

ALASKA LEGISLATURE COMMITTEE FILES 1987-1988 8672

4610 HHS SB 37 - SB 67 (FILE 1)

STATE OF ALASKA  
1988 LEGISLATIVE SESSION

BILL VERSION: CS SB 37  
PUBLISH DATE: 5/4/87

FISCAL NOTE

REQUES.:

Revision Date: \_\_\_\_\_  
Title: "An Act relating to finger-  
printing of minors;"  
Sponsor: Fischer  
Requestor: Senate Judiciary

Agency Affected: Dept. of Administration  
BRU: Public Defender Agency  
Components: Third Judicial District

EXPENDITURES/REVENUES: (Thousands of Dollars)

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

CAPITAL						
---------	--	--	--	--	--	--

REVENUE						
---------	--	--	--	--	--	--

FUNDING: (Thousands of Dollars)

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

POSITIONS:

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

ANALYSIS : (Attach a separate page if necessary)

Prepared by: Dana Fabe, Public Defender Phone: 279-7541  
Division: Public Defender Agency Date: 1/25/88

Approved by Commissioner: John Andrews Date: 1/29/88  
Agency: Department of Administration

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



# CITY OF HOMER

## POLICE DEPARTMENT

4060 HEATH STREET

HOMER, AK., 99603-7609

(907) 235-8113

February 8, 1988

Representative Mike Navarre  
Ak State Legislature  
PO Box V  
Juneau, AK 99811

Re: Senate Bill 37  
Fingerprinting of Minors

Dear Rep. Navarre;

The proposed bill appears appropriate and, if adopted, should enhance our law enforcement operations. I do see a potential problem with inability to fingerprint minors arrested and held on adult status offenses, as the prints are necessary for positive identification in the event the conviction record is used in subsequent sentencing (such as DWI's, Fish and Game, and Parks offenses).

I would propose S.B. 37 be amended to include a new provision, 47.10.097(b)(3) to read:

(3) When the minor is arrested or held on an adult status offense pursuant to A.S. 47.10.010(b).

Without fingerprints, the State would be unable to bring in the prior conviction if the defendant challenged the identity issue successfully.

Sincerely,

*Michael L. Daugherty*  
Michael L. Daugherty  
Director of Public Safety

MLD/db

SB

42

STATE OF ALASKA  
THE LEGISLATURE

POUCH Y - STATE CAPITOL  
JUNEAU, ALASKA 99811  
907-465-3800

LEGISLATIVE AFFAIRS AGENCY  
LEGISLATIVE REFERENCE LIBRARY

May, 1988

Copies of minutes listed below were originally included in this file. The minutes are available on the STAIRS database CMPR. In order to save space copies of minutes have not been left in the files.

Mary Van Nimwegen

*House Hess:*

*April 18, 1988*

# HOUSE COMMITTEE REPORT

4/18

(7)

Date referred: 4/12/88

FURTHER REFERRALS:

Finance

DATE: 4-18-88

The Health, Education and Social Services Committee has considered CSSB 42(Fin)

"An Act relating to territorial service and BIA service under the retirement incentive program; and providing for an effective date."

**RECOMMENDS:**

- replace with \_\_\_\_\_  the same title
- attached amendment(s)  a new title
- do pass
- do not pass
- no recommendation
- individual recommendations
- additional referral to the \_\_\_\_\_ Committee

**ADOPTS:**  \_\_\_\_\_ letter of intent

**ATTACHES NEW FISCAL NOTE(S):**

- fiscal impact  same as previous fiscal note published 3/16/88
- zero fiscal note  same as previous zero fiscal note published \_\_\_\_\_
- zero with analysis

**SIGNING DO PASS:**

*[Handwritten signatures]*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SIGNING OTHER RECOMMENDATIONS:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*[Handwritten signature]*  
Chairman's signature

*[Handwritten signature]*

FISCAL NOTE

REQUEST:

Revision Date: \_\_\_\_\_ Agency Affected: Department of Administration  
 Title: An act relating to the Retirement Incentive Program BRU: Retirement and Benefits  
 Sponsor: Duncan Components: Retirement and Benefits  
 Requestor: Duncan

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
PERSONAL SERVICES	3.0	6.0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	3.0	6.0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	3.0	6.0	0	0	0	0
TOTAL	3.0	6.0	0	0	0	0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	1	1	0	0	0	0

ANALYSIS: (Attach a separate page if necessary)

See attached

Prepared By: Robert F. Stalnaker, Acting Director  
 Division: Retirement and Benefits

Phone: 465-4460  
 Date: 3-16-88

Approved by Commissioner: John M. Andrews  
 Agency: Department of Administration

Date: \_\_\_\_\_

Distribution (by preparer):

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



# Alaska State Legislature

SENATOR JIM DUNCAN

P. O. Box V JUNEAU, ALASKA 99811

(907) 465-4766

COMMITTEES:  
FINANCE  
RESOURCES  
BUDGET AND AUDIT

MARCH 22, 1988

TO: REPRESENTATIVE FRAN ULMER, CHAIR  
HOUSE STATE AFFAIRS COMMITTEE

FROM: SENATOR JIM DUNCAN

SUBJECT: CS SENATE BILL 42 (FINANCE), AN ACT RELATING TO  
TERRITORIAL SERVICE AND BIA SERVICE UNDER THE  
RETIREMENT INCENTIVE PROGRAM.

CS SENATE BILL 42 (FINANCE), RELATING TO TERRITORIAL SERVICE AND BIA SERVICE UNDER THE RETIREMENT INCENTIVE PROGRAM IS CURRENTLY BEFORE THE HOUSE STATE AFFAIRS COMMITTEE.

THE CURRENT VERSION OF THE BILL WOULD REMEDY AN INEQUITABLE SITUATION WHICH AROSE AS THE RESULT OF THE ORIGINAL RETIREMENT INCENTIVE PROGRAM. A HANDFUL OF TEACHERS WHO HAD SERVICE TIME WITH THE BUREAU OF INDIAN AFFAIRS AS TEACHERS IN ALASKA WERE NOT ELIGIBLE TO PARTICIPATE IN THE INCENTIVE BECAUSE OF AN AMENDMENT TO THE ORIGINAL LEGISLATION WHICH EXCLUDED THE USE OF BIA SERVICE CREDIT FOR THE PURPOSES OF QUALIFYING FOR THE INCENTIVE. SO, EVEN THOUGH THESE TEACHERS TAUGHT IN ALASKAN SCHOOLS WHICH WERE OPERATED BY THE BIA UNTIL THE EARLY 1970'S, THEY DID NOT QUALIFY TO PARTICIPATE IN THE INCENTIVE.

THE FINANCE CS FOR SB 42 WOULD OPEN A SHORT WINDOW PERIOD BETWEEN ENACTMENT OF THE BILL AND AUGUST 1, 1988, EXCLUSIVELY FOR THE TEACHERS DISCUSSED ABOVE.

I WOULD APPRECIATE YOUR SCHEDULING CS SB 42 (FINANCE) FOR A STATE AFFAIRS HEARING AS SOON AS POSSIBLE. I HAVE ATTACHED BACKGROUND INFORMATION FOR YOUR USE. MY STAFF CONTACT ON THIS BILL IS ROXANNE STEWART AT 465-4766.

ATTACHMENTS

RECEIVED JAN 29 1988

Box 246  
Barrow, Alaska 99723  
January 15, 1988

Alaska State Legislature  
Senator Jim Duncan  
P. O. Box V  
Juneau, Alaska 99811

Dear Senator Duncan.

First, I wanted to express our appreciation for your efforts to correct the inequity in the RIP statute which prevented the participation of long-time Alaskan teachers with Alaskan BIA teaching service. Your assistance as prime sponsor of Senate Bill 42 has been very encouraging.

Secondly, my husband and I urge you to continue efforts in this regard. To facilitate this we are enclosing a brief summary of our past correspondence with you, along with recent developments in this area.

Although the RIP window is closed, there are a few persons around the state who were deprived of the opportunity to participate in that program because part of their teaching was under the BIA. They met TRS "20 and out" regulations, and desired to participate.

My husband and I have taught in Barrow for the past 18 years, all in the same school. The first 5 years were under the BIA, before the North Slope Borough was formed. We saw fellow employees from the BIA years (BIA Maintenance, Public Works, Roads, Utilities employees from round the state) receive credit for their BIA service and qualify for RIP under PERS. This was also true of former Public Health nurses and employees who had transferred into PERS with North Slope Borough service.

When we first heard of RIP nearly 2 years ago, we assumed we were included, as TRS has already included our category in the "20 and out" retirement option. It was with shock and disappointment that we found ourselves eliminated due to the Kerttula amendment's use of the definition of "employer." As we did not have access to the "Definitions" of the

sections related to education, it was several months before we found we were not included. To us, it seems that we are not accorded "equal protection" under the Constitution. . . however inadvertently that may have been. Our hopes rose last year as remediation under your SB 42 or HB 17 seemed possible. These were delayed past the window deadline by the budget shuffle.

We now find that the inequitable statute has been inequitably applied, and that 2 persons in Anchorage have actually retired using BIA teaching service both to complete required years, and also for credit. Our investigations indicate that their retirement cannot be nullified (for which we are glad), however for us to achieve the benefit they enjoy, legislative action is necessary.

Just before Christmas, I contacted all other known teachers around the state with Alaskan BIA teaching experience. Of those who responded to previous questionnaires, there are 7 who could not retire last year because of the Kerttula Amendment that still are interested in retiring.

It is our hope that SB 42 could be reworked to provide this remediation and relief by perhaps opening a 90-day enrollment period for teachers unfairly prevented from participating last year. It is obvious that this is not a high-cost correction, and it would still have some economic benefits to school districts.

Bob Manners, our NEA-Alaska Legislative liason man has been aware of the constitutional equity problems of the original RIP as they relate to former BIA teachers, and is our contact person there in Juneau for attempting to resolve this problem. His phone number is 586-3090.

As persons who love their professions, and have spent much of our adult lives in the service of native Alaskans, we beg your assistance with this problem. A letter from Jan Faiks, received last spring is attached along with a copy of your letter to us at that time.

Thank you very much for your assistance in "helping to make it fair."

Sincerely,

*Peggy & John*

Peggy and John Davis, Teachers

*Thank you for your letter of support last spring!*



Official Business

Alaska State Legislature  
House of Representatives

Al Adams  
Chairman  
Committee on Finance

February 25, 1988

WHILE IN SESSION  
P.O. Box V  
State Capitol  
Juneau, Alaska 99811  
(907) 465-3706

OUT OF SESSION  
P.O. Box 333  
Kotzebue, Alaska 99752  
(907) 442-3320

1024 W. 6th  
Anchorage, Alaska 99501  
(907) 274-0615

Peggy & John Davis  
P.O. Box 246  
Barrow, AK 99723

Dear Ms. & Mr. Davis:

Thank you for your letter regarding participation in the Retirement Incentive Program by former Alaskan BIA teachers.

Although I have not been an enthusiastic supporter of the RIP program, I whole-heartedly agree with your position that this program has unfairly treated those employees who would have otherwise qualified for early retirement except for the fact that a portion of their teaching career in Alaska was under the BIA.

I have spoken to Mr. Bob Manners of the NEA and Senator Duncan's office and understand that Senate Bill 42 will be under consideration in the Senate Finance Committee next week to deal with this oversight in the original legislation. At this time I can assure you that I will do everything possible to see that this measure receives favorable consideration in the House at such time as it passes the Senate.

Again, thank you for bringing this matter to my attention. If there is anything further I can do for you at this time, please don't hesitate to contact my office.

Sincerely,

A handwritten signature in cursive script that reads "Al Adams".

Al Adams  
Chairman  
House Finance Committee

PUBLIC OPINION MESSAGE

RECEIVED MAR 14 1988

PUBLIC OPINION MESSAGE

DEAR: SENATOR DUNCAN

DEAR: SENATOR DUNCAN

NAME: LARRY M. SMITH

NAME: JED WHITTAKER

TITLE:

TITLE:

ADDRESS: 3434 CAMPBELL AIRSTRIP ROAD

ADDRESS: 2004 ASPEN

CITY: ANCHORAGE

ZIP: 99504

CITY: ANCHORAGE

ZIP: 99507

PHONE: 333-9173

PHONE: N/R-

TEL NO: SD 42

BILL NO:

SUBJECT: EXTEND EARLY RETIREMENT INCENTIVE PROGRAM

SUBJECT: DEMOCRACY

MESSAGE: I STRONGLY SUPPORT THE AMENDMENT TO SB 42 WHICH WOULD ALLOW BIA

MESSAGE: PLEASE BRING HJR 4 TO A FLOOR VOTE. IT IS ONLY DEMOCRATIC TO DO SO.

SERVICE TO BE CREDITED UNDER THE RETIREMENT INCENTIVE PROGRAM.

BY SENATOR BINKLEY AND SENATOR HALFORD

PLEASE KEEP ME ADVISED TO THE STATUS OF THIS BILL.

POMID: 03095256

POMID: 03095817

DATE: 03/14/88

DATE: 03/14/88

TIME: 09:52:56

TIME: 09:58:17

ORIG: ANCHORAGE LIO

ORIG: ANCHORAGE LIO

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PETTYJOHN	PHILLIPS	RODEY
POURCHOT	RIEGER	STURGULEWSKI
SHULTZ	SPRINGER	SZYMAŃSKI
SUND	SWACKHAMMER	UEHLING
TAYLOR	ULMER	ZHAROFF
WALLIS	ZANACKI	

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BINKLEY
COGHILL
ELIASON
FAHRENKAMP
FAIKS
FANNING
FISCHER
HALFORD
HENSLEY
JONES
JOSEPHSON
KELLY
KERTTULA
RODEY
STURGULEWSKI
SZYMAŃSKI
UEHLING
ZHAROFF

## PUBLIC OPINION MESSAGE

DEAR: SENATOR DUNCAN

NAME: MILDRED JOHNSON  
 TITLE:  
 ADDRESS: 202 STEWART  
 CITY: ANCHORAGE  
 PHONE: 335-8656  
 BILL NO: SB 42

ZIP: 99508

SUBJECT: EXTEND EARLY RETIREMENT INCENTIVE PROGRAM  
 MESSAGE: I STRONGLY SUPPORT THE AMENDMENT TO SB 42 WHICH WOULD ALLOW BIA SERVICES TO BE CREDITED UNDER THE RETIREMENT INCENTIVE PROGRAM.

