual audit.

Sec. 14.42.500. _DEFINITIONS. Defines the corporation and board.

*Section 2. AS 14.42.265. The board may select underwriters only by using a competitive method.

*Section 3. AS 14.43.090(a). Amends the power of the Postsecondary Education Corporation to pay the cost of administering student loans and sell or assign loans to the Alaska Student Loan Corporation.

*Section 4. AS 14.43.090(d). It allows the student financial aid committee to sell loans to the Alaska Student Loan Corporation and enter into agreements with the corporation relating to loans.

*Section 5. AS 14.43.120(d). Scholarship loans may not be made to students who attend an institution where the default rate on loans made to students to attend the institution exceeds the program default rate by more than 150%.

*Section 6. AS 14.43.120(r). Interest rates on scholarship loans may be modified to maintain the corporation's tax-exempt status under the Internal Revenue Code.

*Section 7. AS 14.43.255(a). Amends the Memorial Scholarship Loan Fund to allow the loans to be sold or assigned to the Alaska Student Loan Corporation.

*Section 8. AS 14.43.255(c). Allows the State Aid Committee to sell and administer Memorial Scholarship Loans to the Alaska Student Loan Corporation.

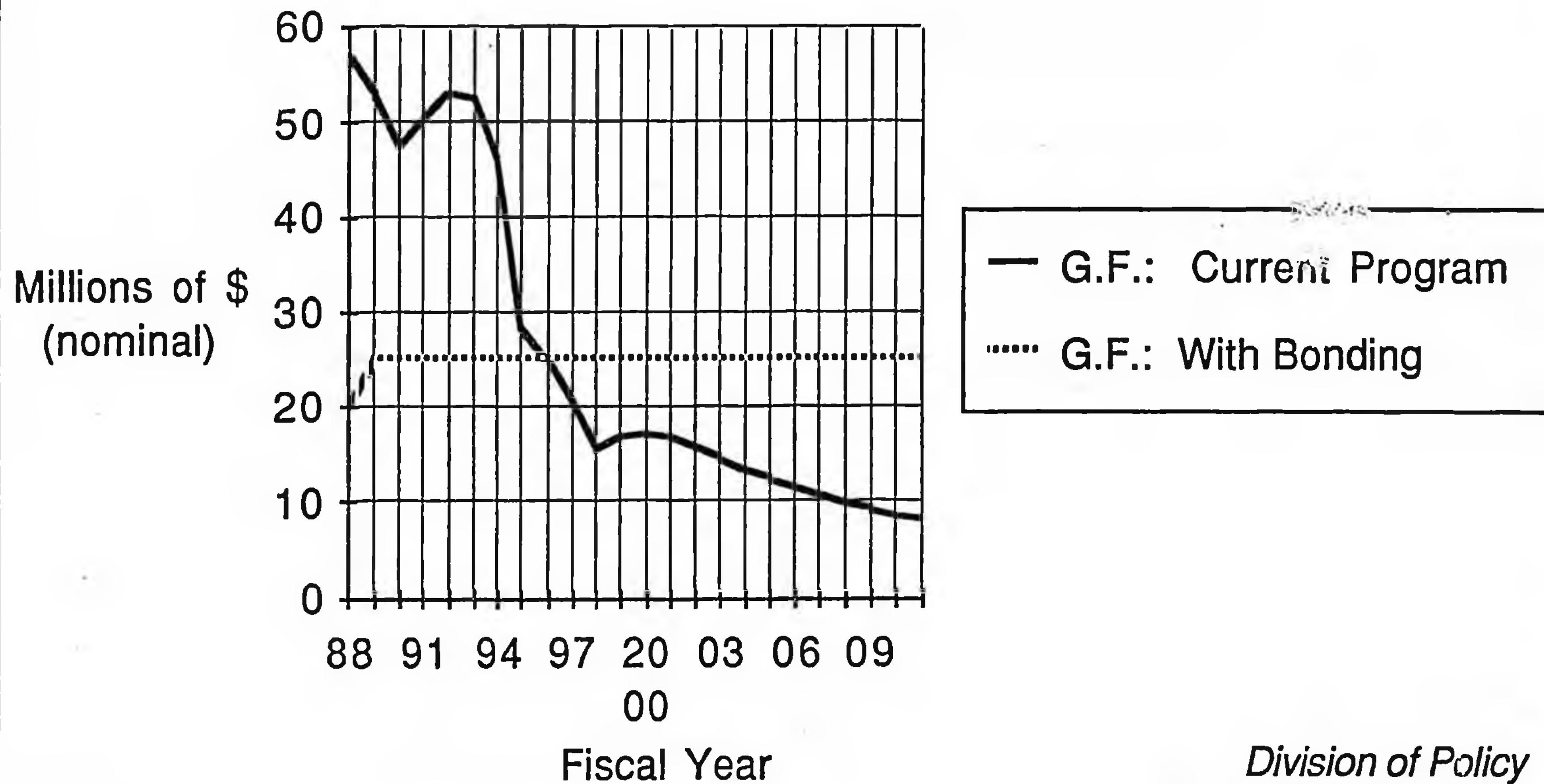
*Section 9. AS 14.43.620 Amended to allow the Teacher Scholarship Revolving Loan Fund to sell or assign loans to the Alaska Student Loan Corporation..

*Section 10. AS 14.43.620(b). The student financial aid committee may sell teacher scholarship loans to the Alaska Student Loan Corporation and may enter into agreements related to such loans.

*Section 11. The act takes effect immediately.

*Section 12. The competitive underwriting section takes effect July 1, 1988.

Comparison of General Fund Requirements for Current Student Loan Program and Nuveen Bonding Proposal



2/10/87

Division of Policy
Office of the Governor
Source: ACPE

TABLE 1

COMPARISON OF GENERAL FUND REQUIREMENTS FOR CURRENT STUDENT LOAN PROGRAM AND NUVEEN BONDING PROPOSAL

(nominal dollars)

Fiscal Year	Loan Awards 2	Loan Volume 3	Loan Collections 4	Loan Forgiveness 5	General Fund Requirement 6	General Fund With Bonding 7	Savings(Cost) With Bonding 8
1988	17,204	$80,000,000	$23,298,455	$3,786,944	$56,701,545	$20,000,000	$36,701,545
1989	16,738	80,345,504	27,587,414	4,441,374	52,758,090	25,000,000	27,758,090
1990	16,381	80,676,052	33,387,487	5,326,377	47,288,565	25,000,000	22,288,565
1991	16,044	81,024,565	40,624,030	6,430,564	50,400,535	25,000,000	25,400,535
1992	16,248	82,865,042	44,721,848	7,584,355	53,143,194	25,000,000	28,143,194
1993	16,491	85,341,434	52,739,315	8,745,092	52,602,119	25,000,000	27,602,119
1994	16,708	87,298,990	56,381,286	9,831,303	45,917,704	25,000,000	20,917,704
1995	16,675	88,375,670	59,929,106	10,789,747	28,446,564	25,000,000	3,446,564
1996	16,653	88,261,738	63,349,462	11,571,828	24,912,276	25,000,000	(87,724)
1997	16,416	87,007,173	66,563,505	12,187,296	20,443,668	25,000,000	(4,556,332)
1998	16,018	84,895,801	69,475,575	12,679,094	15,420,226	25,000,000	(9,579,774)
1999	16,745	88,748,536	71,991,794	13,069,109	16,756,742	25,000,000	(8,243,258)
2000	17,201	91,166,845	74,056,739	13,360,407	17,110,106	25,000,000	(7,889,894)
2001	17,546	92,991,621	76,271,198	13,587,333	16,720,423	25,000,000	(8,279,577)
2002	17,765	94,155,886	78,537,715	13,750,923	15,618,171	25,000,000	(9,381,829)
2003	17,949	95,130,963	80,787,019	13,899,705	14,343,944	25,000,000	(10,656,056)
2004	18,154	96,214,236	82,951,870	14,064,996	13,262,366	25,000,000	(11,737,634)
2005	18,368	97,349,392	85,015,769	14,238,204	12,333,623	25,000,000	(12,666,377)
2006	18,578	98,462,230	86,996,273	14,408,006	11,465,957	25,000,000	(13,534,043)
2007	18,773	99,498,206	88,906,992	14,566,080	10,591,214	25,000,000	(14,408,786)
2008	18,960	100,489,383	90,752,988	14,717,319	9,736,395	25,000,000	(15,263,605)
2009	18,965	101,518,364	92,532,964	14,874,404	8,985,400	25,000,000	(16,014,600)
2010	19,375	102,687,093	94,248,233	15,052,656	8,438,860	25,000,000	(16,561,140)
2011	19,621	103,992,073	95,908,070	15,251,776	8,084,003	25,000,000	(16,915,997)
TOTALS	419,576	2,188,496,797	1,637,015,107	278,214,892	611,481,690	595,000,000	16,481,690

