

ALASKA LEGISLATURE COMMITTEE FILES 1985-1986 86/2

3494

HLAB

HB 317

370

METHODS CONTINUED

RECIPROCITY:

The practice of reciprocity is used only when formal reciprocal agreements are established between states. It promotes the attitude of "we will accept your licenses if you accept ours." Reciprocity is possible only between states who have the legal authority to enter into an agreement and is willing to do so. Applicants eligible for licensure by reciprocity usually are not required to meet or produce evidence of any additional qualifications other than current licensure from the other state.

CREDENTIALS:

Credentials is a method of licensure based solely on evidence of formal education, professional experience, and licensure in another state, if licensing requirements in the other state are similar or higher to those of this State.

COMITY:

Comity is the recognition and acceptance of licensure from another jurisdiction conditioned upon proof of education and training submitted by the applicant. It allows flexibility of educational courses in lieu of examinations, etc.

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* DELIVER TO: JPOM *
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* ORIGINAL *
* SENT: 04/08/85 TIME: 15:38 *
* FROM: LANA TRUJILLO *
* SUBJECT: POM *
* PRINT DATE: 04/08/85 TIME: 15:38 *
* *

TO: HOUSE LABOR AND COMMERCE

REP. NAVARRE, DAVIS, BOUCHER, KOPONEN, PEARCE, COLLINS AND HANLEY

SENATE HESS

SEN. FAHRENKAMP, STURGULEWSKI, P. FISCHER, DEVRIES AND JOSEPHSON

FROM: ROBERT NIELSEN, 4938 MILLS DR., ANCHORAGE, 99508, 333-1481(HM), 274-6524(WK)

RE: SB 227 AND HB 317, SOCIAL WORK LICENSURE

SOCIAL WORK IS A PROFESSION THAT NEEDS TO BE LICENSED IN THAT THESE WORKERS RELATE TO PEOPLE IN MANY DIFFERENT CONFIDENTIAL WAYS. SOCIAL WORK IS A HUMAN SERVICE WHICH I SUPPORT AND URGE YOUR AFFIRMATIVE VOTE. THANK YOU.

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* DELIVER TO: JFOM *
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* ORIGINAL *
* SENT: 04/08/85 TIME: 15:42 *
* FROM: HARRY MANDREGAN *
* SUBJECT: POM *
* PRINT DATE: 04/08/85 TIME: 15:42 *
* *

TO: SENATE HESS COMMITTEE, SENATORS FAHRENKAMP, STURGULEWSKI,
PAUL FISCHER, DEVRIES AND JOSEPHSON
HOUSE LABOR AND COMMERCE COMMITTEE, REPRESENTATIVES NAVARRE,
DAVIS, BOUCHER, KOPONEN, PEARCE, COLLINS AND HANLEY

FROM: MILLI ANDREINI
3524 STANFORD DRIVE
ANCHORAGE, ALASKA 99508
HOME NO.: 274-8706
WORK NO.: 276-4994

RE: SOCIAL WORK LICENSING

I URGE YOUR SUPPORT OF HB 317 AND SB 227 TO LICENSE SOCIAL WORKERS. SOCIAL WORKERS PROVIDE A RANGE OF SERVICES WHICH AFFECT PEOPLES LIVES. YET, THEY ARE NOT REGULATED BY LICENSURE. INSURE COMPETENT SOCIAL WORK IN ALASKA. PLEASE SUPPORT THIS NEEDED LEGISLATION.

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* DELIVER TO: JFOM
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* ORIGINAL
* SENT: 04/08/85 TIME: 13:05
* FROM: MICKI HENSON
* SUBJECT: POM
* PRINT DATE: 04/08/85 TIME: 13:05
*

TO: SENATE H.E.S.S.

SENATORS FAHRENKAMP, STURGULEWSKI, P. FISCHER, DEVRIES,
JOSEPHSON

HOUSE LABOR AND COMMERCE

REPRESENTATIVES NAVARRE, DAVIS, BOUCHER, KOPONEN, PEARCE,
COLLINS, HANLEY

FROM: DIANE SCHANDER
9221 KAVIK STREET
ANCHORAGE, AK. 99515 PHONE: 243-5597 HM.

RE. SB 277/HB 317- SOCIAL WORK LICENSING

I URGE PASSAGE OF SB 277/HB 317. IN MY CASE INSURANCE COVERAGE
IS NON-EXISTENT WITHOUT LICENSING.

*
* DELIVER TO: JFOM *
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* ORIGINAL *
* SENT: 04/08/85 TIME: 12:47 *
* FROM: LANA TRUJILLO *
* SUBJECT: POM *
* PRINT DATE: 04/08/85 TIME: 12:47 *
*

13

TO: SENATE HESS

SEN. FAHRENKAMP, STURGULEWSKI, P. FISCHER, DEVRIES AND JOSEPHSON

HOUSE LABOR AND COMMERCE

REP. NAVARRE, DAVIS, BOUCHET, KOPONEN, FEARCE, COLLINS AND HANLEY

FROM: NICKI J. NIELSEN, 4938 MILLS DR., ANCHORAGE, 99508, 333-1481(HM), 561-1361(WK)

RE: B 227 AND HB 317, SOCIAL WORK LICENSURE

PLEASE SUPPORT THE SOCIAL WORK LICENSURE BILLS. SOCIAL WORK LICENSURE IS IMPORTANT SO QUALIFIED PEOPLE WILL BE HELPING PERSONS WHO NEED THE IMPORTANT SERVICES THAT SOCIAL WORKERS PROVIDE. THANK YOU VERY MUCH FOR YOUR SUPPORT OF THESE BILLS:

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* DELIVER TO: JFOM *
*
* ORIGINAL *
* SENT: 04/08/85 TIME: 15:20 *
* FROM: MARTIE ROZKYDAL *
* SUBJECT: POM - MATR-0201 *
* PRINT DATE: 04/08/85 TIME: 15:21 *
*

TO: REPRESENTATIVES NAVARRE, DAVIS, BOUCHER, COLLINS, HANLEY,
KOPONEN AND PEARCE

FROM: LESLIE BOGDA
PO BOX 264
PALMER 99645
DAYTIME PHONE 376-4080

I AM IN SUPPORT OF HB 317/LICENSING OF SOCIAL WORKERS. I
HAVE A BACHELOR'S DEGREE IN SOCIAL WORK FROM THE UNIVERSITY OF
ALASKA.

*
* DELIVER TO: JFOM *
* *
* ORIGINAL *
* SENT: 04/08/85 TIME: 11:40 *
* FROM: LANA TRUJILLO *
* SUBJECT: POM *
* PRINT DATE: 04/08/85 TIME: 11:40 *
* *

TO: REP. N. VARRE, DAVIS, BOUCHER, KOPONEN, PEARCE, COLLINS,
HANLEY

FROM: MARY LEE NICHOLSON, P.O. BOX 771052, EAGLE RIVER, 99577,
694-2377(HM)

RE: HB 317, LICENSING SOCIAL WORKERS

TO ENSURE THOUGHTFUL APPLICATION OF KNOWLEDGE, SKILLS AND HUMAN
VALUES TO ALASKA'S TOUGH SOCIAL PROBLEMS I URGE YOUR SUPPORT OF
HB 317, SOCIAL WORK LICENSING.

State Comparison of Laws Regulating Social Work

July 1984

- TABLE I** *Year of Enactment, Type, and Administration of State Statute*
- TABLE II** *Levels of Practice Regulated and Renewal Periods*
- TABLE III** *Exclusions, Privileged Communication, and Other Features*
- TABLE IV** *Continuing Education Provisions*
- TABLE V** *Vendorship Provisions*

National Association of Social Workers, Inc.
7981 Eastern Avenue
Silver Spring, MD 20910

For Information: Myles Johnson, LCSW
Staff Associate

TABLE I—Year of Enactment, Type, and Administration

State (In Order of Enactment)	Year of Enactment		Type ¹	Name of State Regulatory Agency	Location Within State Government	Number of Board Members	
	First	Amended				Total	SW
1. Puerto Rico	1934	1940	L	Board of Examiners of Social Workers ²	Independent Board	7	7
2. California	1945	1971 ²⁸	R	Board of Behavioral Science Examiners	Department of Consumer Affairs	11	2 ³
	1968	1973	L				
3. Rhode Island	1961	1984	R	Board of Registration	Dept. of Social & Rehabilitative Services	5	5
4. Oklahoma	1965	1982	R	State Board of Licensed Social Workers	Independent Board	7	4
5. New York	1965		R	State Board of Social Work	The State Education Department	10 ²¹	9
6. Virginia	1966	1975 ¹⁰	L	Virginia Board of Social Workers ¹⁰	Dept. of Health Regulatory Boards	5	5
7. Illinois	1967		R	Social Workers Examining Committee	Dept. of Registrations & Education	7	7 ⁶
8. South Carolina	1968		R	State Board of Social Worker Registration	Independent Board	7	7
9. Maine	1969	1978	R/L	State Board of Social Worker Registration	Dept. of Business Regulation	8	7
10. Michigan	1972	1981	R	Board of Examiners of Social Work	Dept. of Licensing & Regulation	9	6 ⁷
11. Louisiana	1972		L ⁸	State Bd of Bd Certified Social Work Examiners	Dept. of Health & Human Resources	5	5
12. Utah	1972	1977	L	Board of Social Work Examiners	Department of Registration	5	5 ¹⁷
13. Kansas	1974	1980	L	Behavioral Sciences Regulatory Board ²⁴	Independent Board	7	2 ²⁴
14. Kentucky	1974	1976	L	State Board of Examiners of Social Work	Div. of Occup. & Prof., Dept. of Finance	7	6 ⁹
15. Arkansas	1975	1981	L	Social Work Licensing Board	Independent Board	7	6 ¹²
16. South Dakota	1975		L	Board of Social Work Examiners	Dept. of Commerce & Consumer Affairs	5	4 ¹³
17. Maryland	1975	1983 ²⁷	R	State Board of Social Work Examiners	Dept. of Health & Mental Hygiene	4	4 ¹⁴
18. Colorado	1975	1981 ³⁷	R/L ¹¹	Board of Social Work Examiners	Dept. of Regulatory Agencies	7	3 ¹⁵
19. Idaho	1976		L	State Board of Social Work Examiners	Dept. of Self-Governing Agencies	5	5 ¹⁶
20. Delaware	1976		L	State Board of Social Work Examiners	Independent Board	5	3 ¹⁸
21. Alabama	1977	1984	L	Alabama Board of Examiners in Social Work	Independent Board	7	7 ¹⁹
22. Oregon	1977	1979	R	State Board of Clinical Social Workers	Dept. of Human Resources, Health Division	7	4 ²⁵
23. Massachusetts	1977		L	Board of Registration of Social Workers	Independent Board	7	4 ²²
24. Tennessee	1980	1984 ³⁷	R	Board of Social Work Certification and Licensure	State Licensing Board for Healing Arts	5	4 ²³
25. Texas	1981	1983 ²⁹	R	Council for Social Work Certification	Texas Board of Human Resources	9	6 ²⁶
26. Florida	1981		R	No Board	Department of Professional Regulation	—	—
27. Montana	1983		R	State Board of Social Work Examiners	Independent Board	5	4 ³⁰
28. North Dakota	1983		L	Board of Social Work Examiners	Independent Board	6	4 ³¹
29. North Carolina	1983		R	Certification Board for Social Work	Independent Board	7	4 ³²
30. New Hampshire	1983		R	Board of Examiners of Psychologists	Independent Board	7	1 ³³
31. Virgin Islands	1983		L	Board of Social Work Licensure	Independent Board	5	4
32. Georgia	1984 ³⁴		R	Composite Bd of Professional Counselors, Social Workers and Marriage and Family Counselors	Independent Board	10	3 ³⁹
33. West Virginia	1984		R/L ³⁵	Board of Social Work Examiners	Independent Board	7	6
34. Iowa	1984		R	Board of Social Work Examiners	Department of Health	5	3
35. Ohio	1984		R/L ³⁸	Counselor and Social Worker Board	Independent Board	11 ³⁸	4

TABLE I—YEAR OF ENACTMENT, TYPE, AND ADMINISTRATION

- ¹R = Registration of certification of a use of a title; L = license to practice
- ²1940 amendment established a College of Social Workers of Puerto Rico, comprised of all social workers licensed in Puerto Rico. (P.R.)
- ³Two Clinical Social Workers (Cal.)
- ⁴Three Licensed Social Workers; Two Lic. Social Work Associates, President, Okla. NASW; one public member. (Okla.)
- ⁶Four with MSW Degrees; three with undergraduate degrees. (Ill.)
- ⁷Amended by comprehensive Occupational Code acts. (Mich.)
- ⁸Law actually grants "right to practice and use the title" but prohibits only misuse of title. (La.)
- ⁹Two each Certified Social Workers, Social Workers and persons licensed for independent practice. (Ky.)
- ¹⁰Legislature dismantled Board of Behavioral Science Examiners in 1983. (Va.)
- ¹¹Act establishes registration of MSW or BA + 2 years level and licensure of other levels. (Colo.)
- ¹²Three Certified Social Workers; Two Master Social Workers; One Social Worker; One public member. (Ark.)
- ¹³Two certified Social Workers; one Social Worker, one Social Work Associate. (S.D.)
- ¹⁴Appointments of one person each required from lists by Md. Chapter, and Metro D.C. Chapter, NASW. (Md.)
- ¹⁵Requires at least one member engaged in "Direct services" and one member in "education, training, or research in Social Work." (Colo.)
- ¹⁶Three Certified Social Workers; Two Social Workers. (Idaho)
- ¹⁸Three Licensed Clinical Social Workers; one 'general public' member. (Del.)
- ¹⁹Four licensed Certified Social Workers; Two licensed Graduate S.W.; One licensed Bachelor S.W. (Ala.)
- ²⁰Three clinical social workers; one public citizen; one consumer of clinical services. (Ore.)
- ²¹Law provides "not less than seven" CSW and requires one consumer representative. Ten persons currently appointed. (N.Y.)
- ²²Four social workers, representing each of the licensed levels, three persons to represent the general public. (Mass.)
- ²³Four Certified MSW, two independent practitioners, and 1 public member. (Tenn.)
- ²⁴Board regulates both Psychologists & Social Workers: Two Certified Psychologists; Two Social Workers; Three Members of general public. (Kansas)
- ²⁵Four Clinical Social Workers; two public members; one consumer member. (Ore.)
- ²⁶Three Certified Social Workers; Three Social Workers or Social Work Associates; Three public members. (Tx.)
- ²⁷Sunset review reenactment expanded coverage to public employees (Md.)
- ²⁸Act amended to end RSW registration level in 1983. No new registrations issued. (Cal.)
- ³⁰One each social worker member employed in private practice, state social service agency, medical or social welfare field, and social work education. (Mont.)
- ³¹Two Licensed Social Workers and Two Certified Social Workers. (N.D.)
- ³²Two Certified Social Workers and Two Certified Clinical Social Workers. (S.C.)
- ³³A single Certified Clinical Social Worker is added to an existing state board of psychologists. (N.H.)
- ³⁴Implementation of act delayed pending appropriation act scheduled for 1984 session. (Ga.)
- ³⁵Title protector for "Social Worker", "Graduate Social Worker", and "Certified Social Worker"; Licensure of "private, independent practice of social work." (W.Va.)
- ³⁶Board composed of 4 Professional Counselors, 2 Social Workers, 2 Independent Social Workers, and 3 "representatives of the general public." (Ohio)
- ³⁷Law re-enacted following Sunset review. (Ala., Tenn, Colo.)
- ³⁸Licenses practice of social work and authorizes registration of "Social Work Assistants". (Ohio)
- ³⁹Board composed of 3 professional members for each profession and 1 public member. Each three member group comprises a "Standards Committee" for their profession. (Ga.)