POHID: 03162813  
 DATE: 02/22/88  
 TIME: 16:28:13  
 LIONAME: ANCHORAGE LIO

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SHULTZ	SPRINGER	SZYMANSKI
SUND	SHACKHAMMER	UEHLING
TAYLOR	ULMER	ZHAROFF
WALLIS	ZAWACKI	

## PUBLIC OPINION MESSAGE

DEAR: SENATOR DUNCAN

NAME: MARY K. GLOVER  
 TITLE:  
 ADDRESS: 4660 REKA, RD 23  
 CITY: ANCHORAGE  
 PHONE: 337-3021  
 BILL NO: SB 42

ZIP: 99508

SUBJECT: EXTEND EARLY RETIREMENT INCENTIVE PROGRAM  
 MESSAGE: I STRONGLY SUPPORT THE AMENDMENT IN SB 42 WHICH WOULD ALLOW BIA SERVICE TO BE CREDITED UNDER THE RETIREMENT INCENTIVE PROGRAM.

POHID: 03133009  
 DATE: 02/22/88  
 TIME: 13:38:09  
 LIONAME: ANCHORAGE LIO

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ADAMS	BARNES	ABOOD
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MEHARD	MILLER	KELLY
NAVARRE	PEARCE	KERTTULA
PETTYJOHN	PHILLIPS	RODEY
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SHULTZ	SPRINGER	SZYMANSKI
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RECEIVED FEB 23 1988

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## PUBLIC OPINION MESSAGE

DEAR: SENATOR DUNICAN

NAME: CURMIE WEBB

TITLE:

ADDRESS: 1804 SOUTH SALEM DRIVE

CITY: ANCHORAGE, ALASKA

PHONE: 561-0534

BILL NO: SB 42

SUBJECT: EXTEND EARLY RETIREMENT INCENTIVE PROGRAM

MESSAGE: I STRONGLY SUPPORT AMENDMENT TO SB 42 WHICH WOULD ALLOW B.I.A. SERVICE TO BE CREDITED UNDER THE RETIREMENT INCENTIVE PROGRAM.

ZIP: 99515

*Sheldon Rayanne*  
*Reply*

POMID: 03120433

DATE: 02/22/88

TIME: 12:04:33

LOCATION: ANCHORAGE LIO

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ADAMS	BARNES	ABOOD
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DONLEY	ELLIS	FAIKS
FRANK	FURNACE	FANNING
GOLL	GRUENBERG	FISCHER
GRUSSENDORF	HANLEY	HALFORD
HERRMANN	HOFFMAN	HENSLEY
HUDSON	KOPONEN	JONES
LARSON	MARTIN	JOSEPHSON
NEHARD	MILLER	KELLY
NAVAPRE	PEARCE	KERTTULA
PETTYJOHN	PHILLIPS	RODEY
POURCHOT	RIEGER	STURGULEWSKI
SHULTZ	SPRINGER	SZYMANSKI
SUND	SHACKHAMMER	UEHLING
TAYLOR	ULMER	ZHAROFF
WALLIS	ZAWACKI	

## PUBLIC OPINION MESSAGE

DEAR: SENATOR DUNICAN

NAME: PHYLISS BRACKEN

TITLE:

ADDRESS: P.O. BOX 771551

CITY: EAGLE RIVER

PHONE: 694-9609

BILL NO: SB 42

SUBJECT: EXTEND EARLY RETIREMENT INCENTIVE PROGRAM

MESSAGE: I STRONGLY SUPPORT THE AMENDMENT TO SB 42 WHICH WOULD ALLOW BIA SERVICE TO BE CREDITED UNDER THE RETIREMENT INCENTIVE PROGRAM.

ZIP: 99577

*Reply*  
*Sheldon Rayanne*

POMID: 03121648

DATE: 02/22/88

TIME: 12:16:48

LOCATION: ANCHORAGE LIO

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DONLEY	ELLIS	FAIKS
FRANK	FURNACE	FANNING
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NAVAPRE	PEARCE	KERTTULA
PETTYJOHN	PHILLIPS	RODEY
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RECEIVED FEB 23 1988

RECEIVED FEB 23 1988

## PUBLIC OPINION MESSAGE

DEAR: SENATOR DUNICAN

NAME: HANCY MCGEE  
 TITLE:  
 ADDRESS: 3134 DELTA DRIVE  
 CITY: ANCHORAGE  
 PHONE: 248-0241  
 BILL NO: SB 42  
 SUBJECT: EXTEND EARLY RETIREMENT INCENTIVE PROGRAM  
 MESSAGE: I SUPPORT THE AMENDMENT TO SB 42 WHICH WOULD ALLOW BIA SERVICES TO BE CREDITED UNDER THE RETIREMENT INCENTIVE PROGRAM.

ZIP: 99502

*Debbie  
 Casanova  
 Reply*

## PUBLIC OPINION MESSAGE

DEAR: SENATOR DUNICAN

NAME: JACKIE SMITH  
 TITLE:  
 ADDRESS: 3434 CAMPBELL AIRSTRIP RD.  
 CITY: ANCHORAGE  
 PHONE: 333-9173  
 BILL NO: SB 42  
 SUBJECT: EXTEND EARLY RETIREMENT INCENTIVE PROGRAM  
 MESSAGE: I STRONGLY SUPPORT THE AMENDMENT TO SB 42 WHICH WOULD ALLOW BIA SERVICE TO BE CREDITED UNDER THE RETIREMENT INCENTIVE PROGRAM.

ZIP: 99504

FORMID: 03112716  
 DATE: 02/22/88  
 TIME: 11:27:16  
 LOCATION: ANCHORAGE LIO

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ADAMS	BARNES	ABOOD
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NAVARRE	PEARCE	KERTTULA
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SUND	SHACKHAMMER	UEHLING
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FORMID: 03112918  
 DATE: 02/22/88  
 TIME: 11:29:18  
 LOCATION: ANCHORAGE LIO

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ADAMS	BARNES	ABOOD
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LARSON	MARTIN	JOSEPHSON
MEHARD	HILLER	KELLY
NAVARRE	PEARCE	KERTTULA
PETTYJOHN	PHILLIPS	RODEY
POURCHOT	RIEGER	STURGULEWSKI
SHULTZ	SPRINGER	SZYMAWSKI
SUND	SHACKHAMMER	UEHLING
TAYLOR	ULMER	ZHAROFF
WALLIS	ZAWACKI	

RECEIVED FEB 23 1988

RECEIVED FEB 23 1988

## PUBLIC OPINION MESSAGE

DEAR: SENATOR DUNCAN

NAME: MORGEN PAULK  
 TITLE:  
 ADDRESS: 4201 1 INA APT. 4  
 CITY: ANCHORAGE  
 PHONE: 581-1111  
 BILL NO:

ZIP: 99502

SUBJECT: EXTEND EARLY RETIREMENT INCENTIVE PROGRAM  
 MESSAGE: SUPPORT THE AMENDMENT FOR THE B.I.A. TO BE CREDITED UNDER THE  
 RETIREMENT INCENTIVE PROGRAM.

FOMID: 03075807  
 DATE: 02/22/88  
 TIME: 07:50:07  
 LOCATION: ANCHORAGE LIO

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GOLI	GRUENBERG	FISCHER
GRUSSENDORF	HANLEY	HALFORD
HEPPEL	HOFFMAN	HENSLEY
HUDSON	KOPONEN	JONES
LARSON	MARTIN	JOSEPHSON
NICHARD	MILLER	KELLY
HAVARRE	PEARCE	KERTTULA
PETTYJOHN	PHILLIPS	ROBEY
POUPCHOT	RIEGER	STURGULEWSKI
SHULTZ	SPRINGER	SZYMANSKI
SUID	SWACKHAMMER	UEHLING
TAYLOR	ULMER	ZHAROFF
WALLIS	ZAWACKI	

## PUBLIC OPINION MESSAGE

DEAR: SENATOR DUNCAN

NAME: PEGGY DAVIS  
 TITLE:  
 ADDRESS: P.O. BOX 246  
 CITY: BARROW  
 PHONE: 852-4711  
 BILL NO: SB 42

ZIP: 99723

SUBJECT: EXTEND EARLY RETIREMENT INCENTIVE PROGRAM  
 MESSAGE: WITH 17 YEARS BARROW TEACHING, I COULD NOT RETIRE UNDER R.I.P. BECAUSE  
 5 BARROW YEARS WERE UNDER B.I.A.. OTHER FORMER B.I.A. EMPLOYEES COUNTED THEIR  
 YEARS TOWARD R.I.P./P.E.R.S.. SUPPORT WORDING TO OPEN A CORRECTIVE R.I.P. WINDOW  
 FOR APPROXIMATELY 7 TEACHERS LEFT STATEWIDE. WE CARED. DO YOU?  
 HELP MAKE IT FAIR!

FOMID: 04140203  
 DATE: 03/02/88  
 TIME: 14:02:03  
 LOCATION: BARROW INFO OFFICE

COPIES: SENATORS

BINKLEY  
 FISCHER  
 HALFORD  
 HENSLEY  
 UEHLING  
 ZHAROFF

RECEIVED MAR 03 1988

RECEIVED MAR 23 1988

PUBLIC OPINION MESSAGE

DEAR: SENATOR DUNCAN

NAME: JOHN DAVIS

TITLE:

ADDRESS: BOX 246

CITY: BARROW

PHONE: 852-6745

BILL NO: SD 42

SUBJECT: EXTEND EARLY RETIREMENT INCENTIVE PROGRAM

MESSAGE: TREAT ALL ALASKAN TEACHERS EQUITABLY. PASS SD 42.

ZIP: 99723

FOIID: 04172346

DATE: 03/02/88

TIME: 17:23:46

LOCATION: BARROW INFO OFFICE

COPIES: SENATORS

BINKLEY  
FISCHER  
HALFORD  
HENSLEY  
UENLING  
ZHAROFF

RECEIVED MAR 03 1988

PUBLIC OPINION MESSAGE

DEAR: SENATOR DUNCAN

NAME: RUTH ANN HOAR

TITLE:

ADDRESS: P.O. BOX 113

CITY: TOK

PHONE: 893-5532

BILL NO: SD 42

SUBJECT: EXTEND EARLY RETIREMENT INCENTIVE PROGRAM

MESSAGE: I WAS DENIED THE OPTION OF THE EARLY RETIREMENT INCENTIVE PROGRAM LAST YEAR BECAUSE MY SERVICE TIME INCLUDED ALASKA STA TEACHING. TEACHERS WHO TAUGHT NATIVE CHILDREN SHOULD BE ENTITLED TO THE SAME BENEFITS THAT OTHER TEACHERS IN THE STATE RECEIVED. PLEASE SUPPORT SD 42 TO RECTIFY THIS INEQUALITY.

ZIP: 99780

FOIID: 02094729

DATE: 03/03/88

TIME: 09:47:29

LOCATION: DELTA JUNCTION LIO

COPIES: SENATORS

BINKLEY  
FISCHER  
HALFORD  
HENSLEY  
UENLING  
ZHAROFF

RECEIVED MAR 03 1988

PUBLIC OPINION MESSAGE

DEAR: SENATOR DUNCAN

*Reply*

NAME: MICHAEL HOAR  
TITLE:  
ADDRESS: BOX 113  
CITY: TOK, ALASKA  
PHONE: 883-5532  
BILL NO: SB 42

ZIP: 99780

SUBJECT: EXTEND EARLY RETIREMENT INCENTIVE PROGRAM  
MESSAGE: I AM A LONG TIME TEACHER IN THE STATE OF ALASKA WHO WAS DENIED THE  
EXTENSION OF THE EARLY RETIREMENT INCENTIVE PROGRAM LAST YEAR BECAUSE MY SERVICE  
INCLUDED ALASKA BIA TEACHING. I URGE YOU TO SUPPORT SB 42 TO RECTIFY THIS IN-  
EQUITY. IN THE INTEREST OF FAIRNESS, PLEASE SUPPORT SB 42.

PO MID: 02155255  
DATE: 03/01/88  
TIME: 15:52:55  
FROM NAME: DELTA JUNCTION LIO

COPIES: REPRESENTATIVE    SENATORS

SHULTZ	COGHILL
	BINKLEY
	FISCHER
	HALFORD
	HENSLEY
	UEHLING
	ZHAROFF

RECEIVED MAR 02 1988

*as SB42 #4*

PUBLIC OPINION MESSAGE

DEAR: SENATOR DUNCAN

RECEIVED MAR 03 1988

*Reply*

NAME: TIM MACDONALD  
TITLE:  
ADDRESS: P.O. BOX 272  
CITY: DOT LAKE  
PHONE: 882-2665  
BILL NO: SB 42

ZIP: 99737

SUBJECT: EXTEND EARLY RETIREMENT INCENTIVE PROGRAM  
MESSAGE: PLEASE SUPPORT THOSE TEACHERS WHO HAVE DEDICATED THEMSELVES TO THE  
EDUCATION OF RURAL ALASKA SCHOOLS WHILE UNDER BIA CONTROL. BENEFITS FOR EARLY  
RETIREMENT SHOULD BE EXTENDED TO INCLUDE THESE DEDICATED EDUCATORS OF ALASKA'S  
EARLY RURAL EDUCATIONAL EFFORT. PLEASE VOTE YES FOR SB 42.

PO MID: 02120839  
DATE: 03/02/88  
TIME: 12:08:39  
FROM NAME: DELTA JUNCTION LIO

COPIES: SENATORS

BINKLEY
FISCHER
HALFORD
HENSLEY
UEHLING
ZHAROFF

PUBLIC OPINION MESSAGE

DEAR: SENATOR LUNICAN

*Rog*

NAME: SALLY MCCLELLEN  
TITLE: TEACHER  
ADDRESS: BOX 311  
CITY: KOTZEBUE  
PHONE: 442-3250  
BILL NO: SB 42

ZIP: 99752

SUBJECT: EXTEND EARLY RETIREMENT INCENTIVE PROGRAM  
MESSAGE: I BEGAN TEACHING CHILDREN IN KOTZEBUE FOR THE B.I.A. IN 1973. I'M STILL HERE TEACHING FOR THE H.N.A.B.S.D. WHICH WOULD BENEFIT FINANCIALLY FROM MY RETIREMENT. SEVEN NORTHERN ALASKAN TEACHERS, INCLUDING ME, WERE UNFAIRLY DENIED OUR BENEFITS UNDER THE EARLIER RETIREMENT BILL. PLEASE SUPPORT SB 42 NOW IN SENATE COMMITTEE.