Present Value of Bonding Savings (Cost) (@9% discount rate) 101,318,127

NOTE: General Fund Requirements shown in FY 91-94 are increased by a total of $60 million to provide adequate cash flow for fall loan disbursements.

FY 91 Increase= $10 million
FY 92 Increase= $15 million
FY 93 Increase= $20 million
FY 94 Increase= $15 million

Revised 2/10/87
JK/Divison of Policy
Office of the Governor
Source: ACPE

NUVEEN

John Nuveen & Co. Incorporated
Investment Bankers

333 West Wacker Drive
Chicago, Illinois 60606-1286

Telephone 312.917.7700

Memorandum

February 25, 1987

To: Sterling Gallagher

From: Richard Li

Re: Analysis of Student Loan Program

Version A (Base Case):

- State Appropriations start at $22,000,000.
- State Appropriations decline by $250,000 per year.
- Default Rate at 15.00%
- Forgiveness at 17.50%
- Coverage is 1.27

Version B (Forgiveness Eliminated):

- State Appropriations start at $18,500,000.
- State Appropriations decline by $500,000 per year.
- Default Rate at 18.00%
- Forgiveness Eliminated
- Coverage is 1.25

Version C (Interest Grace Period Eliminated):

- State Appropriations start at $20,250,000.
- State Appropriations decline by $250,000 per year.
- Default Rate at 16.00%
- Forgiveness at 17.50%
- Interest Begins to Accrue from Date of Separation
- Repayment Begins 1 year after Date of Separation
- Coverage is 1.26

Version D (Forgiveness and Interest Grace Period Eliminated):

- State Appropriations start at $17,500,000.
- State Appropriations decline by $750,000 per year.
- Default Rate at 19.00%
- Forgiveness Eliminated
- Interest Begins to Accrue from Date of Separation
- Repayment Begins 1 year after Date of Separation
- Coverage is 1.26

Doc. #3297W

ALASKA COMMISSION ON POSTSECONDARY EDUCATION
ALASKA STUDENT LOAN PROGRAM
SUMMARY OF NEW LOAN ORIGINATION

Version A
LOAN RATE: 8.00%

YEAR ENDING 6/30	STATE APPROPRIATIONS 1 +	SYSTEM EQUITY (a) 2 +	BOND PROCEEDS 3 =	TOTAL FUNDS AVAILABLE 4 -	EXPENSES (b) 5 -	DEBT SERVICE (c) 6 =	NEW LOANS 7	COVERAGE 8
1987	0	0	0	0	0	0	0	NA
1988	22,000,000	20,480,579	46,900,000	89,380,579	6,097,000	3,283,000	80,000,579	6.14
1989	21,750,000	27,111,879	46,670,000	95,531,879	5,743,600	9,784,900	80,003,379	2.71
1990	21,500,000	34,292,872	45,725,000	101,517,872	5,272,250	16,244,200	80,001,422	2.06
1991	21,250,000	41,761,078	44,270,000	107,281,078	4,714,100	22,562,700	80,004,278	1.80
1992	21,000,000	49,499,905	42,245,000	112,744,905	4,061,850	28,681,150	80,001,905	1.68
1993	20,750,000	57,214,040	39,930,000	117,894,040	3,354,900	34,535,250	80,003,890	1.61
1994	20,500,000	64,340,257	37,975,000	122,815,257	2,678,250	40,133,300	80,003,707	1.56
1995	20,250,000	70,487,360	36,930,000	127,667,360	2,099,400	45,567,450	80,000,510	1.51
1996	20,000,000	75,284,306	37,415,000	132,699,306	1,691,450	51,005,450	80,002,406	1.44
1997	19,750,000	78,773,546	39,625,000	138,148,546	1,466,750	56,678,450	80,003,346	1.36
1998	19,500,000	81,279,916	43,440,000	144,219,916	1,394,200	62,825,100	80,000,616	1.27
1999	19,250,000	83,029,282	40,985,000	143,264,282	1,134,050	62,126,950	80,003,282	1.31
2000	19,000,000	84,149,839	38,945,000	142,094,839	945,850	61,147,300	80,001,689	1.35
2001	18,750,000	84,873,851	37,220,000	140,843,851	805,100	60,035,800	80,002,951	1.39
2002	18,500,000	85,170,729	35,990,000	139,660,729	725,200	58,931,650	80,003,879	1.42
2003	18,250,000	85,222,502	35,195,000	138,667,502	686,850	57,977,850	80,002,802	1.44
2004	18,000,000	85,219,034	34,725,000	137,944,034	666,750	57,276,650	80,000,634	1.46
2005	17,750,000	85,192,734	34,535,000	137,477,734	660,550	56,815,850	80,001,334	1.47
2006	17,500,000	85,166,490	34,490,000	137,156,490	660,200	56,494,850	80,001,440	1.48
2007	17,250,000	85,140,215	34,355,000	136,745,215	656,150	56,088,250	80,000,815	1.49
2008	17,000,000	85,113,595	33,830,000	135,943,595	636,400	55,304,350	80,002,845	1.51
2009	16,750,000	85,086,124	32,575,000	134,411,124	586,250	53,821,550	80,003,324	1.55
2010	16,500,000	85,057,890	31,520,000	133,077,890	543,100	52,534,000	80,000,790	1.59
2011	16,250,000	85,028,951	30,635,000	131,913,951	506,550	51,405,300	80,002,101	1.63

NOTES:
(a) System Equity cosists of recycling of repayments on old loans plus earnings on Debt Service Reserve.

(b) Expenses consist of funding of a Debt Service Reserve (10% of Bond Issue) and Costs of Issuance (3% of Bond Issue).

Base Case. Default Rate at 15%.

