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Introduction

Historically, the social work profession has focused on both people and their social environment. Clinical social work, whose focus is on individuals, families, and groups, has its roots in social casework, which always has been a primary method for the delivery of social work services. The number of clinical social workers has grown continuously; and clinical social work continues to contribute significantly to the development of knowledge and skills for the profession. In 1978, the National Association of Social Workers (NASW) formally recognized clinical social work as part of a process of organizational differentiation. At that time, NASW established the Task Force on Clinical Social Work, which became the Provisional Council on Clinical Social Work in 1982.

Clinical social workers have practiced in governmental and voluntary agencies and, since the time of pioneer social worker Mary Richmond, in private practice. In 1961, NASW defined private practice as a setting for the delivery of clinical social work services and published its first *Handbook on the Private Practice of Social Work* in 1967.

Clinical practice continues to be an integral part of the services delivered in agency settings. At the same time, an increasing number of clinical practitioners have been moving into independent private practice, which further attests to the commitment of trained and experienced professionals to the direct treatment of individuals, families, and groups. This development, encompassing solo and group practice as well as other arrangements, is in addition to the practice of clinical social work in traditional voluntary and governmental agency settings.

Many states require the legal regulation of social work practice; some states require a special license for practitioners of clinical social work as well as those in independent private practice. Generally, certification for clinical social work requires a master's degree in social work plus at least two years' experience as well as an examination.

Given the variations among the states regarding legal regulation and the needs of clinical social work practitioners, NASW has taken appropriate responsibility for establishing standards of practice for all clinical social workers in all settings. These standards are to be considered desirable for all clinical social workers and are designed to do the following:

- Guide clinical social work practice.
- Guide state regulatory agencies

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which all members are bound. A summary of the Code of Ethics will be found following these standards.

Definitions

The following definition of clinical social work was accepted by the NASW Board of Directors at its January 1984 meeting:

> 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, and 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.

In May 1961, the NASW Board of Directors endorsed the following definition of private practitioners of social work:

> Private practitioners are social workers who, wholly or in part, practice social work outside a governmental or duly incorporated voluntary agency, who have responsibility for their own practice and set up conditions of exchange with their clients, and identify themselves as social work practitioners in offering services.

The goals of the standards are

- To maintain and improve the quality of services provided by clinical social workers.
- To establish professional expectations so social workers can monitor and evaluate their clinical practice.
- To provide a framework for clinical social workers to assess responsible professional behavior.
- To inform consumers, governmental regulatory bodies, and others, such as insurance carriers, about the profession's standards for clinical social work practice.

Toward the achievement of these goals, the standards

- Define and delineate clinical social work and the private practice of clinical social work.
- Establish specific ethical guidelines for the practice of clinical social work in agency or private practice settings.
- Provide documentation of professional expectations for agencies, peer review committees, state regulatory bodies, insurance carriers, and others.

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Standards for the Practice of Clinical Social Work

Standard 1. Clinical social workers shall function in accordance with the ethics and the stated standards of the profession, including its accountability procedures.

Interpretation

All social workers have a fourfold responsibility: to clients, to the profession, to self, and to society. Social workers shall identify themselves as members of the social work profession. NASW members shall be familiar with and adhere to the NASW Code of Ethics and shall cooperate fully and in a timely fashion with the adjudication procedures of the Committee of Inquiry, peer review, and appropriate state boards. They shall be aware of and adhere to relevant stated professional standards for social work practice.

All clinical social workers shall be willing to have judgments and decisions reviewed by knowledgeable peers in a formal process. When requested by a client, the clinical social worker will provide information about how to file a complaint charging unethical behavior.

Standard 2. Clinical social workers shall have and continue to develop specialized knowledge and understanding of individuals, families, and groups and of therapeutic and preventive interventions.

Interpretation

Areas of knowledge about individuals, families, and groups required for effective clinical intervention encompass the following:

1. Social, psychological, and health factors and their interplay on psychosocial functioning, such as these:
   - theories of personality and behavior,
   - social-cultural influences,
   - environmental influences,
   - physical health, and
   - impairment and disability, including mental and emotional conditions.
2. Community resources
   - available social resources in the community and their operation and how to use them in the client's behalf and
   - how to identify appropriate services and negotiate a referral.
3. Specific practice skills, including the ability to
   - establish
   - obtain, analyze, classify, and interpret social and personal data, including assessment and diagnosis,
   - establish compatible goals of service with the client,
   - bring about changes in behavior (thinking, feeling, or doing) or in the situation in accordance with the goals of service.
4. Knowledge about and skills in using research to evaluate the effectiveness of a service.

The clinical social worker shall have available a variety of appropriate social work therapeutic intervention techniques that he or she uses selectively, depending on the client's needs and capacity for change.

When knowledge and skills are acquired, other than those specific to social work, the practitioner is responsible for obtaining the appropriate training and certification. Clinical social workers shall maintain and enhance their skills through appropriate forms of professional development and continuing education (see *NASW Standards for Continuing Professional Education*) and are personally accountable for all aspects of their professional behavior and decisions.

Standard 3. Clinical social workers shall respond in a professional manner to all persons who seek their assistance.

Interpretation

Clinical social workers shall respond to each client regardless of the client's lifestyle, origin, race, sex, religion, or sexual orientation.

Clinical social workers shall limit their practice to those clients whom they have the skills and resources to serve. However, they shall be aware of and seek to ameliorate any of their attitudes and practices that may interfere with their ability to offer competent and equitable service. They have a professional responsibility to help a client establish contact with other appropriate resources when they cannot meet the needs for service of a particular client.

If the clinical social worker is unable to schedule a timely appointment for an initial assessment, he or she may screen the client by telephone to determine the urgency of the client's situation. The well-being of the client is the key factor in all decisions. In emergency situations in which the clinical social worker cannot be available to a new client, every effort should be made to find an appropriate source of immediate help.

On occasion, a client may decide to terminate treat-

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premature but the client persists in his or her decision, it is the clinician's responsibility to refer the client to another appropriate treatment resource or, failing that, to help the client terminate treatment as constructively as possible, leaving the door open for the client to reapply for service at another time.

Standard 4. Clinical social workers shall be knowledgeable about the services available in the community and make appropriate referrals for their clients.

Interpretation

In accordance with the definition of clinical social work (see "Definitions"), the perspective of the person-in-situation is central to clinical practice. Therefore, clinical social workers must be alert to the clients' situations, especially those that affect the clients' behavior and functioning, and must be able to modify the environment, when possible, by referrals to other community services. There will also be occasions when advocacy on behalf of a client will be necessary to obtain needed services.

When a client is being served by other agencies, the clinical social worker shall maintain collaborative contacts as necessary with the other providers to ensure the coordination of services and the client's receipt of optimal benefits from the various services.

When the client is involved with more than one clinician, collaborative consultation shall be maintained as necessary to ensure delineation of the specific areas of responsibility. The clinician shall not share information about a client without the client's informed consent. (See Standard 6 for an elaboration of confidentiality.)

Standard 5. Clinical social workers shall maintain their accessibility to clients.

Interpretation

In the process of managing a therapeutic relationship, various factors or events may create problems of accessibility. The clinician shall be able to respond to the unanticipated needs of a client by, for example, having telephones answered, either by a person or machine, and messages relayed promptly and accurately. When the clinical social worker is unavailable because of vacation, illness, or any other reason, he or she should make arrangements for coverage by competent peers. These details should be discussed with the client at the beginning of

In establishing an office, the clinical social worker shall be aware that some clients may have or develop physical handicaps. Thus, the clinical social worker shall make every attempt to ensure that offices are free of impediments to mobility and that helping devices are available for sensorially impaired clients. The office's accessibility by public transportation, when it is available, also should be a consideration.

Standard 6. Clinical social workers shall safeguard the confidential nature of the treatment relationship and of the information obtained within that relationship.

Interpretation

Respect for the client as a person and for the client's right to privacy underlies the maintenance of confidentiality in the client-clinician relationship. Although assurance of this confidentiality enhances the therapeutic interaction, the client should be advised that there are circumstances in which confidentiality cannot be maintained. These circumstances would include but not necessarily be limited to the legally mandated requirement to report to appropriate authorities a suspicion of child abuse, including the sexual abuse of children, or a suspicion of bodily harm or violence to some other person.[1] In some circumstances, a clinician may need to advise the parents of a child client's self-destructive behavior to ensure adequate protection for the child. In all such situations, the clinician shall advise the client of the exceptions to confidentiality and privilege, be prepared to share with the client the information that is being reported, and handle the feelings evoked. Except for such explicit, overriding requirements, the clinical social worker shares information only with the written and informed consent of the client.

Standard 7. Clinical social workers shall maintain access to professional case consultation.