TABLE II—Levels of Practice Regulated—Renewal Periods

	Title	Initials	Education	Experience Required	Current Employment Required	Exam Required	Renewal Period
ALABAMA	Independent Practice		MSW	+ 2 ¹⁷		YES	2 years
	Certified Social Worker	LCSW	MSW	+ 2 yrs.		YES	
	Graduate Social Worker	LGSW	MSW		NO	YES	
	Bachelor Social Worker	LBSW	BSW	¹⁸	NO	YES	
ARKANSAS	Licensed Certified Social Worker	LCSW	MSW	+ 2 years		YES	2 years
	Licensed Master Social Worker	LMSW	MSW		NO	YES	
	Licensed Social Worker	LSW	BSW			YES	
CALIFORNIA	Licensed Clinical Social Worker	LCSW	MSW	+ 2 years ³	NO	YES	Annual
COLORADO	Licensed Social Worker II	LSWII ¹¹	MSW	+ 5 years		YES	2 years
	Licensed Social Worker	LSWI	MSW	+ 2 years	NO	YES	
	Registered Social Worker	RSW	MSW or BA	+ 2 years		NO	
DELAWARE	Licensed Clinical Social Worker	LCSW	MSW	+ 2 years	NO	YES	2 years
FLORIDA	Clinical Social Worker	LCSW	MSW	+ 3 years ²⁴	NO	YES ²⁵	2 years
GEORGIA	Clinical Social Worker	LCSW	MSW	+ 3 years	NO	YES	³⁰
	Master Social Worker	LMSW	MSW	+ 2 years	NO	YES	
IDAHO	Independent Practice	—	MSW	+ 2 years		NO	Annual
	Certified Social Worker	CSW	MSW		NO	YES	
	Social Worker	SW	BSW ¹⁴			YES	
ILLINOIS	Certified Social Worker	CSW	MSW		NO	YES	2 years
	Social Worker	SW	BA	+ 2 years	YES	YES	
IOWA	Licensed Social Worker	LSW	MSW	+ 2 years	NO	YES	Annual
KANSAS	"Specialties"		MSW	+ 2 years		YES	2 years
	Master Social Worker	MSW	MSW		YES ⁶	YES	
	Baccalaureate Social Worker	BSW	BSW			YES	
KENTUCKY	Independent Practice		MSW	+ 2 years		YES	3 years
	Certified Social Worker	CSW	MSW		NO	YES	
	Social Worker	SW	BSW			YES	
LOUISIANA	Board Certified Social Worker	BCSW	MSW	+ 2 years	NO	YES	Annual

TABLE II—Levels of Practice Regulated—Renewal Periods—Continued

	Title	Initials	Education	Experience Required	Current Employment Required	Exam Required	Renewal Period
MAINE	Independent Practice		MSW	+ 2 years		YES ²⁰	2 years
	Certified Social Worker	CSW	MSW			YES	
	Registered Social Worker	RSW	BSW		NO	YES	
	Associate Social Worker	ASW	BA or	+ 2 years 6 years		YES	
MARYLAND	Independent Practice		MSW	+ 2 years		YES	2 years
	Certified Social Worker	CSW ¹⁰	MSW	+ 2 years		YES	
	Graduate Social Worker	GSW	MSW		NO	YES	
	Social Work Associate	SWA	BSW			YES	
MASSACHUSETTS	Independent Clinical Social Worker	LICSW	MSW	+ 3 years		YES	2 ¹
	Certified Social Worker	LCSW	MSW			YES	
	Social Worker	LSW	BSW or BA	+ 2 years	NO	YES	
	Social Work Associate	LASW	AA/BA			YES	
MICHIGAN	Certified Social Worker	CSW	MSW	+ 2 years	NO	NO	2 years
	Social Worker	SW	MSW or BA	+ 2 years	YES ^{7, 13}	NO	
	Social Worker Technician	SWT	2 yr. BA or	1 year	YES ⁸	NO	
MONTANA	Licensed Social Worker	LSW	MSW ⁴	+ 2 ²⁶	NO	YES	2 years
NEW HAMPSHIRE	Certified Clinical Social Worker	CCSW	MSW	+ 2 ²⁷	NO	NO	—
NEW YORK	Certified Social Worker	CSW	MSW ⁴		NO	YES	2 years
NORTH CAROLINA	Certified Clinical Social Worker	CCSW	MSW	+ 2 ²⁸	NO	YES	2 years
	Certified Social Work Manager	CSWM	BSW	+ 2 ²⁸	NO	YES	
	Certified Master Social Worker	CMSW	MSW		NO	YES	
	Certified Social Worker	CSW	BSW		NO	YES	
NORTH DAKOTA	Independent Practice		MSW	+ 3	NO	NO	2 years
	Licensed Certified Social Worker	LCSW	MSW		NO	YES	
	Licensed Social Worker	LSW	BSW		NO	YES	
OHIO	Independent Social Worker	LISW	MSW	+ 2 years	NO	YES	2 years
	Social Worker	LSW	BSW/MSW		NO	YES	
	Social Work Assistant	RSWA	AA ²⁷				

TABLE II—Levels of Practice Regulated—Renewal Periods—Continued

	Title	Initials	Education	Experience Required	Current Employment Required	Exam Required	Renewal Period
OKLAHOMA	Licensed Social Worker	LSW	MSW	+ 2 years	NO	YES	Annual
	Licensed Social Work Associate	LSWA	BSW	+ 2 years	NO	YES	
OREGON	Registered Clinical Social Worker	RCSW	MSW	+ 2 years	NO ¹⁹	NO	Annual ¹⁹
PUERTO RICO	Social Worker		BA-MSW ¹	+ 2 years	NO	NO	None
RHODE ISLAND	Registered Independent Social Worker	RISW	MSW	+ 2 years	NO	YES	Annual
	Registered Social Worker	RSW	MSW		NO	YES	Annual
SOUTH CAROLINA	Registered Social Worker	RSW	MSW ⁵		NO	NO	Annual
SOUTH DAKOTA	Independent Practice	CSW-PIP	MSW	+ 2 years		YES	
	Certified Social Worker	CSW	MSW			YES	
	Social Worker	SW	MSW		NO	YES	
	Social Work Associate	SWA	AA-BA			YES	2 years
TENNESSEE	Independent Practice	—	MSW	+ 5 years	NO	NO	Annual
	Master Social Worker	MSW	MSW		NO	NO	Annual
TEXAS	Private Practice		CSW	+ Exper. ²²		NO	Annual
	Certified Social Worker	CSW	MSW		NO	YES	Annual
	Social Worker	SW	BSW			YES	Annual
	Social Work Associate ²³	SWA	HS/BA	+ SW exp.		YES	Annual
UTAH	Independent Practice ¹⁵	—	MSW	+ 2 years		YES	Annual
	Certified Social Worker	CSW	MSW		NO	YES	
	Social Services Worker	SSW	BSW			YES	Annual
	Social Service Aide	SSA					
VIRGIN ISLANDS	Social Work Associate	SWA	AA/BA		NO		
	Social Worker	SW	BSW or BA	+ 2	NO		
	Certified Social Worker	CSW	MSW		NO	NO	
	Certified Independent Social Worker	CISW	MSW	+ 2	NO		2 years
VIRGINIA	Clinical Social Worker ¹⁸	CSW	MSW	+ 3 years	NO	YES	
	Social Worker	SW	MCW	+ 3 years		YES	2 years
WEST VIRGINIA	Certified Social Worker	LCSW	MSW	+ 2 years	NO	YES ²⁰	2 years
	Graduate Social Worker	LGSW	MSW				
	Social Worker	LSW	BSW				

TABLE II—LEVELS OF PRACTICE REGULATED

¹Act provides eligibility for either of BA + 2 years post graduate study (MSW), BA + 1 year post graduate study + 2 years experience, or BA with Social Work major (BSW) + 3 years of experience. (P.R.)

²1972 amendments provide eligibility for MSW, BSW + 3 years of experience, BA + 5 years of experience, and 1 year Social Work Master's study + 1 year other MA study—2 years experience. (Cal.)

³One year of experience must be in a hospital, clinic, or agency and providing psychotherapy. (Cal.)

⁴Master's or equivalent degree in Social Work. (N.Y.)

⁵Or membership in NASW on May 28, 1968. (Effective date of Act). (S.C.)

⁶Legal resident or employed in the state. (Kansas.)

⁷Or has the equivalent of 4,000 hours of voluntary service. (Mich.)

⁸Or has the equivalence of 2,000 hours of voluntary service, was previously certified, or has AA in Social Work. (Mich.)

⁹Only Certified Social Workers may practice independently. (Md.)

¹⁰Only LSW-11 with 4 years experience may practice independently, other two levels have title protection only. (Cal.)

¹¹Employment not required if person has an accredited BSW or MSW, or was previously certified. (Mich.)

¹²BA in "related fields . . . approved by the board" recognized. (Idaho)

¹³Includes specialty license as "Clinical Social Worker." (Utah)

¹⁴Previous titles continued temporarily. (Va.)

¹⁵Experience required in 2 years full time or 3 years part time; 4 years full time or 5 years part time for specialty license. (Ala.)

¹⁶Effective January 1, 1984, LBSW with 2 or more years of continuing supervision from LGSW or LCSW may work without supervision if in "same type" of practice. (Ala.)

¹⁷Renewal requires one to have been "actively engaged" in practice during registration period. (Ore.)

¹⁸Applicant must submit evidence of qualification to practice independently. (Maine)

¹⁹Period for renewal to be set by Board. (Mass.)

²⁰Dept. to establish procedures including "the number of years of acceptable Social Work experience." (Tex.)

²¹The SWA certificate was open for application for two years only ending August 1983. (Tex.)

²²The MSW must have "a major emphasis or specialty in direct patient or health care services," and be CSWE accredited. Doctoral degree need not be CSWE accredited. (Fla.)

²³Exam to be "prepared by dept. or State professional organization." (Fla.)

²⁴MSW or "doctorate" required plus 3,000 hours in psychotherapy, in past 5 yrs. Three references also required. (Mont.)

²⁵"2 years or 3,000 hours of post-masters supervised, paid clinical experience." (N.H.)

²⁶The Certified Clinical S.W. requires the CMSW license; the Certified S.W. Manager requires a CSW license. (N.C.)

²⁷ACSW certification may be substituted for the exam. (W.Va.)

²⁸Expiration and renewal dates to be set by the Board. (Ga.)

²⁹A Registered Social Work Assistant may not practice social work except under the supervision of an LISW (Ohio).

TABLE III—Exclusions, Privileged Communication, and Other Features

	EXCLUDED GROUPS			Privileged Communi- cations	Reciprocity	FEES		PENALTY	
	Private					Initial	Renewal	Fine	Imprisonment
	Public Employees	Agency Employees	Students						
ALABAMA	YES	NO	YES	NO	YES	Min \$50	Min \$25	None	None
ARKANSAS	NO	NO	YES	YES	NO	2	2	\$100-500	
CALIFORNIA	YES	YES	NO	YES	NO	\$5-10	\$3-11	3	
COLORADO	NO	NO	NO	YES	YES	\$10-50	\$250-\$20	Class 3 Misdemeanor ¹	
DELAWARE	YES	YES	NO	YES	YES	5	7	Class A Misdemeanor ²	
FLORIDA	YES	NO	YES	NO	YES	Max \$250	Max \$150	Misdemeanor 1st degree	
GEORGIA	YES	NO ¹⁴	YES	NO	YES	2	2	Misdemeanor	
IDAHO	NO	NO	YES	YES	YES	\$50	\$50	"Misdemeanor"	
ILLINOIS	NO	NO	YES	YES	YES	\$25	\$10	\$50-500	And/or 18 month
IOWA	NO	NO	NO	YES	YES	2	2	Misdemeanor	
KANSAS	NO	NO	NO	NO	YES	\$10-50	\$10-50	Class C Misdemeanor ³	
KENTUCKY	YES	NO	NO	YES	YES	Max \$30	Max \$50	Max \$500	
LOUISIANA	YES	YES	YES	YES	YES	\$50	\$20	\$100-500 or 6 months max	
MAINE	YES	NO ⁸	NO	YES	YES	8	8	\$50-500	
MARYLAND	YES	NO	YES	NO	YES	Max \$50	Max \$50	Max \$500	And/or 90 day max
MASSACHUSETTS	YES	NO	YES	YES	YES	2	2	Max \$500	Max 3 mos
MICHIGAN	NO ⁴	NO	NO	YES	YES	\$25 ⁷	\$15	3	
MONTANA	YES	YES ¹¹	YES	YES	YES	2	2	Max \$500	Not to exceed 6 mos
NEW HAMPSHIRE				YES				Misdemeanor	
NEW YORK	NO	NO	NO	YES	YES ¹	\$110	\$30	Class A Misdemeanor ¹⁸	
NORTH CAROLINA	YES ¹²	NO	NO	YES	YES	Max \$150	Max \$15	Max \$200	Not to exceed 6 mos
NORTH DAKOTA	NO	NO	YES	NO	YES	Max \$100	Max \$20	Class B Misdemeanor	
OHIO	YES ¹⁴	NO ¹⁵	YES	YES	YES ¹³	2	2	Misdemeanor ¹⁶	
OKLAHOMA	NO	NO	NO	YES	NO	Max \$75	Max \$50	\$100-500	
OREGON	YES	YES	YES	NO	NO	Max \$50	Max \$40	Class C Misdemeanor ³	
PUERTO RICO	NO	NO	YES	NO	NO	\$3	15	3	
RHODE ISLAND	NO	NO	NO	NO	NO	\$50	\$25	\$500	
SOUTH CAROLINA	NO	NO	NO	NO	NO	\$10 ⁹	\$5	Min \$100 or Min 30 days	
SOUTH DAKOTA	NO	NO	YES	YES	NO	2	2	Max \$500	And/or 30 day max
TENNESSEE	NO	NO	NO	NO	NO	\$50	\$50	Misdemeanor	
TEXAS	NO	NO	NO	NO	NO	2	2	10	None
UTAH	NO	NO	NO	NO	YES	\$25 ⁶	3		
VIRGIN ISLANDS	NO	NO	YES	YES	NO	2	2	\$100-500	None
VIRGINIA	YES	YES	YES	YES	YES	\$175	\$60	\$50-500	
WEST VIRGINIA	NO ¹⁷	NO	NO	YES	2	2	Misdemeanor		

TABLE III—EXCLUSIONS

A "YES" indicates group is exempted from coverage of act, under "EXCLUDED GROUPS" only.

¹ Authority to waive qualifying requirements given to Board. (N.Y.)

² Authority to set fees given to Board. (Ark., S.D., Del., Mass., Tex., Mont., V.I., Iowa, Ga.)

³ Specifics not included in chapter on social work regulations. (Utah, Calif., P.R., Mich.)

⁴ Excludes "School Social Worker" title use in Dept. of Education. (Mich.)

⁵ Excludes persons employed in church-operated or affiliated agencies. (Ky.)

⁶ \$25 for CSW and SW; \$7.50 for Social Service Att. (Utah)

⁷ S.W. Technician; \$15 initial fee, \$10 renewal. (Mich.)

⁸ Fees vary according to licensure level. (Maine)

⁹ Excludes a person employed by a hospital accredited by the Joint Commission on the Accreditation of Hospitals (JCAH) who is practicing independently. (Maine)

¹⁰ Attorney General is authorized to file a civil suit for "injunctive relief or to recover the civil penalty." (Tex.)

¹¹ Employees in an "educational research or charitable institution" are not prohibited from the duties or use of titles of their position. (Mont.)

¹² The act specifically prohibits making a certificate or an examination of this act a requirement for any position. (N.C.)

¹³ Law also provides authority for Board to evaluate equivalence of non-U.S. degrees. (Ohio)

¹⁴ Voluntary licensure specifically authorized for civil service employees. (Ohio)

¹⁵ Hospital and Nursing Home employees are exempt for "social services other than counseling and the use of psychosocial interventions and social psychotherapy." Also, alcoholism and drug abuse counselors certified by the Dept. of Health are exempt, as are "union counselors" and certain employees of the American Red Cross. (Ohio)

¹⁶ First offense shall be "minor misdemeanor"; second offense, misdemeanor of the 4th degree; others, misdemeanor of the 1st degree. (Ohio)

¹⁷ School social workers employed by county boards exempt but required to have state education board certification. (W.Va.)

¹⁸ Exempted are employees of hospitals, long-term care facilities, certified school social workers, and persons practicing "in accordance with Biblical doctrine". BSW graduates specifically authorized to use title of "Social Worker" without license. (Ga.)

TABLE IV—Continuing Education Provisions

The authorizing provisions included in the legislation are listed below, for states that have acts which specify some form of continuing education requirement for the renewal of a license or certificate. Specific regulations should be obtained from the respective boards.

ALABAMA

Section 12.11

At the time of license renewal each applicant shall present satisfactory evidence that in the period since the license was issued, such applicant has completed the continuing education requirements specified by the Board. At the time of license renewal, the Board may, in its discretion, waive the continuing education requirement upon a showing by an applicant that prolonged illness or other extenuating circumstances prevented completion of such requirement. A waiver shall not be granted to any applicant twice in succession.

ARKANSAS

Section 10(d)

At the time of license renewal, each applicant shall present satisfactory evidence that in the period since the license was issued, he has completed the continuing education requirements as required by the Board.

COLORADO

Section 12-63.5-111

Every person seeking a renewal of a certificate shall show evidence to the board that he has been engaged in at least fourteen classroom clock hours of continuing education under the sponsorship of an accredited school or a program approved by the board. The board has the authority to revise the criteria so that time, content, and appropriateness of continuing education activities may be kept current, effective, and relevant. Any revision of criteria regarding time, content, or appropriateness of continuing education must be made known by inclusion in the annual notice of renewal of licensure and registration.

DELAWARE

Section 378

At the time of the license renewal each applicant shall present satisfactory evidence that in the period since the license was issued, he or she has completed continuing education requirements as developed and specified by the Board.

FLORIDA

Section 490.007(2)

Each applicant for renewal shall present satisfactory evidence that in the period since the license was issued, the applicant has completed continuing education requirements set by rule of the department or, in the case of psychologists, by rule of the board. Not more than 25 hours of continuing education per year shall be required.

GEORGIA

Section 43-7A-16

The board shall establish continuing education requirements for license renewal. The number of hours of continuing education in each specialty shall not exceed the number of hours available that year in each such specialty in board approved courses within the state. The board may waive these continuing education requirements for not more than 12 months, but such waiver shall only be available upon the licensee's satisfactory showing to the board of undue hardship.

KANSAS

Section 23(b)

Except as otherwise provided in KSA 75-5356, as amended, a license may be renewed by the payment of the renewal fee set forth in this act and the execution and submission of a signed statement, on a form to be provided by the board, attesting that the applicant's license has been neither revoked nor currently suspended and that applicant has met the requirements for continuing education established by the board.

KENTUCKY

Section 335, 130(4)

The board may, at its discretion, require continuing education as a condition of license renewal. (Enact. Acts 1974, ch. 279 & 13.)

MAINE

Section 7060

... Every 2nd renewal shall be contingent upon evidence of participation in a continuing professional education course or program as approved by the Board.

MARYLAND

Section 648(E)

At the time of renewal, the board may require the licensee to produce evidence of keeping abreast of new developments in the applicant's area of specialization in the field of social work. This requirement shall be standardized for all licensees within each category and within each specialization.

MASSACHUSETTS

Section 136

At the time of license renewal, each applicant shall present satisfactory evidence that in the period since the license was issued, he has completed the continuing education requirements specified by the board.

MONTANA

Section 9(2)

Application for renewal must be made upon a form provided by the department. A renewal license must be issued upon payment of a renewal fee set by the board and upon submitting proof of completion of continuing education requirements.