Minimum Coverage: 1.27

ALASKA COMMISSION ON POSTSECONDARY EDUCATION — Version 8

ALASKA STUDENT LOAN PROGRAM — LOAN RATE: 8.00%

SUMMARY OF NEW LOAN ORIGINATION

YEAR ENDING 6/30	STATE APPROPRIATIONS 1 +	SYSTEM EQUITY (a) 2 +	BOND PROCEEDS 3 =	TOTAL FUNDS AVAILABLE 4 -	EXPENSES (b) 5 -	DEBT SERVICE (c) 6 =	NEW LOANS 7	COVERAGE 8
1987	0	0	0	0	0	0	0	NA
1988	18,500,000	20,510,959	51,240,000	90,250,959	6,661,200	3,586,800	80,002,959	5.62
1989	18,000,000	27,177,399	51,990,000	97,167,399	6,405,200	10,761,100	80,001,099	2.46
1990	17,500,000	34,609,374	51,925,000	104,034,374	6,009,250	18,023,400	30,001,724	1.86
1991	17,000,000	42,641,073	51,105,000	110,746,073	5,485,150	25,257,050	80,003,873	1.64
1992	16,500,000	51,435,868	49,205,000	117,140,868	4,792,650	32,345,450	90,002,768	1.54
1993	16,000,000	60,497,342	46,670,000	123,167,342	3,995,100	39,169,550	80,002,692	1.50
1994	15,500,000	69,034,806	44,385,000	128,919,806	3,210,050	45,706,100	80,003,656	1.47
1995	15,000,000	76,613,826	42,925,000	134,538,826	2,509,250	52,028,850	80,000,726	1.44
1996	14,500,000	82,834,436	42,940,000	140,274,436	1,969,200	58,304,950	80,000,286	1.39
1997	14,000,000	87,738,464	44,620,000	146,358,464	1,602,100	64,754,250	80,002,114	1.32
1998	13,500,000	91,650,067	47,830,000	152,980,067	1,375,400	71,603,400	80,001,267	1.25
1999	13,000,000	94,793,791	43,955,000	151,748,791	917,650	70,830,500	80,000,641	1.31
2000	12,500,000	97,086,248	40,380,000	149,966,248	540,400	69,424,550	80,001,298	1.37
2001	12,000,000	98,662,348	37,115,000	147,777,348	234,450	67,541,300	80,001,598	1.43
2002	11,500,000	99,310,930	34,605,000	145,415,930	46,650	65,365,300	80,003,980	1.49
2003	11,000,000	99,414,309	32,680,000	143,094,309	(65,600)	63,156,500	80,003,409	1.55
2004	10,500,000	99,389,193	31,015,000	140,904,193	(157,050)	61,057,750	80,003,493	1.60
2005	10,000,000	99,310,408	29,525,000	138,835,408	(238,750)	59,072,200	80,001,958	1.66
2006	9,500,000	99,228,934	28,030,000	136,758,934	(323,100)	57,080,400	80,001,634	1.71
2007	9,000,000	99,144,369	26,290,000	134,434,369	(420,300)	54,853,800	80,000,869	1.78
2008	8,500,000	99,056,030	23,985,000	131,541,030	(543,450)	52,081,150	80,003,330	1.88
2009	8,000,000	98,962,895	20,760,000	127,722,895	(708,700)	48,431,300	80,000,295	2.02
2010	7,500,000	98,864,779	17,650,000	124,014,779	(873,500)	44,886,550	80,001,729	2.18
2011	7,000,000	98,761,322	14,630,000	120,391,322	(1,039,600)	41,428,050	80,002,872	2.36

NOTES:

(a) System Equity cosists of recycling of repayments on old loans plus earnings on Debt Service Reserve.

(b) Expenses consist of funding of a Debt Service Reserve (10% of Bond Issue) and Costs of Issuance (3% of Bond Issue).

Forgiveness Eliminated. Default Rate Raised to 18%.

Minimum Coverage: 1.25

ALASKA COMMISSION ON POSTSECONDARY EDUCATION
ALASKA STUDENT LOAN PROGRAM
SUMMARY OF NEW LOAN ORIGINATION

Version C

LOAN RATE:
8.00%

YEAR ENDING 6/30	STATE APPROPRIATIONS 1 +	SYSTEM EQUITY (a) 2 +	BOND PROCEEDS 3 =	TOTAL FUNDS AVAILABLE 4 -	EXPENSES (b) 5 -	DEBT SERVICE (c) 6 =	NEW LOANS 7	COVERAGE 8
1987	0	0	0	0	0	0	0	NA
1988	20,250,000	20,495,769	49,070,000	89,815,769	6,379,100	3,434,900	80,001,769	5.87
1989	20,000,000	27,143,554	49,175,000	96,318,554	6,054,250	10,262,150	80,002,154	2.58
1990	19,750,000	34,426,180	48,520,000	102,696,180	5,602,100	17,091,600	80,002,480	1.96
1991	19,500,000	42,119,508	47,245,000	108,864,508	5,045,350	23,814,900	80,004,258	1.72
1992	19,250,000	50,278,440	45,190,000	114,718,440	4,364,200	30,350,650	80,003,590	1.61
1993	19,000,000	58,527,660	42,695,000	120,222,660	3,606,850	36,611,950	80,003,860	1.56
1994	18,750,000	66,213,494	40,495,000	125,458,494	2,870,850	42,586,150	80,001,494	1.51
1995	18,500,000	72,927,531	39,165,000	130,592,531	2,226,950	48,362,250	80,003,331	1.47
1996	18,250,000	78,287,040	39,315,000	135,852,040	1,746,950	54,104,150	80,000,940	1.41
1997	18,000,000	82,334,190	41,145,000	141,479,190	1,444,350	60,034,500	80,000,340	1.34
1998	17,750,000	85,393,432	44,530,000	147,673,432	1,287,900	66,383,450	80,002,082	1.26
1999	17,500,000	87,689,971	41,210,000	146,399,971	920,300	65,477,450	80,002,221	1.31
2000	17,250,000	89,267,763	38,220,000	144,737,763	625,100	64,111,950	80,000,713	1.36
2001	17,000,000	90,320,238	35,510,000	142,830,238	384,300	62,442,200	80,003,738	1.42
2002	16,750,000	90,744,954	33,340,000	140,834,954	222,700	60,608,600	80,003,654	1.47
2003	16,500,000	90,803,377	31,610,000	138,913,377	112,300	58,798,250	80,002,827	1.52
2004	16,250,000	90,775,229	30,115,000	137,140,229	16,450	57,123,400	80,000,379	1.56
2005	16,000,000	90,709,668	28,795,000	135,504,668	(71,650)	55,575,100	80,001,218	1.61
2006	15,750,000	90,640,480	27,480,000	133,870,480	(163,100)	54,033,200	80,000,380	1.65
2007	15,500,000	90,567,186	25,925,000	131,992,186	(267,750)	52,258,100	80,001,836	1.71
2008	15,250,000	90,489,076	22,805,000	127,544,076	(397,830)	49,942,850	80,001,076	1.79
2009	15,000,000	90,405,183	20,780,000	126,185,183	(573,600)	46,756,300	80,002,483	1.91
2010	14,750,000	90,315,138	17,810,000	122,875,138	(751,200)	43,625,500	80,000,838	2.05
2011	14,500,000	90,218,584	14,855,000	119,573,584	(933,850)	40,503,800	80,003,634	2.20

NOTES:

(a) System Equity cosists of recycling of repayments on old loans plus earnings on Debt Service Reserve.

(b) Expenses consist of funding of a Debt Service Reserve (10% of Bond Issue) and Costs of Issuance (3% of Bond Issue).

Interest Grace Period Eliminated. Default Rate Raised to 16%.