Interpretation

In an agency setting, professional social work supervision or consultation should be available to all social work staff, either in the agency or through a contractual arrangement. If clinical social workers are not available, case con-

[1] Tarasoff v. Regents of the University of California, 551 P

sultation may be obtained from qualified professionals of other disciplines.

The beginning clinical social worker requires regular case-consultation supervision. For the first two years of professional experience, at least one hour of supervision should be provided for every fifteen hours of face-to-face contact with clients. After the first two years, the ratio may be reduced to a minimum of one hour of case-consultation supervision for every thirty hours of face-to-face contact with clients. In some situations, additional consultation will be sought by the clinician, because of complex issues involving a client or suggested by the consultant, because of difficulties the consultant perceives in the clinician's handling of a situation.

Clinicians with five years or more of experience should utilize consultation on an as-needed, self-determined basis. Although clinicians who are in independent practice shall utilize more case consultation when they first begin practicing, they should maintain consultative arrangements throughout the time they are in practice. Clinical social workers shall be knowledgeable about how and when to utilize the expertise of other professional disciplines in the area of medical problems, including pharmacology, and alert to the effects of prescription drugs on a client they can provide feedback to the client's physician.

Standard 8. Clinical social workers shall establish and maintain professional offices and procedures.

Interpretation

The clinical social worker keeps records of clients that substantiate service in a secure place. He or she maintains the records accurately and in a manner that is free from bias or prejudicial content. The social worker makes these records available to clients at their request.

The clinical social worker should ensure that appropriate insurance is maintained: agency liability, personal professional liability, premises protection, and other pertinent policies.

Clinical social workers shall establish a fee structure when in independent private practice or utilize the fee structure of the agency in which they are working. All terms and procedures for payment shall be discussed with the client at the beginning of treatment; to minimize misunderstanding, it is useful to present these policies in writing as well. This discussion should include the use of insurance reimbursement and how it will be handled; fees for missed [illegible] and collateral contacts; and any other financial issues.

Clinical social workers shall not refuse service to clients solely because the clients are not covered by insurance. They shall not engage in fee splitting: a practice by which a client's payments are divided between the service provider and a non-service provider, such as a referral source.

Billing procedures shall be included in the original discussion and clients' accounts shall be maintained according to acceptable accounting methods, with all bills and receipts provided on a regular and timely schedule. Clinical social workers shall discuss overdue accounts with clients and make every effort to avoid accrual of debt. When it is clear to a client and clinician that, for whatever reason, the client can no longer afford to pay for treatment, a mutually acceptable alternative plan for compensation or an orderly and appropriate termination or referral shall be instituted. Nothing in this standard shall be construed to rule out an individual clinician's decision to provide services on a *pro bono* basis.

When all efforts to collect an overdue account from a client have failed, the client should be informed that unpaid accounts may be turned over to a collection agency or small claims court or that other types of legal action will be taken. If there is a dispute over charges, the clinical social worker should make every effort to resolve it without damaging the therapeutic relationship.

Waiting rooms and offices should be kept clean, and the environment should be properly maintained to ensure a reasonable degree of comfort. Interviewing rooms should ensure privacy and be free of distractions. Steps should be taken to assure the client's and the social worker's personal security.

Standard 9. Clinical social workers shall represent themselves to the public with accuracy.

Interpretation

The public needs to know how to find help from qualified clinical social workers. Both agencies and independent private practitioners should ensure that their therapeutic services are made known to the public. In this regard, it is important that telephone listings be maintained in both the classified and alphabetical sections of the telephone directory describing the clinical social work services available.

Although advertising in various media was thought to be [illegible]

have made such advertising acceptable. The advertisement must be factual. It should be worded to avoid false promises of cures and should not include testimonials or any other hint of enticement.

The content of the advertisement shall include (1) the private practitioner's or agency's name and professional credentials and (2) the address and telephone number or other contact information. It may also include the type of services provided (e.g., individual, family, or group therapy; alcoholism counseling; divorce mediation; and so forth) and the type of problems that are dealt with (e.g., marital distress, parent-child conflicts, eating disorders).

Standard 10. Social workers shall engage in the independent private practice of clinical social work only when qualified to do so.

Interpretation

Many states have legal regulations for social workers at a clinical or independent-practice level. If practitioners work in such a state, they must be licensed or certified at this level to engage in independent private practice.

The NASW standards for the independent practice of clinical social work are those required for inclusion in the *NASW Register of Clinical Social Workers:*

1. A graduate degree from a social work program accredited by the Council on Social Work Education.
2. Two years of full-time (or equivalent part-time) clinical social work experience supervised by a clinical social worker.
3. Current membership in the Academy of Certified Social Workers or a license or certification in a state at the appropriate level.

Standard 11. Clinical social workers shall have the right to establish an independent private practice.

Interpretation

Clinical social workers shall have the right to establish a separate independent practice as a form of secondary employment or after leaving a place of employment. When they establish such a practice, either alone or as part of a group, they are responsible for assuring that the diagnostic and treatment services meet professional standards. If such a practitioner hires clinical social workers or other emplo-

the services provided, for maintaining all these standards, and for upholding all applicable local, state, or federal regulations.

Clinical social workers who are employed by agencies and have an independent private practice should not refer agency clients to themselves unless they have made a specific agreement with the agency and have offered alternative options to the clients. Agencies have the responsibility to establish written, reasonable guidelines or policies about secondary employment (see *NASW Standards for Social Work Personnel Practices*). When an agency does not have clear written policies, the clinical social worker may cite the relevant NASW standards.

When a clinical social worker leaves an agency to establish an independent private practice, he or she must take great care not to coerce or entice agency clients to the private practice. Clients in treatment may be offered various options after consultation with the agency. These options include (1) transferring to another staff member in the agency, (2) continuing with the same clinician in an independent setting, (3) transferring to another agency or to a different private practitioner, or (4) terminating treatment. The overriding principle is the client's right to self-determination and freedom of choice. That is, the client's best interests must always be paramount in these decisions.

Code of Ethics

SUMMARY OF MAJOR PRINCIPLES

I. The Social Worker's Conduct and Comportment as a Social Worker

A. *Propriety.* The social worker should maintain high standards of personal conduct in the capacity or identity as social worker.

B. *Competence and Professional Development.* The social worker should strive to become and remain proficient in professional practice and the performance of professional functions.

C. *Service.* The social worker should regard as primary the service obligation of the social work profession.

D. *Integrity.* The social worker should act in accordance with the highest standards of professional integrity.

E. *Scholarship and Research.* The social worker engaged in study and research should be guided by the conventions of scholarly inquiry.

II. The Social Worker's Ethical Responsibility to Clients

F. *Primacy of Clients' Interests.* The social worker's primary responsibility is to clients.

G. *Rights and Prerogatives of Clients.* The social worker should make every effort to foster maximum self-determination on the part of clients.

H. *Confidentiality and Privacy.* The social worker should respect the privacy of clients and hold in confidence all information obtained in the course of professional service.

I. *Fees.* When setting fees, the social worker should ensure that they are fair, reasonable, considerate, and commensurate with the service performed and with due regard for the clients' ability to pay.

III. The Social Worker's Ethical Responsibility to Colleagues

J. *Respect, Fairness, and Courtesy.* The social worker should treat colleagues with respect, courtesy, fairness, and good faith.

K. *Dealing with Colleagues' Clients.* The social worker has the responsibility to relate to the clients of colleagues with full professional consideration.

IV. The Social Worker's Ethical Responsibility to Employers and Employing Organizations

L. *Commitments to Employing Organizations.* The social worker should adhere to commitments made to the employing organizations.

V. The Social Worker's Ethical Responsibility to the Social Work Profession

M. *Maintaining the Integrity of the Profession.* The social worker should uphold and advance the values, ethics, knowledge, and mission of the profession.

N. *Community Service.* The social worker should assist the profession in making social services available to the general public.

O. *Development of Knowledge.* The social worker should take responsibility for identifying, developing, and fully utilizing knowledge for professional practice.

VI. The Social Worker's Ethical Responsibility to Society

P. *Promoting the General Welfare.* The social worker should promote the general welfare of society.

This summary is of the NASW Code of Ethics, effective July 1, 1980, as adopted by the 1979 NASW Delegate Assembly. The complete text, including the preamble and expanded definitions of principles, is available on request.