TABLE IV—Continuing Education Provisions—Continued

NORTH CAROLINA	<p><i>Section 90B-9(b)</i> All certificates issued hereunder shall be renewed at the times and in the manner provided by this section. At least 45 days prior to expiration of each certificate, the Board shall mail a notice for certificate renewal to the person certified for the current certification period. Prior to the expiration date, the applicant must return the notice properly completed, together with a renewal fee established by the Board and evidence of completion of the continuing education requirements established by the Board under G.S. 90B-6(g), upon receipt of which the Board shall issue to the person to be certified the renewed certificate for the period stated on the certificate.</p>	TEXAS	<p><i>Section 50.023(b)</i> The department shall notify each person certified of the date of the expiration of a certificate or order of recognition issued to him, the amount of the fee for renewal, and the continuing education provisions that are required for its renewal for one year. The notice shall be mailed by United States mail to the person certified at least 30 days in advance of the date of the expiration of the certificate or order of recognition.</p>
NORTH DAKOTA	<p><i>Section 12(5)</i> At the time of renewal the board shall require each applicant to present satisfactory evidence that the applicant has completed the continuing education requirements specified by the board.</p>	UTAH	<p><i>Section 58-35-8</i> At the time of license renewal the social work licensure board may require a licensee to produce evidence of having upgraded themselves in their areas of practice or expertise. This requirement may be satisfied through professional learning or practice.</p>
OHIO	<p><i>Section 4757.11</i> ... Subject to section 4757.13 of the Revised Code, the board shall issue a renewed license or certificate of registration to each applicant who has paid the renewal fee established by the board under division (C) of section 4757.15 of the Revised Code and satisfied the continuing education requirements established by the board under division (B) of section 4757.05 of the Revised Code or, in the case of a social worker who holds only a baccalaureate degree in a program closely related to social work and who is applying for the first renewal of his license, satisfied the continuing education requirements established under division (A) of section 4757.09 of the Revised Code.</p>	VIRGINIA	<p><i>Regulations—Section IV-B</i> Renewal applications may contain questionnaire on continuing education, inspection of practices, and other related professional matters. The continuation of a license is contingent upon the completion of these questionnaires.</p>
OKLAHOMA	<p>Section 8.B on Independent practice requires that the licensee "3. Shall continue to meet continuing education requirements set by the board." (Effective after October 1, 1980).</p>	VIRGIN ISLANDS	<p><i>Section 520 Duties of the Board</i> (b) Promulgate rules and regulations that set standards for professional practice and continuing education requirements for certified independent social workers, certified social workers, social workers, and social work associates.</p>
SOUTH DAKOTA	<p><i>Section 25</i> Attendance at post graduate work as may be prescribed by the board, is a further requirement for renewal of said license. In no instance may the board require a greater number of hours of annual continuing education study than are available at courses approved by the board and held within the state. The board shall be allowed to waive the continuing education requirement in case of certified illness or undue hardship.</p>	WEST VIRGINIA	<p><i>Section 30.30-10</i> ... At the time of renewal, each applicant shall submit satisfactory evidence that he or she has completed the continuing educational requirements as specified by the board during the tenure of his or her license: <i>Provided</i>, That the board may waive these requirements upon a showing that the applicant suffered from a prolonged illness during the license period or upon proof of other extenuating circumstances which hindered the completion of the requirement: <i>Provided, however</i>, That no waiver may be granted in succession. ...</p>

TABLE V—Vendorship Provisions

STATE	EFFECTIVE DATE	LICENSE REQUIRED	ADDITIONAL REQUIREMENTS	COVERAGE	COVERED IF INSURANCE WRITTEN IN ANOTHER STATE	REFERRAL
California	January 1977 Amended 1984	Licensed Clinical Social Worker	None	Policies with mental health coverage must recognize LCSWs as reimbursible providers	Yes	By licensed physician or surgeon
Kansas	April 1982	Specialist Clinical Social Worker	None	SCSW must be reimbursed for services within their scope of practice unless policy holder refuses such coverage in writing	No	Not required
Louisiana	July 1977	Board Certified Social Worker	Must be listed in a National Clinical Social Work Registry	Policies with mental health coverage must reimburse BCSWs	No	Physician consultation and collaboration
Maine	January 1984	Certified Social Worker; Clinical Social Worker (after 1/1/85)	None	Policies with mental health coverage must reimburse CSWs	No	Not required unless a condition is diagnosed beyond the scope of CSW licensure.
Maryland	January 1978	Licensed Certified Social Worker	Must be on approved vendor list	Policies with mental health coverage must reimburse CSWs	Yes	Physician
Massachusetts	March 1982	Independent Clinical Social Worker	None	Policies with mental health coverage must reimburse ICSWs	Yes	Not required
New Hampshire	January 1984	Certified Clinical Social Worker	None	Coverage for CCSW must be offered to policyholders (who have mental health benefits) for a separate & identifiable premium	Yes	Not required
New York	January 1978	Certified Social Worker	Must have a "P" (Psychotherapy) endorsement which attests to 3 years of post-masters experience	Coverage for CSW must be offered to policy holders but is not mandated	Yes	Not required
Oklahoma	October 1982	Clinical Social Worker	None	Policies with mental health coverage must reimburse CSWs	Not specifically but may be	Not required
Oregon	July 1981	Registered Clinical Social Worker	None	Benefits to be paid whether service is given by physician, psychologist or clinical social worker	No	Physician or Psychologist
Utah	July 1978	Clinical Social Worker	None	Coverage of mental health benefits must reimburse CSWs	No	Not required
Virginia	July 1979	Clinical Social Worker	None	Coverage for CSW must be offered to policy holders but a special endorsement on the policy specifying CSW coverage is required	No	Not Required

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Office of the Assistant Secretary for Health

Regulating Health Professionals: A Review of the Empirical Literature

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AS PART OF THE SEARCH FOR AN EFFECTIVE APPROACH to health care cost-containment, existing systems for regulating health professionals are being scrutinized. The federalized system of control mechanisms for credentialing, together with the procedures of accreditation, institutional rationing of practice privileges, peer review, malpractice actions, and the like, supplies a complex and often redundant array of regulations. These devices are manipulated by several federal agencies, each of the 50 states, professional groups, and several private organizations. These regulations are perceived by many to be a significant barrier to ongoing efforts to encourage cost-containment through more widespread use of competitive incentives in the health care industry.

Health manpower regulations govern the locations and settings within which professionals can work and the activities of professionals in the course of their practice. The justification for these controls is the belief that the public interest will best be served if poorly trained, incompetent, and unethical people are kept from practicing. If these regulations are effective, they will ensure the patients' safe treatment by prohibiting some people from pursuing careers and will appropriately modify the behavior of practicing professionals. An unfortunate by-

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product, however, is that regulations limit the numbers, mobility, and activities of practices and professionals. Thus the cost-effectiveness of health delivery systems may be undermined by curtailing the availability of services for some consumers and distorting the incomes, fees, and career mobility of practicing professionals.

United States public policy regarding the stringency of health manpower regulations has shifted in tandem with evolving market circumstances and health policy objectives. Initially, the Constitution delegated responsibility for public activities relating to health professional control to the states in the form of police powers over activities that might threaten the public health and safety. Beginning early in the nineteenth century, a growing population and an expanding frontier increased the demand for medical services beyond the capacity of the existing supply of practitioners. The arguments made at the time for opening up the medical (and legal) professions are now familiar:

- Professionals had sufficiently complicated the process of delivering health care that individuals could not effectively present cases of malpractice before the courts, nor could they acquire the information they needed to care properly for themselves.
- The professional societies had become monopolies in restraint of trade, regarding new developments in health care and restricting entry of those desiring to practice in unorthodox ways.
- The professional societies were fostering a system of medical care that delivered services only to the wealthy and checked the entry of the lower classes into the medical occupations.

The result was a relaxed attitude of states about licensure policy and a significant increase in the number of practicing physicians in the 1870s. In turn, medical societies began to rekindle enthusiasm for rigid state licensure statutes. After the Flexner Report (1910) (medicine) and the Gies Report (1926) (dentistry), both documenting the need for higher quality training and practice, the situation had come full circle: undergraduate medical and dental education became even more scientific, and the professional aspects of training came under the purview of the postgraduate experience. Upgrading the scientific content of professional health education led to the formulation of new occupations and the development of specialties within professions. This trend has continued, resulting in increased specialization and

even more opportunities for professionals themselves to control competence through postgraduate review mechanisms—a process complicated by a need for credentialing a larger number of professions that are fragmented by specialities.

Several fundamental issues must be resolved if the refinements being made in health manpower regulatory policy are to be consonant with the public interest:

- How can the regulatory system be restructured so as to relieve some of the cost and access problems without compromising competency standards?
- How can the regulatory system be made more responsive to the public interest and the interests of all health professionals as opposed to the interests of members of select occupations?
- How can manpower regulations be structured so as to promote competency throughout the duration of professional practice without being unduly burdensome and counterproductive?
- How can the regulatory system be restructured so as to minimize frictions between occupations and allow employers to benefit from the most effective staffing patterns?

These issues evidence a need to incorporate broad policy objectives of cost-effectiveness and equity into the regulatory mission of ensuring professional competency. Reinforcing this need is a body of literature that establishes a strong linkage between the stringency of competency control mechanisms and the availability of services and overall health care costs.

Credentialing

Credentialing is a generic term that refers to several procedures designed to legitimize the roles of health professionals. The most important operational differences among the various credentialing mechanisms—which include registration, certification, and licensure—are the source of legitimacy or information, the rigor of entry screening, and the mechanism for securing compliance.

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- Do the barriers to occupational entry impose identifiable burdens on access, fees, and service delivery productivity?
- Do states with less restrictive rules suffer adverse health and safety effects?
- If licensing is needed, how can exclusionary burdens be minimized through changes in the structure of the practice act and in the process of administration?

Exclusionary Effects of Credentialing on Occupational Freedom of Choice

One of the principal burdens tight regulation places on occupational entry relates to the aspiring professional's freedom of occupational choice. Supreme Court rulings characterize freedom of occupational choice as an "inalienable right"¹ and the "most precious liberty that man possesses."² Yet, in granting what amounts to a monopoly franchise, the licensure act forbids practice by those who are unlicensed and protects the earning power of those with the education and moral stature necessary to become licensed. The exclusionary burden of licensure falls on those who are capable of performing all or part of the licensed tasks in a given state, but who are, for reasons of incompetency or variation from accepted ethical norms, unable to obtain a license and are, therefore, precluded from exercising their right to freedom of occupational choice.

Practice acts delineate career opportunities in two ways. For a particular profession, the practice act specifies the range or scope of tasks that can be performed. By specifying entry requirements, the licensure process also establishes the terms on which movement from one occupation to another can occur. This movement requires the prescribed training for entry into the "higher-level" occupation. Unless its statutory scope of practice is wide, a licensed profession affords little vertical career development.

Groups of health professions have actively sought the legitimacy provided from credentialing. The proliferation of licensed professions has come, in part, as a result of rapidly changing technology, constantly

¹ *Butcher's Union Co. v. Crescent City Co.*, 111 U.S. 746, 762 (1884).

² *Bersky v. Board of Regents of New York*, 347 U.S. 442, 472 (1954).

creating new needs for skills, specialties, and subspecialties. With licensure, and the legitimacy it provides, comes balkanization of the health care work force—that is, distinct groups of professionals, each with prescribed job duties. Ironically, boundaries used to define a scope of practice and a limit to encroachment of other workers also limit career mobility of persons in the profession (Curran 1970). Indeed, the proliferation of credentialed professions in health care has created widespread conflict as professionals seek to assume new responsibilities as they acquire experience. According to Greenfield (1969, 101), interoccupational conflict, largely over licensing arrangements, causes

. . . jurisdictional disputes between contiguous groups such as the LPN, [licensed practical nurse] and RN [registered nurse], the medical technicians and technologists, and even the RN and MD. These interoccupational disputes . . . not only are the source of friction among workers but are also the cause of malutilization of hospital manpower.

Frech (1974, 128) refers to licensure as "the main weapon in each jurisdictional joust." In discussing the effects of the licensure of Child Health Associates in Colorado, Curran (1970) argues that the specificity with which permissible tasks must be stated in the licensure act will result in fewer, rather than more, opportunities for professionals to assume significant new duties.

The research on the potential for safe expansion of the roles of some medical, dental, and inpatient nursing professionals shows that present role limitations may be unnecessarily rigid. For medical and nursing practitioners, an excellent review by Sox (1979) shows that nurse practitioners and other mid-level personnel competently provide many services restricted by law to physicians. For dental professionals, there are similar findings regarding auxiliary staff who are less expensive than dentists (Abramowitz 1966; Abramowitz and Berg 1973; Hammons and Jamison 1967, 1968, 1971; Lotzkar, Johnson, and Thompson 1971; Pelton, Bethart, and Goller 1972; Pelton et al. 1973; Soriceiii 1971; Milgrom 1978; Dolan and Milgrom 1980).

In spite of the limits on occupational freedom, legal scholars feel that the courts will continue to defer to the states' constitutional authority rather than substitute their own judgment with regard to the appropriate level of consumer protection. In one scholar's words, "It is more likely that a reviewing court would view a licensing

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restriction as a permissible exercise of state regulation of health and safety rather than as an interference with a constitutionally protected right" (MacBridge 1974). The courts have regularly upheld the states' authority to license occupations, however exclusionary the effects. In the words of Justice Black:

[The Court is not] concerned . . . with the wisdom, need, or appropriateness of the [licensing] legislation. Legislative bodies may have broad scope to experiment with economic problems, and this Court does not sit to subject the state to intolerable supervision.³

While courts continue to uphold statutory actions by state legislatures, there are instances where ethical prohibitions fostered by state licensing bodies have been reversed. The basis for these court and FTC actions has been concern about perverse impacts on the marketplace and the consumer, rather than concern about restrictions on freedom of occupational choice. These actions are discussed below, after the review of the accumulated evidence on market impacts of exclusionary practices.

Exclusionary Effects of Licensure on Provider Incomes, Fees, and Health Care Costs

The restrictions that credentialing imposes on occupational freedom of choice, in turn, affect the locational patterns and supply of professionals. A large number of studies have been done that measure the consequences of locational barriers imposed by licensure on fee levels and health care costs.

The findings of studies that examine the effect of licensing stringency on the incomes of dentists suggest that mobility barriers created by licensure work to increase the earning power of dentists in restrictive states. Most studies use the stringency of reciprocity rules as an indicator of restrictiveness. Holen (1965), for example, found that dental incomes are higher in states with restrictive use of reciprocity agreements. Maurizi (1974) and Conrad and Emerson (1981) discovered that dental board testing standards and reciprocity arrangements protect the incomes of dentists. These studies and one by Benham, Maurizi, and Reder (1968) all suggest that dentists tend to locate where there

³ *Ferguson v. Skrupa*, 83 U.S. 1028 (1963).

is potential for high income, except when reciprocity prohibits them from doing so. A study of dentist and dental hygienist mobility patterns by Conrad and Dolan (1980) showed that reciprocity rules limit the migration of professions into restrictive states. A study by Boulter (1974) provides evidence that the level of difficulty of state exams is adjusted as a means of protecting dental incomes, a finding confirmed by the Benham, Maurizi, and Reder (1968) study.

Stringent licensure of dentists in some states creates significant burdens on consumers in those states who are patients and must pay higher bills, as well as on consumers who have reduced access to dental providers. Using state-level data, one study found that fees are about 15 percent higher in states where entry is limited by the absence of reciprocity agreements (Shepard 1978). In a study using data from individual dentists, it was found that fees were only 5 to 10 percent higher in states with limited reciprocity agreements (House 1979). Shepard (1978) estimates that licensing regulations increased the bill for dental care in the United States during 1976 by \$700 million because the existing stock of dentists were unable to move freely between states. Recent attempts to standardize testing for dentists across regions (Regional Dental Testing Boards) should markedly reduce the mobility barriers and diminish the effects cited above.

The consequences of interstate differences in licensing practices are not as striking for physicians as they are for dentists. While there is evidence of correlation between the stringency of the licensing process (measured by state board examination failure rates) and physicians' incomes, there is strong evidence of physician movement into high-income areas in spite of stringent licensing practices (Benham, Maurizi, and Reder 1968). In another study comparing physicians with dentists, the effect of restrictive reciprocity practices in a state was a significant predictor of higher physician incomes, although by not as much as was the case for dental incomes (Holen 1965). The association between income and failure rate may indicate an effort, unsuccessful in the case of physicians, to restrict entry. It may also mean that high-income areas are more likely to attract applicants who are less likely to pass.

These findings are not surprising given the fact that the interstate variations in the degree of stringency of licensure practices is smaller for physicians than for dentists. Moreover, the use of similar exams and extensive reciprocity agreements for physicians limits the opportunities for boards' arbitrary restriction of entry into the states.

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DENTISTS

procompetitive policies will necessitate the development of information about the range of market options. Without ready access to information, the policies will fail to exploit fully the opportunities for cost-containment. Fortunately, large increases are expected in supplies of medical manpower. The pressure on fees, incomes, and admitting privileges that can be expected to occur has a potential for significant (favorable) impact on health care costs and access to services. Through reforms of the exclusionary and self-serving aspects of credentialing, these regulations will better serve the public interest in providing cost-effective and accessible health care services.

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There is evidence that state medical boards do exercise control over the number of practitioners in the way they license foreign medical graduates (FMGs). A study by Butter (1976) shows that procedures used by state boards to weight components of the standardized licensing exam provide an opportunity to vary the standards for licensure—in this case, with the result of high failure rates for FMGs in some states. The study did not find any evidence that high failure rates in some states were explained by the lesser competence of their applicants. In another study, the failure rate of FMGs on these exams was more highly correlated with visa status and country of origin than with other factors (such as the training institution) that are more likely to be associated with competence (Butter 1976).

Several studies of the economic effects of interstate variation in licensure stringency for nurses are in disagreement about the consequences for incomes and manpower availability. Monheit (1975) concludes that mandatory nurse licensure for RNs has a positive impact on RN wages and RN employment relative to LPNs. That is, requiring employers to use only licensed nurses appears to result in a restrictive influence on the use of non-RNs and a positive influence on RN wages, presumably because the requirement shrinks the supply of available nurses. In another recent study of nurses and other hospital employees, the stringency of licensure was found to have significant positive effects on wages for RNs, LPNs, and medical technologists in restrictive states (Sloan and Steinwald 1980); wages for RNs are 2 to 3 percent higher, LPN wages are 5 to 6 percent higher, and medical technologist wages are about 13 percent higher than in non-restrictive states. This study did not examine the effects of licensure on staffing mix, but the substantial effects on wages likely have corollary and suppressive effects on employment levels. Contradicting these results, Dusansky and Walsh (1979) found that the geographic variation in nurse employment levels is not due to mandatory licensure, nor do they find any subsidiary influence of state licensure policy on RN wages or employment levels, relative to LPNs. The location of training opportunities and the factors associated with labor force participation rates (e.g., husband's earnings) and the demand for employment (e.g., hospital revenues) were found to be most explanatory of variations in employment patterns.