Minimum Coverage: 1.26

ALASKA COMMISSION ON POSTSECONDARY EDUCATION
ALASKA STUDENT LOAN PROGRAM
SUMMARY OF NEW LOAN ORIGINATION

Version D

LOAN RATE: 8.00%

YEAR ENDING 6/30	STATE APPROPRIATIONS 1 +	SYSTEM EQUITY (a) 2 +	BOND PROCEEDS 3 =	TOTAL FUNDS AVAILABLE 4 -	EXPENSES (b) 5 -	DEBT SERVICE (c) 6 =	NEW LOANS 7	COVERAGE 8
1987	0	0	0	0	0	0	0	NA
1988	17,500,000	20,519,639	52,480,000	90,499,639	6,822,400	3,673,600	80,003,639	5.49
1989	16,750,000	27,197,699	53,740,000	97,687,699	6,623,700	11,060,400	80,003,599	2.39
1990	16,000,000	34,741,623	54,125,000	104,866,623	6,274,250	18,590,400	80,001,973	1.81
1991	15,250,000	43,030,359	53,665,000	111,945,359	5,779,450	26,163,550	80,002,359	1.59
1992	14,500,000	52,310,383	51,895,000	118,705,383	5,083,350	33,618,300	80,003,733	1.51
1993	13,750,000	61,992,545	49,345,000	125,087,545	4,260,350	40,823,350	80,003,845	1.48
1994	13,000,000	71,181,145	46,995,000	131,176,145	3,442,350	47,729,850	80,003,945	1.45
1995	12,250,000	79,421,905	45,460,000	137,131,905	2,704,800	54,425,150	80,001,955	1.42
1996	11,500,000	86,301,709	45,385,000	143,186,709	2,125,050	61,058,600	80,003,059	1.38
1997	10,750,000	91,862,182	46,965,000	149,577,182	1,714,950	67,858,650	80,003,582	1.32
1998	10,000,000	96,427,250	50,060,000	156,487,250	1,441,800	75,044,500	80,000,950	1.26
1999	9,250,000	100,221,119	45,850,000	155,321,119	926,000	74,392,800	80,002,319	1.32
2000	8,500,000	103,062,848	41,925,000	153,487,848	497,250	72,988,400	80,002,198	1.38
2001	7,750,000	105,042,476	38,360,000	151,152,476	154,800	70,996,500	80,001,176	1.45
2002	7,000,000	105,865,668	35,730,000	148,595,668	(38,600)	68,630,200	80,004,068	1.52
2003	6,250,000	106,007,416	33,805,000	146,062,416	(136,850)	66,198,100	80,001,166	1.57
2004	5,500,000	105,989,395	32,190,000	143,679,395	(207,300)	63,884,350	80,002,345	1.63
2005	4,750,000	105,906,165	30,780,000	141,436,165	(264,100)	61,699,550	80,000,715	1.69
2006	4,000,000	105,821,862	29,390,000	139,211,862	(320,800)	59,531,000	80,001,662	1.75
2007	3,250,000	105,736,202	27,785,000	136,771,202	(387,450)	57,156,900	80,001,752	1.82
2008	2,500,000	105,648,737	25,650,000	133,798,737	(477,000)	54,272,750	80,002,987	1.92
2009	1,750,000	105,558,699	22,635,000	129,943,699	(604,450)	50,544,150	80,003,999	2.06
2010	1,000,000	105,466,101	19,830,000	126,296,101	(726,100)	47,019,350	80,002,851	2.22
2011	250,000	105,370,929	17,215,000	122,835,929	(842,550)	43,676,600	80,001,879	2.39

NOTES:

(a) System Equity cosists of recycling of repayments on old loans plus earnings on Debt Service Reserve.

(b) Expenses consist of funding of a Debt Service Reserve (10% of Bond Issue) and Costs of Issuance (3% of Bond Issue).

Forgiveness Eliminated, Interest Grace Period Eliminated. Default Rate Raised to 19%.

Minimum Coverage: 1.26

ALASKA STATE LEGISLATURE

15th Legislature 1st Session

SENATE BILL NO. 66

By KELLY, HALFORD, KERTTULA, FAIKS, STURGULEWSKI

"An Act relating to student loans; creating the Alaska Student Loan Corporation; and providing for an effective date."

Introduced in the Senate 1/19, 1987

HISTORY IN THE SENATE

1987

Read first time and referred to Committee on

1 19 HESS AND FINANCE

3 9 Reported back with HESS recommendation that replaced w/CS, 3 do pass, fiscal impact to Finance. Fin:

Read second time and

Read third time and

PASS	Effective Date
Yeas	Yeas
Nays	Nays
Absent	Absent
Excused	Excused

Reconsideration

PASS	Effective Date
Yeas	Yeas
Nays	Nays
Absent	Absent
Excused	Excused

Reported correctly engrossed
Signed by President
Sent to House

SECRETARY OF THE SENATE

HISTORY IN THE HOUSE

19

Read first time and referred to Committee on

Reported back with recommendation that

Read second time and

Read third time and

PASS	Effective Date
Yeas	Yeas
Nays	Nays
Absent	Absent
Excused	Excused

Reconsideration

PASS	Effective Date
Yeas	Yeas
Nays	Nays
Absent	Absent
Excused	Excused

Reported correctly engrossed
Signed by Speaker
Returned to Senate

CHIEF CLERK OF THE HOUSE

HISTORY IN THE SENATE

19

Received from House

To enrolling

Reported correctly enrolled

Sent to Governor

.... by Governor

Filed with Lt. Governor

Chapter No. ....

NUVEEN

John Nuveen & Co. Incorporated
Investment Bankers
333 West Wacker Drive
Chicago, Illinois 60606-1286
Telephone 312.917.7700

Memorandum

February 25, 1987

To: Sterling Gallagher

From: Richard Li

Re: Analysis of Student Loan Program

Version A (Base Case):

- State Appropriations start at $22,000,000.
- State Appropriations decline by $250,000 per year.
- Default Rate at 15.00%
- Forgiveness at 17.50%
- Coverage is 1.27

Version B (Forgiveness Eliminated):

- State Appropriations start at $18,500,000.
- State Appropriations decline by $500,000 per year.
- Default Rate at 18.00%
- Forgiveness Eliminated
- Coverage is 1.25

Version C (Interest Grace Period Eliminated):

- State Appropriations start at $20,250,000.
- State Appropriations decline by $250,000 per year.
- Default Rate at 16.00%
- Forgiveness at 17.50%
- Interest Begins to Accrue from Date of Separation
- Repayment Begins 1 year after Date of Separation
- Coverage is 1.26

Version D (Forgiveness and Interest Grace Period Eliminated):

- State Appropriations start at $17,500,000.
- State Appropriations decline by $750,000 per year.
- Default Rate at 19.00%
- Forgiveness Eliminated
- Interest Begins to Accrue from Date of Separation
- Repayment Begins 1 year after Date of Separation
- Coverage is 1.26