FORMID: 10112605  
DATE: 03/03/88  
TIME: 11:26:05  
FROM: KOTZEBUE INFORMATION OFFICE

COPIES: SENATORS

BINKLEY  
FISCHER  
HALFORD  
HENSLEY  
UEHLING  
ZHAROFF

*SB 42 #4*

PUBLIC OPINION MESSAGE

RECEIVED MAR 03 1988

DEAR: SENATOR DUNICAN

*Rog*

NAME: MARY MACDONALD  
TITLE:  
ADDRESS: P.O. BOX 272  
CITY: DOT LAKE  
PHONE: 892-2665  
BILL NO: SB 42

ZIP: 99737

SUBJECT: EXTEND EARLY RETIREMENT INCENTIVE PROGRAM  
MESSAGE: PLEASE SUPPORT THOSE TEACHERS WHO HAVE DEDICATED THEMSELVES TO THE EDUCATION OF RURAL ALASKA SCHOOLS WHILE UNDER BIA CONTROL. BENEFITS FOR EARLY RETIREMENT SHOULD BE EXTENDED TO INCLUDE THESE DEDICATED EDUCATORS OF ALASKA'S EARLY RURAL EDUCATION EFFORT. PLEASE VOTE YES FOR SB 42.

POMID: 02121051  
DATE: 03/02/88  
TIME: 12:10:51  
FROM: DELTA JUNCTION LIO

COPIES: SENATORS

BINKLEY  
FISCHER  
HALFORD  
HENSLEY  
UEHLING  
ZHAROFF

RECEIVED MAR 03 1988

PUBLIC OPINION MESSAGE

*copy*

DEAR: SENATOR DUNICAN

NAME: TONI HASSETT  
 TITLE:  
 ADDRESS: 111 KNOWLES CIRCLE  
 CITY: ANCHORAGE, ALASKA  
 PHONE: 349-2190  
 BILL NO: SB 42  
 SUBJECT: EXTEND EARLY RETIREMENT INCENTIVE PROGRAM  
 MESSAGE: I STRONGLY SUPPORT AMENDMENT TO SB 42 WHICH WOULD ALLOW B.I.A.  
 SERVICE TO BE CREDITED UNDER THE RETIREMENT INCENTIVE PROGRAM.

*Reply*

ZIP: 99515

POMID: 03130248  
 DATE: 02/22/88  
 TIME: 13:02:48  
 LIONAME: ANCHORAGE LIO

COPIES: REPRESENTATIVES    REPRESENTATIVES    SENATORS

ADAMS	BARNES	ABOOD
BOUCHER	BOYER	BINKLEY
BROWN	CATO	COGHILL
COLLINS	COTTEN	ELIASON
DAVIDSON	DAVIS	FAHRENKAMP
DONLEY	ELLIS	FAIKS
FRANK	FURNACE	FANNING
GOLL	GRUENBERG	FISCHER
GRUSSENDORF	HANLEY	HALFORD
HERRMANN	HOFFMAN	HENSLEY
HUDSON	KOPONEN	JONES
LARSON	MARTIN	JOSEPHSON
MEHARD	MILLER	KELLY
NAVARRE	PEARCE	KERTTULA
PETTYJOHN	PHILLIPS	RODEY
POURCHOT	RIEGER	STURGULEWSKI
SHULTZ	SPRINGER	SZYMAWSKI
SUND	SWACKHAMMER	UEHLING
TAYLOR	ULMER	ZIAROFF
WALLIS	ZAHACKI	

*LVL*

Box 246  
Barrow, Alaska 99723  
March 25, 1988

Representative Fran Ulmer, Chairman  
House Committee on State Affairs  
P. O. Box V  
Juneau, AK 99811

Dear Representative Ulmer,

In January, I wrote you to express our appreciation for your efforts as sponsor of HB 17 to correct the inequity in the RIP statute which prevented the participation of long-time Alaskan teachers with Alaskan BIA teaching service. Since that time it has been encouraging to learn of passage by the Senate of SB 42 in a revised form that we understand has had input from the TRS, the House Research Agency - possibly including your office, and other interested parties as well.

My husband and I urge you and Representative Menard, as co-sponsors of HB 17, and members of the House State Affairs Committee to work for rapid movement of CSSB 42 in your committee, and to facilitate its movement through HESS and Finance in a timely fashion. It appears that possibilities may be good, with two sponsors in State Affairs which reviews the bill first, and the assistance of Representative Adams. Though not an avid supporter of the "RIP" concept Representative Adams has written us of his support for this Bill because of the equity issues involved.

A brief summary of our difficulties and the reasons we are so interested in obtaining legislative relief may be of help to you in this effort.

Although the RIP window is closed, there are a few persons around the state who were deprived of the opportunity to participate in that program because part of their teaching was under the BIA. They met TRS "20 and out" retirement regulations, and desired to participate.

My husband and I have taught in Barrow for the past 18 years, all in the same school. The first 5 years were under the BIA, before the North Slope Borough was formed. We saw fellow employees from the BIA years (BIA Maintenance, Public Works, Roads, Utilities) employees from round the

state) receive credit for their BIA service and qualify for RIP under PERS. This was also true of former Public Health nurses and employees who had transferred into PERS with North Slope Borough service. Not BIA teachers.

When we first heard of RIP nearly 2 years ago, we assumed we were included, as TRS has already included our category in the "20 and out" retirement option. It was with shock and disappointment that we found ourselves eliminated due to the Kerttula amendment's use of the definition of "employer". As we did not have access to the "Definitions" of the sections related to education, it was several months before we found we were not included. To us, it seems that we are not accorded "equal protection" under the Constitution. . . however inadvertently that may have been. Our hopes rose last year as remediation under HB 17 or SB 42 seemed possible. These were delayed past the window deadline by the budget shuffle.

We now find that the inequitable statute has been inequitably applied, and that 2 persons in Anchorage have actually retired using BIA teaching service both to complete required years, and also for credit. Our investigations indicate that their retirement cannot be nullified (for which we are glad), however for us to achieve the benefit they enjoy, it will be necessary for us to have help.

Just before Christmas, I contacted all other known teachers around the state with Alaskan BIA teaching experience. Of those who responded to previous questionnaires, there are 7 who could not retire last year because of the Kerttula Amendment that still are interested in retiring.

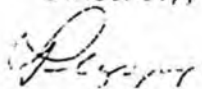
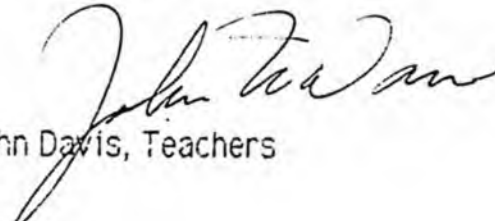
The CSSB 42 which passed the Senate last week corrects this inequity by opening an enrollment period for teachers unfairly prevented from participating last year, and does so economically - the estimated cost being but about \$6000 to \$9000, I believe. Yet passage of the Bill would still have some economic benefits to school districts.

We now earnestly request your support and assistance, both moral and actual in seeing that this handful of hardworking professionals are not penalized for making years of contribution to the native people of our state during the years when neither state nor local governments took responsibility for the education of children in remote villages of the north.

Bob Manners, our NEA-Alaska Legislative liason man has been aware of the constitutional equity problems of the original RIP as they relate to former BIA teachers, and is our contact person there in Juneau for attempting to resolve this problem. His phone number is 598-7090. A letter from Jan Faiks, received last spring is attached including a relevant summary of the problem.

Thank you very much for your interest in "helping to make it fair." Anything you can do to help bring about an equitable solution, will be appreciated.

Sincerely,

   
Peggy and John Davis, Teachers

SB

67

file 1

STATE OF ALASKA  
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY  
LEGISLATIVE REFERENCE LIBRARY

POUCH Y - STATE CAPITOL  
JUNEAU, ALASKA 99811  
907-465-3800

May, 1988

Copies of minutes listed below were originally included in this file. The minutes are available on the STAIRS database CMPR. In order to save space copies of minutes have not been left in the files.

Mary Van Nimwegen

*House Hess:*

*February 9, 1988*

*February 16, 1988*

*February 24, 1988*

# STATE OF ALASKA

## DEPARTMENT OF ADMINISTRATION

### DIVISION OF RETIREMENT & BENEFITS

PLEASE REPLY TO:

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

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

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

STEVE COWPER, GOVERNOR

February 24, 1988

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

Dear Representatives Koponen and Ellis:

Re: House CS CSSB 67 (HESS)

This letter is meant to provide our analysis of the fiscal impact if HCS CSSB 67 (HESS) is passed into law. This analysis consists of two separate components. The first addresses the direct increase to health insurance premiums for active state employees for an increased level of coverage. The second addresses the costs to the retirement systems due to the increased levels of coverage for the retiree's health plan.

Premiums for active state employees is estimated to increase \$3.70 per month per employee effective July 1, 1989. The costs are assumed to stay level each year thereafter because the state does not have any experience analysis to indicate that costs will increase annually for this additional benefit and it is a small portion of the total health insurance package.

The FY 90 estimated cost for active state employees is calculated as follows:

The increase of \$3.70 per month times the number of state employees (12,000) x 12 months	\$532,800
---	-----------

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

February 24, 1988

The cost to the state of \$1,034.6 is calculated as follows:

The increase in the PERS contribution rate  
(.20%) times the estimated FY 90 state PERS  
payroll (\$479,549,872) equals: \$ 959.1

The increase in the TRS contribution  
rate (.15%) times the estimated FY 90  
University of Alaska TRS payroll  
(\$44,753,863) equals: 67.1

The increase in the TRS contribution rate  
(.15%) times the estimated FY 90 Department  
of Education TRS payroll (\$5,613,930) equals: 8.4

\$1,034.6

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

The increase in the PERS contribution rate  
(.20%) times the estimated FY 90 political  
subdivision payroll (\$329,744,333) equals: \$ 659.5

The increase in the TRS contribution rate  
(.15%) times the estimated FY 90 school  
districts' payroll (\$319,882,344) equals: \$ 479.8  
\$1,139.3

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

Sincerely,

*Robert F. Stalnaker*  
Robert F. Stalnaker  
Acting Director

RFS/MBC/cam/6

# HOUSE COMMITTEE REPORT

5/9/87

Date referred:

FURTHER REFERRALS:

Judiciary  
Finance

Health, Education and  
Social Services

DATE: 2-24-88  
CSSB 67 (HESS)

The \_\_\_\_\_ Committee has considered  
"An Act relating to insurance coverage for the treatment of a mental or  
nervous condition."

**RECOMMENDS:**

- replace with HCS SB 67 (HESS)  the same title
- attached amendment(s)  a new title
- do pass
- do not pass
- no recommendation
- individual recommendations
- additional referral to the \_\_\_\_\_ Committee

**ADOPTS:**  \_\_\_\_\_ letter of intent

**ATTACHES NEW FISCAL NOTE(s):**

- fiscal impact  same as previous fiscal note published \_\_\_\_\_
- zero fiscal note  same as previous zero fiscal note published \_\_\_\_\_
- zero with analysis

**SIGNING DO PASS:**

[Signature]  
[Signature]  
[Signature]  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SIGNING OTHER RECOMMENDATIONS:**

[Signature] - NO Rec.  
[Signature] NO Rec  
[Signature] NO Rec  
[Signature] - NO Rec  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

[Signature]  
 CO-Chairman's signature  
[Signature]



15700 Dayton Avenue North/P. O. Box 327  
Seattle, Washington 98111-0327  
206/361-3000

BLUE CROSS OF WASHINGTON AND ALASKA  
PROPOSED 2/16/88 AMENDMENT TO  
1988 ALASKA HCS CSSB NO. 67

Section 21.42.365(c)(2) should be amended to read as follows:

- (2) "cost" means the lesser of the following
- (a) the actual charge for the treatment received for a mental or nervous condition; or
  - (b) the usual, customary and reasonable charge for the treatment as determined by the contract of coverage; or
  - (c) the charge agreed to by contract between the provider and the third party payor;

# STATE OF ALASKA

## DEPARTMENT OF ADMINISTRATION

DIVISION OF RETIREMENT & BENEFITS

PLEASE REPLY TO:

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

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

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

STEVE COWPER, GOVERNOR

February 12, 1988

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

Dear Representatives Koponen and Ellis:

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

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

The financial impact shown in this letter represents the costs to employers participating in the state's retirement plans due to the increased limits of coverage for mental or nervous conditions under the retiree's health plan. In addition to the costs to the state's operating budget outlined on the fiscal note, this bill is estimated to result in a .20% increase in the PERS employer contribution rate and a .15% increase in the TRS employer contribution rate and a .15% increase in the TRS State Match contribution rate in FY 89. The estimated FY 89 payrolls are listed below and are assumed to remain level each year thereafter.

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

The increase in the PERS contribution rate  
(.20%) times the estimated FY 89 state PERS  
payroll (\$479,549,872) equals: \$ 959.1

The increase in the TRS contribution  
rate (.15%) times the estimated FY 89  
University of Alaska TRS payroll  
(\$44,753,863) equals: 67.1

The increase in the TRS contribution rate  
(.15%) times the estimated FY 89 Department  
of Education TRS payroll (\$5,613,930) equals: 8.4

\$1,034.6

February 12, 1988

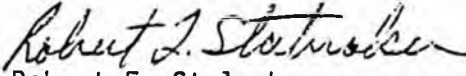
In addition to the state costs described above, there would also be an increase in political subdivisions' FY 89 contribution rate of .20% and in school districts' contribution rate of .15%. This would result in an increase in their annual costs as follows:

The increase in the PERS contribution rate  
(.20%) times the estimated FY 89 political  
subdivision payroll (\$329,744,333) equals: \$ 659.5

The increase in the TRS contribution rate  
(.15%) times the estimated FY 89 school  
districts' payroll (\$319,882,344) equals: \$ 479.8  
\$1,139.3

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

Sincerely,

  
Robert F. Stalnaker  
Acting Director

RFS/bb/7

FISCAL NOTE

REQUEST:

Revision Date: \_\_\_\_\_ Agency Affected: All Agencies  
 Title: An Act relating to insurance coverage for mental and nervous disorders. BRU: Retirement and Benefits  
 Sponsor: Faiks and Kerttula Components: Retirement and Benefits  
 Requestor: \_\_\_\_\_ (CHLB)

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
PERSONAL SERVICES	0	0	532.8	532.8	532.8	532.8
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	0	532.8	532.8	532.8	532.8
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	0	0	481.6	481.6	481.6	481.6
FEDERAL FUNDS	0	0	24.5	24.5	24.5	24.5
OTHER	0	0	26.7	26.7	26.7	26.7
TOTAL	0	0	532.8	532.8	532.8	532.8

POSITIONS:

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

ANALYSIS: (Attach a separate page if necessary)

**DRAFT**

Prepared By: Robert F. Stalnaker, Acting Director Phone: 465-4470  
 Division: Retirement and Benefits Date: 2-11-88

Approved by Commissioner: John M. Andrews Date: \_\_\_\_\_  
 Agency: Department of Administration

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

House Committee Substitute for Senate Bill 67  
(2/9/88 Draft Version)  
Fiscal Note Analysis  
Prepared by Division of Retirement & Benefits  
Department of Administration

February 11, 1988

Analysis:

This bill would require would require increased limits of coverage for mental or nervous disorders under the state's health plans for active employees of the state and retirees.