The work by Sloan and Steinwald indicating large wage effects is probably more valid than that of Dusansky and Walsh. Sloan and Steinwald were able to control for the effects of many extraneous

influences on hospitals' staffing behaviors. Taken together, the Sloan-Steinwald and Monheit findings show a fairly dramatic pattern of effects on hospital wages and employment patterns. Whether higher wages in states with restrictive licensure is accompanied by higher quality nursing care is not known.

Patterns of restrictive entry requirements and higher fees are beginning to emerge for other health professions. In optometry, studies of examination prices and quality have shown that occupational entry restrictiveness are associated with higher fees and no improvement in the thoroughness of exams (Haas-Wilson 1984). In a study of clinical laboratory personnel, White (1979) notes that the exclusionary effects of licensure on fees, incomes, and supply also exist, and can be expected to increase in importance over time. This phenomenon occurs because the number of "grandfathered" personnel exempted from initial compliance decreases over time with their relocation and retirement. The author also notes evidence of the impacts of licensure on laboratory personnel in the forms of reduced employment and higher wages.

The uniformity of findings in the literature on the exclusionary effects of licensure is also reflected in studies on nonhealth professionals. Rayack and Stevens (1975, iii) analyze 12 occupations in 3 states, with data for a number of years on employment and pass/fail rates on exams. They conclude that "the examination process is used to insulate from competition those already licensed."

To summarize, the specific findings about the exclusionary effects of stringent practices for licensing health professionals are the following:

- Interstate differences in licensure stringency inhibit mobility of professionals, driving up fees and incumbent incomes in the most restrictive states.
- Interstate differences in licensure stringency have had adverse effects on the staffing mix and wage levels in dental and inpatient settings.
- Liberalization of reciprocity rules and/or use of national testing would eliminate interstate barriers to mobility and would bring fees and incomes down in the most restrictive states.
- The effects of licensure, however stringent, as contrasted with certification or other nonlicensure credentialing alternatives, are not known and are difficult to study.
- The effects of licensure stringency on health professionals other

interest will continue to be compromised in favor of professional interests as long as boards are dominated by professions. He argues:

Expectations [of public accountability] are ephemeral as long as the professions continue to dominate the boards. Health care delivery has become so complex and politicized that virtually any decision coming before these gatekeepers can have enormous impact on matters of quality, access, distribution and the cost of health care (Cohen 1980, 303).

The proposal includes a board for each cluster of professions to be regulated by the state. The board would be composed of persons having no self-interest in the professions being regulated, but would have statutory responsibility for formally consulting with members of the various professions, who can contribute necessary technical opinions. At present, the only forum for the public and other interested professions to comment on decision making is the legislature. Even in states like Minnesota, which have a centralized agency to administer credentialing activities, there is no provision for internalizing commentary from other related professions.

No research has been done on the "performance" of these new statutes or proposals in achieving the objectives noted above. There seems to be no indication that such systems will eliminate state disparities in licensing stringency or in the lifetime competence of professionals. Both of these factors were noted in the research as important to the efficacy of regulation. These systems, however, may help to make the license-granting process more rational, in that the central agency may become a forum for internalizing state manpower planning concerns, interoccupational conflicts, and service delivery productivity losses. The California statute is notable in its encouragement of "experiments" in education and delivery for members of new professions. This promises to be a liberalizing force in times of expanding technologies—one that welds education, practice, and regulation into a more coherent package.

While the ideal solution to problems caused (or not solved) by existing regulatory systems is not obvious, federal reforms of the exclusionary aspects of credentialing and those provisions relating to ethical prohibitions do seem essential if the current policies to contain health care costs are to succeed. Based heavily on incentives for patients and payers to engage in comparison shopping, these

are not likely to be effective in relieving the inadequacies of current licensing practices.

As noted above, most refinements in credentialing attempt to make regulators more accountable to public interests by granting regulatory authority to a board or agency. The most popular and politically acceptable change has been the use of sunset provisions for licensing boards. This attempt to extract accountability through periodic scrutiny has been employed in 35 states. Clearly, the purpose here is to regulate the regulators. Attempts to make licensing boards accountable for their actions, rather than assuming accountability because of their composition, may encourage higher rates of sanctions and possibly more evaluative research. However, there is no evidence to suggest that this form of scrutiny will constitute anything more than a resource allocation tool for state budgeting purposes. For sunset provisions to contribute the appropriate incentives, it will be essential to stipulate achievement of public objectives of accessible and cost-effective services as criteria to be met in the sunset performance evaluation. While the notion of accountability is laudable, the problems of measurement of board effectiveness on dimensions of access, cost, and quality are likely to be prohibitively large.

The second type of refinement that is being proposed for credentialing systems is an alteration of the structure of the licensing agency. One such approach is to change the locus of the licensing function to a state regulatory agency, providing a better opportunity for integrating the manpower and cost policies of the state into the competence control process. The problems of proliferation of credentialing, coordination of tasks across professions, and the continued threats of board control by the professions can be addressed through creation of a centralized administrative body within the state vested with legislative authority to license by regulation, rather than by statute. States such as California, Michigan, Virginia, and Minnesota have implemented such systems. Another variation of this approach is to group related professions together on boards, while continuing to license them separately (for example, physicians, physician assistants, and nurse practitioners). This administrative change will shift the disputes over roles and responsibilities from the legislature to the board.

A recent proposal by Cohen (1980) would attempt to combine some of the best features of these reforms. Fundamental to this proposal is the belief, overwhelmingly supported in the literature, that the public

than physicians, dentists, nurses, optometrists, and laboratory personnel have not been studied. The consistent findings in professions that have been studied are probably generalizable to other professions that have national job markets—e.g., where job search and employer search are regularly conducted on a national rather than a localized basis.

Practice Act Limitations, Career Mobility, and Health Delivery Productivity

Limitations on the scope of practice of licensed personnel may preclude some options for deploying professionals in the most cost-effective fashion. These problems arise because of explicit limits on numbers of aides (as in some dental practice acts) or because lower level (and less expensive) staff are precluded from performing certain tasks. Staffing-mix rigidities due to licensing may increase the cost of services from health care enterprises and may, correspondingly, limit the opportunities for professionals to assume new responsibilities on the basis of their experience.

The effects of practice-act limitations on the efficiency of health care delivery have been shown to be present in dental care, but the issue has yet to be studied carefully for outpatient and inpatient medical settings. A study of dental service delivery by Conrad and Emerson (1981) indicates that delegation of responsibility to dental hygienists is definitely impeded by state practice acts. They conclude that regulations governing the number of hygienists per dentist result in higher dental fees. A General Accounting Office study (1980) also concluded that expanded use of auxiliary staff would improve dental practice productivity. Work by Lipscomb and Scheffler (1975) indicated that practice revenue might be doubled in a solo dental practice by hiring one auxiliary professional.

For ambulatory medical settings, the evidence is not very compelling. Reinhardt (1970) found considerable opportunity for physicians to employ cost-effectively more aides; however, he does not suggest that the shortfall in productivity is due to licensure restrictions.

There is evidence that liberalization of statutory prohibitions against task delegation in dental and ambulatory settings will not be sufficient to prompt staffing-mix changes. Reinhardt's work (1970) is indicative of this concern, as are survey results for dentists (Cohen 1978; McKenzie

and Born 1973; Leske and Leverett 1976) and for physicians (Lawrence et al. 1977). These surveys show that only about one-third of practitioners would hire an extender, though many approve of the idea in theory. There is a uniform view across all surveys that, without practitioners' exposure to auxiliaries, possibly through a joint training experience, the auxiliaries' employability would not increase.

The effects of licensure on staffing mix for inpatient settings has not been studied carefully. A study of RN/LPN substitution in hospitals (Dusansky and Walsh 1979, 17) found clear evidence that "mandatory licensure does not appear to play a significant inhibitive role in hospital substitution among auxiliary personnel. There is only a slight suggestion that mandatory licensure plays a role in hospital substitution between LPNs and attendants." The study by Sloan and Steinwald (1980) found that wages are higher in restrictive states, suggesting that staffing mix is probably affected, although this problem is not explicitly addressed. Monheit's research (1975) showed that employment levels of RNs relative to LPNs is altered through licensure, but he did not attempt a study of more general patterns of substitution or of the cost-effectiveness of staffing patterns. No other studies were found that examined the effect of licensure on staffing patterns in acute hospital settings. One study of staffing patterns in state mental hospitals (Windham et al. 1978) found that restrictive licensure policies toward FMGs caused institutions to rely more heavily on supervisory, licensed physicians. There was evidence of higher costs when FMGs were subject to strict licensure, though no evidence of concurrent, higher quality patient care was found.

Ethical Prohibitions in Credentialing

In addition to stipulating limits on the scope of practice and the range of delegating authority, licensing acts often include other constraints to ensure ethical behavior. The vast majority of license revocations stem not from incompetence but from violations of these precepts. Many of these requirements for licensure are simply invasive; others, such as advertising bans, may limit the operation of competitive forces. (An example of the former is the application form for the now-defunct character reference program, designed by the American Association of Dental Examiners. On the last page of the questionnaire, there was a notarized statement whereby the applicant waived rights to

Control of hospital practice privileges can be based on direct observation, yet many professionals do not need to exercise such privileges in order to care for their clients.

Credentialing regulations, then, seem, in theory, to be the most comprehensive set of mechanisms for monitoring both initial and subsequent competence. Yet, the research on credentialing shows that: contemporary credentialing procedures may not be reliably screening actual practice competence; they certainly are not effective in ensuring lifetime competence; and the current practice of credentialing can have undesirable consequences for access and health care costs.

In addition to the liberalizing actions taken by the courts and the FTC, many states have begun to reform their credentialing practices, with the general aim of making regulation more accountable to broad public interests and less responsive to the narrow interests of particular professions.

While reforms have tended to focus on relieving deleterious economic side effects of credentialing practices, the presumption of need to regulate competency remains. Little has been done to make credentialing practices more reliable in ensuring practice competence. One proposal being made to improve competency is mandatory relicensure. Mandatory relicensure at regular intervals focuses on lifetime (rather than initial) competence. The research offers three pertinent findings relating to the value of systems of relicensure. First, the research on competence and quality of care indicates that professional obsolescence is a real concern. There is a need for augmenting the knowledge base and clinical skills as technology changes and as encounters with particular case problems and clinical tools become less frequent as a result of specialization. Second, the literature advises that implementation by states of more obtrusive systems of credentialing offers the potential for even wider interstate disparity in stringency. These variations have consistently been shown to hamper professional mobility across states and to place access, fee, and health care cost burdens on residents in the most restrictive states. Third, the research shows that current credentialing methods for assessing patient care competence (initial or periodic) are not reliable and that current techniques for disseminating new skills are not effective in altering actual behavior. The only demonstrably reliable way to monitor continued competence and remedy deficiencies is through the use of "output monitoring" and corresponding deficiency-oriented training. For these reasons, standards for relicensure

in the Medicare program. If enacted, this proposal would, among other things, dilute financial incentives inherent in malpractice threats to maintain competence.

Summary and Implications

Research evidence does not inspire confidence that the wide-ranging systems for regulating health professionals have served the public interest. Though researchers have not been able to observe the consequences of a totally unregulated environment, observation of *incremental* variations in regulatory practices generally supports the view that tighter controls do not lead to improvements in quality of service. The research is quite clear that restrictive practices invariably contribute to higher fees and practitioner incomes, thereby benefiting the protected professional groups at the public's expense. This evidence of self-serving regulation is particularly compelling for advertising and other ethical prohibitions, which limit competition and cause markedly higher fees without evidence of improving quality.

The public health of citizens may well be harmed by severe regulatory restrictions limiting citizen access to services. Research suggests two mechanisms which may restrict access. First, there is accumulating evidence that exclusionary practices may prohibit capable and experienced persons from practicing, thereby restricting the supply of available professionals. Second, artificially elevated fees will preclude access to some persons for whom ability to pay is a problem. No doubt price rationing is more of a problem for services that are not frequently insured, like optometric and dental services.

The available research does not suggest that existing systems of regulation have effectively controlled initial or subsequent competency of professionals. Each of the noncredentialing controls on professional manpower is predicated on a useful but insufficient set of concepts for ensuring competence. Peer review of deficiencies and malpractice sanctions are useful in very limited ways to control competence once professionals are already in practice, but they provide no guarantee of initial competence. Accreditation of training institutions, on the other hand, can be employed to control the level and types of educational experiences of aspiring professionals, but this form of regulation fails to monitor actual practice behavior. Controls used by third-party insurers may be motivated (and distorted) by financial considerations.

denial, confrontation, or rebuttal of any information given to the examiners, and released from liability anyone supplying such data, whether true or false.) These restrictions are vestiges of the objective of maintaining credibility for professions in the eyes of the public. Professional codes often prohibit advertising, limit name identification on products, discourage public evaluation of professional work, and place limits on public indications of the price and quality of services provided. Indeed, the professional ethical standards endeavor to mask any indicators that might show professionals to be engaged in commerce.

Studies of the effects of prohibitions on advertising show that withholding information from consumers will cause the range of prices across sellers to widen and the average of these prices to increase (Stigler 1961, 1968; Nelson 1970; Maurizi 1976). Several studies of optometric goods and services show that prices are much higher in states that restrict advertising. Benham, using 1963 data, found that the price of eyeglasses in states that permitted advertising was about \$7.50 lower than in the others, although the savings for the glasses *plus* examination was only about \$4.50. However, when the "most" and "least" restrictive states were compared, the differentials widened markedly to \$19 and \$21, respectively. Benham (1972, 344-45) concludes:

... advertising restrictions in this market increase the prices paid by 25 percent to more than 100 percent. Furthermore, these estimates are likely to understate the total savings to consumers occasioned by advertising, since the search process itself is less expensive when information is more readily and cheaply available.

Optometry has continued to be a fertile area for study due to the wide variation in regulatory restrictions across states. In their initial work, Feldman and Begun (1978) found that both price and quality of eye exams are higher in restrictive states. Lifting the ban on advertising would have the effect of cutting price by 10 percent although visit length and the amount of capital available would diminish. Extending this analysis, Begun and Feldman (1981) conclude that the combined effects of advertising, employment and branch office restrictions and continuing education requirements have raised examination prices by 31.6 percent. The advertising restriction alone accounts for an 11 percent price increase. The national income transfer favoring optometry which is created by these regulations is estimated

to be \$139.5 million annually. Recent studies by the Federal Trade Commission (FTC) (1980) and Haas-Wilson (1984), using 1978 data, also show that restrictions on advertising and business practices will increase price. These studies used data from several hundred visits to optometrists across the country (where vision care needs were known in advance by the investigators). Quality of the visit was measured by thoroughness of the exam, accuracy of the prescription, and accuracy of the eyeglass lenses. The FTC analysis showed that commercially permissive regulations, in general, and advertising, in particular, tend to reduce prices. Using the same data and adjusting for quality of service and products, Haas-Wilson (1984) finds that elimination of regulatory restrictions in optometry would be associated with a 20 to 25 percent reduction in eyeglass prices, holding other aspects of regulation constant. Neither advertising nor other regulatory policies tend to affect quality levels.

A study by the FTC of veterinary services indicates that restrictions on advertising cause consumers to pay more for routine services (Smith, Teply, and Folsom 1978). A survey was done in 1978 at 216 small animal practices in six large cities. Employing the data on price dispersions for dog spays, the authors calculate that consumers pay an excess of \$12 million per year over what they might have paid had no price dispersion existed. They suggest that the "savings from the other routine services is even higher." They do not, however, measure the fraction of the price dispersion due to prohibition of advertising; rather, they contend that advertising restrictions create most, if not all, of the price dispersion and that consumers would realize a substantial savings if advertising were permitted.

A study of advertising restrictions for retail prescription drugs showed that prices are 5 percent higher in restrictive states (Cady 1975). Quality indicators such as availability of credit, home delivery, and waiting-area services were about the same regardless of advertising, though expanded emergency services were more prevalent and family drug monitoring was lower in the states permitting advertising. For prescription drugs, recent work by Leffler (1981) shows that advertising and promotion of new drugs has beneficial effects on the rate of adoption of therapeutically important drugs and tends to make pricing in the drug family more competitive.

A study of the effects of advertising in dentistry shows that liberalization of some states' advertising laws has had a negative effect

competence control. "What seems clear is that malpractice suits are a symptom rather than a cure of the current malaise of state regulation [of competence]" (Blair and Rubin 1980). These authors argue that the growing use of this final enforcer of competence is the result of heightened consumer litigiousness, higher expectations of professional performance, the impersonality of professional service delivery, a breakdown in professional screening and discipline due to the growth in the number of practicing professionals, and ambitions of malpractice lawyers.

Even though malpractice represents a final screen on competence, studies by the Commission on Medical Malpractice (1973) found that only about 6 percent of physician-inflicted injuries eventually resulted in a suit. There is also reason to believe that reliance on malpractice to regulate quality will increase costs to the extent that its threat warrants expensive insurance coverage and creates defensive practices by practitioners, which tend to feed the cost spiral. Greenwald and Mueller (1978) find that rising risks of malpractice actions have caused increases in physician and hospital costs which exceed the increases in malpractice premiums. Their findings are consistent with the survey finding that more than half of United States physicians believe they practice defensive medicine (Commission on Medical Malpractice 1973). Not only is reliance on malpractice an expensive form of regulation but there are risks that defensive medicine may actually be harmful to the public.

Forty years ago . . . malpractice resulting from an injury caused by improper therapy was almost an impossibility, since most therapies were placebos. . . . Today . . . unfortunately, new therapies are also capable of producing serious iatrogenic disease (Brook, Brutoco, and Williams 1975, 1209).