Doc. #3297W

ALASKA COMMISSION ON POSTSECONDARY EDUCATION
ALASKA STUDENT LOAN PROGRAM
SUMMARY OF NEW LOAN ORIGINATION

Version A

LOAN RATE: 8.00%

YEAR ENDING 6/30	STATE APPROPRIATIONS 1 +	SYSTEM EQUITY (a) 2 +	BOND PROCEEDS 3 =	TOTAL FUNDS AVAILABLE 4 -	EXPENSES (b) 5 -	DEBT SERVICE (c) 6 =	NEW LOANS 7	COVERAGE 8
1987	0	0	0	0	0	0	0	NA
1988	22,000,000	20,480,579	46,900,000	89,380,579	6,097,000	3,283,000	80,000,579	6.14
1989	21,750,000	27,111,879	46,670,000	95,531,879	5,743,600	9,784,900	80,003,379	2.71
1990	21,500,000	34,292,872	45,725,000	101,517,872	5,272,250	16,244,200	80,001,422	2.06
1991	21,250,000	41,761,078	44,270,000	107,281,078	4,714,100	22,562,700	80,004,278	1.80
1992	21,000,000	49,499,905	42,245,000	112,744,905	4,061,850	28,681,150	80,001,905	1.68
1993	20,750,000	57,214,040	39,930,000	117,894,040	3,354,900	34,535,250	80,003,890	1.61
1994	20,500,000	64,340,257	37,975,000	122,815,257	2,678,250	40,133,300	80,003,707	1.56
1995	20,250,000	70,487,360	36,930,000	127,667,360	2,099,400	45,567,450	80,000,510	1.51
1996	20,000,000	75,284,306	37,415,000	132,699,306	1,691,450	51,005,450	80,002,406	1.44
1997	19,750,000	78,773,546	39,625,000	138,148,546	1,466,750	56,678,450	80,003,346	1.36
1998	19,500,000	81,279,916	43,440,000	144,219,916	1,394,200	62,825,100	80,000,616	1.27
1999	19,250,000	83,029,282	40,985,000	143,264,282	1,134,050	62,126,950	80,003,282	1.31
2000	19,000,000	84,149,839	38,945,000	142,094,839	945,850	61,147,300	80,001,689	1.35
2001	18,750,000	84,873,851	37,220,000	140,843,851	805,100	60,035,800	80,002,951	1.39
2002	18,500,000	85,170,729	35,990,000	139,660,729	725,200	58,931,650	80,003,879	1.42
2003	18,250,000	85,222,502	35,195,000	138,667,502	686,850	57,977,850	80,002,802	1.44
2004	18,000,000	85,219,034	34,725,000	137,944,034	666,750	57,276,650	80,000,634	1.46
2005	17,750,000	85,192,734	34,535,000	137,477,734	660,550	56,815,850	80,001,334	1.47
2006	17,500,000	85,166,490	34,490,000	137,156,490	660,200	56,494,850	80,001,440	1.48
2007	17,250,000	85,140,215	34,355,000	136,745,215	656,150	56,088,250	80,000,815	1.49
2008	17,000,000	85,113,595	33,830,000	135,943,595	636,400	55,304,350	80,002,845	1.51
2009	16,750,000	85,086,124	32,575,000	134,411,124	586,250	53,821,550	80,003,324	1.55
2010	16,500,000	85,057,890	31,520,000	133,077,890	543,100	52,534,000	80,000,790	1.59
2011	16,250,000	85,028,951	30,635,000	131,913,951	506,550	51,405,300	80,002,101	1.63

NOTES:

(a) System Equity cosists of recycling of repayments on old loans plus earnings on Debt Service Reserve.

(b) Expenses consist of funding of a Debt Service Reserve (10% of Bond Issue) and Costs of Issuance (3% of Bond Issue).

Base Case. Default Rate at 15%.

Minimum Coverage: 1.27

ALASKA COMMISSION ON POSTSECONDARY EDUCATION
ALASKA STUDENT LOAN PROGRAM
SUMMARY OF NEW LOAN ORIGINATION

Version 8

LOAN RATE:
8.00%

YEAR ENDING 6/30	STATE APPROPRIATIONS	SYSTEM EQUITY (a)	BOND PROCEEDS	TOTAL FUNDS AVAILABLE	EXPENSES (b)	DEBT SERVICE (c)	NEW LOANS	COVERAGE
	1 +	2 +	3 =	4 -	5 -	6 =	7	8
1987	0	0	0	0	0	0	0	NA
1988	18,500,000	20,510,959	51,240,000	90,250,959	6,661,200	3,586,800	80,002,959	5.62
1989	18,000,000	27,177,399	51,990,000	97,167,399	6,405,200	10,761,100	80,001,099	2.46
1990	17,500,000	34,609,374	51,925,000	104,034,374	6,009,250	18,023,400	80,001,724	1.86
1991	17,000,000	42,641,073	51,105,000	110,746,073	5,485,150	25,257,050	80,003,873	1.64
1992	16,500,000	51,435,868	49,205,000	117,140,868	4,792,650	32,345,450	80,002,768	1.54
1993	16,000,000	60,497,342	46,670,000	123,167,342	3,995,100	39,169,550	80,002,692	1.50
1994	15,500,000	69,034,806	44,385,000	128,919,806	3,210,050	45,706,100	80,003,656	1.47
1995	15,000,000	76,613,826	42,925,000	134,538,826	2,509,250	52,028,850	80,000,726	1.44
1996	14,500,000	82,834,436	42,940,000	140,274,436	1,969,200	58,304,950	80,000,286	1.39
1997	14,000,000	87,738,464	44,620,000	146,358,464	1,602,100	64,754,250	80,002,114	1.32
1998	13,500,000	91,650,067	47,830,000	152,980,067	1,375,400	71,603,400	80,001,267	1.25
1999	13,000,000	94,793,791	43,955,000	151,748,791	917,650	70,830,500	80,000,641	1.31
2000	12,500,000	97,086,248	40,380,000	149,966,248	540,400	69,424,550	80,001,298	1.37
2001	12,000,000	98,662,348	37,115,000	147,777,348	234,450	67,541,300	80,001,598	1.43
2002	11,500,000	99,310,930	34,605,000	145,415,930	46,650	65,365,300	80,003,980	1.49
2003	11,000,000	99,414,309	32,680,000	143,094,309	(65,600)	63,156,500	80,003,409	1.55
2004	10,500,000	99,389,193	31,015,000	140,904,193	(157,050)	61,057,750	80,003,493	1.60
2005	10,000,000	99,310,408	29,525,000	138,835,408	(238,750)	59,072,200	80,001,958	1.66
2006	9,500,000	99,228,934	28,030,000	136,758,934	(323,100)	57,080,400	80,001,634	1.71
2007	9,000,000	99,144,369	26,290,000	134,434,369	(420,300)	54,853,800	80,000,869	1.78
2008	8,500,000	99,056,030	23,985,000	131,541,030	(543,450)	52,081,150	80,003,330	1.88
2009	8,000,000	98,962,895	20,760,000	127,722,895	(708,700)	48,431,300	80,000,295	2.02
2010	7,500,000	98,864,779	17,650,000	124,014,779	(873,500)	44,886,550	80,001,729	2.18
2011	7,000,000	98,761,322	14,630,000	120,391,322	(1,039,600)	41,428,050	80,002,872	2.36

NOTES:

(a) System Equity cosists of recycling of repayments on old loans plus earnings on Debt Service Reserve.

(b) Expenses consist of funding of a Debt Service Reserve (10% of Bond Issue) and Costs of Issuance (3% of Bond Issue).

Forgiveness Eliminated. Default Rate Raised to 18%.