5-0356X
Ford
2/13/88

Original sponsors: Faiks and Kerttula

IN THE SENATE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

HOUSE CS FOR CS FOR SENATE BILL NO. 67 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FIFTEENTH LEGISLATURE - SECOND SESSION

A BILL

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

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

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

Sec. 21.42.365. COVERAGE FOR TREATMENT OF A MENTAL OR NERVOUS CONDITION. (a) An insurer authorized under AS 21.09 to offer, issue for delivery, deliver, or renew a group disability insurance policy for major medical coverage on an expense-incurred basis in the state, or a hospital or medical service corporation authorized under AS 21.87 to offer or renew a group contract for major medical coverage in the state, must provide the insured or subscriber the following coverage for treatment of a mental or nervous condition of the insured, subscriber, or other person covered by the policy or contract:

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

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

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

(c) In this section

(1) "consulting relationship" means a relationship that

involves review of treatment plans and goals and in-person patient contact on at least a quarterly basis;

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

(3) "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;

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

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

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

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

(C) a hospital that is located in

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

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

(6) "major medical coverage" means a disability insurance contract, or a subscriber contract, that provides benefits for hospital and medical care with potential lifetime maximum benefits for the insured or subscriber of at least $10,000;

(7) "mental or nervous condition" means a mental disorder

identified in

(A) the most current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or

(B) the most current edition of the ICD-9-CM published by the Commission on Professional and Hospital Activities;

(8) "national professional organization" means the National Association of Social Workers; the National Registry of Health Care Providers; and the American Board of Examiners in clinical social work;

(9) "office visit" means treatment that is not inpatient treatment or outpatient treatment and that is provided through the professional offices of

(A) a psychiatrist who is licensed by a state as a physician and certified, or eligible for certification, in psychiatry by the American Board of Psychiatry and Neurology;

(B) a physician who is employed by the federal government in a state and certified or eligible for certification in psychiatry by the American Board of Psychiatry and Neurology;

(C) a psychologist or psychological associate licensed by a state;

(D) a person who works in a consulting relationship with a mental health care provider licensed by a state and has a masters or doctoral degree in psychology, nursing, or social work; or

(E) a clinical social worker who is

(i) licensed or certified as a clinical social worker by a state; or

(ii) certified by a national professional

organization offering certification of clinical social workers;

(10) "outpatient treatment" means treatment that is not inpatient treatment and that is provided

(A) in the outpatient department of

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

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

(iii) an entity that is designated by the Department of Health and Social Services as an organizational unit in a geographical area to receive funds under AS 47.30.520 - 47.30.620; and

(B) by one or more of the following:

(i) a psychiatrist who is licensed by a state as a physician and certified, or eligible for certification, in psychiatry by the American Board of Psychiatry and Neurology;

(ii) a physician who is employed by the federal government in a state and certified or eligible for certification in psychiatry by the American Board of Psychiatry and Neurology;

(iii) a psychologist licensed by a state;

(iv) a person who works in a consulting relationship with one or more licensed mental health care providers licensed by a state and has a masters or doctoral degree in psychology, nursing, or social work, and is employed by the

same health care facility providing treatment; or

(v) a clinical social worker who is licensed or certified as a clinical social worker by a state or certified by a national professional organization offering certification of clinical social workers.

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

(d) Except to the extent necessary to comply with AS 21.42.365, a [A] person may not practice or permit unfair discrimination against a person who provides a 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 the service is within the scope of the provider's occupational license. In this subsection, "provider" means a state licensed physician, dentist, osteopath, optometrist, chiropractor, or nurse midwife, naturopath, physical therapist, or occupational therapist.

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

Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the provisions contained or referred to previously in this chapter, the following chapters and provisions of this title also apply with respect to service corporations to the extent applicable and not in conflict with the express provisions of this chapter and the reasonable implications of the express provisions, and for the purposes of the application the corporations shall be considered to be mutual "insurers":

(1) AS 21.03

(2) AS 21.06

(3) AS 21.09, except AS 21.09.090

(4) AS 21.18.010

(5) AS 21.18.030

(6) AS 21.18.040

(7) AS 21.18.120

(8) AS 21.21.321

(9) AS 21.36

(10) AS 21.69.400

(11) AS 21.69.520

(12) AS 21.69.600, 21.69.620, and 21.69.630

(13) AS 21.78

(14) AS 21.90

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

(16) AS 21.89.040

(17) AS 21.89.060.

* Sec. 4. AS 21.42.365, enacted by sec. 1 of this Act, applies to group disability insurance policies and hospital or medical service subscriber contracts entered into or renewed on or after January 1, 1989.

5-0356X
Ford
2/9/88

Original sponsors: Faiks and Kerttula

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

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

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

(c) In this section

(1) "co-payment" means the portion of the cost in excess of

the deductible portion to be paid by the insured or subscriber;

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

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

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

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

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(C) a hospital that is located in

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

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

(5) "major medical coverage" means a disability insurance contract, or a subscriber contract, that provides benefits for hospital and medical care with potential lifetime maximum benefits for the insured or subscriber of at least $10,000;

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Psychiatric Association; or

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(7) "national professional organization" means the National Association of Social Workers; the National Registry of Health Care Providers; and the American Board of Examiners in clinical social work;

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(A) a psychiatrist who is licensed as a physician in the state and certified, or eligible for certification, in psychiatry by the American Board of Psychiatry and Neurology;

(B) a physician who is employed by the federal government in the state and certified or eligible for certification in psychiatry by the American Board of Psychiatry and Neurology;

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

(D) a person who works under the supervision of a mental health care provider licensed in the state and has a masters or doctoral degree in psychology, nursing, or social work; or

(E) a clinical social worker who is

(i) licensed or certified as a clinical social worker by a state; or

(ii) certified by a national professional organization offering certification of clinical social workers;

(9) "outpatient treatment" means treatment that is not inpatient treatment and that is provided

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

(iii) an entity that is designated by the Department of Health and Social Services as an organizational unit in a geographical area to receive funds under AS 47.30.520 - 47.30.620; and

(B) by one or more of the following:

(i) a psychiatrist who is licensed as a physician in the state and certified, or eligible for certification, in psychiatry by the American Board of Psychiatry and Neurology;

(ii) a physician who is employed by the federal government in the state and certified or eligible for certification in psychiatry by the American Board of Psychiatry and Neurology;

(iii) a psychologist licensed under AS 08.86;

(iv) a person who works under the supervision of one or more licensed mental health care providers licensed in the state and has a masters or doctoral degree in psychology, nursing, or social work, and is employed by the same health care facility providing treatment; or

(v) a clinical social worker who is licensed or certified as a clinical social worker by a state or certified by a national professional organization offering

certification of clinical social workers.

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

(d) Except to the extent necessary to comply with AS 21.42.365, a [A] person may not practice or permit unfair discrimination against a person who provides a 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 the service is within the scope of the provider's occupational license. In this subsection, "provider" means a state licensed physician, dentist, osteopath, optometrist, chiropractor, or nurse midwife, naturopath, physical therapist, or occupational therapist.

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

Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the provisions contained or referred to previously in this chapter, the following chapters and provisions of this title also apply with respect to service corporations to the extent applicable and not in conflict with the express provisions of this chapter and the reasonable implications of the express provisions, and for the purposes of the application the corporations shall be considered to be mutual "insurers":

(1) AS 21.03

(2) AS 21.06

(3) AS 21.09, except AS 21.09.090

(4) AS 21.18.010

(5) AS 21.18.030

(6) AS 21.18.040

(7) AS 21.18.120

(8) AS 21.21.321

(9) AS 21.36

(10) AS 21.69.400

(11) AS 21.69.520

(12) AS 21.69.600, 21.69.620, and 21.69.630

(13) AS 21.78

(14) AS 21.90

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

(16) AS 21.89.040

(17) AS 21.89.060.

* Sec. 4. AS 21.42.365, enacted by sec. 1 of this Act, applies to group disability insurance policies and hospital or medical service subscriber contracts entered into or renewed after January 1, 1989.

SB

67

file 2

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 8, 1988

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

Dear Messrs. Koponen and Ellis:

Re: CSSB 67 (HESS)

The purpose of this letter is to provide you an analysis of the fiscal impact of CSSB 67 (HESS). The present version of the bill would have no fiscal impact on the cost of health insurance for the state. Our analysis indicates that insurers would be required to offer the option to receive the minimum level of coverage for treatment of a mental or nervous condition.

It is our understanding that an employer, as policyholder of a group plan, could elect this option for covered employees. Employees in a group plan could not make this election on an individual basis.

The State of Alaska now provides mental health coverage for all eligible employees. The level of this coverage is somewhat less than that provided for in the bill in an effort for cost containment in the plan. Health insurance benefits are determined at the bargaining table and may not be changed as a result of this bill.

Please let me know if you have any questions regarding this matter or should you require further information.

Sincerely,

Robert F. Stalnaker
Acting Director

RFS/MBC/cam/III

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

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Please let me know if you have any questions regarding this matter or should you require further information.