It does appear that malpractice, despite its perceived prevalence, is a poor substitute for other competence-control mechanisms, and that reliance upon it is ill-advised and may promote overuse of costly "defensive" services.

Proposals are beginning to be heard in Congress, which, if enacted, would dramatically reduce the financial risk of medical incompetence. Medicare beneficiaries would be precluded from collecting any punitive damages from physicians who participate (those who accept assignment)

is paid a fixed price for each type of patient. The hospital is at financial risk for the level and mix of hospital services prescribed by the admitting physician, including excessive laboratory testing and unnecessarily long lengths of stay. Consequently, hospitals will have little recourse but to become more aggressive in their scrutiny of physician behavior. Some admitting physicians will lose privileges as a result. The degree of hospital "leverage" will also increase as physician supply increases and competition for privileges intensifies. Interestingly, such regulation by hospitals is not necessarily related to competency, but related instead to the cost-effectiveness of physician practice patterns.

Organized peer review has been found to be influential in reducing hospital costs, but little evidence exists that the professional review organization (PRO) mechanism will improve competence. Little is known about the effectiveness of this control mechanism; however, some evidence exists which suggests that hospital expenditures have been reduced as a result of elimination of unnecessary testing and excessively long periods of hospitalization (Institute of Medicine 1976; Brock, Williams, and Ralph 1978; Health Care Financing Administration 1979).

No research has been done to determine the value of PRO review to clinical competence per se and only recently has research begun on the effects of experimental PRO monitoring of behavior in ambulatory settings. The study by Brook, Williams, and Ralph (1978) of the experimental medical care review organization (EMCRO) program in New Mexico, a precursor of PRO, showed that organized peer review did reduce the number of unnecessary injections. In a study of PRO activities in long-term care settings, researchers were not able to confirm that PRO activities increased the quality of care; however, they were optimistic that they had the potential for identifying deficiencies in care (Rand Corporation 1979). On balance, there is little in the extant research to suggest that organized peer review, whether of the PRO or other forms, can be relied upon to control the level of competence in professional practice.

Malpractice actions represent a limited and ex post facto method of seeking redress of incompetent actions of professionals. Malpractice is essentially a mechanism of client recourse for damages caused by professionals who do not exercise reasonable and customary care in their actions. Its use reflects the inadequacy of other mechanisms of

on dental incomes (Conrad and Emerson 1981). The research shows that prices advertised for dentures by dentists were often below those being charged by denturists.

The Supreme Court has taken notice of these research findings on the economic effects of advertising prohibitions. Referring to the findings of Benham (1972) about optometric markets, Justice Blackmun wrote, in a landmark case:

Although it is true that the effect of advertising on the price of services has not been demonstrated, there is revealing evidence with regard to products; where consumers have the benefit of price advertising, retail prices are often dramatically lower than they would be without advertising.⁴

With reference to the impact of this posture on professionalism, Blackmun said:

(We) find the postulated connection between advertising and the erosion of true professionalism to be severely strained. At its core, the argument presumes that attorneys must conceal from themselves and their clients the real-life fact that lawyers earn their livelihood at the bar. . . . Since the belief that lawyers are somehow "above" trade has become an anachronism, the historical foundation for the advertising restraint has crumbled.

Only two significant court actions have occurred, both supporting the right of professionals to advertise. In the cases of *Bates v. State Bar of Arizona*⁵ (lawyers) and *Virginia Pharmacy Board v. Virginia Consumer Council*⁶ (pharmacists), price advertising was upheld as a form of free speech as protected under the First Amendment. While both decisions were narrow, failing to clarify issues of nonprice advertising and nonprint media, the FTC has been more aggressive, ordering organized medicine and dentistry to cease attempts to limit advertising among members (Bloom and Stiff 1980). These procompetitive actions have probably encouraged the rapid growth in nontraditional commercial

⁴ *Bates v. State Bar of Arizona*, 97 U.S. 2961 (1977).

⁵ *Ibid.*

⁶ 425 U.S. 748 (1976).

medical practices such as urgent-care clinics in shopping center locations, though no research has yet documented this linkage.

The FTC and court actions have also caused professions to consider recourse potentially available through the *Parker v. Brown*⁷ doctrine. This important precedent allows trade restrictions approved by states to be exempt from antitrust liability. The earlier decisions of *Goldfarb v. Virginia Bar*⁸ and *National Society of Professional Engineers v. United States*⁹ established that professions are not exempt from federal antitrust prohibitions or actions that restrict competition. Consequently, professions might lobby for statutory restrictions on advertising as a way to avoid the federal directives (Heitler 1982). Clearly, the sovereignty of professionals to advertise (as an expression of free speech) and the sovereignty of states to enact legislation which protects the public create a potentially important area of constitutional conflict over advertising and other commercial practices for the health professions.

The research findings on the consequences of ethical prohibitions support the view that the public interest is not being served through continuation of all of these restrictions. However, these research findings cannot necessarily be generalized to cases where advertising is prohibited for nonroutine, highly technical services. In such instances, there is still reason to believe, despite the lack of supporting research, that advertising would not aid comparison shopping by consumers and may, therefore, not further serve the public interest. However, there is certainly no research supporting the view that prohibitions of commercial practices and advertising would benefit the public. It is likely that these kinds of restrictions will serve as a barrier to realizing the gains in economy sought by firms and public programs as they attempt to insert "price sensitivity" into their health insurance policies through the additions of copayments and other forms of cost-sharing.

Effects of Credentialing Practices on the Quality of Care

Because the existing systems of licensure have not eliminated professional judgment errors and careless practice, there are those who would argue

⁷ 198 U.S. 795 (1961).

⁸ 421 U.S. 773 (1975).

⁹ 98 U.S. 1355 (1978).

The Standards for Hospital Accreditation, the state licensing regulations and the defendant's bylaws, demonstrate that the medical profession and other responsible authorities regard it as both desirable and feasible that a hospital assume certain responsibilities for the care of the patient.

Most hospitals do limit the privileges of general practitioners (Rayack 1967). Patient outcome studies by Payne and Lyons (1972) support the restrictions of certain types of privileges (surgical) to only board-certified or board-eligible practitioners. The practice of restricting practice privileges to "certified specialists" does, of course, enhance the role of the certifying boards in the regulatory process. Specialty certification per se has no bearing on occupational freedom in the eyes of the state.

Like hospitals, third-party payers often have more restrictive standards of competence than does the state. While licensure is always a necessary prerequisite to eligibility for reimbursement, third-party payers often determine practitioners' eligibility to care for their subscribers and, more important, refuse to reimburse them for certain types of services under the terms of the contract. Public payers, such as Medicare and Medicaid, certify the adequacy of institutional providers and also determine the eligibility of individuals to receive reimbursement. With their authority to withhold reimbursement, third parties, including government, have ultimate control over the attractiveness of health careers. The research showing earning potential as a determinant of availability of professionals also suggests that, as the scope of insured services increases, third-party control over professional standards increases as well.

Professions have sought control of third-party reimbursement policy. Langwell and Moore (1982) review the research on profession control of third-party reimbursement policy. They conclude that evidence on physician control of Blue Shield plans and dentist control of Delta dental plans is ambiguous on the issue of provider control of fee levels. For physicians, there is some evidence that professional control of membership on Blue Shield boards has contributed to payment of higher fees (Kass and Pautler 1979).

Recent changes in hospital reimbursement policy by Medicare can be expected to have pronounced effects on physician practices within institutions. Under the new prospective-payment system, the hospital

the economic consequences of an admission to the highly competitive professional schools. The income earning potential of physicians and dentists, when compared to that of other professionals for whom accreditation is not as important, suggests that the admission itself (like a taxi medallion or an FCC license) has an economic value. In both medicine (Sloan 1970) and dentistry (Maurizi 1974), the returns on professional training are about twice as high as the returns on alternative professional training, suggesting the presence of restrictive monopoly privileges accruing to the fortunate few who are admitted. Menemeyer (1978) has estimated that physicians and dentists earn rates of return on their educations (discounted at 4 percent) which are respectively 44 percent and 24 percent higher than the rate of return earned by Ph.D.s in the life and physical sciences. Dresch (1981) estimates that the economic value of the "acceptance" to medical school is equivalent to an annual annuity of \$4,000 over a 47-year period.

Hospital practice privileges offer a legally acceptable and often stringent check on the competence of professionals to perform some specialized tasks. It is well documented that hospitals have restricted the growth and legitimacy of some health professionals by not extending admitting privileges to podiatrists, midwives, chiropractors, clinical psychologists, and others (Pollard and Leibenluft 1981). Even for physicians, many institutions reserve the right of conferring certain privileges on practitioners who meet standards of competence higher than those required for licensure. Legal precedent allows such restrictions. In *Ferrante v. City of New York*,¹⁰ the New York Supreme Court held that the city hospitals could limit the practice of surgery to board-certified surgeons. A similar ruling was made in the case of *Dade County v. Trombly*.¹¹ One reason why hospitals are inclined to adopt higher standards than are required for licensure is that they are liable for negligence, not only of their employees but of their practicing physicians as well. In the precedent-setting case of *Darling v. Charleston Community Hospital*,¹² the opinion stated:

¹⁰ 17 N.Y. 616 (1964).

¹¹ 104 Fla. 606 (1958).

¹² 86 U.S. 1204 (1966).

for more stringent regulatory practices. While there have not been many useful studies of the impact of licensure or other credentialing mechanisms on the quality of services provided, large bodies of research point to the fact that the existing systems of regulation have not eliminated mistakes or poor judgment by providers.

One study indicated that 5 percent of America's doctors are unfit to practice (Derbyshire 1975). Other studies have indicated that between 29 and 62 percent of patients receiving hospital care are victims of serious errors in medical management, resulting in preventable deaths or invalid diagnoses (Trussell 1962), and that between 8 and 22 percent of obstetric patients receive deficient care (Payne and Lyons 1972). A study of medical records in two hospitals revealed that 7.5 percent of all cases indicated physician-inflicted injury (Pocincki, Dogger, and Schwartz 1973). The assessments of physicians' ambulatory care performance is even worse; between 61 and 65 percent of well-care patients received deficient care during their visits to physicians (Payne and Lyons 1972).

Physicians are not the only licensed professionals described by such findings; others simply are not studied as often. A study of the quality of laboratory practices at the Center for Disease Control indicated that slides made from Pap smears containing highly suspicious evidence of carcinoma were missed 30 percent of the time by technicians. Even more disheartening, when this same test was given to pathologists, they missed the suspected carcinomas 37 percent of the time (LaMotte 1976).

This sort of evidence is not intended to disparage the professionals being studied, for it is certain that some of the norms used in these tests to define levels of inadequate performance are quite rigorous. Moreover, health care management is often characterized by uncertainty. Nonetheless, this evidence provides grist for those who wish to perpetuate and even toughen the control mechanisms on health professionals. Second, and more important, the evidence indicates that the current competency control systems are not sufficient to eliminate errors in judgment, obsolete practices, and undisciplined, careless practice. To some observers, this suggests that our mechanisms of control need overhaul, that there may be undue emphasis on the quality of resources and on tests of competence and too little emphasis on actual patient outcomes. Others go so far as to suggest that lifting controls altogether would not lessen the frequency of such findings, but, indeed, might

actually cause the level of competence to rise in response to market pressure (Friedman 1962).

Studies in optometry suggest that regulation does not enhance quality, though it may reduce the price consumers must pay to upgrade quality of service. Studies using data collected by the FTC show no significant effects of licensing restrictiveness on quality of services provided (Haas-Wilson 1984). Here, quality of service was measured by a scale for thoroughness of the optometric exam. Licensing rigor was measured by the failure rate on entry exams. Though suggestive, more work using better quality measures available in the FTC data (accuracy of prescriptions, accuracy of lenses) would be more definitive. Begun and Feldman (1981), using length of exam and number of procedures as measures of quality, find evidence that regulation may prompt more competition on the basis of quality.

Studies of the determinants of the quality of care delivered by physicians support the view that general licensure is not as conducive to quality control as more specific licensure. In a carefully controlled study in Hawaii, Payne and Lyons (1972) found the quality of ambulatory and inpatient care to be better when rendered by a specialist or other physician with extensive experience in treating similar cases. Studies of presurgical screening mechanisms show that surgical recommendations of specialists are overturned in peer review less often than those of nonspecialists (Poggio et al. 1981). These findings confirm the common-sense notion that experience and additional training make a difference.

The effects of licensing on provider mobility and fees point to an adverse corollary effect on quality of life for residents of restrictive states; by excluding manpower from the state and driving up the fees of incumbent practitioners, restrictive states deprive some consumers of services. Thus, the consequences of restrictive state-licensure policy will be to force some consumers to forego services altogether. This deleterious effect on access and the health status of the population has not been documented by research. These effects should be stronger in dentistry than in medicine, for two reasons. First, the exclusionary consequences of state licensure were found to be more pronounced for dentistry. Second, dental care consumption is much more sensitive to fee variation than is medical care, for which insurance coverage is much more common.

An indirect way of asking if licensure ensures competence and high-quality services is indicated by those studies investigating whether

The Effects of Other Regulatory Mechanisms

A variety of mechanisms other than credentialing presently control aspects of practicing behavior and manpower distribution and indirectly influence the competence of professionals and the costs of care. They include:

- accreditation of training institutions;
- granting of hospital admitting privileges;
- third-party reimbursement privileges;
- review by professional review organizations; and
- threats of malpractice actions.

The practice for accrediting educational programs represents the most binding constraint on the availability of professionals and on their levels of practice competence. No research exists on the consequences of stringent accreditation for the quality of care, though much has been written about the link between the tightening of these controls (as was done early in this century) and the growth of specialization and consequent growth in professional control of practice through specialty boards (Stevens 1971).

Strengthened accreditation policies had an immediate effect on medical education following the Flexner (1910) (medical) and Gies (1926) (dental) proposals for reform. For example, following the Flexner report the number of medical schools dropped from more than 130 to about 78, where it remained until the 1970s; the number of graduates per year fell from over 4,000 to about 3,000 (Frech 1974). (For blacks the reforms were clearly a source of discrimination; the number of predominantly black medical schools fell from 7 to 2 and the percentage of blacks in the physician population also fell. For females the discriminatory effects were similar. The proportion of physicians that were female fell from its peak in 1910, and even the absolute number of female physicians fell.)

An opportunity for measuring the effect of stringent accreditation on professional availability is indicated in the research demonstrating the high economic value of an admission to health professional schools. Theorists note that the restrictions on admission to professional schools are a potentially more binding constraint on availability than any other type of control. Building on this notion, studies have measured

practitioners are most prone to enroll in voluntary programs but that, no matter who enrolls, it is difficult to change behavior back at the office. Similar findings have been found for dentistry (Long 1969; Ryan 1971; Gessner 1973). These studies also show that, if continuing activities are focused on specific provider deficiencies, the likelihood of favorable results is increased. Brown and Uhl (1970) argue persuasively that a focus on physician-specific needs, identified through audit, will produce the largest changes in behavior.

It should not be concluded that the efficacy of continuing education has always been thought to rest on behavioral change in practice behavior or in patient outcomes. Many course sponsors believe that changes in attitude, pre/posttesting proficiencies, and assessment of the quality of the course itself are suitable guides to the effectiveness of courses. A survey of such activities in nursing by Forni and Overman (1974) showed that of 18 educational projects, 14 were evaluated on the basis of some form of "happiness" index. Most of this nonoutcome sentiment has disappeared, at least in medicine, following the study done on the "Dr. Fox Lecture" (Naftulin, Ware, and Donnelly 1973), where it was shown that participants rated a course highly on each of a number of features, even though the material was specifically designed to be void of logic and relevance and contrary to truth, and the teacher was a trained actor. Clearly, an educational experience cannot be judged on the basis of how well it is received by the participants (Chabbers et al. 1976). Studies by McGuire et al. (1964) offer less visceral, more scientific evidence of the failure of subjective opinion to proxy behavioral change. They found that courses favorably received did not prompt the desired changes in patient care behavior.

This literature suggests that, if credentialing is to be relied upon to ensure competence, both the initial and subsequent performance checks must better link actual practice behavior to the content of educational processes and to the performance measures used in the credentialing process. Clearly, a credentialing system based on "competence" rather than "evidence of being able to be competent" offers more hope for ensuring quality care. The idea of pegging continuing education to areas where there is evidence of chronic incompetence is an appealing one; it puts educational resources where they do the most good for patients, and it signals a possible break in the tradition of basing licensure on structural factors such as educational achievement and test-taking ability.

the quality of care would be impaired if tasks were performed by people not meeting the criteria for licensure. Many studies on both the medical and dental professions have been done, all of which show that the quality of care would not suffer if licensure policies were selectively liberalized allowing mid-level practitioners to perform some tasks now reserved only for dentists or physicians. (Sox [1979] reviews the medical literature. For dentistry, see Abramowitz [1966] Abramowitz and Berg [1973]; Hammons and Jamison [1967, 1968, 1971]; Lotzkar, Johnson, and Thompson [1971]; Pelton et al. [1972, 1973]; Soricelli [1971]; and Dolan and Milgrom [1980].) Studies of dental mechanics (denturists) in Canada are indicative of the general thrust of most findings. Hammons and Jamison (1967) found that carefully selected high school graduates could be trained to do most basic dental procedures at a level of competence at least as great as that achieved by dental students in their final year of study. The possibility of paying lower prices (fees) to less intensively trained providers would improve access by more of the population, and thereby contribute positively to the population's general dental health status.

Ensuring Competence

Evidence of the efficacy of mechanisms used within the licensing process to control competence offers corroborating evidence that licensing practices do little to increase the quality of professional practice. For example, according to a survey of deans and professors of dentistry, 49 percent of the deans and 39 percent of the professors believed that licensing boards do not accurately assess the practice competence of applicants (American Dental Association 1972). The research points to several reasons for such findings. First, licensure criteria are heavily based on considerations other than practice performance, namely, on a test of student performance; that is, the standard for competence is the assimilation of the concepts and scientific content of the educational program. Performance in the treatment of clients is not part of the screening protocol, nor is performance subsequent to the initial credentialing an area of concern. At issue here is the "validity" of the test used to screen licensing applicants; the inadequacy of a test of the performance of a student as a predictor of practice performance (Williamson, Alexander, and Miller 1976).