This bill is estimated to result in a \$3.70 per month increase in Health Insurance costs of an estimated 12,000 state employees effective July 1, 1988. The costs are assumed to remain level each year thereafter because the state does not yet have any experience analysis to indicate that costs will increase annually for this additional benefit, and it is a small portion of the total Health Insurance package.

The FY 89 estimated cost for active state employees is calculated as follows:

The increase of \$3.70 per month health cost times the number of state employees (12,000)	\$532,800
---	-----------

Additional costs reflected in increased employer contribution rates in the Public Employees' (PERS) and Teachers' (TRS) Retirement Systems are discussed in a separate letter to Representatives Ellis and Koponen.

**DRAFT**

POSITION PAPER

Committee Substitute  
for  
Senate Bill 67 (HESS)

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

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

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

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

Acute psychiatric care facilities are an essential part of a complete continuum of psychiatric services. However, many persons who suffer from a mental or nervous condition may receive appropriate inpatient treatment in the less restrictive and less costly environment of a licensed group home or residential care center. The only private acute psychiatric care hospital in Alaska listed an FY 1986 cost of \$551.00 per day. By comparison, per day costs for group homes range from \$39.25 to \$210.00.

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

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

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

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

(3) works in conjunction with a licensed provider.

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

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

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

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

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

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

RECOMMENDED BY:

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

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

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

Date: February 4, 1988

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

FISCAL NOTE

REQUEST:

Revision Date: \_\_\_\_\_ Agency Affected: Health & Social Services  
 Title: ...relating to insurance coverage for BRU: Community Mental Health Grants,  
the treatment of a mental or nervous cond. Institutions and Administration  
 Sponsor: \_\_\_\_\_ Components: Community Mental Health  
 Requestor: \_\_\_\_\_ Grants, Alaska Psychiatric Institute

EXPENDITURES/REVENUES: (Thousands of Dollars)

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

FUNDING: (Thousands of Dollars)


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

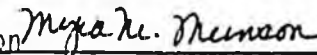
POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS : (Attach a separate page if necessary)

see attached sheet

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

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

Distribution (by preparer):

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

## FISCAL NOTE

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

# STATE OF ALASKA

## DEPARTMENT OF ADMINISTRATION DIVISION OF RETIREMENT & BENEFITS

PLEASE REPLY TO:

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

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

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

STEVE COOPER, GOVERNOR

February 12, 1988

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

Dear Representatives Koponen and Ellis:

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

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

The financial impact shown in this letter represents the costs to employers participating in the state's retirement plans due to the increased limits of coverage for mental or nervous conditions under the retiree's health plan. In addition to the costs to the state's operating budget outlined on the fiscal note, this bill is estimated to result in a .20% increase in the PERS employer contribution rate and a .15% increase in the TRS employer contribution rate and a .15% increase in the TRS State Match contribution rate in FY 89. The estimated FY 89 payrolls are listed below and are assumed to remain level each year thereafter.

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

The increase in the PERS contribution rate  
(.20%) times the estimated FY 89 state PERS  
payroll (\$479,549,872) equals: \$ 959.1

The increase in the TRS contribution  
rate (.15%) times the estimated FY 89  
University of Alaska TRS payroll  
(\$44,753,863) equals: 67.1

The increase in the TRS contribution rate  
(.15%) times the estimated FY 89 Department  
of Education TRS payroll (\$5,613,930) equals: 8.4

\$1,034.6

February 12, 1988

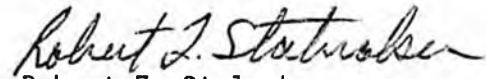
In addition to the state costs described above, there would also be an increase in political subdivisions' FY 89 contribution rate of .20% and in school districts' contribution rate of .15%. This would result in an increase in their annual costs as follows:

The increase in the PERS contribution rate  
(.20%) times the estimated FY 89 political  
subdivision payroll (\$329,744,333) equals: \$ 659.5

The increase in the TRS contribution rate  
(.15%) times the estimated FY 89 school  
districts' payroll (\$319,882,344) equals: \$ 479.8  
\$1,139.3

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

Sincerely,

  
Robert F. Stalnaker  
Acting Director

RFS/bb/7

FISCAL NOTE

REQUEST:

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

Agency Affected: All Agencies  
BRU: Retirement and Benefits  
Components: Retirement and Benefits (CHLB)

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
PERSONAL SERVICES	0	0	532.8	532.8	532.8	532.8
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	0	532.8	532.8	532.8	532.8
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	0	0	481.6	481.6	481.6	481.6
FEDERAL FUNDS	0	0	24.5	24.5	24.5	24.5
OTHER	0	0	26.7	26.7	26.7	26.7
TOTAL	0	0	532.8	532.8	532.8	532.8

POSITIONS:

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

ANALYSIS: (Attach a separate page if necessary)

**DRAFT**

Prepared By: Robert F. Stalnaker, Acting Director  
Division: Retirement and Benefits

Phone: 465-4470  
Date: 2-11-88

Approved by Commissioner: John M. Andrews  
Agency: Department of Administration

Date: \_\_\_\_\_

Distribution (by preparer):

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

House Committee Substitute for Senate Bill 67  
(2/9/88 Draft Version)  
Fiscal Note Analysis  
Prepared by Division of Retirement & Benefits  
Department of Administration

February 11, 1988

Analysis: This bill would require would require increased limits of coverage for mental or nervous disorders under the state's health plans for active employees of the state and retirees.

This bill is estimated to result in a \$3.70 per month increase in Health Insurance costs of an estimated 12,00 state employees effective July 1, 1988. The costs are assumed to remain level each year thereafter because the state does not yet have any experience analysis to indicate that costs will increase annually for this additional benefit, and it is a small portion of the total Health Insurance package.

The FY 89 estimated cost for active state employees is calculated as follows:

The increase of \$3.70 per month health cost times the number of state employees (12,000)	\$532,800
---	-----------

Additional costs reflected in increased employer contribution rates in the Public Employees' (PERS) and Teachers' (TRS) Retirement Systems are discussed in a separate letter to Representatives Ellis and Koponen.

**DRAFT**

SPRING 1986

# PERSPECTIVE

THE BLUE CROSS AND BLUE SHIELD MAGAZINE

SEVEN  
QUESTIONS  
READERS ASK ...

Including the cost of  
high-tech baby care



# Why Are Mental Health Benefits So Troublesome For Health Insurers?

## MENTAL HEALTH SERVICES - EAST



# Q & A

July 1983  
...g Their Regulation of  
Benefits, Eligibility

Health ... THE MILWAUKEE JOURNAL

## Mental health benefits: Not enough? Go on?

By Neil D. Rosenberg  
Journal Medical Reporter

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

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

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

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

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

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

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

## CONGRESS FEARFUL

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

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

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

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

But insurers find it nearly impossible to identify displaced costs.

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



Rep. Merkt



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

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

*That's 22 states in the 1970's.*

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

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

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

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

\*not counting mentally handicapped (32 states)

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

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

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

California, Maryland and Oregon were in that maiden group.

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

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

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

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

## WISCONSIN CARE BOOMING

Wisconsin's experience matches Massachusetts':

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

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

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

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

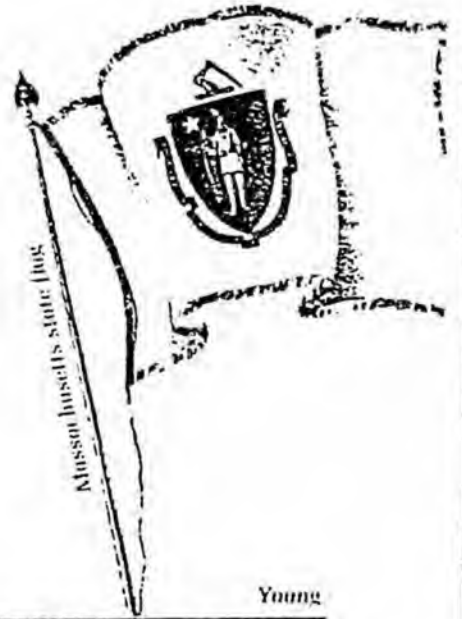
- \$6 extra family fees per month in Massachusetts,
- "nearly \$5" in Kansas, and
- "between \$2 and \$3" in Maryland.

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

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

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

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





CONGRESSIONAL BUDGET OFFICE  
U.S. CONGRESS  
WASHINGTON, D.C. 20515

April 2, 1987

NON-  
DISCR.

Honorable William H. Gray, III  
Chairman  
Committee on the Budget  
U.S. House of Representatives  
Washington, DC

Dear Mr. Chairman:

This letter responds to a request by the Committee Staff for an estimate of H.R. 1067, the "Medicare Mental Illness Non-Discrimination Act" introduced by Representative Downey. Technical problems with the legislative language in the bill prevented us from estimating the bill as introduced. However, discussions with your and Representative Downey's staffs permitted the following general estimates to be developed.

The intent of the bill is to remove the current limitations on Medicare coverage of mental health and inpatient psychiatric hospital services. Current law limits the maximum reimbursement for services provided by a psychiatrist or non-psychiatric physician providing for the treatment of mental, psychoneurotic, or personality disorder to \$250 per calendar year for each Medicare beneficiary. Medicare only recognizes a maximum of 62.5 percent of \$500 of such charges, or \$312.50, and will reimburse 80 percent of this amount or \$250. Consequently, the effective coinsurance rate is 50 percent for the first \$500, and 100 percent thereafter. The reimbursement limit applies to all mental health services whether or not they are supplied by a physician or psychiatrist. However, the limit does not include diagnostic services supplied by a physician. Current law also limits inpatient psychiatric hospital care to 190 days during a beneficiary's lifetime.

Our estimate of the cost of removing the current limitations on mental health and inpatient psychiatric hospital care is contained in the following table. Per your staffs' request, we also have included an alternative approach where the mental health benefit limit is raised from \$250 to \$2000 per calendar year. The unrounded increase in the Part B monthly premium for each option is also shown as requested. All estimates are in millions of dollars for fiscal years.

Option	Fiscal Years					5-Year Total
	1988	1989	1990	1991	1992	
1. Eliminate Mental Health Limit of \$250 per year						
Outlay Increase (millions of \$)	150	230	300	450	520	1690
Premium Increase (\$ per month)	.11	.12	.13	.13	.13	
2. Increase Mental Health Limit from \$250 per year to \$2000 per year						
Outlay Increase (millions of \$)	140	210	300	400	460	1510
Premium Increase (\$ per month)	.10	.10	.11	.11	.12	
3. Eliminate Inpatient Psychiatric Hospital Lifetime Limit						
Outlay Increase (millions of \$)	270	410	460	510	560	2210
Premium Increase (\$ per month)	.20	.21	.21	.22	.23	

Development of this estimate involved using data from the Medicare and the Medicaid Statistical Systems. The estimate also benefited from the recently completed Medicare Mental Health Demonstration conducted by the Department of Health and Human Services. This demonstration was a multi-year, multi-million dollar examination of the expansion of Medicare's mental health benefit. Several of the experimental variations examined by the demonstration were very similar to the modifications of current Medicare law proposed in the bill.

#### Mental Health Estimates

The Medicare statistical system data showed that approximately 465,000 Medicare beneficiaries used \$47 million in mental health services in 1985. Hence, the average user of mental health services used \$101 in 1985. In addition, approximately 10 percent of the beneficiaries who had mental health services had claims that totaled very near or at the \$250 limit. More importantly, this 10 percent of users consumed approximately 29 percent of all Medicare mental health outlays.

The Medicare mental health demonstration had a number of demonstration sites where Medicare beneficiaries were allowed unlimited mental health benefits. The average weighted cost per Medicare user in these sites was over \$510 per year. However, the demonstration did focus on providing services through carefully selected provider groups and outreach activities. A more general expansion of the mental health benefits might therefore not be expected to produce increases of this magnitude. Hence, we reduced this estimate of per capita spending in an unlimited setting by 25 percent to approximately \$384 per year. One approach to the estimate would have been to assume that provision of an unlimited mental health benefit would have raised the average outlay per user from \$101 to \$384 per year. However, such an approach would omit several important considerations.

First, many observers believe that some elderly who currently need mental health services are receiving them through providers billing mental health services through other billing codes not subject to the mental health limit, thus avoiding \$250 limitation. We were unable to locate any reliable data regarding the frequency of this occurrence. However, we did reduce the overall increase in cost per user by 5 percent to account for this factor based on widespread agreement that at least some care is being provided in this manner. A second consideration in the estimate is the increase in the number of users of mental health services that removing the limit would produce. The Medicare Mental Health Demonstration found that the number of users of services doubled during the demonstration. Since the 465,000 current users represent 1.52 percent of Medicare enrollees, that would mean that approximately 3 percent of all Medicare enrollees could become users. Given the estimates of the prevalence of mental health problems among the elderly which range as high as 18 percent, an increase from 1.52 percent to 3 percent users seems reasonable. However, although we believe that this level of use would eventually be reached, it would take several years to reach these levels due to such constraints as the available supply of providers. Hence, we have assumed that the use rate would be 1.8 percent in 1988, 2.1 percent in 1989, 2.6 percent in 1990 and 3 percent in 1991 and 1992. Finally, although the Medicaid statistical system could not produce exact estimates, it appears that eleven states offer some additional mental health coverage to Medicare beneficiaries who are also Medicaid eligible. Based on conversations with Medicaid staff in these states, we reduced the estimate by 5 percent to account for this factor.

Our estimate of eliminating the Mental Health Limit (option 1) involved combining the foregoing assumptions with our baseline assumptions concerning increases in program prices and overall Medicare program growth. The estimate of placing a \$2000 per calendar year limit on mental health reimbursement (option 2) built on the estimate of option 1. Specifically, the Medicare Mental Health Demonstration found that 6.2 percent of the users exceeded \$2000 per year in costs.

Honorable William H. Gray, III  
April 2, 1987  
Page 4

The 6.2 percent of users consumed 12 percent of total mental health services, and we have reflected this in our estimate.