Sincerely,

Robert F. Stalnaker
Acting Director

RFS/MBC/cam/III

5-0356T
Ford
2/18/88

Original sponsors: Faiks and Kerttula

IN THE SENATE

HOUSE CS FOR CS FOR SENATE BILL NO. 67 ( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

FIFTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to insurance coverage for the treatment of a mental or nervous condition; and providing for an effective date."

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

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

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

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

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

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

(c) In this section

(1) "consulting relationship" means a relationship that involves review of treatment plans and goals and in-person patient contact on at least a quarterly basis;

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

(3) "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;

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

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

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

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

(C) a hospital that is located in

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

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

(6) "major medical coverage" means a disability insurance contract, or a subscriber contract, that provides benefits for hospital and medical care with potential lifetime maximum benefits for the insured or subscriber of at least $10,000;

(7) "mental or nervous condition" means a mental disorder identified in

(A) the most current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or

(B) the most current edition of the ICD-9-CM published by the Commission on Professional and Hospital Activities;

(8) "national professional organization" means the National Association of Social Workers; the National Registry of Health Care Providers; and the American Board of Examiners in clinical social work;

(9) "office visit" means treatment that is not inpatient treatment or outpatient treatment and that is provided through the professional offices of

(A) a psychiatrist who is licensed by a state as a physician and certified, or eligible for certification, in psychiatry by the American Board of Psychiatry and Neurology;

(B) a physician who is employed by the federal government in a state and certified or eligible for certification in psychiatry by the American Board of Psychiatry and Neurology;

(C) a psychologist or psychological associate licensed by a state;

(D) a person who works in a consulting relationship with a mental health care provider licensed by a state and has a masters or doctoral degree in psychology, nursing, or social work; or

(E) a clinical social worker who is

(i) licensed or certified as a clinical social worker by a state; or

(ii) certified by a national professional organization offering certification of clinical social workers;

(10) "outpatient treatment" means treatment that is not inpatient treatment and that is provided

(A) in the outpatient department of

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

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

(iii) an entity that is designated by the Department of Health and Social Services as an organizational unit in a geographical area to receive funds under AS 47.30.520 - 47.30.620; and

(B) by one or more of the following:

(i) a psychiatrist who is licensed by a state as a physician and certified, or eligible for certification, in psychiatry by the American Board of Psychiatry and Neurology;

(ii) a physician who is employed by the federal government in a state and certified or eligible for certification in psychiatry by the American Board of Psychiatry and Neurology;

(iii) a psychologist licensed by a state;

(iv) a person who works in a consulting relationship with one or more licensed mental health care providers licensed by a state and has a masters or doctoral degree in psychology, nursing, or social work, and is employed by the

same health care facility providing treatment; or

(v) a clinical social worker who is licensed or certified as a clinical social worker by a state or certified by a national professional organization offering certification of clinical social workers.

* Sec. 2. AS 21.42.365(a) is repealed and reenacted to read:

(a) An insurer authorized under AS 21.09 to offer, issue for delivery, deliver, or renew a group disability insurance policy for major medical coverage on an expense-incurred basis in the state, or a hospital or medical service corporation authorized under AS 21.87 to offer or renew a group contract for major medical coverage in the state, must provide the insured or subscriber the following coverage for treatment of a mental or nervous condition of the insured, subscriber, or other person covered by the policy or contract:

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

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

* Sec. 3. AS 21.36.090(d) is amended to read:

(d) Except to the extent necessary to comply with AS 21.42.365, a [A] person may not practice or permit unfair discrimination against a person who provides a 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 the service is within the scope of the provider's occupational license. In this subsection, "provider" means a state licens physician, dentist, osteopath, optometrist, chiropractor, or nurse midwife, naturopath, physical therapist, or occupational therapist.

* Sec. 4. AS 21.87.340 is amended to read:

Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the provisions contained or referred to previously in this chapter, the following chapters and provisions of this title also apply with respect to service corporations to the extent applicable and not in conflict with the express provisions of this chapter and the reasonable implications of the express provisions, and for the purposes of the application the corporations shall be considered to be mutual "insurers":

(1) AS 21.03

(2) AS 21.06

(3) AS 21.09, except AS 21.09.090

(4) AS 21.18.010

(5) AS 21.18.030

(6) AS 21.18.040

(7) AS 21.18.120

(8) AS 21.21.321

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(10) AS 21.69.400

(11) AS 21.69.520

(12) AS 21.69.600, 21.69.620, and 21.69.630

(13) AS 21.78

(14) AS 21.90

(15) <u>AS 21.42.345 - 21.42.365</u> [AS 21.42.345 AND 21.42.355]

(16) AS 21.89.040

(17) AS 21.89.060.

* Sec. 5. AS 21.42.365, as enacted by sec. 1 of this Act, applies to group disability insurance policies and hospital or medical service subscriber contracts entered into or renewed on or after January 1, 1989.

* Sec. 6. AS 21.42.365, as amended by sec. 2 of this Act, applies to

group disability insurance policies and hospital or medical service subscriber contracts entered into or renewed on or after January 1, 1990.

* Sec. 7. Section 2 of this Act takes effect January 1, 1990.

Blue Cross
of Washington and Alaska

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) <u>the charge agreed to by contract between the provider and the third party payor</u>;

743.540 Application and certificates not required, blanket health insurance policies. An individual application need not be required from a person insured under a blanket health insurance policy, nor shall it be necessary for the insurer to furnish each person a certificate. [1967 c.359 §467]

743.543 Facility of payment, blanket health insurance policies. All benefits under a blanket health insurance policy shall be payable to the person insured, or to the designated beneficiary or beneficiaries of the person, or to the estate of the person, except that if the person insured is a minor or otherwise not competent to give a valid release, such benefits may be made payable to the parent, guardian or other person actually supporting the person. However, the policy may provide that all or a portion of any indemnities provided by such policy on account of hospital, nursing, medical or surgical services may, at the option of the insurer and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but the policy may not require that the services be rendered by a particular hospital or person. Payment so made shall discharge the obligation of the insurer with respect to the amount of insurance so paid. [1967 c.359 §468]

743.546 Policy form approval, blanket health insurance. The commissioner may exempt from the policy form filing and approval requirements of ORS 743.006, for so long as the commissioner deems proper, any blanket health insurance policy to which in the opinion of the commissioner such requirements may not practicably be applied, or may dispense with such filing and approval whenever, in the opinion of the commissioner, it is not desirable or necessary for the protection of the public. [1967 c.359 §469]

743.549 Restriction on reduction of benefits provisions in group and blanket health policies. No group or blanket health insurance policy providing hospital, medical or surgical expense benefits, and which contains a provision for the reduction of benefits otherwise payable thereunder on the basis of other existing coverages, shall provide that such reduction will operate to reduce total benefits payable below an amount equal to 100 percent of total allowable expenses. [1973 c.143 §2]

743.552 Guidelines for application of ORS 743.549. The commissioner shall by rule establish guidelines for the application of ORS 743.549, including:

(1) The procedures by which persons insured under such policies are to be made aware of the existence of such a provision;

(2) The benefits which may be subject to such a provision;

(3) The effect of such a provision on the benefits provided;

(4) Establishment of the order of benefit determination; and

(5) Reasonable claim administration procedures to expedite claim payments under such a provision which shall include a time limit of 14 days beyond which the insurer shall not delay payment of a claim by reason of the application of coordination of benefits provision. [1973 c.143 §3]

743.555 Application of ORS 743.549 and 743.552. ORS 743.549 and 743.552 shall apply to any group or blanket health insurance policy containing a provision described in ORS 743.549 which is issued more than 90 days after June 26, 1973. Policies which are in existence 90 days after June 26, 1973, shall be brought into compliance on the next anniversary date, renewal date or the expiration date of the applicable collectively bargained contract, if any, whichever date is latest. [1973 c.143 §4]

743.557 Group health insurance coverage for treatment for chemical dependency including alcoholism; limitation on deductibles and coinsurance; eligible treatments and programs; allowable limits on payments; cost containment. A group health insurance policy providing coverage for hospital or medical expenses shall provide coverage for expenses arising from treatment for chemical dependency including alcoholism. The following conditions apply to the requirement for such coverage:

(1) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance. Deductibles and coinsurance for treatment in health facilities or residential facilities shall be no greater than those under the policy for expenses of hospitalization in the treatment of illness. Deductibles and coinsurance for outpatient treatment shall be no greater than those under the policy for expenses of outpatient treatment of illness.