This issue is actually only a glimpse at a larger problem, that of

developing a consistent set of interlocking relationships among curriculum content, credentialing, and subsequent practice performance. Within the federal government, studies are under way to identify the functional or task content of professional practices with the hope that both curricula and credentialing practices can ultimately be made more conformable with the actual practice requirements.

The efficacy of licensure practices to regulate competence is further undermined by a reluctance to enforce compliance in cases of identified incompetence. Medical boards in many states do not even specify incompetence as grounds for disciplinary action. In a study by the staff of the Senate Subcommittee on Health of the Committee on Labor and Public Welfare in 1976, it was noted that only 12 physicians in the entire nation lost licenses during 1975 because of incompetence or malfeasance. The reluctance of licensing bodies to impose sanctions gives rise to skepticism as to whether the licensing function provides any useful incentives for, or represents any effective control over, competence at all.

One contemporary licensing tool that is used to promote continuing or lifetime competence is mandatory continuing education. The use of continuing education is expanding, but without any hard evidence of its efficacy in promoting competence. In California alone, 40,000 physicians participated in continuing education activities in 1978 for a total of 9.6 million credit hours. In response to physician recognition award (PRA) standards used in many states for licensing, certification, or membership in medical societies, an estimated annual expenditure of \$3 billion is made; the expenses are, of course, eventually passed on to consumers, who reap an uncertain benefit in terms of quality. For example, states often allow courses in office management and estate planning, and Ohio gives credit for reading medical journals or appearing on television shows.

In studies of the effectiveness of continuing education activities, researchers conclude that courses without specific behavior-changing objectives are not useful. The objectives can be generally based (determined by the educators) or problem-specific (determined through identification of dissatisfactions with provider behavior). Early work by Peterson et al. (1956) demonstrated that, judging by observers' findings on the practitioner at work, education had no effect. In a statewide study of voluntary programs available to all Kansas physicians

for a period of 10 years (1956-1965), the investigators found that 7 percent of all MDs consumed half the continuing education credit awarded. More important, there was no relation between credits awarded in obstetric and pediatric courses and perinatal death rates (Lewis and Hassanein 1970). Recent graduates were, unfortunately, found to be higher users than the older physicians. In an earlier study of 41 Kansas physicians and 1,093 of their patients, the authors found no evidence of behavior change among those attending continuing education activities. They did find, however, that the more competent physicians were more likely to enroll in the courses (Roney and Roark 1967).

Kane and Bailey (1971) note in their study of an "objectiveless" course in early cancer detection that physicians were not encouraged to make sufficient use of Pap smears. They emphasize that, had the course focused specifically on getting physicians to do more of these screening tests, results might have improved. Inui, Yourtee, and Williamson (1976), in an evaluation of a very focused continuing education situation (designed to increase patient compliance with physician orders about hypertension), found favorable responses of the physicians and of their patients. However, in a recent random study covering problems confronted in a general practice (Sibley et al. 1982), no overall impact of the educational program was observed on quality of patient care. The educational program did have favorable effects on the subset of issues that were *not* preferred study areas by the participating physicians. The investigators conclude that mandatory programs of continuing education that allow MDs to choose their areas of study are both burdensome and fruitless.

In dentistry, a study to teach four-handed dentistry was shown to be quite successful in altering specific behaviors; in fact, the authors noted on poststudy site visits a tendency on the part of dentists to "modify" course concepts to "fit" their practice (Chambers et al. 1976). Work by Condon (1971, 1972) shows that objective-oriented, specially designed in-service training programs altered the behavior of nurses. In a thoughtful review of the issues in continuing education, Dixon (1977) notes that useful courses must not only focus on specific objectives to alter behaviors but must also use carefully selected behavior-modifying objectives. Suitable objectives are those that are either patient outcomes or are known to be related to patient outcomes.

The tendencies we note from these studies are that the "best"

Shana Denise Hermann

ALASKA CHAPTER
NATIONAL ASSOCIATION OF SOCIAL WORKERS
P. O. Box 10430
Fairbanks, Alaska 99710
457-5914

TESTIMONY ON HB 317: A BILL TO LICENSE SOCIAL WORKERS

The Alaska Chapter of the National Association of Social Workers supports HB 317, a bill to license social workers.

HB 317 would license only those social workers practicing under the title of "social worker" in order to help the public to identify qualified social work practitioners. The bill establishes the requirements for licensure of a bachelor, master or independent social worker including education required, references, examination, and meeting regulations of the Board. The bill would license by credentials social workers who are licensed in other states provided they meet the other requirements under Sec. 08.87.120. The bill would also "grandparent" persons who do not have a degree in social work from an accredited social work program or persons who hold a bachelor's or masters in a related field, and who have been practicing under the title of "social worker" for at least twenty-four consecutive months prior to July 1, 1987. The bill would create a Board of Social Work Examiners consisting of five members, including three master social workers one of whom is engaged in private practice, one bachelor social worker and one public member.

Social workers need to be licensed because their actions have significant impact on the mental health, safety, and economic well-being of their clients. This legislature has recognized that services to the chronically mentally ill and to physically and sexually abused children is inadequate. Licensing of social workers will improve the delivery of these services by requiring social work practitioners to meet nationally-recognized educational standards, to pass an examination, and to abide by a strict code of ethics governing the worker-client relationship.

We estimate that between 315-350 Alaskan social workers in all practice settings will be subject to this Act if it is passed. Nearly two-thirds work in private practice or in settings such as mental health clinics, family treatment agencies, hospitals, nursing homes, and institutions for the developmentally disabled and mentally ill. Approximately one-third work for the Division of Family and Youth Services which provides mandated child protection services. Nationwide, social workers deliver more than 50% of mental health services, and they are particularly a vital provider of these services in rural areas where psychiatrists are not available. Thirty-nine states have passed laws regulating social work practice including Montana, North Dakota, Oregon, and Idaho. Sufficient fees will be generated if this bill is passed to pay for the costs of a Board of Social Work Examiners, including travel and per diem. We urge you to pass HB 317 and become the 40th state to regulate social work practice.



Employee Benefits Division

4300 'B' Street, Suite 205

Anchorage, Alaska 99503

561-0011

July 3, 1984

Employee Assistance Consultants of Alaska

341 West Tudor

Anchorage, Alaska 99503

Attention: Pat Mackey

Dear Ms. Mackey:

The following information should give you guidelines to follow in referring clients for treatment covered under the Aetna Group Health Plan for ARCO and Alyeska Pipeline Service Company.

ARCO

Covers charges by a licensed or certified psychologist for services performed within the scope of his/her license or certification.

Covers the services of licensed social workers under the direct supervision of a medical doctor, psychiatrist or licensed or certified psychologist.

Since Alaska does not license their social workers, Aetna will cover charges for services of psychiatric social workers (MSW/ACSW) when:

The social worker is employed by a clinic, hospital, or psychiatrist (M.D.) and the services are billed for by the employer.

ALYESKA PIPELINE

Covers charges made by a psychologist

Through an administrative liberalization covers services of a MSW working in the office of a licensed psychologist or psychiatrist with periodic intervention (1 visit per month/every 4th visit) of a licensed provider.

No physician (M.D.) referral is needed if referred through the Employee Assistance program.

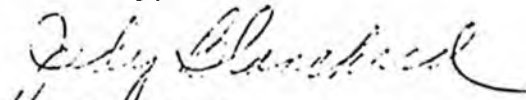
UNDER BOTH PLANS

Claims will be considered based on the diagnosis, nature of the service and whether the service is required for diagnosis or treatment of a mental/nervous disorder which is covered under the plan.

Benefits are payable at 50% of reasonable and customary fees for outpatient treatment subject to each plan's calendar year deductible. Alyeska has a \$2,000.00 calendar year maximum per person. ARCO has no calendar year maximum.

I hope this helps in your referral service for the employees of the respective companies. Should you have any further questions, please feel free to contact me.

Sincerely,



Judy Blanchard
Quality Coordinator
Employee Benefits Division - Claim Dept.
Aetna Life and Casualty

jwl

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January 18, 1985

Trustees of Alaska Human
Services Network

Dear Trustees:

Cost Containment
Travelers Insurance Company

We have contacted The Travelers regarding benefit alternatives and cost containment measures that could be incorporated into the Alaska Human Services Network Plan. The following are the Cost Containment features offered by Travelers:

1. Incentive Second Surgical Opinion - When an insured individual has received a recommendation to have surgery, the reasonable charge for a second consultation with a Board Certified surgeon will be paid. The benefit includes the examination and necessary laboratory and x-ray procedures ordered by the consulting surgeon. Also, certain specified procedures will be paid at 100 percent if a Second Surgical Opinion is obtained.
2. Convalescent Facility Care - Charges made by a Convalescent Facility will be covered for 120 days of confinement for semi-private room and board plus medical services and supplies. The covered charge will not exceed 50 percent of the semi-private rate of the hospital from which the insured individual was discharged. Convalescent Care must be prescribed by a physician and must commence within 14 days following termination of a minimum three (3) day hospital confinement.

JAN 24 1985

Trustees of Alaska Human
Services Network
January 18, 1985
Page two

3. Home Health Care - The following medically necessary services and supplies furnished to an insured individual by a Home Health Care agency in the insured's home will be covered:

- a. Part-time or intermittent nursing care provided by or under the supervision of a registered graduate nurse (R.N.);
- b. Part-time or intermittent home health aide services which consist primarily of caring for the patient; and
- c. Physical therapy, occupational therapy, and speech therapy provided by the Home Health Care Agency.

A maximum of 40 visits in any calendar year will be covered. Home Health Care must be prescribed by a physician and must commence within 14 days following termination of a minimum three day hospital confinement.

4. Hospice Care - Benefits are paid for the following:

- a. Room and Board charged by the Hospice.
- b. Other services and supplies.
- c. Part-time nursing care by or under the supervision of a registered graduate nurse (R.N.).
- d. Home Health Care Services as described in number three (3) above without limiting the number of visits or requiring prior hospital confinement.
- e. Counseling services by a licensed social worker or a licensed pastoral counselor for the patient and the patient's immediate family.
- f. Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family.
 - (1) The bereavement services must be furnished within 6 months after the patient's death.
 - (2) Payment will be limited to 50 percent of the charges for the services and not more than a total of 15 visits per family.

Trustees of Alaska Human
Services Network
January 18, 1985
Page three

Services to the patient must be furnished in an inpatient hospice facility or in the patient's home. The physician must have certified:

- a. The patient is terminally ill.
- b. The patient's life expectancy is 6 months or less.

The term "patient's immediate family" is limited to the patient's wife or husband and dependent children who are covered under this benefit. Counseling services received in connection with a terminal illness as described in items e. and f. above will not be considered to have been received due to a mental or nervous disorder. The following charges will not be covered expenses:

- a. Services of a social worker other than a clinical social worker or those described under Hospice Care services;
 - b. Hospice care services by volunteers or individuals who do not regularly charge for their services; and
 - c. Hospice care services by a licensed pastoral counselor to a member of his or her congregation. These are the services in the course of duties to which he or she is called as a pastor or minister.
5. Outpatient Surgery at 100 percent - Surgical procedures done on an outpatient basis will be reimbursed at 100 percent. Surgical procedures done as a hospital inpatient would be reimbursed according to regular plan benefits.
 6. Ambulatory Surgical Center - When a surgical procedure is performed in an Ambulatory Surgical Center, payment will be made for services and supplies furnished by the center. Related charges are also payable within 72 hours after the surgery, and within 7 days prior to the surgery for diagnostic tests.
 7. One routine pap smear each calendar year as an allowable expense.
 8. Pre-admission Testing - The reasonable charge will be paid for pre-surgical laboratory tests performed on an insured individual prior to confinement provided:
 - a. The tests are related to scheduled surgery;
 - b. The tests have been ordered by a physician after the need for surgery has been confirmed; and

Trustees of Alaska Human
Services Network
January 18, 1985
Page four

- c. The insured individual is subsequently admitted to the hospital unless confinement is cancelled or postponed because a hospital bed is unavailable or because there is a change in health conditions which precludes surgery.
9. Nonemergency use of emergency room (outpatient care in a hospital) - Specific limits could be incorporated into the plan which restrict the use of the outpatient emergency room facilities on a nonemergency basis such as during the day when the doctor's offices and clinics are normally open. These limits could include:
 - a. Reduced coinsurance payment such as 50 percent instead of 80 percent; and/or
 - b. Additional deductible amount applied to these expenses such as \$25 or \$50.

We have also been requested to obtain information from The Travelers to change the existing Dental and Vision benefits. Travelers proposes the following changes in the dental plan:

1. Alternative I:

- a. Elimination of the deductible for preventive services and increase the reimbursement rate for these expenses from 80 percent to 100 percent.
- b. \$50 deductible for general dentistry and prosthetics. The reimbursement rate for general dentistry being 80 percent and for prosthetic services being 50 percent. *on Ho?*
- c. The maximum benefit remaining at \$2,000 per calendar year.

2. Alternative II:

- a. \$150 deductible per insured on all services combined with the medical deductible. \$450 maximum deductible per family.
- b. Reimbursement of preventive services at 100 percent, general dentistry at 85 percent, and prosthetic services at 50 percent.
- c. \$2,000 calendar year maximum.

Trustees of Alaska Human
Services Network
January 18, 1985
Page five

3. Alternative III:
 - a. No deductible on preventive services, reimbursement at 100 percent.
 - b. \$150 deductible per insured on general and prosthetic services with reimbursement on general services at 80 percent and on prosthetic services at 50 percent.
 - c. \$2,000 calendar year maximum.

Travelers proposes the following increase in the Vision benefits:

1. Examination to \$ 55
2. Lenses (pair)
 - Single vision to \$ 45
 - Bifocal to \$ 75
 - Trifocal to \$ 90
 - Lenticular to \$135
3. Frames to \$ 35
4. Contact lenses
 - Medically necessary to \$270
 - All other contacts to \$ 80

Enclosed is Exhibit I outlining the cost impact of the cost containment provisions and Dental and Vision Plan revisions. Please review these cost containment and proposed plan revisions. We will be prepared to further discuss them at the upcoming meeting.

Sincerely,



Robert W. Lucas, CLU
Vice President

RWL:bd
enclosure

EXHIBIT I

Alaska Human Services Network

Cost Containment & Benefit Revisions Costs

<u>Cost Containment Benefit/Revision</u>	<u>Cost (monthly)</u>	
	<u>Employee</u>	<u>Dependent</u>
1. Incentive Second Surgical Opinion	No Charge	No Charge
2. Convalescent Care	+\$.12	+\$.11
3. Home Health Care	+ .04	+ .03
4. Hospice Care	+ .09	+ .09
5. Outpatient Surgery at 100%	No Charge	No Charge
6. Ambulatory Surgical Center	No Charge	No Charge
7. Routine Pap	+ .48	+ .76
8. Pre-admission Testing	No Charge	No Charge
9. Nonemergency use of emergency room	No Charge	No Charge
<u>Dental Plan Revisions</u>		
Alternative I	+\$ 3.05	+\$ 6.01
Alternative II	+ .94	+ 1.59
Alternative III	+ 1.97	+ 4.43
<u>Vision Plan Revision</u>	+\$ 1.42	+\$ 2.37

Prepared by
Johnson & Higgins of Washington, Inc.
January 1985

Social Workers Gain Reimbursement Parity

Cuomo Signs New York Vendorship Law

ON JANUARY 1, a New York state law went into effect requiring that health insurance policies covering mental health care must reimburse beneficiaries for the services of qualified clinical social workers. Its enactment by Governor Mario M. Cuomo on December 18, 1984, was a victory for a coalition that included the NASW New York City and New York State chapters and the New York Society of Clinical Social Work Psychotherapists.

Under a 1977 state law, still in effect, clinicians with an MSW degree and three years of supervised practice experience are considered "optional" providers of mental health care, meaning that clients are reimbursed for so-

The new law makes MSWs with six years of supervised clinical experience "mandated" providers, meaning that they must be included, along with psychiatrists and psychologists, in any mental health care component of an insurance policy. "We're very pleased," says Carole O. Smith, the state chapter's legislative director.

cial work services if their employers request that those services be included in the mental health care component of their insurance policies.

The new law, however, makes MSWs with six years of supervised experience "mandated" providers, meaning that they must be included, along with psychiatrists and psychologists, in any mental health care component of an insurance policy. (Policies in New York do not have to include mental health care coverage.)

According to NASW member Carole O. Smith, the New York State Chapter's director of political action and legislation, the "optional" status granted under the 1977 law "was always a very vulnerable position. We are now firmly in place."

She says experience with the first law helped to allay the fears of some that coverage of clinical social work

services would result in a flooding of the mental health care market with social workers and would thus drive up insurance premiums. Less than 4,000 clinicians were approved for reimbursement privileges under the 1977 law.

Even so, when Smith met with the leadership of both houses of the state legislature about getting a mandated-provider proposal into the hopper, "it became clear that we would have to require more experience" in order to overcome objections from the business community and insurance companies.

It then took the coalition a year to reach consensus within its own ranks on what the new bill's experience requirement should be. Many wanted to maintain the three-year requirement of the 1977 law, but six years eventually became the agreed-upon compromise.

"The compromise was hard to swallow for many of us," she says. "But once that agreement was reached among the coalition members, then we went in with a very strong position."

The coalition worked with the bill's sponsors and interested groups to draft legislation that would "still protect us as much as possible." Smith says the coalition "would not compromise" on the issue of social workers' autonomy and refused to include any requirement that qualified clinicians must practice under the supervision of psychiatrists.

The bill was introduced in early 1984 and, as expected, met with strong opposition from business groups and insurers, as well as from psychiatrists who took the position that social workers are not qualified to diagnose mental conditions.

But Smith notes that "the psychologists were very supportive of us. A lot of people don't understand that. They really were adamant supporters of us, and we needed their support."

Backed by "very strong grass-roots lobbying," the bill passed both houses of the legislature last June. But opponents continued to fight it while it awaited Governor Cuomo's signature, which Smith says reflects "the controversy that went right to the executive chamber." In December, however, the governor signed the bill.