It should be noted that an argument can be made that other Medicare savings will accrue because of the improved health status of those receiving these expanded services. However, the demonstration evaluators found no such effects. Based on their findings and a lack of other evidence on whether such offsets exist, we made no adjustment in our estimates.

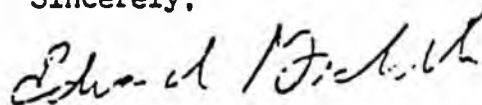
Inpatient Psychiatric Benefit Estimate

Medicare spent approximately \$550 million on providing 103,400 beneficiaries inpatient psychiatric hospital care in 1985. Unfortunately, the Medicare Statistical system could not identify the exact number of persons that reached their limit during the year. However, the Medicaid Statistical system identified approximately 31,000 Medicare enrollees that received \$813 million in inpatient psychiatric hospital services through the Medicaid program. If the current 190 day lifetime Medicare reimbursement limit were eliminated, Medicare would pay for many of the services currently being reimbursed through Medicaid, and federal costs would increase by the state share of Medicaid. In addition, some additional utilization would occur from beneficiaries or their families who are financing care not currently being paid for by either Medicare or Medicaid. After examining the current distribution of stays in such hospitals, it appears that a 12 percent increase could be expected based on the number of stays at the current limit. As was the case with the mental health estimate, the combination of the foregoing assumptions and our baseline assumptions yielded our estimate of eliminating the Medicare inpatient psychiatric hospital limit.

Please note that all estimates are preliminary pending final legislative language. If you have any further questions, please call me or have your staff contact Don Muse (226-2820).

With best wishes,

Sincerely,



Edward M. Gramlich  
Acting Director

cc: Honorable Thomas J. Downey

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## Changes in Health Care Costs and Utilization Associated With Mental Health Treatment

Harold D. Holder, Ph.D.  
James O. Blose, M.P.P.

*Health insurance claims of families covered by Aetna's Federal Employees Health Benefit Program from 1980 through 1983 were analyzed to determine if any changes in total health care utilization and costs were associated with the initiation of mental health treatment. A total of 26,915 families in which at least one member received mental*

*health treatment were compared with a randomly selected group of 16,468 families in which no member had received mental health treatment. Total health care costs for those receiving mental health treatment were significantly higher than costs for the comparison group. However, those costs dropped significantly after initiation of mental health treatment and continued to decline over the study period. The biggest declines occurred among*

*persons age 45 and older, a finding that may have important policy considerations.*

While mental health care could be seen as adding to the overall cost of general health care, there is growing evidence that mental health care actually results in lower total health care utilization and costs for treated persons. This can be the result even when the cost of mental health care itself is included. Follette and Cummings (1), in

one of the first major American studies of this question, found that the use of nonpsychiatric medical services dropped following the initiation of psychotherapy. Jones and Vischi (2) reviewed 13 studies and found that 12 showed reductions in medical care utilization, ranging from 5 to 85 percent following mental health intervention.

Mumford, Schlesinger, and Glass (3), in a meta-analysis of 15 controlled cost-offset studies published before 1978, estimated the cost-reduction effect for mental health treatment at between 0 and 14 percent.

Mumford, Schlesinger, and Glass (4), following a review of research on the impact of psychological intervention on recovery from surgery and heart attacks, found that on the average psychological intervention reduced hospitalization by approximately two days below the control group's average of 9.92 days.

Another study by Mumford and associates (5), which utilized a meta-analysis of published cost-offset research, found that the range in outcomes varied from a 72.4 percent increase in the use of medical services following psychotherapy to a 181.6 percent decrease. The study found that the offset effect is likely to be greater for inpatient medical care utilization than for outpatient utilization. It also found that older people had greater offset effects following mental health treatment than did younger people.

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The same research team has also conducted a five-year longitudinal analysis of medical care utilized by persons enrolled with the Blue Cross/Blue Shield Federal Employees Benefit Program from 1974 through 1978. They found that persons with from seven to 20 mental health outpatient visits had medical care charges that were \$309 lower than those of the comparison group, and those with more than 21 visits had charges \$284 lower than the comparison group (6).

Two studies have been conducted involving patients from the Columbia Medical Plan. Kessler and associates (7) found a 7.6 percent reduction in medical visits for adults in the year following the beginning of the psychiatric episode compared with the year before, and a 9.3 percent reduction for children. Hankin and associates (8) found that the receipt of specialty mental health care was followed by a short-term reduction in nonpsychiatric utilization.

Emotional problems could be associated with either underutilization or overutilization of medical care (3). Underutilization as a result of self-abuse or neglect can contribute to excess morbidity and untreated physical disability or disease. Thus higher medical care costs could follow mental health treatment as a consequence of an improved emotional state and increased self-awareness (9,10).

On the other hand, overutilization prior to initiation of mental health treatment could result in substantially higher general medical care costs. The above studies suggest that overutilization of health care prior to initiation of mental health treatment is more likely than underutilization, on the average.

#### Research design

This paper describes the results of a research project to further investigate the question of over- or underutilization of health care and to document the nature of changes in health care costs and utilization

following initiation of mental health care. The findings described are from a study of federal employees and their family members enrolled with the Aetna Life and Casualty Company under the Federal Employees Health Benefit Program (FEHBP) during the calendar years 1980 through 1983. To document changes in total health care utilization and costs, the study analyzed all health insurance claims filed by covered individuals who began mental health treatment.

During the years covered by this study, Aetna FEHBP was the second largest of more than 100 health plans available to federal employees. Two benefit options were available under the plan: the high-option plan, which set limits of \$20,000 annually for inpatient mental health care and \$1,000 annually for outpatient mental health care; and the low-option plan, which had limits of \$15,000 and \$750, respectively.

Both options included coverage for treatment services rendered by a wide range of practitioners and facilities, as long as overall care of the patient was evaluated and controlled by a physician. There were no changes in mental health coverage during the study period.

In this study, persons receiving mental health treatment were defined as those who had received medical treatment under a primary diagnosis of mental illness. All health care claims were reviewed to locate all families with one or more members who had filed at least one claim for mental health treatment and who were continuously enrolled with Aetna during the study period. The number of such families totaled 26,915, and 33,009 individuals in these families received mental health treatment.

In addition, a random sample from the total continuously enrolled population of families who did not file claims for mental health treatment was selected as a comparison group. This random sample was composed of 16,468 families and included 41,829 indi-

viduals who were stratified by age to match the age distribution of the mental health study group. Families with any member receiving treatment for alcoholism or drug abuse were excluded from both the comparison group and the mental health study group.

The ideal research design for determining statistically significant changes in total health care patterns would use experimental treatment and no-treatment control groups randomly assigned from the same population. However, the identification of a diagnosed but untreated group is impossible in a large field study utilizing health insurance claims as a means to identify the treatment population.

An alternative is a quasi-experimental design that utilizes a non-equivalent comparison group as well as multiple pretests and posttests (11,12). A pre-post design was used to compare pre-mental-health-treatment averages over various time periods with averages after initiation of treatment.

Since the comparison group is a nonequivalent one, it can be used only for baseline comparisons with the mental health treatment group.

In addition, a longitudinal analysis that pooled available data from all individuals was used to describe long-term patterns. The pre-post analysis permits reliable testing for statistically significant changes in cost and utilization. The longitudinal analysis permits use of all the available data to document long-term trends and tendencies.

#### Comparison of the groups

The mental health study group and the comparison group were quite similar in average family age, family size, and type of health insurance plan option. The average family size for those with at least one member receiving mental health care was 2.57 persons, compared with 2.54 persons in families in the random sample. The average family age (as of January 1984) was 48.8 years for the mental health treatment group and 49.2 years for the comparison group. The same percentage of both groups (79 per-

cent) were enrolled under high-option coverage.

The monthly per-person costs (in January 1980 dollars) for all health care for families with at least one member receiving mental health treatment were \$158.82, compared with \$91.35 for the random sample. Most of this difference was the result of inpatient treatment costs (\$104.85 a month for the mental health treatment group versus \$60.12 a month for the random sample). However, there were also differences between the two groups in ambulatory care and other costs over the four-year study period.

The families with at least one member receiving mental health treatment averaged .39 inpatient days per person per month compared with .18 days for the random sample. Mental health treatment costs amounted to \$22 per month, or 14 percent of the \$159 average monthly costs for all health care for persons in the mental health study group, thus indicating that these cost differences are not due primarily to the cost of mental health treatment. All of these comparisons were statistically significant at  $p < .001$ . In point of fact, given the relatively large treatment group and comparison group sizes utilized in this study, most differences were statistically significant.

#### Mental health treatment costs and utilization

During the 1980-83 period, those in the continuously enrolled population who filed mental health treatment claims were largely female (60.6 percent). The mean age was 45.3 years but varied widely. More than 16 percent of the group were under 21 years old and 23 percent were 65 and over. Forty-five percent of the group were enrollees (federal employees or annuitants), 33 percent were spouses, and 22 percent were dependent children. Less than 1 percent were other dependents.

The cost of mental health care per person receiving care during the study period was \$2,079 (January 1980 dollars), of which 63.4 percent was paid by Aetna as

health insurance benefits. Inpatient care, though utilized by only 20 percent of the mental health patients, accounted for 60 percent of mental health treatment costs. The average length of inpatient mental health treatment was 32.2 days. More than half of the inpatient stays were 21 days or less, and almost a fourth were seven days or less. The average cost per admission was \$3,887 (January 1980 dollars), and the average number of admissions per person utilizing inpatient care was 1.57. No data were available on whether the inpatient stays were in specialty facilities or general hospitals.

Ambulatory care was used by 83.7 percent of those receiving mental health treatment, and they had an estimated 22 mental health ambulatory visits per person during the study period. The number of estimated visits is based on claims data from institutional providers only; whether a similar number of visits were made to private practitioners is unknown. The primary providers of ambulatory mental health care were physicians, who accounted for 71 percent of total visits (Aetna's codes did not distinguish between types of physicians); psychologists, who accounted for 20 percent; and psychiatric social workers, who accounted for slightly more than 3 percent.

#### Pre-post patterns of medical care

Total medical care costs and utilization for individuals receiving mental health treatment were analyzed using the first such treatment event as a reference point. Individuals began treatment during each month of the study period, and there were varying amounts of data available for analysis before and after initiation of treatment. For example, persons beginning treatment in early 1980 would have only a few months of pretreatment data but more than three years of posttreatment data. For those whose initial treatment was in mid-1983, the opposite situation applied.

The primary research question

was whether there was a reduction in total health care utilization and cost following initiation of mental health treatment. Thus the study tested for statistically significant changes in medical care costs and utilization using three groups composed of individuals having similar pre- and posttreatment periods. The first group contained persons for whom 12 months of pretreatment data and 12 months of posttreatment data were available ( $N=12,699$ ). Analysis found a statistically significant decrease in total monthly health care costs per person ( $t=6.44$ ,  $df=25,396$ ,  $p<.001$ ). The costs dropped from \$263.28 before treatment to \$208.79 after initiation of treatment (January 1980 dollars).

Longer and more meaningful periods of comparison were provided by group 2, persons for whom a full 24 months of pretreatment data and 12 months of posttreatment data were available ( $N=5,213$ ). In general, cost and utilization levels in group 2 increased from the 13- to 24-month pretreatment period to the 12 months preceding initial mental health treatment; they then declined during the first 12 months after initiation of treatment. Total health care costs per month per person increased from \$121 to \$278 and then fell to \$202 after initiation of treatment ( $F=102.14$ ,  $df=15,638$ ,  $p<.001$ ). This pattern is primarily due to changes in inpatient costs, which went from \$74.91 during the 13- to 24-month pretreatment period to \$201.33 after initiation of treatment. Inpatient costs in the 12-month period after initiation of mental health treatment dropped to \$127.70. The differences were statistically significant ( $F=82.02$ ,  $df=15,638$ ,  $p<.001$ ). Ambulatory costs and utilization remained essentially the same during the first year after initiation of treatment.

These results are confirmed in the analysis of group 3, those with at least 12 months pre- and 24 months posttreatment data. This group provides clear evidence that the decline in cost and utilization continues in the second year fol-

lowing the initiation of mental health treatment. Total health care costs per month per person fell from \$242 in the year before treatment to \$214 in the first year after treatment began to \$162 in the following year. These differences were statistically significant ( $F=21.88$ ,  $df=17,642$ ,  $p<.001$ ). As with group 2, this drop was

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**These results provide considerable evidence that total health care costs and utilization gradually increased before mental health treatment was initiated and decreased afterward.**

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primarily the result of decreases in inpatient days per month per person from .63 to .52 to .39 days ( $F=19.02$ ,  $df=17,642$ ,  $p<.001$ ) and inpatient costs per month per person from \$167 to \$133 and \$106 ( $F=13.95$ ,  $df=17,642$ ,  $p<.001$ ). Ambulatory care costs actually increased in the year following initiation of treatment (from \$59.15 in the year before to \$64.15 in the year after) due to the use of ambulatory mental health services, but they fell below the pretreatment level in the second posttreatment year (\$42.29). These differences were also statistically significant ( $F=60.59$ ,  $df=17,642$ ,  $p<.001$ ).

These results provide considerable evidence that the total health care cost and utilization for treated persons gradually increased prior to the initiation of mental health treatment and then decreased afterward. This is true even when all mental health treatment costs and utilization are included in the analysis. Ambulatory care often did not follow this pattern, likely due to extensive use of ambulatory mental health care during the period after initiation of treatment.

The health care patterns of the family members of persons receiving mental health treatment were

also analyzed. Total monthly health care costs for the family members of mental health patients showed a downward trend, beginning before the point of initiation of mental health treatment of the family member or members. For example, untreated individuals with data for at least 24 months before and after initiation of treatment for a member of their family ( $N=3,074$  families) had total health care costs per month per person of \$101.71 in the 13- to 24-month pretreatment period, \$93.13 in the 12-month pretreatment period, and \$74.03 in the 12-month period after initiation of treatment ( $F=5.05$ ,  $df=9,221$ ,  $p<.01$ ).

While in general the health care patterns of the family members of mental health patients follows that of the treated group, that is, costs are higher before treatment and lower after initiation of treatment, the peak in costs occurred in the second year prior to treatment and declined after that point. This could suggest that family members anticipated the start of mental health treatment, or that they put more personal energy into support and less into utilization of health care as the family member with mental health problems became increasingly disabled just prior to treatment. It is also possible that the increasing disability of the family member with emotional problems in some ways deterred other members from utilizing health care.