(2) Treatment shall include treatment provided in health facilities, residential facilities or outpatient services, as defined in ORS 430.010, within the limits specified in this section. Notwithstanding the limits for particular types of

services specified in subsections (6) to (8) of this section, a policy may limit the total of payments for all treatment of any kind under this section for chemical dependency including alcoholism, together with payments for all treatment of any kind under ORS 743.558 for mental or nervous conditions, to $6,000 in any 24-consecutive month period, except as otherwise provided in ORS 743.558. For persons requesting, in any 24-consecutive month period, payments for treatment of any kind for chemical dependency including alcoholism, but not requesting payments for treatment of any kind of mental or nervous conditions, a policy may limit the total of payments for all treatment to $6,000 in that 24-consecutive month period.

(3) Subject to the provisions of ORS 743.123, 743.128 and 743.135, programs in which staff are directly supervised by a medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon as provided under ORS 677.010 to 677.450; a psychologist licensed by the State Board of Psychologist Examiners as provided under ORS 675.010 to 675.150; a nurse practitioner registered by the Oregon State Board of Nursing as provided under ORS 678.010 to 678.410; or a clinical social worker registered by the State Board of Clinical Social Workers as provided under ORS 675.510 to 675.610, and programs in which individual client treatment plans are approved by a medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon as provided under ORS 677.010 to 677.450; a psychologist licensed by the State Board of Psychologist Examiners as provided under ORS 675.010 to 675.150; a nurse practitioner registered by the Oregon State Board of Nursing as provided under ORS 678.010 to 678.410; or a clinical social worker registered by the State Board of Clinical Social Workers as provided under ORS 675.510 to 675.610, shall be eligible to receive payments for treatment. In addition, an insurer or insurers and the Mental Health Division may mutually develop agreements, standards and procedures through which Mental Health Division approved programs with alternative arrangements for supervision or for review of treatment plans may become qualified to receive payments for treatment.

(4) Chemical dependency, for purposes of this section, refers to the addictive relationship an individual may have with any drug or alcohol agent. This dependency may be characterized by either a physical or psychological relationship, or both, to the extent that it interferes with the individual's social, psychological or physical adjustment to common problems on a daily basis. For purposes of this section, chemical dependency does not include addiction to, or dependency on, tobacco, tobacco products or foods.

(5) Payments shall not be made under this section for educational programs to which drinking drivers are referred by the judicial system, nor for volunteer mutual support groups.

(6) Except as permitted by subsections (1) and (2) of this section, the policy shall not limit payments for inpatient care and treatment in hospitals and other health facilities thereunder for chemical dependency including alcoholism to an amount less than $4,500 in any 24-consecutive month period.

(7) Except as permitted by subsections (1) and (2) of this section, in the case of benefits for care and treatment in residential facilities for chemical dependency including alcoholism, the policy shall not limit payments to an amount less than $3,000 in any 24-consecutive month period. Within this dollar limit, payments shall be made for either full-day, supervised, residential treatment and care, or for part-day treatment on an organized, formal, regularly scheduled basis consisting of at least four hours of structured treatment per day, for at least four days each week. Payments for part-day treatment on a less intensive schedule shall be made within the dollar limit for outpatient payments.

(8) Except as permitted by subsections (1) and (2) of this section, in the case of benefits for outpatient services, the policy shall not limit payments to an amount less than $1,500 in any 24-consecutive month period. If so specified in the policy, outpatient coverage may include follow-up in-home service associated with any health facility, residential or outpatient services. The policy may limit coverage for such service to persons who have properly completed their initial health facility, residential or outpatient treatment and did not terminate that initial treatment against advice. The policy may also limit coverage for in-home service by defining the circumstances of need under which payment will or will not be made.

(9) Under ORS 430.315, the Legislative Assembly has found that health care cost containment is necessary and intends to encourage insurance policies designed to achieve cost containment by assuring that reimbursement is limited to appropriate utilization under criteria incorporated into such policies, either directly or by reference.

(10) A group health insurance policy may provide, with respect to treatment for chemical

dependency including alcoholism, that any one or more of the following cost containment methods shall be in effect and the method or methods used by an insurer in one part of the state may be different from the method or methods used by that insurer in another part of the state:

(a) Proportion of coinsurance required for treatment in residential facilities, outpatient services, or both, less than the proportion of coinsurance required for treatment in health facilities.

(b) Subject to the patient or client confidentiality provisions of ORS 40.235 relating to physicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists and ORS 40.250 and 675.580 relating to social workers, review, for level of treatment, of admissions and continued stays for treatment in health facilities or in both health facilities and residential facilities or in health facilities, residential facilities and outpatient services by either insurer staff, personnel under contract to the insurer, or by a utilization review contractor, who shall have the power to certify for or deny level of payment. This review shall be made according to criteria made available to providers in advance. Review shall be performed by a medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon as provided under ORS 677.010 to 677.450; a psychologist licensed by the State Board of Psychologist Examiners as provided under ORS 675.010 to 675.150; a nurse practitioner registered by the Oregon State Board of Nursing as provided under ORS 678.010 to 678.410; or a clinical social worker registered by the State Board of Clinical Social Workers as provided under ORS 675.510 to 675.610, with physician consultation readily available. Review shall be on a post-admission basis rather than by mandatory prior approval, although policy holders or persons acting on their behalf shall be encouraged to make advance inquiries when feasible. An appeals process shall be provided. An insurer may choose to review all providers on a sampling or audit basis only; or to review, on a less frequent basis, those providers who consistently supply full documentation, consistent with confidentiality statutes, on each case, in a timely fashion, to the insurer.

(11) For purposes of paragraph (b) of subsection (10) of this section, a utilization review contractor is a professional standards review organization, foundation for medical care or similar entity which, under contract with an insurance carrier, performs certification of reimbursability of level of treatment for admissions and maintained stays in treatment programs, facilities or services.

(12) For purposes of paragraph (b) of subsection (10) of this section, when implemented through an insurance contract, reimbursability of treatment at the health facility level of treatment, as defined in ORS 430.010, requires demonstration that medical circumstances require 24-hour nursing care, or physician or nurse assessment, treatment or supervision that cannot be readily made available on an outpatient basis, or in:

(a) The current living situation;

(b) An alternative, nontreatment living situation; or

(c) An alternative residential facility.

(13) For purposes of paragraph (b) of subsection (10) of this section, when implemented through an insurance contract, reimbursability of treatment at the residential facility level of treatment, as defined in ORS 430.010 and under subsection (7) of this section, shall require demonstration that outpatient services, as defined in ORS 430.010 and under subsection (7) of this section, if appropriate and less costly than residential facility services:

(a) Are not presently appropriate and available;

(b) Cannot be readily and timely made available; and

(c) Cannot meet documented needs for nonmedical supervision, protection, assistance and treatment, either in the current living situation or in a readily and timely available alternative, nontreatment living situation, taking into account the extent of both the available positive support and existing negative influences in the occupational, social and living situations; risks to self or others; and readiness to participate consistently in treatment.

(14) For purposes of paragraph (b) of subsection (10) of this section, reimbursability of treatment at the level for outpatient facility, service or program, as defined in ORS 430.010 and under subsections (7) and (8) of this section, shall require demonstration that treatment is justified, considering the individual's history, and the current medical, occupational, social and psychological situation, and the overall prognosis. [1975 c.689 §2; 1977 c.632 §3; 1981 c.319 §2; 1983 c.601 §5]

Note: See note under 743.558.

743.558 Group health insurance coverage for mental or nervous conditions; limitation on deductibles and coinsurance; eligible treatments and programs; allowable limits on payments; cost containment. Every insurer offering group health insurance

benefits shall provide benefits for expense arising from mental or nervous conditions that meet the following requirements:

(1) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance. Deductibles and coinsurance for treatment in health facilities or residential facilities shall be no greater than those under the policy for expenses of hospitalization in the treatment of illness. Deductibles and coinsurance for outpatient treatment shall be no greater than those under the policy for expenses of outpatient treatment of illness.

(2) Treatment shall include treatment provided in health facilities, residential facilities or outpatient services, as defined in ORS 430.010 within the limits specified in this section. Notwithstanding the limits for particular types of services specified in subsections (4) to (6) of this section, a policy may limit the total of payments for all treatment of any kind under ORS 743.557 for chemical dependency including alcoholism, together with payments for all treatment of any kind under this section for mental or nervous conditions, to $6,000 in any 24-consecutive month period, except as otherwise provided in this section. However, for person requesting, in any 24-consecutive month period, payments for treatment of any kind for mental or nervous conditions, but not requesting payments for treatment of any kind for chemical dependency including alcoholism, a policy may not limit the total of payments for all treatment to less than $9,000 in that 24-consecutive month period.