The next step is the drafting of regulations that will implement the new law. According to Smith, the coalition is offering its recommendations to the State Board for Social Work, and "our help has been welcomed." Final regulations must be approved by the New York Board of Regents.

She says the regulations will be "significant" in defining "exactly what the six years of experience means" in the law. She expects that the regs will be "in place probably by early summer."

Overall, despite the compromise along the way, says Smith, "we're very pleased." □

The New York bill was introduced in early 1984 and, as expected, met with strong opposition from business groups and insurers, as well as from psychiatrists who took the position that social workers are not qualified to diagnose mental conditions. But psychologists, the NASW chapter says, "were very supportive of us. A lot of people don't understand that. And we needed their support."

Excellence . . .

(From previous page)

be established. School nutrition programs should be expanded, as should the federal Head Start and Chapter 1 programs for disadvantaged youth.

• ***Develop and Implement Strategies for Overcoming Student Barriers to Excellence.*** To overcome students' low self-esteem, as well as truancy and other behavior problems, opportunities should be provided for them to render community service and to excel in specific areas of interest. Parents and others should be encouraged to serve as volunteers in schools, and orientation programs should be provided to help students make transitions from grade school to junior high, from junior high to high school.

• ***Develop and Implement Strategies for Overcoming School Barriers to Success.*** Schools should focus "on people as well as academics." Conduct codes and noncorporal discipline procedures should be developed. Students' human and social needs should be annually reviewed, just as academic performance is, and actions should be taken to meet those needs. Special programs should be provided to "at risk" groups, such as programs on suicide prevention and substance-abuse prevention. In-service workshops on the roles of various school staff should be held to promote greater cooperation. College-level students of education should receive basic training about the impact of human and social needs on learning ability.

• ***Develop and Implement Strategies to Overcome Community, Policy, Legislative and Funding Barriers to Excellence.*** Cooperative programs between schools and the business community should be encouraged, such as a business "adopting a school" and providing increased educational opportunities for students. Federal support for education should be increased, and state and federal funding of public schools should be equitable throughout the country. A combination of special education and general education funding should support pupil services positions.

Copies of "The Human Factor: A Key to Excellence in Education" are available at \$4.50 each (including postage and handling) from NASW Publications Sales, 7081 Eastern Avenue, Silver Spring, MD 20910. □

Social Workers in Ohio Named EAP Providers

ACSW Set as Vendorship Standard

OHIO NASW members who belong to the Academy of Certified Social Workers (ACSW) have been accepted as reimbursable service providers by Ohio's new employee assistance program for state workers, about 57,000, and their dependents. The program will provide mental health and substance abuse counseling services.

According to Ohio Chapter Executive Director Antoinette Shimer, 2,205 ACSW members had filed their Social Security or tax identification numbers with Blue Cross of Central Ohio, the program's insurance carrier, by mid-January. Both ACSWs in private practice and those employed by agencies are eligible to participate.

The chapter will revise the list of Ohio ACSWs twice a year following the biannual administration of the Academy's certification process.

Since the enactment of Ohio's social work licensure law last year, participating practitioners must hold a state license in addition to ACSW certification, but Shimer says the state was willing to accept ACSWs as reimbursable providers even before licensure took effect.

Under the employee assistance program, the state is divided into 30 service areas, with one "community service center" in each area. The service centers, which are facilities that employ at least one ACSW member, will handle the initial assessment of cases and will

refer them to private practitioners or appropriate agencies.

Ohio ACSWs interested in participating in the program must call the service center nearest them to be put on the referral list and must provide the requisite Social Security or tax identification information to Blue Cross. A list of service centers is available from the NASW chapter office.

When the employee assistance program was in the planning stages, Shimer says, the state contacted her for information about social workers' fees. At the time, the chapter's Professional Standards Committee was conducting a survey of ACSW members to determine how many were in private practice, what they charged, and so forth.

The committee found that the social workers charged no more, and often less, than psychiatrists and psychologists, a fact that attracted the state's interest. The chapter suggested that ACSW certification be used as a qualification for participating social work service providers, and the state agreed.

Shimer says that when the insurance contract for the program is renegotiated in the future, a further qualification — listing in the *NASW Register of Clinical Social Workers* — may be added.

She calls the recognition of ACSWs in Ohio "exciting, because it shows that we've been accepted. It sets a precedent, so we're extremely pleased by it." □

*
* DELIVER TO: JPOM *
*
* ORIGINAL *
* SENT: 04/08/85 TIME: 15:38 *
* FROM: LANA TRUJILLO *
* SUBJECT: POM *
* PRINT DATE: 04/08/85 TIME: 15:38 *
*

13

TO: HOUSE LABOR AND COMMERCE

REP. NAVARRE, DAVIS, BOUCHER, KOPONEN, PEARCE, COLLINS AND HANLEY

SENATE HESS

SEN. FAHRENKAMP, STURGULEWSKI, F. FISCHER, DEVRIES AND JOSEPHSON

FROM: ROBERT NIELSEN, 4938 MILLS DR., ANCHORAGE, 99508, 333-1481(HM), 274-6524(WK)

RE: SB 227 AND HB 317, SOCIAL WORK LICENSURE

SOCIAL WORK IS A PROFESSION THAT NEEDS TO BE LICENSED IN THAT THESE WORKERS RELATE TO PEOPLE IN MANY DIFFERENT CONFIDENTIAL WAYS. SOCIAL WORK IS A HUMAN SERVICE WHICH I SUPPORT AND URGE YOUR AFFIRMATIVE VOTE. THANK YOU.

*
* DELIVER TO: JFOM *
*
* ORIGINAL *
* SENT: 04/08/85 TIME: 15:42 *
* FROM: HARRY MANDREGAN *
* SUBJECT: POM *
* PRINT DATE: 04/08/85 TIME: 15:42 *
*

TO: SENATE HESS COMMITTEE, SENATORS FAHRENKAMP, STURGULEWSKI,
PAUL FISCHER, DEVRIES AND JOSEPHSON
HOUSE LABOR AND COMMERCE COMMITTEE, REPRESENTATIVES NAVARRE,
DAVIS, BOUCHER, KOPONEN, PEARCE, COLLINS AND HANLEY

FROM: MILLI ANDREINI
3524 STANFORD DRIVE
ANCHORAGE, ALASKA 99508
HOME NO.: 274-8706
WORK NO.: 276-4994

RE: SOCIAL WORK LICENSING

I URGE YOUR SUPPORT OF HB 317 AND SB 227 TO LICENSE SOCIAL WORKERS. SOCIAL WORKERS PROVIDE A RANGE OF SERVICES WHICH AFFECT PEOPLES LIVES. YET, THEY ARE NOT REGULATED BY LICENSURE. INSURE COMPETENT SOCIAL WORK IN ALASKA. PLEASE SUPPORT THIS NEEDED LEGISLATION.

*
* DELIVER TO: JFOM *
*
* ORIGINAL *
* SENT: 04/08/85 TIME: 13:05 *
* FROM: MICKI HENSON *
* SUBJECT: POM *
* PRINT DATE: 04/08/85 TIME: 13:05 *
*

TO: SENATE H.E.S.S.

SENATORS FAHRENKAMP, STURGULEWSKI, P. FISCHER, DEVRIES,
JOSEPHSON

HOUSE LABOR AND COMMERCE

REPRESENTATIVES NAVARRE, DAVIS, BOUCHER, KOPONEN, PEARCE,
COLLINS, HANLEY

FROM: DIANE SCHANDER
9221 KAVTK STREET
ANCHORAGE, AK. 99515 PHONE: 243-5597 HM.

RE: SB 277/HB 317- SOCIAL WORK LICENSING

I URGE PASSAGE OF SB 277/HB 317. IN MY CASE INSURANCE COVERAGE
IS NON-EXISTENT WITHOUT LICENSING.

*
* DELIVER TO: JPOH *
*
* ORIGINAL *
* SENT: 04/08/85 TIME: 12:47 *
* FROM: LANA TRUJILLO *
* SUBJECT: POM *
* PRINT DATE: 04/08/85 TIME: 12:47 *
*

TO: SENATE HESS

SEN. FAHRENKAMP, STURGILEWSKI, P. FISCHER, DEVRIES AND JOSEPHSON

HOUSE LABOR AND COMMERCE

REP. NAVARRE, DAVIS, BOUCHER, KOPONEN, PEARCE, COLLINS AND HANLEY

FROM: NICKI J. NIELSEN, 4938 MILLS DR., ANCHORAGE, 99508, 333-1481(HM), 561-1361(WK)

RE: SB 227 AND HB 317, SOCIAL WORK LICENSURE

PLEASE SUPPORT THE SOCIAL WORK LICENSURE BILLS. SOCIAL WORK LICENSURE IS IMPORTANT SO QUALIFIED PEOPLE WILL BE HELPING PERSONS WHO NEED THE IMPORTANT SERVICES THAT SOCIAL WORKERS PROVIDE. THANK YOU VERY MUCH FOR YOUR SUPPORT OF THESE BILLS.

*
* DELIVER TO: JFOM *
* *
* ORIGINAL *
* SENT: 04/08/85 TIME: 15:20 *
* FROM: MARTIE ROZKYDAL *
* SUBJECT: POM - MATR-0201 *
* PRINT DATE: 04/08/85 TIME: 15:21 *
* *

TO: REPRESENTATIVES NAVARRE, DAVIS, BOUCHER, COLLINS, HANLEY,
KOPONEN AND PEARCE

FROM: LESLIE BOGDA
PO BOX 264
PALMER 99545
DAYTIME PHONE 376-4080

I AM IN SUPPORT OF HB 317/LICENSING OF SOCIAL WORKERS. I
HAVE A BACHELOR'S DEGREE IN SOCIAL WORK FROM THE UNIVERSITY OF
ALASKA.

*
* DELIVER TO: JPOM *
*
* ORIGINAL *
* SENT: 04/08/85 TIME: 11:40 *
* FROM: LANA TRUJILLO *
* SUBJECT: POM *
* PRINT DATE: 04/08/85 TIME: 11:40 *
*

TO: REP. NAVARRE, DAVIS, BOUCHER, KOPONEN, PEARCE, COLLINS,
HANLEY

FROM: MARY LEE NICHOLSON, P.O. BOX 771052, EAGLE RIVER, 99577,
694-2377(HM)

RE: HB 317, LICENSING SOCIAL WORKERS

TO ENSURE THOUGHTFUL APPLICATION OF KNOWLEDGE, SKILLS AND HUMAN
VALUES TO ALASKA'S TOUGH SOCIAL PROBLEMS I URGE YOUR SUPPORT OF
HB 317, SOCIAL WORK LICENSING.

INTRODUCTION OF BILLS (House)(cont'd)

HB 316 (cont'd)

of the public to use and have free access to the navigable or public water of the state."

Provides Act takes effect immediately.

Introduced March 25 and referred to Resources, Finance.

Professional Licensing of Social Workers HOUSE BILL NO. 317, by Reps. Koponen, Larson, Hurley, Goll, Gruenberg, Davis & Pignalberi. Identical to Senate Bill 227, page 426.

Introduced March 25 and referred to Labor & Commerce, Health, Education & Social Services, Finance.

Injured State Employees (rights of)

HOUSE BILL NO. 318, by Rep. Szymanski. Amends the State Personnel Act (AS 39.25) by adding new sections that would require the Director of Personnel, in consultation with the appropriate departments or agencies, to prepare and maintain a position description for each position in the classified and partially exempt services that will describe the essential functions of the position and the actual skills and abilities required to perform the assigned task. A general requirement for physical abilities may not be imposed on a job classification unless each position within the class requires the use of physical ability.

Would require a state agency to offer an injured employee the employee's former position if the employee is able to perform the assigned tasks. If another employee has attained permanent status in that position, the agency is required, at the request of the injured employee, to offer the injured employee the position as soon as a vacancy occurs, or, immediately offer the injured employee a comparable position in the same agency.

If an employee can no longer perform all of the assigned tasks, the agency is required to rehire the employee after making a reasonable accommodation to the physical and mental limitations of the employee. Allows the agency to refuse to rehire if the accommodation imposes an undue hardship on the operation of the agency's program, or if, after reasonable efforts at accommodation, the employee cannot perform the essential functions in a manner that would not endanger the health and safety of the employee or to others to a greater extent than if a nonhandicapped person performed the job.

Outlines factors to be considered in determining undue hardship. If an agency is unable to rehire the employee, the employee may request preference for another position. The new section applies to all state employees who were injured on-the-job, and were laid off or terminated after the injury and have requested to return to work for the state. Does not provide effective date (takes effect 90 days after Governor signs bill).

Introduced March 25 and referred to Labor & Commerce, Finance.

INTRODUCTION OF BILLS (Senate)(cont'd)

SB 226 (cont'd)

a misdemeanor and upon conviction is punishable by a fine of between \$50 and \$200, plus the cost of prosecution, and may be imprisoned until the fine and costs are paid or until the convicted person has served one day for every \$2 of the fine and costs, at which time the fine and costs are automatically discharged.

Does not provide for an effective date (becomes law 90 days after signed).

Introduced March 12 and referred to HESS and Judiciary.

Professional
Licensing of
Social Workers

SENATE BILL NO. 227, by Sen. Josephson. Would require licensing of social workers and establish a Board of Social Examiners to oversee licensing procedures.

Establishes three categories of social workers: licensed bachelor social worker (LBSW); licensed master social worker (LMSW); and licensed independent social worker (LISW).

To be eligible for licensure as a bachelor social worker, a person must hold a bachelor's degree in social work from a school with a social work program accredited by the Council on Social Work Education, must be in good professional standing and be fit to practice, must pass a state exam, and must provide three references.

To be eligible for licensure as a master social worker, a person must meet all of the above qualifications; the person must have a master's instead of a bachelor's degree.

A person is eligible for licensure as an independent social worker if the person meets the qualifications for a master social worker and has completed at least 24 months of supervised post-graduate experience in the person's field of specialty.

Limits the practice of psychotherapy to licensed independent social workers who have a clinical specialty or master social workers who are employed in a clinical setting.

"Grandfathers" persons currently working as social workers if they hold a bachelor's or a master's degree in social work and have been practicing under the title "social worker" for at least 24 months before July 1, 1987. A person with a degree from a school with an accredited program could be licensed as a social worker without examination, if the person applies before July 1, 1987.

The Board of Social Worker Examiners, set to expire on June 30, 1989 unless continued by the Legislature, would consist of five members, including three master social workers, one of whom is an independent social worker, one bachelor social worker, and one public member who is not licensed as a social worker and does not work for one.

Includes provisions for board meetings, terms of office, removal

INTRODUCTION OF BILLS (Senate)(cont'd)

SB 227 (cont'd)

of members, per diem and travel expenses, and powers and duties of the board.

Outlines the scope of practice for the three classifications of social worker.

Licenses would be valid for two years.

Sets fees as follows: Application fee--\$100; Initial license by application--\$150; License by credentials--\$100; License renewal--\$200; Reexamination--\$150.

Prohibits use of the title "social worker" or any of the titles listed in the bill (LBSW, LMSW, or LISW) unless a person is licensed.

Prohibits a licensed social worker from disclosing information provided by a client in the course of their professional contact. Does not apply in certain circumstances.

Lists disciplinary sanctions that may be imposed against a licensed social worker and the grounds for imposing them.

Violation of the new laws requiring social workers to be licensed would be a class B misdemeanor.

Effective July 1, 1985.

Introduced March 12 and referred to Labor & Commerce, HESS and Finance.

Appropriation SENATE BILL NO. 228, by Sen. Fahrenkamp. Would appropriate
(special) \$6 million to the Dept. of Health & Social Services for
(Fairbanks purchase or construction of adult and children's mental health
mental Health facilities in Fairbanks. Does not lapse. Effective
facilities) immediately.

Introduced March 13 and referred to HESS and Finance.

Longevity SENATE BILL NO. 229, by Senators Vic Fischer and Roday.
Bonus Payments Amends eligibility requirements for the Alaska Longevity
(absence from Bonus to require recipients to notify the Commissioner of
state) Administration when they expect to be absent from the state for
a continuous period that exceeds 60 days. Presently they are
required to notify the Commissioner if they are gone for 30 days.
They are not eligible to receive the bonus during that time, and
must reapply upon returning to Alaska. Does not provide for an
effective date (become 90 days after signed).

Introduced March 13 and referred to State Affairs, Judiciary and Finance.



Employee Benefits Division

4300 "B" Street, Suite 205
Anchorage, Alaska 99503
561-0011
July 3, 1984

Employee Assistance Consultants of Alaska
341 West Tudor
Anchorage, Alaska 99503
Attention: Pat Mackey

Dear Ms. Mackey:

The following information should give you guidelines to follow in referring clients for treatment covered under the Aetna Group Health Plan for ARCO and Alyeska Pipeline Service Company.

ARCO

Covers charges by a licensed or certified psychologist for services performed within the scope of his/her license or certification.

Covers the services of licensed social workers under the direct supervision of a medical doctor, psychiatrist or licensed or certified psychologist.

Since Alaska does not license their social workers, Aetna will cover charges for services of psychiatric social workers (MSW/ACSW) when:

The social worker is employed by a clinic, hospital, or psychiatrist (M.D.) and the services are billed for by the employer.

ALYESKA PIPELINE

Covers charges made by a psychologist

Through an administrative liberalization covers services of a MSW working in the office of a licensed psychologist or psychiatrist with periodic intervention (1 visit per month/every 4th visit) of a licensed provider.

No physician (M.D.) referral is needed if referred through the Employee Assistance program.

Page 2

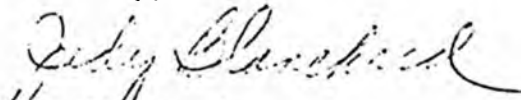
UNDER BOTH PLANS

Claims will be considered based on the diagnosis, nature of the service and whether the service is required for diagnosis or treatment of a mental/nervous disorder which is covered under the plan.