#### Longitudinal analysis of total health care costs

The pre-post analysis confirms that statistically significant changes in health care patterns are associated with the initiation of mental health treatment. However, the patterns of average monthly total health care costs can also be examined longitudinally by pooling the data for all mental health patients (more than 33,000). This yields a distribution of average cost per individual over a six-year period—36 months before and 36 months after the initiation of mental health treatment. The pretreatment val-

ues were \$108 (31 to 36 months), \$128 (25 to 30 months), \$124 (19 to 24 months), \$126 (13 to 18 months), \$147 (seven to 12 months), and \$493 (one to six months). Posttreatment initiation values were \$239 (one to six months), \$183 (seven to 12 months), \$167 (13 to 18 months), \$158 (19 to 24 months), \$144 (25 to 30 months), and \$137 (31 to 36 months).

These data illustrate the gradual rise in total health care costs over the 36-month period before the start of mental health care and a sharp climb in such costs in the six-month period immediately prior to treatment. After treatment began, total costs dropped continuously over the following 36 months.

The longitudinal patterns of age and gender subgroups were similar to that of the overall study population. However, important differences between subgroups did exist. One way of examining these differences is to evaluate the extent to which the health care costs of persons receiving mental health treatment converge with the cost levels of individuals of similar age or sex from the random sample of families in which no members received mental health treatment.

For each six-month interval defined above, monthly total health care costs of treated individuals were transformed into a proportion of the average monthly per-person health care costs of the corresponding age or sex cohort from the random sample. The age and sex cohort provides a baseline for the expected level of cost on the average. For each month of the study period, average total health care costs for the mental health patients (defined by age group or gender) were divided by the monthly average for the corresponding age or sex cohort to develop an index or ratio. Thus a value of 1 indicates that the monthly average for any interval was equal to the monthly four-year average of the baseline group. A value less than 1 means the mental health treatment group experienced costs less than the baseline, and a value greater than 1 indicat-

ed costs higher than baseline.

All of the three youngest treatment subgroups (under 14, 14 to 19, and 20 to 24) incurred initial costs (in the 31- to 36-month pretreatment period) that were higher than their age cohorts, with values of 1.47, 1.19, and 1.61, respectively. By the end of the follow-up period (31 to 36 months after initiation of treatment), health care costs for all groups remained considerably higher than for their age cohorts (2.49 for those under age 14, 3.17 for ages 14 through 19, and 2.44 for ages 20 through 24). The 14 to 19 age group had the highest costs relative to their non-treatment age cohort at the time of initiation of treatment. Their costs peaked at a level 23 times higher than their general age cohort.

Compared with their younger counterparts, mental health patients in the three older subgroups (25 to 44, 45 to 64, and 65 and older) incurred costs that converged more closely with those of their age cohort by the final post-treatment interval (31 to 36 months). This is illustrated by the values of 2.12 for those between age 25 and 44, 1.73 for those between age 45 and 64, and 1.37 for those age 65 and older.

Cost ratios for males and females were also analyzed. Females in the treatment group initially (31 to 36 months prior to treatment) had total health care costs per month that were significantly higher than costs for females in the random sample (a proportional value of 1.77). Males receiving mental health treatment, however, had costs comparable to males from the random sample baseline at this point (1.01). By the final posttreatment period, males were closer to the levels of the random sample (1.66) than were females (1.99), although the costs for treated females were closer to their actual pretreatment costs.

### Conclusions

The results of this study provide confirmation of the findings of previous studies as well as provide new findings, previously unreported, concerning the question of the

potential for mental health treatment to reduce other health care costs.

In this study, the total health care utilization and costs of Aetna FEHBP-enrolled families receiving mental health treatment were higher than those of a demographically similar comparison group of enrolled families not receiving mental health treatment.

The longitudinal pattern of total health care costs illustrates that a marked increase in such costs among individuals with mental health problems can be expected over the 36-month period prior to initiation of treatment. A decrease in total health care costs can be expected following the start of mental health treatment—even when the costs of this treatment are included. This is in contrast to Borus and associates' finding (13) that offset savings in general ambulatory medical care were overshadowed by charges for the specialty mental health care itself.

Our analysis of specific age subgroups indicates that subpopulations are differentially contributing most to the overall drop in total health care utilization. The best convergence with the baseline level of their general age group cohorts occurred for patients who were age 65 and older, followed by those in the 45 to 64 age group. The two youngest groups, ages 14 to 19 and under age 14, had the least convergence with their general age group cohorts. It is possible that these differential cost patterns are due in part to age-related variations in specific diagnoses or in severity of mental illness. This issue could not be addressed with the data available for this study but merits further investigation.

It is not possible to estimate exactly how much of the decline in health care utilization after initiation of treatment is due to treatment per se versus other factors such as self-selection and motivation, regression toward the mean, and so forth. The relatively long periods before and after initiation of treatment used in our analyses, however, provide a valuable perspective for evaluating this issue.

Some previous studies that have utilized relatively short pretreatment periods (usually 12 months) have been open to the criticism that the reductions in health care costs immediately following treatment initiation might be explained by "regression to the mean" (3,5).

Following an extraordinary level of stress and discomfort (one expression of which is increased health care utilization), a subsequent drop in health care utilization could be expected (at least temporarily) simply because of the termination of the crisis at hand.

Some of the observed decreases in costs and utilization in this study are likely related to this natural adjustment. However, we found that the health care costs of treated individuals continued to drop in relation to their prior costs as well as in relation to the costs of untreated persons of similar age and sex for up to three years after initiation of treatment. We believe it is rather unlikely that this decline is totally explained by an ending of a personal crisis (and the resulting statistical regression).

This study, like the others cited earlier, supports a conclusion that the initiation of mental health treatment by self-motivated patients can yield positive reductions in health care utilization and costs for a large insured population even when there is no direct control over the variety and quality of care. Such a finding has important policy implications for prepaid medical groups as well as insurance companies.

No study of the health care costs and utilization of treated persons based on a single enrolled health insurance population is readily generalizable beyond that population. Given the heterogeneity of enrolled populations, the variety of health insurance benefit plans across the country, and the mix of available general health care and mental health treatment services, no single study is likely to be nationally representative.

This study is not as subject to biases due to regional variations in general health or mental health care as is much other research,

since the population of persons filing mental health treatment claims with Aetna is a national one, drawing on all 50 states. However, it is not necessarily geographically representative of either the U.S. population or the population of federal employees, since many factors influence the choice of health plans by government workers.

Roughly 60 percent of Aetna claimants receiving mental health treatment are age 45 and older. The study finding that older age groups have greater opportunity for cost reductions than younger groups is an important policy consideration. Older people tend to use more medical care services than those in younger age groups, specifically more expensive hospital care. As the Aetna-enrolled population is older than many enrolled populations, studies of a noticeably younger enrolled population may find smaller treatment effects.

This study makes an important contribution to an ever-enlarging research base concerning the patterns of health care before and after mental health treatment. The study documents the potential of reductions in total health care costs following initiation of mental health treatment. The longitudinal pooled data show that total health care costs at the end of the 36-month period following initiation of treatment are higher than the costs at the equivalent point 36 months before treatment. However, given the six-year span represented and the general tendency of health care costs to increase as a population ages, this result is not surprising.

Since the cost trend following treatment initiation is downward, it may not be unrealistic to expect even lower total health care costs over a longer follow-up period.

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Official Business

**COMMITTEE:**

HOUSE HESS

**DATE:** 2-9-88

**SIGN-IN**

**Subject of meeting:**

CSSB 530 Approp: DOE for K-12  
HB 372 Suspended Imposition of sentence  
CSSB 67 Health Insurance for Mental Conditions

NAME	ADDRESS	PHONE	REPRESENTING	DO YOU WANT TO TESTIFY? if yes, which one?
BOB STALNAKER	Box CR	465-4470	RETIREMENT + BENEFITS	CSSB 67
Sharon Johnson	3340 Fritz Lane Juneau	586-4950	Mental Health	67
Jerald Michael	Pouch F	465-2865	DOE	no

4



Official Business

**COMMITTEE:**

HOUSE HESS

**DATE:** 2-9-88

**SIGN-IN**

**Subject of meeting:**

CS55 330 - Approp: DOE for K-12  
 HB 372 - Suspended Imposition of Sentence  
 CS513 67 - Health Ins. for Mental Conditions

NAME	ADDRESS	PHONE	REPRESENTING	DO YOU WANT TO TESTIFY? if yes, which one?
Sharon Young	3110 W 11 <sup>th</sup> St	6-1083	AASB	No
Guy Sibley	"	"	"	"
Bob Manners	NS Municipal Way #302	586-3890	NEA	Yes 330
Joanne Clark	Div. of Mental Health + D.D.	465-3370	Div. of Mental Health + D.D.	yes
DAVE WILLIAMS	Div. of Budget & Finance	465-3015	PHS	NO
Nina Keele Kinney	DEPT OF PUBLIC SAFETY PO Box N, 99811	465-4356	Council on Domestic Violence & Sexual Assault	HB 372
Gordon Evans	318 4 <sup>th</sup> St.	586-3210	HIAA	CS55 67 YES
Mike Miller				CS55 67 YES
Clark Kinnear	328 Coleman St	586-8110	APIT	CS55 67 YES
Karen Rentsch		3795	Leg Finance	NO

Stephanie Joannides P.O. Box KC  
 JUN 99811

5-3428

Dept of Law

only if these are full stops - HB372

# Alaska State Legislature



PRESIDENT

907-465-3755

JAN FAIKS  
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JUNEAU, ALASKA 99811

Senate

May 11, 1987

## MEMORANDUM

TO: Representatives Johnny Ellis and Niilo Koponen,  
Co-Chairmen,  
House Health, Education and Social Services  
Committee

FROM: Senator Jan Faiks  
President of the Senate

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

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

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

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

OUT OF SESSION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In a 1983 study, a moderate amount of psychotherapy was shown to significantly reduce hospital costs for persons suffering from four different types of chronic disease. Another study

that same year showed that patients who received outpatient psychotherapy treatment used 56% fewer medical services than those who had not been treated.

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

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

Specifically, this bill proposes the following:

Section 1. COVERAGE FOR TREATMENT OF A MENTAL OR NERVOUS CONDITION. AS 21.42 is amended to add a new section (21.42.365) which will require coverage for treatment of a mental or nervous condition.

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

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

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

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

(c) The Senate HESS CS to this bill provides that if an insured or a subscriber does not opt for the coverage under this section, the insurer or service corporation may offer other coverage for treating a mental or nervous condition.

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

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

I would request that the committee consider changing the definition of "office visit" in section (7) to reflect that treatment which is provided through the professional offices of the listed classes of mental health care providers.

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

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

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

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

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

I am enclosing an amendment and a marked-up copy of SB 67 which reflect the requested changes to this bill. I would appreciate the committee's consideration of the legislation at its earliest convenience. Should you need any additional information, please let me know.

Thank you.

# Sitka Mental Health Clinic

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Michael Boyd, Ph.D.  
Psychologist

12-9-87

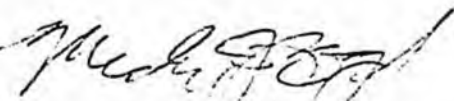
Honorable Nilo Koponen  
Co-Chairman House, Health Ed. and Soc. Svcs. Comm.  
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Dear Representative Koponen:

I am writing concerning CSSB 67 which is scheduled to come before your committee during the upcoming session of the legislature. CSSB provides for insurance coverage for treatment of mental or nervous conditions. I would like to encourage you to speedily act on CSSB 67 and refer it on with a recommendation of approval by the house.

State funded mental health programs depend on insurance payments for much of their revenue. At this time, many insurance companies will not pay for treatment provided by someone who is not a psychiatrist or licensed psychologist. While many clinics are directed by psychologists or psychiatrists, few can afford to have professionals of that level as primary care givers. CSSB 67 provides that state funded mental health clinics would be eligible for insurance payments as long as a therapist is supervised by a physician or a psychologist. With the provisions of CSSB 67, state funded mental health clinics would be more able to collect needed revenue from third party payors.

Respectfully,



Michael J. Boyd, Ph.D.  
Psychologist

MB/imr

cc: Albert P. Adams  
John Sund  
Albert Adams



(2)

The next register will be open in September of 1988. To be eligible ~~as~~ for certification under

~~The~~ the NASW register of Clinical Social Workers a social worker must meet the following requirements:

(1) Masters or doctoral degree in social work in a program accredited by the Council on Social Work Education;

(2) 2 years of full-time experience or 3000 hours accumulated over a period of not less than 24 months, of post-masters clinical social work practice that was supervised by a social worker holding at least a master's degree.

(3) Has at least 2 years of full-time experience or 3000 hours of direct practice within the last 10 years.

(4) Is a current member of the Academy of Certified Social Workers, or is licensed or certified in a state at the appropriate level.

Requirements for the Nat. Registry of H.C. providers are similar. Requirements for the ABESW (referred to as the diploma in clinical social work) are 5 years of direct practice.

(3)

(3) Please be aware that this standard is very stringent (see Vendorship Report, page 4).

Without licensing of social workers by the State of Alaska, this high standard must be ~~not~~ maintained because there is no

mechanism to assure that qualifications are met by practitioners. Additionally, there is the problem of consumer protection and accountability. Because certification currently requires membership either in NASW or the Society of Clinical Social Work Practice (SIC) in Alaska, there are internal grievance committees that can handle ethics complaints.

We can not recommend that ACSW be used as an alternative ~~to~~ to clinical social work certification because not all ACSW's (approx. 125 in Alaska) are engaged in clinical social work practice.

Thanks for your assistance.

ALASKA

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ALASKA

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(5)

# PROFESSIONAL SOCIAL WORK RECOGNITION

## Vendorship Report

June 1987



THE NATIONAL ASSOCIATION OF SOCIAL WORKERS, INC.  
7981 EASTERN AVENUE, SILVER SPRING, MARYLAND 20910  
(301) 565-0333

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## I. INTRODUCTION

This is the latest in a series of reports from the National Association of Social Workers (NASW) on our continuing efforts to achieve recognition of the professional social worker as an independent health-care provider whose charges for treatment services are reimbursable by all private and public health-care insurers. This 1987 Vendorship Report seeks to provide a picture of the current status of these efforts and an overview of the complexities of third-party payment as it pertains to social workers.

Reducing costs while enhancing quality of care is a major issue now affecting every component of the health/mental health delivery system, including social work services. Social workers must be more conscious of and knowledgeable about the actual service delivery costs of their interventions as well as more alert to the cost-benefit implications of the provision of social work services in the larger context of overall expenses for health/mental health care.