(3) Subject to the provisions of ORS 743.123, 743.128 and 743.135, programs in which staff are directly supervised by a medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon as provided under ORS 677.010 to 677.450; a psychologist licensed by the State Board of Psychologist Examiners as provided under ORS 675.010 to 675.150; a nurse practitioner registered by the Oregon State Board of Nursing as provided under ORS 678.010 to 678.410; or a clinical social worker registered by the State Board of Clinical Social Workers as provided under ORS 675.510 to 675.610, and programs in which individual client treatment plans are approved by a medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon as provided under ORS 677.010 to 677.450; a psychologist licensed by the State Board of Psychologist Examiners as provided under ORS 675.010 to 675.150; a nurse practitioner registered by the Oregon State Board of Nursing as provided under ORS 678.010 to 678.410; or a clinical social worker registered by the State Board of Clinical Social Workers as provided under ORS 675.510 to 675.610, shall be eligible to receive payments for treatment.

(4) Except as permitted by subsections (1) and (2) of this section, the policy shall not limit payments for inpatient care and treatment in hospitals and other health facilities thereunder for mental or nervous conditions to an amount less than $7,500 in any 24-consecutive month period, subject to the provisions of subsection (5) of this section.

(5) Except as permitted by subsections (1) and (2) of this section, in the case of benefits for treatment in residential facilities, the policy shall not limit payments to an amount less than $3,000 in any 24-consecutive month period. A policy may specify that any payments made under this subsection shall directly reduce, dollar for dollar, amounts available for payments under subsection (4) of this section. Within the dollar limit in this subsection, payments shall be made for either full-day, supervised, residential treatment and care, or for part-day treatment on an organized, formal, regularly scheduled basis consisting of at least four hours of structured treatment per day, for at least four days each week. Payments for part-day treatment on a less intensive schedule shall be made within the dollar limit for outpatient payments.

(6) Except as permitted by subsections (1) and (2) of this section, in the case of benefits for outpatient treatment, the policy shall not limit payments to an amount less than $2,000 in any 24-consecutive month period. If so specified in the policy, outpatient coverage may include follow-up in-home service associated with any health facility, residential or outpatient services. The policy may limit coverage for in-home service to persons who have properly completed their initial health facility, residential or outpatient treatment and did not terminate that initial treatment against advice. The policy may also limit coverage for in-home service by defining the circumstances of need under which payment will or will not be made.

(7) Under ORS 430.021, the Legislative Assembly has found that health care cost containment is necessary and intends to encourage insurance policies designed to achieve cost containment by assuring that reimbursement is limited to appropriate utilization under criteria incorporated into such policies, either directly or by reference.

(8) A group health insurance policy may provide, with respect to treatment for mental or nervous conditions, that any one or more of the following cost containment methods shall be in effect and the method or methods used by an insurer in one part of the state may be different from the method or methods used by that insurer in another part of the state:

(a) Proportion of coinsurance required for treatment in residential facilities, outpatient services, or both, less than the proportion of coinsurance required for treatment in health facilities.

(b) Subject to the patient or client confidentiality provisions of ORS 40.235 relating to physicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists and ORS 40.250 and 675.580 relating to social workers, review, for level of treatment, of admissions and continued stays for treatment in health facilities or in both health facilities and residential facilities or in health facilities, residential facilities and outpatient services by either insurer staff, personnel under contract to the insurer, or by a utilization review contractor, who shall have the power to certify for or deny level of payment. This review shall be made according to criteria made available to providers in advance. Review shall be performed by a medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon as provided under ORS 677.010 to 677.450; a psychologist licensed by the State Board of Psychologist Examiners as provided under ORS 675.010 to 675.150; a nurse practitioner registered by the Oregon State Board of Nursing as provided under ORS 678.010 to 678.410; or a clinical social worker registered by the State Board of Clinical Social Workers as provided under ORS 675.510 to 675.610, with physician consultation readily available. Review shall be on a post-admission basis rather than by mandatory prior approval, although policy holders or persons acting on their behalf shall be encouraged to make advance inquiries when feasible. An appeals process shall be provided. An insurer may choose to review all providers on a sampling or audit basis only; or to review, on a less frequent basis, those providers who consistently supply full documentation, consistent with confidentiality statutes, on each case, in a timely fashion, to the insurer.

(9) For purposes of paragraph (b) of subsection (8) of this section, a utilization review contractor is a professional standards review organization, foundation for medical care or similar entity which, under contract with an insurance carrier, performs certification of reimbursability of level of treatment for admissions and maintained stays in treatment programs, facilities or services.

(10) For purposes of paragraph (b) of subsection (8) of this section, when implemented through an insurance contract, reimbursability of treatment at the health facility level of treatment as defined in ORS 430.010, requires demonstration that medical circumstances require 24-hour nursing care, or physician or nurse assessment, treatment or supervision that cannot be readily made available on an outpatient basis, or in:

(a) The current living situation;

(b) An alternative, nontreatment living situation; or

(c) An alternative residential facility.

(11) For purposes of paragraph (b) of subsection (8) of this section, when implemented through an insurance contract, reimbursability of treatment at the residential facility level of treatment, as defined in ORS 430.010 and under subsection (5) of this section, shall require demonstration that outpatient services, as defined in ORS 430.010 and under subsection (5) of this section if appropriate, and less costly than residential facility services:

(a) Are not presently appropriate and available;

(b) Cannot be readily and timely made available; and

(c) Cannot meet documented needs for nonmedical supervision, protection, assistance and treatment, either in the current living situation or in a readily and timely available alternative, nontreatment living situation, taking into account the extent of both the available positive support and existing negative influences in the occupational, social and living situation; risks to self or others; and readiness to participate consistently in treatment.

(12) For purposes of paragraph (b) of subsection (8) of this section, reimbursability of treatment at the level for outpatient facility, service or program, as defined in ORS 430.010 and under subsections (5) and (6) of this section, shall require demonstration that treatment is justified, considering the individual's history and the current medical, occupational, social and psychological situation, and the overall prognosis. [1973 c.613 §2; 1983 c.601 §6]

Note: Section 10, chapter 601, Oregon Laws 1983, provides:

Sec. 10. Sections 7, 8 and 11, chapter 601, Oregon Laws 1983, and ORS 743.557, 743.558 and 750.055 as amended by sections 5, 6 and 9, chapter 601, Oregon Laws

B-Engrossed
Senate Bill 31

Ordered by the House June 10
Including Senate Amendments dated April 28
and House Amendments dated June 10

PRINTED PURSUANT TO ORS 171.130 by order of the President of the Senate in conformance with presession filing rules, indicating neither advocacy nor opposition on the part of the President (at the request of State Health Planning and Development Agency)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

Revises health insurance reimbursement requirements for mental or nervous conditions and chemical dependency. Requires that State Health Planning and Development Agency draft model set of review criteria for use in certain health care facilities and residential programs and facilities.

Directs Insurance Division to adopt criteria for determining when health maintenance organization meets specified requirements for provision of chemical dependency benefits and when certain contracts for discounted health care services meet specified requirements. **Allows health maintenance organizations to charge co-payments for mental health care until June 30, 1991. Directs Insurance Commissioner to adopt rules necessary to interpret Act.**

Declares emergency, effective June 30, 1987.

A BILL FOR AN ACT

Relating to health insurance; creating new provisions; amending ORS 430.010, 748.555, 750.055 and section 10, chapter 601, Oregon Laws 1983; repealing ORS 743.557, 743.558 and section 2, chapter 601, Oregon Laws 1983; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Section 2 of this Act is added to and made a part of ORS chapter 743.

SECTION 2. A group health insurance policy providing coverage for hospital or medical expenses shall provide coverage for expenses arising from treatment for chemical dependency including alcoholism and for mental or nervous conditions. The following conditions apply to the requirement for such coverage:

(1) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance. Deductibles and coinsurance for treatment in health care facilities or residential programs or facilities shall be no greater than those under the policy for expenses of hospitalization in the treatment of illness. Deductibles and coinsurance for outpatient treatment shall be no greater than those under the policy for expenses of outpatient treatment of illness.

(2) Treatment provided in health care facilities, residential programs or facilities, day or partial hospitalization programs or outpatient services shall be considered eligible for reimbursement if it is provided by:

(a) Programs or providers described in ORS 430.010 or approved by the office of Alcohol and Drug Abuse Programs or by the Mental Health Division under subsection (3) of this section.

(b) Programs accredited for the particular level of care for which reimbursement is being requested by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation

NOTE: Matter in bold face in an amended section is new; matter *[italic and bracketed]* is existing law to be omitted.

of Rehabilitation Facilities.

(c) Inpatient programs provided by health care facilities as defined in ORS 442.015 (16). Residential, outpatient, or day or partial hospitalization programs offered by or through a health care facility must meet the requirements of either paragraph (a) or (b) of this subsection in order to be eligible for reimbursement.