Minimum Coverage: 1.25

ALASKA COMMISSION ON POSTSECONDARY EDUCATION
ALASKA STUDENT LOAN PROGRAM
SUMMARY OF NEW LOAN ORIGINATION

Version C

LOAN RATE: 8.00%

YEAR ENDING 6/30	S[illegible] APPR[illegible]IONS 1 +	SYSTEM EQUITY (a) 2 +	BOND PROCEEDS 3 =	TOTAL FUNDS AVAILABLE 4 -	EXPENSES (b) 5 -	DEBT SERVICE (c) 6 =	NEW LOANS 7	COVERAGE 8
1987	0	0	0	0	0	0	0	NA
1988	20,250,000	20,495,769	49,070,000	89,815,769	6,379,100	3,434,900	80,001,769	5.87
1989	20,000,000	27,143,554	49,175,000	96,318,554	6,054,250	10,262,150	80,002,154	2.58
1990	19,750,000	34,426,180	48,520,000	102,696,180	5,602,100	17,091,600	80,002,480	1.96
1991	19,500,000	42,119,508	47,245,000	108,864,508	5,045,350	23,814,900	80,004,258	1.72
1992	19,250,000	50,278,440	45,190,000	114,718,440	4,364,200	30,350,650	80,003,590	1.61
1993	19,000,000	58,527,660	42,695,000	120,222,660	3,606,850	36,611,950	80,003,860	1.56
1994	18,750,000	66,213,494	40,495,000	125,458,494	2,870,850	42,586,150	80,001,494	1.51
1995	18,500,000	72,927,531	39,165,000	130,592,531	2,226,950	48,362,250	80,003,331	1.47
1996	18,250,000	78,287,040	39,315,000	135,852,040	1,746,950	54,104,150	80,000,940	1.41
1997	18,000,000	82,334,190	41,145,000	141,479,190	1,444,350	60,034,500	80,000,340	1.34
1998	17,750,000	85,393,432	44,530,000	147,673,432	1,287,900	66,383,450	80,002,082	1.26
1999	17,500,000	87,689,971	41,210,000	146,399,971	920,300	65,477,450	80,002,221	1.31
2000	17,250,000	89,267,763	38,220,000	144,737,763	625,100	64,111,950	80,000,713	1.36
2001	17,000,000	90,320,238	35,510,000	142,830,238	384,300	62,442,200	80,003.738	1.42
2002	16,750,000	90,744,954	33,340,000	140,834,954	222,700	60,608,600	80,003,654	1.47
2003	16,500,000	90,803,377	31,610,000	138,913,377	112,300	58,798,250	80,002,827	1.52
2004	16,250,000	90,775,229	30,115,000	137,140,229	16,450	57,123,400	80,000,379	1.56
2005	16,000,000	90,709,668	28,795,000	135,504,668	(71,650)	55,575,100	80,001,218	1.61
2006	15,750,000	90,640,480	27,480,000	133,870,480	(163,100)	54,033,200	80,000,380	1.65
2007	15,500,000	90,567,186	25,925,000	131,992,186	(267,750)	52,258,100	80,001,836	1.71
2008	15,250,000	90,489,076	22,805,000	127,544,076	(399,830)	49,942,850	80,001,076	1.79
2009	15,000,000	90,405,183	20,780,000	126,185,183	(573,600)	46,756,300	80,002,483	1.91
2010	14,750,000	90,315,138	17,810,000	122,875,138	(751,200)	43,625,500	80,000,838	2.05
2011	14,500,000	90,218,584	14,855,000	119,573,584	(933,850)	40,503,800	80,003,634	2.20

NOTES:

(a) System Equity cosists of recycling of repayments on old loans plus earnings on Debt Service Reserve.

(b) Expenses consist of funding of a Debt Service Reserve (10% of Bond Issue) and Costs of Issuance (3% of Bond Issue).

Interest Grace Period Eliminated. Default Rate Raised to 16%.

Minimum Coverage: 1.26

ALASKA COMMISSION ON POSTSECONDARY EDUCATION
ALASKA STUDENT LOAN PROGRAM
SUMMARY OF NEW LOAN ORIGINATION

Version D

LOAN RATE:
8.00%

YEAR ENDING 6/30	STATE APPROPRIATIONS	SYSTEM EQUITY (a)	BOND PROCEEDS	TOTAL FUNDS AVAILABLE	EXPENSES (b)	DEBT SERVICE (c)	NEW LOANS	COVERAGE
	1 +	2 +	3 =	4 -	5 -	6 =	7	8
1987	0	0	0	0	0	0	0	NA
1988	17,500,000	20,519,639	52,480,000	90,499,639	6,822,400	3,673,600	80,003,639	5.49
1989	16,750,000	27,197,699	53,740,000	97,687,699	6,623,700	11,060,400	80,003,599	2.39
1990	16,000,000	34,741,623	54,125,000	104,866,623	6,274,250	18,590,400	80,001,973	1.81
1991	15,250,000	43,030,359	53,665,000	111,945,359	5,779,450	26,163,550	80,002,359	1.59
1992	14,500,000	52,310,383	51,895,000	118,705,383	5,083,350	33,618,300	80,003,733	1.51
1993	13,750,000	61,992,545	49,345,000	125,087,545	4,260,350	40,823,350	80,003,845	1.48
1994	13,000,000	71,181,145	46,995,000	131,176,145	3,442,350	47,729,850	80,003,945	1.45
1995	12,250,000	79,421,905	45,460,000	137,131,905	2,704,800	54,425,150	80,001,955	1.42
1996	11,500,000	86,301,709	45,385,000	143,186,709	2,125,050	61,058,600	80,003,059	1.38
1997	10,750,000	91,862,182	46,965,000	149,577,182	1,714,950	67,858,650	80,003,582	1.32
1998	10,000,000	96,427,250	30,060,000	156,487,250	1,441,800	75,044,500	80,000,950	1.26
1999	9,250,000	100,221,119	45,850,000	155,321,119	926,000	74,392,800	80,002,319	1.32
2000	8,500,000	103,062,848	41,925,000	153,487,848	497,250	72,988,400	80,002,198	1.38
2001	7,750,000	105,042,476	38,360,000	151,152,476	154,800	70,996,500	80,001,176	1.45
2002	7,000,000	105,865,668	35,730,000	148,595,668	(38,600)	68,630,200	80,004,068	1.52
2003	6,250,000	106,007,416	33,805,000	146,062,416	(136,850)	66,198,100	80,001,166	1.57
2004	5,500,000	105,989,395	32,190,000	143,679,395	(207,300)	63,884,350	80,002,345	1.63
2005	4,750,000	105,906,165	30,780,000	141,436,165	(264,100)	61,699,550	80,000,715	1.69
2006	4,000,000	105,821,862	29,390,000	139,211,862	(320,800)	59,531,000	80,001,662	1.75
2007	3,250,000	105,736,202	27,785,000	136,771,202	(387,450)	57,156,900	80,001,752	1.82
2008	2,500,000	105,648,737	25,650,000	133,798,737	(477,000)	54,272,750	80,002,987	1.92
2009	1,750,000	105,558,699	22,635,000	129,943,699	(604,450)	50,544,150	80,003,999	2.06
2010	1,000,000	105,466,101	19,830,000	126,296,101	(726,100)	47,019,350	80,002,851	2.22
2011	250,000	105,370,929	17,215,000	122,835,929	(842,550)	43,676,600	80,001,879	2.39

NOTES:

(a) System Equity cosists of recycling of repayments on old loans plus earnings on Debt Service Reserve.

(b) Expenses consist of funding of a Debt Service Reserve (10% of Bond Issue) and Costs of Issuance (3% of Bond Issue).

Forgiveness Eliminated, Interest Grace Period Eliminated. Default Rate Raised to 19%.

Minimum Coverage: 1.26

SB67

STATE OF ALASKA
1988 LEGISLATIVE SESSION

Bill Version: HCS CSSB67(HESS)
Publish Date:

FISCAL NOTE

REQUEST:

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

Agency Affected: Department of Administration
BRU: Retirament and Benefits
Components: Retirement and Benefits (GHLB)

EXPENDITURES/REVENUES: (Thousands of Dollars)

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

FUNDING: (Thousands of Dollars)

	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
CENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

POSITIONS:

	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

ANALYSIS: (Attach a separate page if necessary)

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

Robert F. Stalnaker

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

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

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

MAR 3 1988

STATE OF ALASKA

DEPARTMENT OF ADMINISTRATION

DIVISION OF RETIREMENT & BENEFITS

PLEASE REPLY TO:

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

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

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

STEVE COWPER, GOVERNOR

February 19, 1988

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

Dear Representatives Koponen and Ellis:

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

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

The financial impact shown in this letter represents the costs to employers participating in the state's retirement plans due to the increased limits of coverage for mental or nervous conditions under the retiree's health plan. In addition to the costs to the state's operating budget outlined on the fiscal note, this bill is estimated to result in a .20% increase in the PERS employer contribution rate and a .15% increase in the TRS employer contribution rate and a .15% increase in the TRS State Match contribution rate in FY 90. The estimated FY 90 payrolls are listed below and are assumed to remain level each year thereafter.