As more health insurance policies include mental health benefits, and as budgets for agencies decrease, clinical social workers in all settings are steadily exploring with clients the use of health insurance to help defray the cost

of clinical social work services. The use of insurance payments (also called "third-party payments") is thus of vital interest to all clinical social workers.

A further issue is societal recognition of social workers as fully qualified professionals who provide the bulk of mental health services in the United States, but who too frequently are devalued or are seen as legitimately practicing only when under a physician's supervision. This misapprehension is fostered by other professionals who perceive clinical social workers as competitors for clients and dollars. Thus, the struggle for professional recognition is tied to the struggle for independent mental health provider status.

The information contained in this report will be useful to social work practitioners, agency administrators, social work students, and NASW members currently working to achieve full recognition of professional social workers. Efforts are being rewarded through successful legislation and regulation at the federal and state levels, through more knowledgeable consumers, and through successful negotiations with representatives of the insurance industry to recognize social workers.

## II. GENERAL PERSPECTIVES

### A. On Third-Party Reimbursement

Charging fees for service is common practice in social work agencies. The contract for payment, whether verbal or written, is usually between the agency and the client recipient of the service. With the advent of major medical insurance protection in the 1950s and the emergence of federal health-care programs such as Medicare in the 1960s, many persons receiving treatment for emotional and mental illnesses became eligible for reimbursement of all or part of the cost of treatment received from approved health-care providers. Some states have recently enacted legislation requiring health insurance contracts to include coverage for mental health. This is usually for a specific amount and is called "mandated" mental health coverage (see section D below). Some employers, consumers, and unions also insist on coverage for emotional and mental illness and substance abuse in insurance contracts. In spite of this progress, by 1987 most health insurance contracts and many federal health-care programs do not provide benefits for the treatment of emotional or mental illnesses or substance abuse. Moreover, few of the contracts and programs that do provide such benefits recognize clinical social workers as qualified providers of treatment whose fees for service can be reimbursed.

When a client has insurance coverage for mental illness, the policy usually requires that the client pay a certain amount before the insurance is activated. This is called a "deductible" and may vary from \$50 to \$500, depending upon the policy. After the deductible has been met, the insurance policy will reimburse the client for a proportion of the fees charged. This proportion varies from policy to policy but usually is 50 percent to 80 percent of the fees charged. Sometimes there is a maximum allowable amount for a particular service. For example, if the policy pays 50 percent of an allowable fee of \$40 per visit after the deductible has been met, then the company will reimburse the client \$20 for each visit. If the charge is \$30 per hour, the client must pay \$30 per hour to make up the total of \$50. The amount the client pays is referred to as a "copayment."

Insurance companies issue policies which specify the services and service providers they will cover. They may also specify an upper limit to the total amount they will pay, and restrict the number of therapist visits for which they will pay per week or per year. It is therefore important to encourage the client to scrutinize the insurance policy in order to clearly understand entitlements and limitations. It is also important to remember that the insurance reimbursement is to the client, and only if benefits can be and are assigned, will reimbursement checks go directly to the social worker or agency.

Three factors need to be considered in attempting to determine if a client is eligible for reimbursement. They are: (1) Is the client insured for the treatment of the diagnosed illness? (2) Are social workers recognized as qualified providers under the state's insurance laws, the specific insurance contract, or the regulations pertaining to the federal program? (3) Does the provider meet the criteria established by the state, or social work professional association, or insurance contract for recognition as a clinical social worker? The answer to all three questions must be affirmative for the insured person to qualify for reimbursement in accordance with the conditions of the contract or program.

### B. On Securing Recognition

There are four basic methods for securing recognition of clinical social workers as approved providers for reimbursement under health insurance contracts. They are: (1) mandated recognition of the profession by state or federal legislation; (2) voluntary recognition by the insurer; (3) demand for inclusion by the purchaser of the contract; and (4) a negotiated demand by consumer representatives (such as labor unions).

Each of these methods requires that supportive information be amassed by the clinical social work advocate(s) and that appropriate decision makers be convinced that recognition of clinical social workers is a decision that will benefit their constituents.

The process will be much the same whichever population is selected as the immediate target. Success will require fact-finding, the designing of an effective presentation, and the building of an appropriate political support base. Recognition via state or federal legislation is most effective since it affects all of the people under that entity's specific jurisdiction. State licensing at the independent clinical practice level is considered a prerequisite for effecting an amendment to the state's insurance code to include social workers as qualified mental health providers (a vendorship law). Social work licensing and vendorship laws at the state level are more effective than individual negotiation with hundreds of insurers, employers, and consumer groups. Successful vendorship efforts depend upon building a broad political support base; that is, developing a coalition of social work and consumer groups.

The NASW national office provides basic background information, data, and resources to assist in the designing of an effective strategy. Ongoing consultation is available to NASW members and state chapters.

### C. On Freedom-of-Choice or Vendorship Legislation

"Freedom-of-choice" legislation requires that if health insurance provides mental health coverage, the beneficiary has the freedom to choose any qualified mental health provider. "Vendorship" refers to the status of a group, in this case clinical social workers, to be eligible for insurance reimbursement as a qualified provider of mental health services. This legislation is usually an amendment to the state's insurance laws and refers to qualified providers as those who are duly certified or licensed for mental health practice in that state. Thus, legal regulation of social workers is almost always a prerequisite to a state vendorship law. Some states do not have freedom-of-choice legislation but rather specifically mandate that beneficiaries be reimbursed for services provided by appropriately licensed or certified social workers. Vendorship efforts are important to ensure that all citizens are free to choose their mental health provider and are not limited to only one profession.

Fifteen states and the District of Columbia currently have some form of such vendorship legislation: California, Florida, Kansas, Louisiana, Maine, Maryland, Massachusetts, Montana, New Hampshire, New York, Oklahoma, Oregon, Tennessee, Utah, and Virginia, as well as the District of Columbia. See Table 1 for further details of state vendorship laws.

A number of NASW chapters are currently working on vendorship or freedom-of-choice legislation in their states, and the NASW 1984 Delegate Assembly voted vendorship activities as one of the top priorities for the Association.

### D. On Mandated Mental Health Benefits

A number of states have passed legislation mandating that all insurance companies that write health coverage in that state must include, as a covered service, reimbursement for mental health claims. Other states have passed legislation that requires insurance companies to offer these mental health benefits but permits the subscriber to reject the benefits. This latter law is called "mandatory availability." Laws mandating benefits for alcohol and drug treatment or requiring mandated availability have also been passed in many states. Mandated mental health benefits laws frequently provide for reimbursement for licensed social workers and thus the law becomes a vendorship law.

Mandated mental health laws do not usually apply to self-insured plans, which now cover a major portion of employees.

State	Effective Date	Professional Title	Requirements	Coverage Details	Insurance Written in Another State	Referral Requirements
California	January 1977 Amended 1984	Licensed Clinical Social Worker	None	Policies w/ mental health must reimburse LCSWs as reimbursable providers	Yes	By licensed physician or psychologist
District of Columbia	February 1987	Licensed Clinical Social Worker	None	Mandated mental health benefits. Must reimburse LCSWs	Not specific	Not required
Florida	October 1983	Licensed Clinical Social Worker	None	Coverage for LCSW must be offered to policy holders; in-patient minimum 30 days, out-patient max. \$1000	Not specifically but may be	Not required
Kansas	April 1982	Specialist Clinical Social Worker	None	CSW must be reimbursed for services within their scope of practice unless policy holder refuses such coverage in writing	No	Not required
Louisiana	July 1981	Board Certified Social Worker	Must be listed in a National Clinical Social Work Registry	Policies with mental health coverage must reimburse BCSWs	Yes	Referral not required but physician consultation and collaboration required
Maine	January 1984	Certified Social Worker; Clinical Social Worker (after 1/1/85)	None	Policies with mental health coverage must reimburse CSW	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 LCSWs	Yes	Not required
Montana	October 1985	Licensed Social Worker	None	Coverage for mental health benefits must reimburse LSW with mandatory mental health coverage for group health insurance policies	Not specific	Not required
New Hampshire	January 1984	Certified Clinical Social Worker	None	Coverage for CCSW must be offered to policy holders (who have mental health benefits) for a separate & identifiable premium	Yes	Not required
New York	January 1985	Certified Social Worker	Must have "R" endorsement which attests to 6 yrs of post-master's experience	Policies with mental health coverage must reimburse CSW with "R" endorsement	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
Tennessee	July 1985	Licensed Clinical Social Worker	None	Coverage with mental health benefits. Must cover CSW.	Not specific	Not required
Utah	July 1986	Clinical Social Worker	None	Coverage of mental health benefits must reimburse CSWs	No	Not required
Virginia	July 1987	Licensed Clinical Social Worker	None	Policies with mental health coverage must reimburse LCSWs	No	Not required

Under a variety of health insurance and benefit programs the federal government provides health protection for millions of citizens, including federal employees, military personnel and their families, and dependents and wards of the government. This complex array of services and enabling legislation makes it unlikely that a single piece of federal legislation could order that clinical social workers be approved as reimbursable providers under all of these programs. Therefore, NASW advocates and works for the introduction and enactment of many different pieces of federal health and mental health legislation.

The programs presented below represent the major segments of the federal responsibility for health care, and serve as models for the private health insurance industry.

### A. Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)

The Office of the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) is administered directly by the Secretary of Defense through the Office of the Assistant Secretary for Health Affairs. It is the civilian component of the Military Health Services Systems with approximately 6.2 million eligible beneficiaries. It is charged with the responsibility for providing, through fee-for-service arrangements, medical care for military retirees; dependents of military personnel and retirees; members of the Commissioned Corps of the United States Public Health Service; the CHAMPUS/Veterans Administration Program; handicapped dependents of active military personnel; and employees of the National Oceanographic and Atmospheric Administration.

Benefits covered under CHAMPUS roughly parallel those available under other public and major private health care plans. These include most inpatient and outpatient health services, a portion of physician and hospital charges, medical supplies and mental health services. Determination of benefits is made by the Department of Defense, often in response to Congressional action.

CHAMPUS conducted a demonstration project on the reimbursement of clinical social workers as independent mental health care providers between December 20, 1980 and September 30, 1982. Results indicated that treatment services provided by clinical social workers were cost-effective, and, in 1983, Congress directed the Department of Defense to continue the recognition of clinical social workers as independent mental health treatment providers. Accordingly, regulations to that effect were published as a final rule in the March 1, 1984

Federal Register. The following excerpt appears on p. 7562, section 199.12, "Authorized Providers,":

*Certified Clinical Social Workers. A clinical social worker may provide covered services independent of physician referral and supervision, provided the clinical social worker meets the following criteria:*

- (1) is licensed or certified as a clinical social worker by the jurisdiction where practicing; or, if the jurisdiction does not provide for licensure or certification of clinical social workers, is certified by a national professional organization offering certification of clinical social workers; and*
- (2) has at least a master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education; and*
- (3) has had a minimum of two years or three thousand hours of post-master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate clinical setting, as determined by the Director, OCHAMPUS, or a designee.*

NOTE: Patients' organic medical problems must receive appropriate concurrent management by a physician.

In order to be reimbursed by CHAMPUS, a qualified clinical social worker must have a provider number. To obtain this, call or write the fiscal intermediary for your state:

### CHAMPUS Fiscal Intermediaries Claims Processing Jurisdictions

#### BLUE CROSS OF RHODE ISLAND

North Central (E)	Northeast (E)
Illinois	Connecticut
Indiana	Maine
Iowa	Massachusetts
Kentucky	Michigan
Minnesota	New Hampshire
Ohio	New Jersey
West Virginia	New York
Wisconsin	Rhode Island
	Vermont

Blue Cross of Rhode Island  
CHAMPUS Program  
1 Weybosset Hill  
Providence, RI 02903  
(401) 272-8500 X2562

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**BLUE CROSS OF WASHINGTON/ALASKA**

**Northwest (E)**

- |          |              |
|----------|--------------|
| Alaska   | Oregon       |
| Colorado | South Dakota |
| Idaho    | Utah         |
| Montana  | Washington   |
| Nebraska | Wyoming      |

Blue Cross/Blue Shield of Washington/Alaska

CHAMPUS Program

7001 - 220th Street, S.W.

Mt. Lake Terrace, WA 98043

(206) 771-0203

**BLUE CROSS/BLUE SHIELD OF SOUTH CAROLINA**

**Southeast (E)**

- Alabama
- Florida
- Georgia
- Mississippi
- Tennessee

**Southwest (I)**

- Arizona
- California
- New Mexico
- Nevada

Blue Cross/Blue Shield of South Carolina

CHAMPUS Department

1800 St. Julian Place

Columbia, SC 29204

(803) 799-0777 X4131

**HAWAII MEDICAL SERVICE**

**Hawaii (E)**

Hawaii Medical Service

CHAMPUS Program

818 Keolu Drive Street

Honolulu, HI 96814

(808) 944-2355

**WISCONSIN PHYSICIAN'S SERVICE**

**South Central (E)**

- Arkansas
- Kansas
- Louisiana
- Missouri
- Oklahoma
- Texas

**Mid-Atlantic (I)**

- Delaware
- D.C.
- Maryland
- North Carolina
- Pennsylvania
- South Carolina
- Virginia

Wisconsin Physicians Service

CHAMPUS Program

1617 Sherman Avenue

Madison, Wisconsin 53707

(608) 221-4711 X654 (833)

**B. Federal Employees Health Benefits Program**

The Federal Employees Health Benefits Act (FEHBA) mandates that the U.S. Civil Service Commission negotiate with the private insurance industry for health insurance benefits packages for federal employees, retirees, and their dependents. The Office of Personnel Management (OPM) oversees the program. Many companies who provide insurance for federal employees under FEHBA have for many years voluntarily included social workers as reimbursable providers of mental health services. In February 1986, the President signed into law an amendment to FEHBA which requires that such coverage be included in health plans provided for some 10 million federal employees, retirees, and dependents. It further provides that insurance carriers may not require that social workers be supervised by any other health professional, but may require psychiatric referral. The amendments regarding clinical social workers shall be effective with respect to contracts entered into or renewed for calendar years beginning after December 31, 1986.

**C. Medicaid**

Medicaid, authorized by Title XIX of the Social Security Act, is administered by the states, who have the option of authorizing reimbursement of social workers as health-care providers. A number of states will reimburse for clinical social work services if they are provided in an organized medical treatment setting such as a hospital or outpatient clinic. A number of states will also reimburse for clinical social work services if the social worker is an employee of a psychiatrist.

The state Medicaid agency can provide information on each state's policy. Title XIX offers an area in which NASW chapters can advocate for changes in the state law or for regulations to include social workers as eligible for Medicaid reimbursement.