(d) Residential programs or facilities described in subsection (3) of this section if the patient is staying overnight at the facility and is involved in a structured program at least eight hours per day, five days per week.

(e) Programs in which staff are directly supervised or in which individual client treatment plans are approved by a person described in ORS 430.010 (4)(d) and which meet the standards established under subsection (3) of this section.

(3) The office of Alcohol and Drug Abuse Programs shall adopt rules relating to the approval, for insurance reimbursement purposes, of noninpatient chemical dependency programs that are not related to the division or any county mental health program. The Mental Health Division shall adopt rules relating to the approval, for insurance reimbursement purposes, of noninpatient programs for mental or nervous conditions that not related to the division or any county mental health program. Standards proposed by the American Association of Partial Hospitalization should be considered as one possible source for such rules. In addition, an insurer or insurers and the office of Alcohol and Drug Abuse Programs, or an insurer or insurers and the Mental Health Division may mutually develop agreements, standards and procedures for programs that are approved by the office or the division and that provide alternative arrangements for supervision or for review of treatment plans to become qualified to receive payments for treatment.

(4) A program that provides services for persons with both a chemical dependency diagnosis and a mental or nervous condition shall be considered to be a distinct and specialized type of program for both chemical dependency and mental or nervous conditions. The Mental Health Division and the office of Alcohol and Drug Abuse Programs jointly shall develop specific standards related to such programs for program approval purposes and shall adopt rules relating to the approval, for insurance reimbursement purposes, of such noninpatient programs that are not related to the office or the division and any county mental health program.

(5) As used in this section:

(a) "Chemical dependency" means the addictive relationship with any drug or alcohol characterized by either a physical or psychological relationship, or both, that interferes with the individual's social, psychological or physical adjustment to common problems on a recurring basis. For purposes of this section, chemical dependency does not include addiction to, or dependency on, tobacco, tobacco products or foods.

(b) "Child or adolescent" means a person who is 17 years of age or younger.

(c) "Facility" means a corporate or governmental entity or other provider of services for the treatment of chemical dependency or for the treatment of mental or nervous conditions.

(d) "Program" means a particular type or level of service that is organizationally distinct within a facility.

(6) Notwithstanding the limits for particular types of services specified in this section, a policy shall not limit the total of payments for all treatment of any kind under this section for chemical dependency, together with payments for all treatment of any kind for mental or nervous conditions, to less than $10,500 for adults and $12,500 for children or adolescents. For persons requesting

payments for treatment of any kind for chemical dependency, but not requesting payments for treatment of any kind of mental or nervous condition, a policy shall not limit the total of payments for all treatment to less than $6,500 for adults and $10,500 for children and adolescents.

(7) The limits for mental or nervous conditions specified in this section shall apply to persons with diagnoses of both chemical dependency and mental or nervous conditions, who are being treated for both types of diagnosis, as well as persons with only a diagnosis of a mental or nervous condition.

(8) The higher benefit levels in this section for children or adolescents are in recognition of the longer period of treatment and the greater levels of staffing that may be required for children or adolescents and are intended to permit more services to meet the needs of children and adolescents.

(9) Payments shall not be made under this section for educational programs to which drivers are referred by the judicial system, nor for volunteer mutual support groups.

(10) Except as permitted by subsections (1), (6) and (12) of this section, the policy shall not limit payments for inpatient treatment in hospitals and other health care facilities thereunder:

(a) For chemical dependency to an amount less than $4,500 for adults and $4,000 for children or adolescents; and

(b) For mental or nervous conditions to an amount less than $4,000 for adults and $6,000 for children or adolescents.

(11) Except as permitted by subsections (1), (6) and (12) of this section, the policy shall not limit payments for treatment in residential programs or facilities or day or partial hospitalization programs:

(a) For chemical dependency to an amount less than $3,500 for adults and $3,000 for children or adolescents; and

(b) For mental or nervous conditions to an amount less than $1,000 for adults and $2,500 for children or adolescents.

(12) Notwithstanding the minimum benefits for particular types of services specified in subsections (10) and (11) of this section, and except as permitted by subsection (1) of this section, the policy shall not limit total payments for inpatient, residential and day or partial hospitalization program care or treatment:

(a) For chemical dependency to an amount less than $8,500 for children or adolescents; and

(b) For mental or nervous conditions to an amount less than $8,500 for adults and $10,500 for children or adolescents.

(13) Except as permitted by subsections (1) and (6) of this section, in the case of benefits for outpatient services, the policy shall not limit payments:

(a) For chemical dependency to an amount less than $1,500 for adults and $2,000 for children or adolescents; and

(b) For mental or nervous conditions to an amount less than $2,000.

(14) If so specified in the policy, outpatient coverage may include follow-up in-home service associated with any health care facility, residential, day or partial hospitalization or outpatient services. The policy may limit coverage for in-home service to persons who have completed their initial health care facility, residential, day or partial hospitalization or outpatient treatment and did not termin. te that initial treatment against advice. The policy may also limit coverage for in-home service by defining the circumstances of need under which payment will or will not be made.

(15) Under ORS 430.021 and 430.315, the Legislative Assembly has found that health care cost

containment is necessary and intends to encourage insurance policies designed to achieve cost containment by assuring that reimbursement is limited to appropriate utilization under criteria incorporated into such policies, either directly or by reference.

(16) A group health insurance policy may provide, with respect to treatment for chemical dependency or mental or nervous conditions, that any one or more of the following cost containment methods shall be in effect and the method or methods used by an insurer in one part of the state may be different from the method or methods used by that insurer in another part of the state:

(a) Proportion of coinsurance required for treatment in residential programs or facilities, day or partial hospitalization programs or outpatient services less than the proportion of coinsurance required for treatment in health care facilities.

(b) Subject to the patient or client confidentiality provisions of ORS 40.235 relating to physicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists and ORS 40.250 and 675.580 relating to social workers, review for level of treatment of admissions and continued stays for treatment in health care facilities, residential programs or facilities, day or partial hospitalization programs and outpatient services by either insurer staff or personnel under contract to the insurer, or by a utilization review contractor, who shall have the authority to certify for or deny level of payment:

(A) This review shall be made according to criteria made available to providers in advance upon request.

(B) To facilitate implementation of utilization review programs by insurers, the State Health Planning and Development Agency shall draft an advisory or model set of criteria for appropriate utilization of inpatient, residential, day or partial hospitalization, and outpatient facilities, programs and services by adults, children and adolescents, and persons with both a chemical dependency diagnosis and a mental or nervous condition. These criteria shall be consistent with this section and shall not be binding on any insurer or other party. However, at the time of contract negotiation or amendment, with the agreement of the parties to the contract, any insurer may adopt the criteria or similar criteria with or without modification. The agency shall revise these criteria at least every two years. In developing and revising these criteria, the agency shall organize a technical advisory panel including representatives of the Insurance Division, the office of Alcohol and Drug Abuse Programs, the Mental Health Division, the Health Division, the insurance industry, the business community and providers of each level of care. The agency shall place substantial weight on the advice of this panel.

(C) Review shall be performed by or under the direction of a medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon; a psychologist licensed by the State Board of Psychologist Examiners; a nurse practitioner registered by the Oregon State Board of Nursing; or a clinical social worker registered by the State Board of Clinical Social Workers, with physician consultation readily available. The reviewer shall have expertise in the evaluation of mental or nervous condition services or chemical dependency services.

(D) Review may involve prior approval, concurrent review of the continuation of treatment, post-treatment review or any combination of these. However, if prior approval is required, provision shall be made to allow for payment of urgent or emergency admissions, subject to subsequent review. If prior approval is not required, insurers shall permit treatment providers, policy holders or persons acting on their behalf to make advance inquiries regarding the appropriateness of a particular admission to a treatment program. Insurers shall provide a timely response to such inquiries.

Approval of a particular admission does not represent a guarantee of future payment.

(E) An appeals process shall be provided.

(F) An insurer may choose to review all providers on a sampling or audit basis only; or to review on a less frequent basis those providers who consistently supply full documentation, consistent with confidentiality statutes on each case in a timely fashion to the insurer.

(17) For purposes of paragraph (b) of subsection (16) of this section, a utilization review contractor is a professional review organization or similar entity which, under contract with an insurance carrier, performs certification of reimbursability of level of treatment for admissions and maintained stays in treatment programs, facilities or services.

(18) For purposes of paragraph (b) of subsection (16) of this section, when implemented through an insurance contract, reimbursability of inpatient treatment requires demonstration that medical circumstances require 24-hour nursing care, or physician or nurse assessment, treatment or supervision that cannot be readily made available on an outpatient basis, or in:

(a) The current living situation;

(b) An alternative, nontreatment living situation;

(c) An alternative residential program or facility; or

(d) A day or partial hospitalization program.