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

The increase in the PERS contribution rate (.20%) times the estimated FY 90 state PERS payroll ($479,549,872) equals:	$ 959.1
The increase in the TRS contribution rate (.15%) times the estimated FY 90 University of Alaska TRS payroll ($44,753,863) equals:	67.1
The increase in the TRS contribution rate (.15%) times the estimated FY 90 Department of Education TRS payroll ($5,613,930) equals:	8.4
	$1,034.6

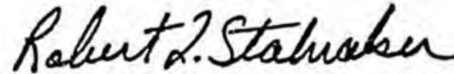
Note: Please Include Your Social Security Number In All Correspondence & Requests Concerning Your Benefits.

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

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

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

Sincerely,



Robert F. Stalnaker
Acting Director

RFS/bb/7

STATE OF ALASKA
1988 LEGISLATIVE SESSION

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

FISCAL NOTE

REQUEST:

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

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

EXPENDITURES/REVENUES: (Thousands of Dollars)

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

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

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

FUNDING: (Thousands of Dollars)

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

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

see attached sheet

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

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

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

FEB 9 1988
LEGISLATIVE FINANCE

FISCAL NOTE

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

POSITION PAPER

Committee Substitute
for
Senate Bill 67 (HESS)

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

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

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

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

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

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

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

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

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

(3) works in conjunction with a licensed provider.

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

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

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

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

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

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

RECOMMENDED BY:

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

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

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

Date: February 4, 1988

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

SENATE COMMITTEE REPORT

FURTHER:

3/31/87

DATE TURNED INTO OFFICE 5/1/87

Mr. President:

FINANCE Committee considered SB 67

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

and recommended:

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

[ ] attached amendment(s) and

[✓] do pass

[ ] do not pass

[ ] no recommendation

[ ] individual recommendations

[ ] further referral to ________

[ ] letter of intent adopted ________

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

MEMBERS SIGNING DO PASS	OTHER RECOMMENDATIONS
[signature]	
[signature]	
[signature]	
[signature]	
[signature]	

[signature] — DO PASS
Chairman signature and recommendation

[ ] Committee Backup Attached

STATE OF ALASKA 1987 LEGISLATIVE SESSION

FISCAL NOTE

Bill Version : SB 67

Publish Date :

REQUEST:

Revision Date:

Title : "An Act Relating to Insurance Coverage of a Mental Health or Nervous Condi.

Sponsor : Faiks and Kertulla

Requestor :

Agency Affected :

BRU : Institutions and Administration

Components : Alaska Psychiatric Institute

EXPENDITURES/REVENUES: (Thousands of Dollars)

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

FUNDING: (Thousands of Dollars)

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

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS : (Attach a separate page if necessary)

See attached

Prepared by : Deborah K. Smith by BAM

Phone : 465-3370

Division :

Date : 1/27/87

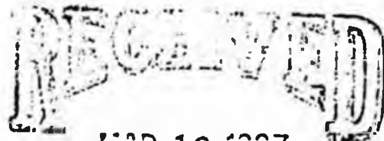
Approved by Commissioner : [signature]

Date : 3/18/87

Agency : Dept. of Health & Social Services

Distribution (by preparer):

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



MAR 18 1987

LEGISLATIVE FINANCE

SB 67

SB 67

FISCAL NOTE

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

Offered: 3/31/87
Referred: Finance

5-0356B

Original sponsors: Faiks and Kerttula

1 IN THE SENATE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

2 CS FOR SENATE BILL NO. 67 (HESS)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 FIFTEENTH LEGISLATURE - FIRST SESSION

5 A BILL

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

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

9 * Section 1. AS 21.42 is amended by adding a new section to read:
10 Sec. 21.42.365. COVERAGE FOR TREATMENT OF A MENTAL OR NERVOUS
11 CONDITION. (a) An insurer authorized under AS 21.09 to offer, issue
12 for delivery, deliver, or renew a group disability insurance policy
13 for major medical coverage on an expense-incurred basis in the state,
14 or a hospital or medical service corporation authorized under AS 21.87
15 to offer or renew a group contract for major medical coverage in the
16 state, shall offer the insured or subscriber an option to receive the
17 following coverage for treatment of a mental or nervous condition of
18 the insured, subscriber, or other person covered by the policy or
19 contract:
20 (1) 45 days a year of inpatient treatment for each covered
21 individual;
22 (2) a total of 50 outpatient treatment or office visits a
23 year for each covered individual.
24 (b) The insurer or service corporation offering coverage under
25 this section may impose reasonable contract limitations but may not
26 require that the insured or subscriber pay a higher deductible or
27 co-payment for the cost of treating a mental or nervous condition than
28 for the cost of treating another condition or illness.
29 (c) If an insured or a subscriber declines the coverage offered

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

(d) In this section

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

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

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

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

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

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

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

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

(C) a hospital that is located in

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

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

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

1 insured or subscriber of at least $10,000;
2 (6) "mental or nervous condition" means a mental disorder
3 identified in
4 (A) the Diagnostic and Statistical Manual of Mental
5 Disorders (Third Edition) published by the American Psychiatric
6 Association; or
7 (B) the ICD-9-CM (First Edition) published by the
8 Commission on Professional and Hospital Activities;
9 (7) "office visit" means treatment that is not inpatient
10 treatment or outpatient treatment and that is provided in the profes-
11 sional offices of
12 (A) a psychiatrist who is licensed as a physician in
13 the state and certified, or eligible for certification, in psy-
14 chiatry by the American Board of Psychiatry and Neurology;
15 (B) a physician who is employed by the federal govern-
16 ment in the state and certified or eligible for certification in
17 psychiatry by the American Board of Psychiatry and Neurology; or
18 (C) a psychologist or psychological associate licensed
19 under AS 08.86;
20 (8) "outpatient treatment" means treatment that is not
21 inpatient treatment and that is provided
22 (A) in the outpatient department of
23 (i) a hospital that is licensed under AS 18.20 or
24 that is specifically exempt under AS 18.20.020 from the
25 licensing requirements of the state;
26 (ii) a hospital that is located in another state
27 and that is either licensed or specifically exempt from the
28 licensing requirements of that state; or
29 (iii) an entity that is designated by the

1 Department of Health and Social Services as the
2 organizational unit in a geographical area to receive funds
3 under AS 47.30.520 - 47.30.620; and
4 (B) by one or more of the following,
5 (i) a psychiatrist who is licensed as a physician
6 in the state and certified, or eligible for certification,
7 in psychiatry by the American Board of Psychiatry and Neu-
8 rology;
9 (ii) a physician who is employed by the federal
10 government in the state and certified or eligible for certi-
11 fication in psychiatry by the American Board of Psychiatry
12 and Neurology;
13 (iii) a psychologist licensed under AS 08.86; or
14 (iv) a person who works in conjunction with one or
15 more licensed mental health care providers and has a
16 master's or doctoral degree in psychology, nursing, or
17 social work, and is employed by the same health care facil-
18 ity providing treatment.
19 * Sec. 2. AS 21.36.090(d) is amended to read:
20 (d) <u>Except to the extent necessary to comply with AS 21.42.365,</u>
21 <u>a</u> [A] person may not practice or permit unfair discrimination against
22 a person who provides a service covered under a group disability
23 policy that extends coverage on an expense incurred basis, or under a
24 group service or indemnity type contract issued by a nonprofit corpo-
25 ration, if the service is within the scope of the provider's occupa-
26 tional license. In this subsection, "provider" means a state licensed
27 physician, dentist, osteopath, optometrist, chiropractor, or nurse
28 midwife.
29 * Sec. 3. AS 21.87.340 is amended to read:

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

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

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

Mental Health Services:
The Case for Insurance Coverage

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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.

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18. Manning et al.

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

Mental Health Services:

The Case for Insurance Coverage

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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.

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.

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

15. Mumford et al., p. 1156.

16. Mumford et al., p. 1154.

Acknowledgements

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

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

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

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

S.A.M.

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.

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]

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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.

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Results

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

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

Study Description

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

Results

Benefits exceeded costs by a 2.5 to 1 margin.