**D. Medicare**

Medicare is authorized by Title XVIII of the Social Security Act. At this time, clinical social work services are sometimes reimbursed for home health care, although the reimbursement patterns vary from region to region.

NASW sponsored legislation that directed the Health Care Financing Administration (HCFA) of the Department of Health and Human Services to conduct a clinical social work Medicare demonstration project. HCFA

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awarded a contract to SRI International (formerly the Stanford Research Institute) and approved California as the demonstration site. The demonstration project ended December, 1985. Analysis of the data is being completed and a final report will be reviewed by HCFA and given to Congress in April, 1987. Because of complications in the development of an evaluation of this project, it is anticipated that the results will be inconclusive.

### **E. Employee Retirement and Income Security Act (ERISA)**

In 1974 Congress passed the Employee Retirement Income Security Act (ERISA). Although its primary purpose was pension reform and protection, it also covers employee welfare benefit plans. In a somewhat confusing fashion, ERISA preempts all state laws that "relate to" employee benefit plans, but does not preempt state laws regulating insurance. This general standard thus affects mandated mental health coverage and vendorship laws in a critical fashion.

For example, some large firms such as IBM, AICOA, J.C. Penney Co., Xerox, and others have taken the position that their self-insured plans are employee benefits and are thus subject to ERISA and exempt from state regulation. Their argument concludes that a state

vendorship law requiring reimbursement of clinical social workers does not apply to them.

In a 1982 Maryland case, Metropolitan Life Insurance Company/General Electric vs. Maryland Insurance Commissioner, the Maryland Court of Special Appeals ruled that to impose the Maryland Vendorship Law (which requires reimbursement of clinical social workers) on the GE employee health insurance contract would preempt ERISA, and that the insurance carrier therefore does not have to recognize clinical social workers for this contract.

A number of state legislatures have passed resolutions urging Congress to revise the ERISA law so that it cannot undermine state's rights.

In the meantime, there have been a number of cases challenging this ERISA preemption. The Supreme Court agreed to hear on its 1984/85 docket the latest case of Metropolitan Life Insurance Co. v. Massachusetts. The insurance company claimed that ERISA exempted them from complying with the law mandating mental health coverage (see above). In June, 1985, the Supreme Court upheld the powers of the state to regulate insurance companies. The state's power to require insurance plans to cover mental disorders, said the court, were not preempted by ERISA.

## IV. NONGOVERNMENT INSURANCE COMPANIES

The question is frequently asked: "What insurance companies reimburse for social work services?" To answer this question, clients must be put into two groups: those who work for the federal government and those who do not. Federal employees are covered by private insurance companies that must adhere to federal policies (see Federal Employees Health Benefits Act on page 6). The dependents of military personnel are covered by CHAMPUS (see page 5).

People who are not federal employees have insurance policies written by private companies for individual employers who may be state or county governments, social agencies, industries, or any of a host of others. Each policy is for the benefit of specific employees and will vary according to the agreement negotiated between the employer and the employees and between the employer and the insurance company. Sometimes the health provisions are a part of union-employer negotiations. Even when a large firm with many work sites negotiates a health package that seems to include or at least not to exclude, social workers as qualified mental health providers, the local claims offices may interpret the contract differently. Thus, unless you are talking about federal employees, it is not possible to list insurance companies that "cover clinical social workers" as qualified providers of mental health services. Many insurance companies have done so in specific contracts, but it must be remembered that those same firms have also written health-benefit plans that exclude social work services.

The following is a partial list of companies that either currently issue, or at one time have issued, policies that reimburse for clinical social work.

- Aetna Life & Casualty Insurance Co.
- Albrite
- American General
- Bankers Life Casualty Insurance Co.
- Blue Cross/Blue Shield (in many localities)
- Central National Insurance Company of Omaha
- Concordia Welfare Plan
- Continental Assurance Co.
- Connecticut General
- Employers of Wausau
- Equitable Insurance & Life Insurance Co.
- The Hartford Group
- John Hancock Insurance Co.
- Liberty Mutual Insurance
- Lincoln National Life Insurance Co.
- Massachusetts Mutual Insurance Co.
- Metropolitan Insurance Co.
- Missouri State Medical Plan
- Mutual Benefit Life Insurance Co.
- Mutual of Omaha
- New England Mutual Life Insurance Co.
- New York Life Insurance Co.
- Northwestern National Life Insurance Co.
- Occidental
- Pacific Mutual Insurance Co.
- Provident Insurance Co.
- Prudential Insurance Co.
- Republic National Insurance Co.
- State Farm
- Travelers Insurance Co.
- Union Pilot Life Insurance Co.
- United of Omaha
- Western and Southern Insurance Co.

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## V. ROLE OF THE PROFESSIONAL ASSOCIATION

The following describes some of NASW's efforts to define clinical social work and the qualifications of practitioners, to set standards for ethical practice, and to establish quality assurance mechanisms.

### A. Clinical Social Work Section

The NASW Clinical Social Work Section is the national unit responsible for identifying the programmatic needs of clinical social workers and making appropriate recommendations to the NASW Board of Directors. The Section collaborates with other national units concerned with health and mental health, occupational social work and families and coordinates activities of peer review, and the NASW Register of Clinical Social Workers. In addition to its work in developing the NASW definition of clinical social work, the Section and its predecessor Council has planned three national conferences on clinical social work, NASW publications on clinical social work, and institutes on clinical social work and on private practice at national conferences. A fourth national clinical conference is being planned for the fall of 1988.

In January 1984, the NASW Board of Directors adopted the following definition of clinical social work:

*Clinical social work shares with all social work practice the goal of enhancement and maintenance of psychosocial functioning of individuals, families, and small groups. Clinical social work practice is the professional application of social work theory and methods to the treatment and prevention of psychosocial dysfunction, disability, or impairment, including emotional and mental disorders. It is based on knowledge of one or more theories of human development within a psychosocial context.*

*The perspective of person-in-situation is central to clinical social work practice. Clinical social work includes interventions directed to interpersonal interactions, intrapsychic dynamics, life support and management issues.*

*Clinical social work services consist of assessment; diagnosis; treatment, including psychotherapy and counseling; client-centered advocacy; consultation; and evaluation. The process of clinical social work is undertaken within the objectives of social work and the principles and values contained in the NASW Code of Ethics.*

This definition was incorporated in the Standards for the Practice of Clinical Social Work that were approved by the NASW Board of Directors in June 1984. Single copies are available free of charge from NASW chapters or from the national office.

NASW believes the credentialing of clinical social workers is the responsibility of the social work profession. It is the profession's criteria that provide the basis for definitions enacted by state and federal legislative and regulatory bodies as well as those approved or accepted by insurers. The Association's standards for the independent practice of clinical social work include the following criteria:

1. A degree from a graduate program in social work accredited by the Council on Social Work Education; and
2. A minimum of two years (full-time) or three thousand hours (part-time) of post-MSW clinical social work practice under the supervision of a master's degree-level social worker; and
3. Certification as a clinical social worker by a professional organization offering such accreditation; or
4. Licensure or certification as a clinical social worker by the state in which care is provided, if the state offers such accreditation. Forty-one jurisdictions currently license or certify social workers (see NASW's State Comparison of Laws Regulating Social Work).

### B. The NASW Register of Clinical Social Work

The NASW Register of Clinical Social Workers was initiated in 1976 as a mechanism for identifying qualified clinical social work practitioners. The Register lists clinical practitioners who meet the following criteria for the independent practice of clinical social work:

#### *Education:*

Has a master's or doctoral degree in social work from a graduate school accredited or recognized by the Council on Social Work Education.

#### *Supervision:*

Has 2 years of full-time experience, or 3,000 hours accumulated over a period not less than 24 months (for part-time experience), of post-master's clinical social work practice that was supervised by a social worker holding at least a master's degree.

#### *Currency:*

Has at least 2 years of full-time experience or 3,000 hours accumulated over a period of not less than 24 months (for part-time experience) of direct practice within the last 10 years.

**ACSW:**

Is a current member of the Academy of Certified Social Workers, or is licensed or certified in a state at the appropriate level.

The 1987 edition of the Register will list over 16,500 clinicians across the United States and Trust Territories. The Register is divided into two major sections: an alphabetical listing within city and state, and an alphabetical index of total listings.

Revised editions are planned on a biennial basis. The Register Board decided that the needs of both clients and social workers demanded an approach for reviewing and accepting applications on a continuing basis. Continuing registration was started following the publication of the 1982 Register and will continue following the publication of the 1987 edition.

Some private insurance carriers accept listing in the NASW Register of Clinical Social Workers as evidence that a practitioner meets the minimum requirements for recognition as an Independent mental health provider. Copies of new editions of the NASW Register are sent to major insurance companies for their use in identifying qualified clinical social workers. The Register is also used for referral purposes by corporations that have their own self-insured health programs. In addition it is used by Aging Network Services as a referral source and by large corporations with Employee Assistance Programs.

Listing in the NASW Register of Clinical Social Workers was one of the criteria for recognition of social workers who would be eligible to participate in the Department of Defense 1980-82 Experimental Study on the Reimbursement of Clinical Social Workers and the Department of Health and Human Services' Direct Reimbursement of Clinical Social Workers Demonstration Project. Listing in the current NASW Register meets one of the eligibility criteria currently accepted by CHAMPUS for direct reimbursement and for approved peer reviewers.

Listing in the NASW Register of Clinical Social Workers may also be used to qualify for membership in specialized treatment associations such as the Society for Clinical and Experimental Hypnosis, Inc. It is used by some NASW state chapters and practitioners as a referral source, and may be used by state social work regulatory boards to identify qualified clinical social workers.

**C. Diplomate in Clinical Social Work**

Established by the Board of Directors in June, 1986, the Diplomate in Clinical Social Work is an advanced

specialization certification. To qualify, a social worker must fulfill the requirements for listing in the NASW Register of Clinical Social Workers, and have completed an additional 3 years of clinical social work experience and an advanced clinical social work examination. Until September 30, 1987, those who are otherwise qualified will be admitted without examination.

**D. Peer Review**

Peer review is a system whereby clinical social workers assess quality of services and analyze professional clinical social work practice. Quality assurance through peer review provides protection of clients. An important test of the quality of work of a clinical social worker is whether the services are, upon review, found to be clinically necessary and of an acceptable level, i.e., in respect to the results obtained, the amount of time required to achieve acceptable results and the method of intervention employed.

In October 1983, NASW established the National Peer Review Advisory Committee to develop guidelines and criteria for a national social work peer review program to work with the CHAMPUS Professional Peer Review System and to provide peer review of individual cases for private insurance carriers.

As of October 1984, approximately three hundred experienced social workers had been selected, and approximately one hundred fifty have completed the NASW peer review training programs. Full integration of social work reviewers into the CHAMPUS peer review system had occurred by January 1985. Peer review is also available for private insurance companies and NASW currently has contracts to provide peer review for Aetna, Metropolitan Life and Prudential of Florida.

**E. NASW Insurance Program**

Since 1967, the NASW Insurance Trust has been offering an expanding array of health, life and disability insurance programs designed exclusively for NASW members. Clinical social workers are recognized as Independent mental health treatment providers under the NASW/Principal Financial Group Insurance Plan. The Insurance Trust sponsors a variety of programs at NASW conferences designed to educate members on insurance issues.

Under the NASW-sponsored professional and office liability insurance program, NASW members can receive professional and premises liability coverage for as little as \$40.00 annually. The program is also avail-

able to agencies, social work students, and their schools. The importance of liability insurance cannot be overstated. Social workers are increasingly involved in malpractice actions. Even if an employer or agency provides some coverage, it is usually in the social worker's best interest to have additional individual coverage. Rates for liability insurance offered to NASW members are the lowest currently available.

## F. Occupational Social Work

Occupational social work is an excellent opportunity for clinical social workers who wish to be on the leading edge of a new employment trend and who have knowledge and experience in chemical dependency treatment. Many employers are developing employee assistance programs to address problems of dysfunction that affect job performance and lower productivity. Whether internal or external to the worksite, these programs help workers and their families cope with such difficulties as alcoholism, drug abuse, mental dysfunction, AIDS, stress and burnout in addition to concerns about child care and elder care. Employee assistance programs are found in a variety of settings: corporations, unions, hospitals, military, small business, government, family service agencies, universities, and private practice.

Social workers wishing to enter this field will find they need specialized training. In most instances, it will be necessary to take courses in employee assistance programs, addiction counseling, labor-management relations, working with unions or coping with the corporate system. Several schools of social work offer a specialization in occupational social work, while numerous schools offer course work and supervised field practice or continuing education in chemical dependency. Other resources include a myriad of institutes, individual entrepreneurs, workshops and conferences that focus on a wide range of topics such as alcohol and drug abuse in the workplace, work and family stresses, drug testing in

the workplace and social worker's role in employee assistance programs and others.

In 1986, NASW established a National Commission on Employment and Economic Support to be responsive to the needs of occupational social workers and to assist the Association in developing programs and policies that meet the challenges of the workplace. We have an Occupational Social Work Information Service and Clearinghouse. Approximately 40 NASW chapters have active programs or interest groups in this practice area. A National Survey of Occupational Social Workers, conducted in 1985, provides a profile of workers, work settings and job tasks. The second National Conference on Occupational Social Work, "Beyond The Leading Edge: The World of Work in the Year 2000," will take place September 9-12, 1987 in New Orleans as part of the NASW Annual Conference.

## G. Academy of Certified Social Workers

The Academy of Certified Social Workers (ACSW) was founded in 1960 by NASW as the first major step toward scientific standard setting for social work practice. The ACSW strives to publicly recognize those social workers who have achieved a level of skill and knowledge beyond that acquired in a graduate program of social work education. Certification is achieved through:

- 1) membership in NASW and adherence to a strict professional code of ethics,
- 2) evaluation of a significant amount of work experience by three professional colleagues,
- 3) an objective written examination.

Academy members have reached a level of practice which qualifies them for independent, self-directed practice.

**OTHER NASW PROFESSIONAL STANDARDS**

Code of Ethics

Standards for Social Work Personnel Practices

Standards for the Classification of  
Social Work Practice

Standards for the Regulation of Social Work Practice

Standards for Continuing Professional Education

Standards for Social Work in Health Care Settings

Standards for Social Work Services in Schools

Standards for Social Work Practice in  
Child Protection

Standards for Social Work Services in  
Long Term Care Facilities

**NASW  
standards  
for the  
practice of  
clinical  
social work**

Prepared by the NASW Provisional Council on  
Clinical Social Work

*Approved by the NASW Board of Directors  
June 1984*

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