Benefits are payable at 50% of reasonable and customary fees for outpatient treatment subject to each plan's calendar year deductible. Alyeska has a \$2,000.00 calendar year maximum per person. ARCC has no calendar year maximum.

I hope this helps in your referral service for the employees of the respective companies. Should you have any further questions, please feel free to contact me.

Sincerely,



Judy Blanchard
Quality Coordinator
Employee Benefits Division - Claim Dept.
Aetna Life and Casualty

jwl

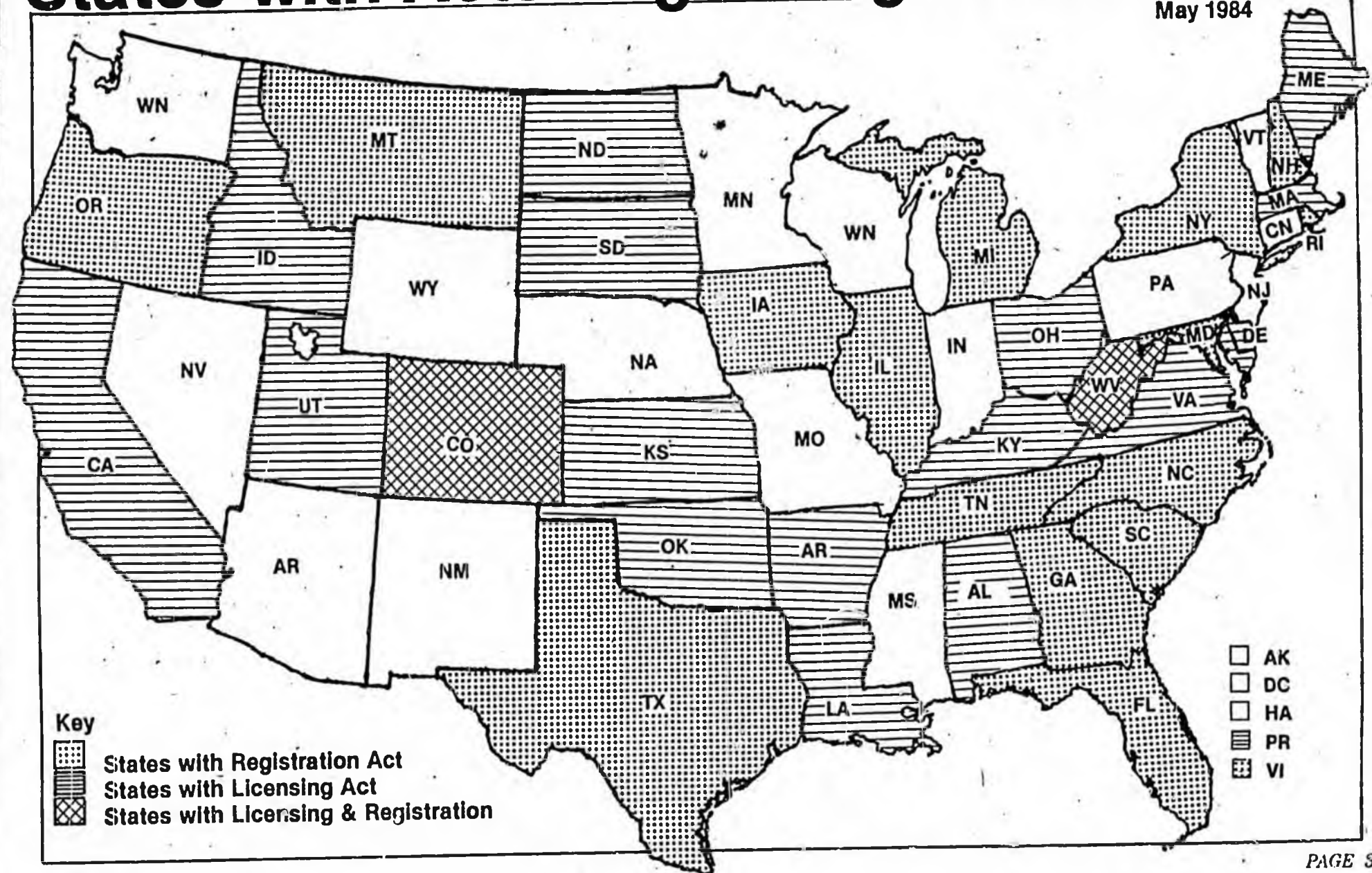
Protected titles include titles of "Social Worker" and "Graduate Social Worker." The highest level, "Certified Social

Worker" title that requires an advanced degree and two years of supervised post-

"Independent Social Worker," requiring 1

States with Acts Regulating Social Work

May 1984



Atlanta
Birmingham
Boston
Charlotte
Chicago
Cleveland
Dallas
Denver
Detroit
Hartford
Honolulu
Houston
Los Angeles
Miami
Minneapolis
New Orleans
New York
Philadelphia
Phoenix
Pittsburgh
Portland
Richmond
St. Louis
San Diego
San Francisco
Seattle
Wilmington
Calgary
Edmonton
Montreal
Quebec
Toronto
Vancouver
Winnipeg

JOHNSON & HIGGINS

OF WASHINGTON, INC.

Business Established New York 1845

INSURANCE BROKERS-AVERAGE ADJUSTERS
ACTUARIES-EMPLOYEE BENEFIT PLAN CONSULTANTS

*Ind 5
9:30 am
OK Cancel in
ad. ch. r.*

Buenos Aires
Adeleide
Brisbane
Hobart
Melbourne
Perth
Sydney
Belem Para
Belo Horizonte
Campinas
Curtiba
Porto Alegre
Rio de Janeiro
Salvador
Sao Paulo
Santiago
Bogota
Cali
London
Paris
Tehran
Milan
Rome
Padua
Tokyo
Auckland
Christchurch
Wellington
Lima
Hong Kong
Singapore
Taipei
Caracas
Maracaibo
Puerto La Cruz

CABLE ADDRESS "KERODEN"

1215 FOURTH AVE., SEATTLE, WA. 98161
TEL. (206) 292-1900

January 18, 1985

Trustees of Alaska Human
Services Network

Dear Trustees:

Cost Containment
Travelers Insurance Company

We have contacted The Travelers regarding benefit alternatives and cost containment measures that could be incorporated into the Alaska Human Services Network Plan. The following are the Cost Containment features offered by Travelers:

1. Incentive Second Surgical Opinion - When an insured individual has received a recommendation to have surgery, the reasonable charge for a second consultation with a Board Certified surgeon will be paid. The benefit includes the examination and necessary laboratory and x-ray procedures ordered by the consulting surgeon. Also, certain specified procedures will be paid at 100 percent if a Second Surgical Opinion is obtained.
2. Convalescent Facility Care - Charges made by a Convalescent Facility will be covered for 120 days of confinement for semi-private room and board plus medical services and supplies. The covered charge will not exceed 50 percent of the semi-private rate of the hospital from which the insured individual was discharged. Convalescent Care must be prescribed by a physician and must commence within 14 days following termination of a minimum three (3) day hospital confinement.

JAN 24 1985

Trustees of Alaska Human
Services Network
January 18, 1985
Page two

3. Home Health Care - The following medically necessary services and supplies furnished to an insured individual by a Home Health Care agency in the insured's home will be covered:
 - a. Part-time or intermittent nursing care provided by or under the supervision of a registered graduate nurse (R.N.);
 - b. Part-time or intermittent home health aide services which consist primarily of caring for the patient; and
 - c. Physical therapy, occupational therapy, and speech therapy provided by the Home Health Care Agency.

A maximum of 40 visits in any calendar year will be covered. Home Health Care must be prescribed by a physician and must commence within 14 days following termination of a minimum three day hospital confinement.

4. Hospice Care - Benefits are paid for the following:
 - a. Room and Board charged by the Hospice.
 - b. Other services and supplies.
 - c. Part-time nursing care by or under the supervision of a registered graduate nurse (R.N.).
 - d. Home Health Care Services as described in number three (3) above without limiting the number of visits or requiring prior hospital confinement.
 - e. Counseling services by a licensed social worker or a licensed pastoral counselor for the patient and the patient's immediate family.
 - f. Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family.
 - (1) The bereavement services must be furnished within 6 months after the patient's death.
 - (2) Payment will be limited to 50 percent of the charges for the services and not more than a total of 15 visits per family.

Trustees of Alaska Human
Services Network
January 18, 1985
Page three

Services to the patient must be furnished in an inpatient hospice facility or in the patient's home. The physician must have certified:

- a. The patient is terminally ill.
- b. The patient's life expectancy is 6 months or less.

The term "patient's immediate family" is limited to the patient's wife or husband and dependent children who are covered under this benefit. Counseling services received in connection with a terminal illness as described in items e. and f. above will not be considered to have been received due to a mental or nervous disorder. The following charges will not be covered expenses:

- a. Services of a social worker other than a clinical social worker or those described under Hospice Care services;
 - b. Hospice care services by volunteers or individuals who do not regularly charge for their services; and
 - c. Hospice care services by a licensed pastoral counselor to a member of his or her congregation. These are the services in the course of duties to which he or she is called as a pastor or minister.
5. Outpatient Surgery at 100 percent - Surgical procedures done on an outpatient basis will be reimbursed at 100 percent. Surgical procedures done as a hospital inpatient would be reimbursed according to regular plan benefits.
 6. Ambulatory Surgical Center - When a surgical procedure is performed in an Ambulatory Surgical Center, payment will be made for services and supplies furnished by the center. Related charges are also payable within 72 hours after the surgery, and within 7 days prior to the surgery for diagnostic tests.
 7. One routine pap smear each calendar year as an allowable expense.
 8. Pre-admission Testing - The reasonable charge will be paid for pre-surgical laboratory tests performed on an insured individual prior to confinement provided:
 - a. The tests are related to scheduled surgery;
 - b. The tests have been ordered by a physician after the need for surgery has been confirmed; and

Trustees of Alaska Human
Services Network
January 18, 1985
Page four

- c. The insured individual is subsequently admitted to the hospital unless confinement is cancelled or postponed because a hospital bed is unavailable or because there is a change in health conditions which precludes surgery.
9. Nonemergency use of emergency room (outpatient care in a hospital) - Specific limits could be incorporated into the plan which restrict the use of the outpatient emergency room facilities on a nonemergency basis such as during the day when the doctor's offices and clinics are normally open. These limits could include:
 - a. Reduced coinsurance payment such as 50 percent instead of 80 percent; and/or
 - b. Additional deductible amount applied to these expenses such as \$25 or \$50.

We have also been requested to obtain information from The Travelers to change the existing Dental and Vision benefits. Travelers proposes the following changes in the dental plan:

1. Alternative I:

- a. Elimination of the deductible for preventive services and increase the reimbursement rate for these expenses from 80 percent to 100 percent.
- b. \$50 deductible for general dentistry and prosthetics. The reimbursement rate for general dentistry being 80 percent and for prosthetic services being 50 percent. *or the?*
- c. The maximum benefit remaining at \$2,000 per calendar year.

2. Alternative II:

- a. \$150 deductible per insured on all services combined with the medical deductible. \$450 maximum deductible per family.
- b. Reimbursement of preventive services at 100 percent, general dentistry at 85 percent, and prosthetic services at 50 percent.
- c. \$2,000 calendar year maximum.

Trustees of Alaska Human
Services Network
January 18, 1985
Page five

3. Alternative III:

- a. No deductible on preventive services, reimbursement at 100 percent.
- b. \$150 deductible per insured on general and prosthetic services with reimbursement on general services at 80 percent and on prosthetic services at 50 percent.
- c. \$2,000 calendar year maximum.

Travelers proposes the following increase in the Vision benefits:

- 1. Examination to \$ 55
- 2. Lenses (pair)
 - Single vision to \$ 45
 - Bifocal to \$ 75
 - Trifocal to \$ 90
 - Lenticular to \$135
- 3. Frames to \$ 35
- 4. Contact lenses
 - Medically necessary to \$270
 - All other contacts to \$ 80

Enclosed is Exhibit I outlining the cost impact of the cost containment provisions and Dental and Vision Plan revisions. Please review these cost containment and proposed plan revisions. We will be prepared to further discuss them at the upcoming meeting.

Sincerely,



Robert W. Lucas, CLU
Vice President

RWL:bd
enclosure

EXHIBIT I

Alaska Human Services Network

Cost Containment & Benefit Revisions Costs

<u>Cost Containment Benefit/Revision</u>	<u>Cost (monthly)</u>	
	<u>Employee</u>	<u>Dependent</u>
1. Incentive Second Surgical Opinion	No Charge	
2. Convalescent Care	+\$.12	+\$.11
3. Home Health Care	+ .04	+ .03
4. Hospice Care	+ .09	+ .09
5. Outpatient Surgery at 100%	No Charge	
6. Ambulatory Surgical Center	No Charge	
7. Routine Pap	+ .48	+ .76
8. Pre-admission Testing	No Charge	
9. Nonemergency use of emergency room	No Charge	
<u>Dental Plan Revisions</u>		
Alternative I	+\$ 3.05	+\$ 6.01
Alternative II	+ .94	+ 1.59
Alternative III	+ 1.97	+ 4.43
<u>Vision Plan Revision</u>	+\$ 1.42	+\$ 2.37

Prepared by
Johnson & Higgins of Washington, Inc.
January 1985

*
* DELIVER TO: JFOM *
*
* ORIGINAL *
* SENT: 03/29/85 TIME: 14:03 *
* FROM: MICKI HENSON *
* SUBJECT: POM *
* PRIN. DATE: 03/29/85 TIME: 14:04 *
*

12

TO: SENATE H.E.S.S COMMITTEE

SENATORS FAHRENKAMP, STURGULEWSKI, P. FISCHER, DEVRIES,
JOSEPHSON

HOUSE LABOR AND COMMERCE COMMITTEE

REPRESENTATIVES NAVARRE, DAVIS, BOUCHER, KOPONEN, PEARCE,
COLLINS, HANLEY

RE: HB 337 , SB 227- LICENSING OF SOCIAL WORKERS

I AM IN SUPPORT OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS
LICENSING BILL TO FULLY INSURE STANDARDS AND QUALITY OF SERVICE
TO EACH INDIVIDUAL

PLEASE NOTE THIS WAS SENT PREVIOUSLY WITH NO SENDER LISTED.

TO: SENATE H.E.S.S COMMITTEE

SENATORS FAHRENKAMP, STURGULEWSKI, P. FISCHER, DEVRIES,
JOSEPHSON

HOUSE LABOR AND COMMERCE COMMITTEE

REPRESENTATIVES NAVARRE, DAVIS, BOUCHER, KOPONEN, PEARCE,
COLLINS, HANLEY

FROM: DONNA STONE
PO BOX 110795
ANCHORAGE, AK. 99511 PHONE: 562-4792

RE: HB 337 , SB 227- LICENSING OF SOCIAL WORKERS

I AM IN SUPPORT OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS
LICENSING BILL TO FULLY INSURE STANDARDS AND QUALITY OF SERVICE
TO EACH INDIVIDUAL

*
* DELIVER TO: LIUJ
*
* ORIGINAL
* SENT 03/28/85 TIME: 14:34
* FROM: VERNITA VESTAL
* SUBJECT: POM
* PRINT DATE: 03/28/85 TIME: 14:35
*
*****8*****

TO: HOUSE LABOR AND COMMERCE COMMITTEE:
REPRESENTATIVES NAVARRE, DAVIS, BOUCHER,
KOPONEN, PEARCE, COLLINS, AND HANLEY

FROM: EILEEN LALLY
200 W 34TH, #427
ANCHORAGE, ALASKA 99503 (H) 274-1233

RE: HB 317-LICENSING SOCIAL WORKERS

I SUPPORT THAT BILL AS A SOCIAL WORKER AND I AM ASKING PLEASE GET
IT OUT OF HOUSE LABOR AND COMMERCE COMMITTEE AND TO A FULL HOUSE
HEARING THIS SESSION.

*
* DELIVER TO: JFOM
*
* ORIGINAL
* SENT: 04/05/85 TIME: 10:31
* FROM: HARRY HANDREGAN
* SUBJECT: POM
* PRINT DATE: 04/05/85 TIME: 10:31 13
*

TO: SENATE HESS COMMITTEE, SENATORS FAHRENKAMP, STURGULEWSKI, PAUL FISCHER, DEVRIES AND JOSEPHSON
HOUSE LABOR AND COMMERCE COMMITTEE, REPRESENTATIVES NAVARRE, DAVIS, BOUCHER, KOPONEN, PEARCE, COLLINS AND HARLEY

FROM: KEN TAYLOR
7330 CHRISTOPHER CIRCLE
ANCHORAGE, ALASKA 99507
HOME NO.: 344-9271
WORK NO.: 561-1633

RE: SB 227 - LICENSING SOCIAL WORKERS AND HB 317 - LICENSING SOCIAL WORKERS

I WOULD LIKE TO STATE MY SUPPORT THE SOCIAL WORK LICENSE BILL. PROFESSIONALS WHO HAVE DIRECT IMPACT ON THE LIVES OF OTHERS SHOULD BE GOVERNED AND SHOULD BE ACCOUNTABLE TO SOME LICENSED BOARD. LICENSING IS IMPERATIVE IN ANY PROFESSIONAL PRACTICE.

*
* DELIVER TO: JPOM *
*
* ORIGINAL *
* SENT: 04/04/85 TIME: 14:50 *
* FROM: LANA TRUJILLO *
* SUBJECT: POM *
* PRINT DATE: 04/04/85 TIME: 14:50 *
*

TO: HOUSE LABOR AND COMMERCE

REP. NAVARRE, DAVIS, BOUCHER, KOPONEN, PEARCE, COLLINS,
HANLEY

FROM: ELEANOR PATELLA, 3401 TURNAGAIN, #6, ANCHORAGE, 99503,
248-7475(HM), 786-1766(WK)

RE: HB 317, SOCIAL WORK LICENSING

I URGE YOUR SUPPORT FOR SOCIAL WORK LICENSING. LICENSING WILL
ESTABLISH A PROCESS FOR MONITORING ETHICAL PRACTICE AND ENSURING
MINIMAL TRAINING FOR SOCIAL WORK JOBS.