Comment

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

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

Study Description

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

Results

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

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

Study Description

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

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

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

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

Study Description

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

Results

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

Comment

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

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

Study Description

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

1

Executive Summary

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

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

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

Myth #1:

The problems of behavior-related illnesses are not serious.

Reality

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

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

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

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

Myth #2:

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

Reality

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

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

Myth #3:

The costs of mental health care usually exceed the benefits.

7

The Benefits of Psychiatric Care Relative to Cost

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

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

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

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

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

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

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

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

Reality

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

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

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

Myth #4:

Mental health services are substantially overused and misused.

Reality

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

Summary

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

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

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

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

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

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

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

EXHIBIT NINE

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

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

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

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

2

Insurer Concerns

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

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

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

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

Finally, insurers are concerned that there is vast misuse

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

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

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

attributable only to C-group members.

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

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

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

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

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

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

[i]Interviewers' assessments.

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

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

	C	E	E - C
8. Illegal activity costs: Total	1.0	0.8	-0.2[a]
No. of arrests for felony	0.2	0.2	0.0[a]
9. Patient mortality costs (percentage dying during the year)			
Suicide	1.5%	1.5%	0%
Natural causes	0%	4.6%	4.6%
BENEFITS			
Benefits for which monetary estimates have been made			
1. Earnings[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

3

Prevalence and Cost of Mental Illness

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

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

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

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

★ ★ ★ ★

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

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

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

EXHIBIT ONE
PREVALENCE OF MENTAL ILLNESS WITHIN A SIX-MONTH PERIOD

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

*highest rate of treatment

Source: National Institute of Mental Health

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

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

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

EXHIBIT SEVEN

ECONOMIC OUTCOMES OF REVIEWED RANDOMIZED CONTROL STUDIES[a]

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

a. Berk, p. 23.

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

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

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

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

EXHIBIT TWO

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

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

Totals may not add due to rounding.

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

b. Components are indicated in parentheses.

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

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

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

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

EXHIBIT SIX

ECONOMIC OUTCOMES OF REVIEWED SIMULTANEOUS CONTROL STUDIES[a]

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

a. Berk, p. 22.

EXHIBIT FIVE

CLINICAL OUTCOMES OF REVIEWED RANDOMIZED CONTROL TRIALS[a]

Setting		Setting results			
Experimental	Control	Experimental Better	Control Better	Not Determinate	Number of Studies
Partial Hospital-ization	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 Hospital-ization	Traditional Inpatient	1			1
Home care — With Drugs or With Placebos	Traditional Inpatient	1			1

a. Berk, p. 2.

EXHIBIT THREE

DIRECT ADM COSTS BY SETTING, 1984*

($ MILLION)

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

Totals may not add due to rounding.

a. Less than $.5 million.

b. A small portion of these were in non-hospital-based facilities.

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

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

EXHIBIT FOUR

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

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

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

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

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

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

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

4

What is Mental Health Care?

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

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

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

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

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

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

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

4. OTA, p. 13.

6

Comparison of the Costs and Outcomes of Different Treatment Settings

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

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

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

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

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

Key findings from the 28-month study period were:

1. the cost per patient in the TCL program were slightly higher, *but*

2. the benefits, mainly in the form of patient earnings, also were higher;

3. the net result was that benefits valued in monetary terms for the TCL program were still less than valued costs, but the

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

A review of the literature on the effectiveness of psychiatric care also shows that, in combination with drug therapy, it is useful in the treatment of such disorders as "the schizophrenias, manic-depressive disorders, psychosomatic disorders, antisocial disorders, alcoholism, drug abuse, and childhood hyperactivity and severe learning disabilities."[10] 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.

5
Is Mental Health Care Effective?

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

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

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

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

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

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

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

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

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

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

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

6. OTA, p. 44.

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

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

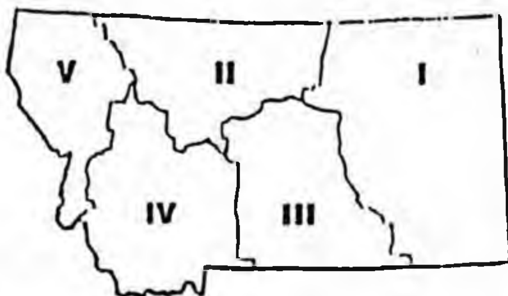
Smith et al. developed a standardized measure for the size of the effect of psychotherapy for each of the 475 studies selected for review. By standardizing the measure of effect, Smith et al. were able to compare results across studies. The findings of Smith, Glass and Miller offer impressive scientific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

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

When is mental health care effective?

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

8. OTA, p. 46.



Montana Council of Regional Mental Health Boards, Inc.

2/21/86

See P2

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

Dear Nancy:

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

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

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

REGION I
EASTERN MONTANA COMMUNITY MENTAL HEALTH CENTER
Miles City, Montana

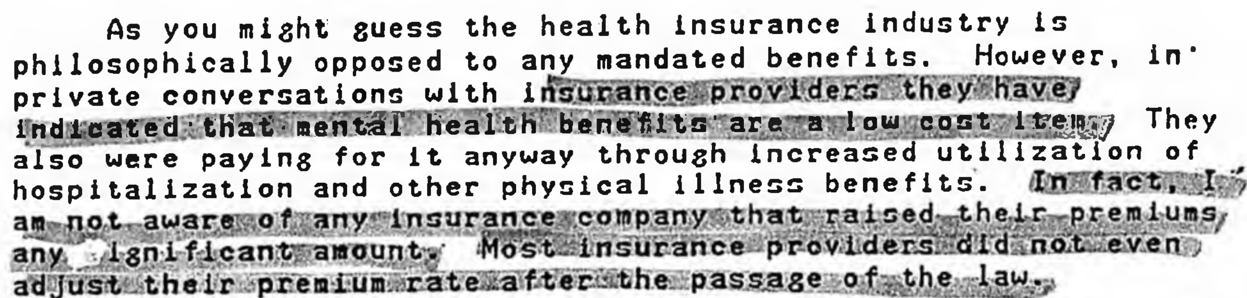
REGION II
GOLDEN TRIANGLE COMMUNITY MENTAL HEALTH CENTER
Holiday Village Shopping Center
Great Falls, Montana

REGION III
MENTAL HEALTH CENTER
Billings, Montana

REGION IV
MENTAL HEALTH SERVICES INC.
Helena, Montana

REGION V
WESTERN MONTANA COMMUNITY MENTAL HEALTH CENTER
Missoula, Montana

Duncan
4/27/87



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

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

Best regards,

Steve Waldron
Executive Director

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

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

February 24, 1986

MEMORANDUM

TO: Representative Mike Davis

ATTN: Marilyn Heiman

FROM: Nancy Pease *Nancy Pease*
Legislative Analyst

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

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

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

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

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

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

Costs of Mental Health Insurance in Other States

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

* * *

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

NP

Attachment

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

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

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

Equal Insurance Coverage
For
Mental Illness

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The experience of many major insurance plans suggests that:

only a small proportion of the insured population uses outpatient mental health benefits;

the number of visits is generally low, particularly when controlled by a combination of co-payments, deductibles or visit limits;

expenditures for mental health services are not a disproportionate part of health benefit packages (Corrigan and Koyanagi, 1982).

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

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

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

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

two percent of the population used supplemental benefits for outpatient mental health services;

those who used outpatient services made an average of 32.7 visits during the year;

fifty percent of people using outpatient services had 20 visits or less; 63 percent had 30 visits or less and only six percent had more than 100 visits.

for 506,451 outpatient contacts, the cost was about $26.50 per insured person and the average cost for an outpatient visit was $39.72 (Towery, Sharfstein and Goldberg, 1980).

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

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

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

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

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

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

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

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