(19) For purposes of paragraph (b) of subsection (16) of this section, when implemented through an insurance contract, reimbursability of treatment at the residential, day or partial hospitalization level of treatment shall require demonstration that outpatient services, if appropriate and less costly than residential, day or partial hospitalization services:

(a) Are not presently appropriate and available;

(b) Cannot be readily and timely made available; and

(c) Cannot meet documented needs for nonmedical supervision, protection, assistance and treatment, either in the current living situation or in a readily and timely available alternative, nontreatment living situation, taking into account the extent of both the available positive support and existing negative influences in the occupational, social and living situations; risks to self or others; and readiness to participate consistently in treatment.

(20) For purposes of paragraph (b) of subsection (16) of this section, reimbursability of treatment at the level for outpatient facility, service or program shall require demonstration that treatment is justified, considering the individual's history, and the current medical, occupational, social and psychological situation, and the overall prognosis.

(21) Discrete medical or neurologic diagnostic or treatment services including any professional component of that service, costing in excess of $300, occurring concurrently with but not directly related to treatment of mental or nervous conditions shall not be charged against the inpatient benefit level.

(22) The benefits described in this section shall renew in full either on the first day of the 25th month of coverage following the first use of services for the treatment of chemical dependency or mental or nervous conditions, or both, or on the first day following two consecutive contract years.

(23) Health maintenance organizations, as defined in ORS 750.005 (3), shall be subject to the following conditions and requirements in their provision of benefits for chemical dependency or mental or nervous conditions to enrollees:

(a) Notwithstanding the provisions of subsection (1) of this section, health maintenance organizations may establish reasonable provisions for enrollee cost-sharing, so long as the amount the

enrollee is required to pay does not exceed the amount of coinsurance and deductible customarily required by other insurance policies which are subject to the provisions of ORS chapter 743 for that type and level of service.

(b) Nothing in this section prevents health maintenance organizations from establishing durational limits which are actuarially equivalent to the benefits required by this section.

(c) Health maintenance organizations may limit the receipt of covered services by enrollees to services provided by or upon referral by providers associated with the health maintenance organization.

(d) The Insurance Division shall make rules establishing objective and quantifiable criteria for determining when a health maintenance organization meets the conditions and requirements of this subsection.

(24) Nothing in this section shall prevent an insurer or health care service contractor other than a health maintenance organization, except as provided in subsection (23) of this section, from contracting with providers of health care services to furnish services to policy holders or certificate holders according to ORS 743.531 or 750.005, subject to the following conditions:

(a) An insurer or health care service contractor may establish limits for contracted services which are actuarially equivalent to the benefits required by this section, so long as the same range of treatment settings is made available.

(b) An insurer or health care service contractor, other than a health maintenance organization, may negotiate with contracting providers as to the cost of actuarially equivalent benefits, and such actuarially equivalent benefits for services of contracting providers shall be deemed to equal the minimum benefit levels specified in this section.

(c) An insurer or health care service contractor is not required to contract with all eligible providers, and payment for covered services of contracting providers may be in alternative methods or amounts rather than as specified in this section.

(d) Insurers and health care service contractors other than health maintenance organizations shall pay benefits toward the covered charges of noncontracting providers of services for the treatment of chemical dependency or mental or nervous conditions at the same level of deductible or coinsurance as would apply to covered charges of noncontracting providers of other health services under the same group policy or contract. The insured shall have the right to use the services of a noncontracting provider of services for the treatment of chemical dependency or mental or nervous conditions. Policies described in this subsection shall be subject to the provisions of subsection (1) of this section, whether or not the services for chemical dependency or mental or nervous conditions are provided by contracting or noncontracting providers.

(e) The Insurance Division shall make rules establishing objective and quantifiable criteria for determining that a contract meets the conditions and requirements of this subsection and that actuarially equivalent services of contracting providers equal or exceed services obtainable with the minimum benefits specified in this section.

(25) The intent of the Legislative Assembly in adopting this section is to reserve benefits for different types of care to encourage cost effective care and to assure continuing access to levels of care most appropriate for the insured's condition and progress.

(26) The Insurance Commissioner, after notice and hearing, may adopt reasonable rules not inconsistent with this section that are considered necessary for the proper administration of these provisions.

SECTION 3. ORS 750.055 is amended to read:

750.055. (1) The following provisions of the Insurance Code shall apply to health care service contractors to the extent so applicable and not inconsistent with the express provisions of this chapter:

(a) ORS 731.004 to 731.150, 731.162, 731.204 to 731.362, 731.382, 731.386, 731.390, 731.398 to 731.430, 731.450, 731.454, 731.504, 731.508, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.804 and 731.844 to 731.992.

(b) ORS 732.230, 732.245, 732.250, 732.320, 732.325 and 732.505 to 732.595.

(c)(A) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.700 to 733.780, apply to not for-profit health care service contractors.

(B) ORS chapter 733 applies to for-profit health care service contractors.

(d) ORS chapter 734.

(e) ORS 743.003 to 743.011, 743.012, 743.018 to 743.030, 743.037 to 743.108, 743.114, 743.116, 743.119 to 743.128, 743.350 to 743.370, 743.402, 743.412, 743.492, 743.495, 743.498, 743.527, 743.529, 743.549 to 743.555, 743.800 to 743.833 and 743.850 to 743.890.

(f) ORS 743.522 and 743.528, except that individual policies may be issued to the persons or families insured in lieu of issuance of a single group policy as referred to in ORS 743.522. An individual policy issued under this paragraph shall be considered the statement of the essential features of the insurance coverage required under ORS 743.528 (2).

(g) ORS 744.005 to 744.265.

(h) ORS 746.005 to 746.140, 746.160, 746.180, 746.220 to 746.370 and 746.600 to 746.690.

(i) ORS 743.135, except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is referred by a physician associated with a group practice health maintenance organization.

(j) ORS 743.557 and 743.558 except that group practice or staff health maintenance organizations which are federally qualified pursuant to Title XIII of the Public Health Service Act shall be deemed to comply with the requirements of ORS 743.557 and 743.558.

(k) Section 2 of this 1987 Act.

(2) For the purposes of this section only, health care service contractors shall be deemed insurers.

(3) Any for-profit health care service contractor organized under the laws of any other state which is not governed by the insurance laws of such state, will be subject to all requirements of ORS chapter 732.

(4) The commissioner may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025 and 752.045 that are deemed necessary for the proper administration of these provisions.

SECTION 4. ORS 430.010 is amended to read:

430.010. As used in ORS 430.010 to 430.050, 430.100 to 430.170, 430.260 to 430.270 and 430.610 to 430.700, unless the context requires otherwise:

(1) "Division" means the Mental Health Division.

(2) "Health facility" means a facility licensed as required by ORS 441.015 or a facility accredited by the Joint Commission on Accreditation of Hospitals, either of which provides full-day or part-day acute treatment for alcoholism, drug addiction or mental or emotional disturbance, and is licensed to admit persons requiring 24-hour nursing care.

(3) "Residential facility" or "day or partial hospitalization program" means a program or facility providing an organized full-day or part-day program of treatment, but not licensed to admit persons requiring 24-hour nursing care. Such a program or facility shall be:

(a) Licensed, approved, established, maintained, contracted with or operated by the [*Mental Health Division*] **office of Alcohol and Drug Abuse Programs** under ORS 430.041, 430.260 to 430.380 and 430.610 to 430.880 for alcoholism;

(b) Licensed, approved, established, maintained, contracted with or operated by the [*Mental Health Division*] **office of Alcohol and Drug Abuse Programs** under ORS 430.041, 430.260 to 430.380, 430.405 to 430.565 and 430.610 to 430.880 for drug addiction; or

(c) Licensed, approved, established, maintained, contracted with or operated by the Mental Health Division under ORS 430.041 and 430.610 to 430.880 for mental or emotional disturbance.

(4) "Outpatient service" means a program or service providing treatment by appointment. Such a program or service shall be:

(a) Licensed, approved, established, maintained, contracted with or operated by the [*Mental Health Division*] **office of Alcohol and Drug Abuse Programs** under ORS 430.041, 430.260 to 430.380 and 430.610 to 430.880 for alcoholism;

(b) Licensed, approved, established, maintained, contracted with or operated by the [*Mental Health Division*] **office of Alcohol and Drug Abuse Programs** under ORS 430.041, 430.260 to 430.380, 430.405 to 430.565 and 430.610 to 430.880 for drug addiction;

(c) Licensed, approved, established, maintained, contracted with or operated by the Mental Health Division under ORS 430.041 and 430.610 to 430.880 for mental or emotional disturbance; or

(d) Provided by medical or osteopathic physicians licensed by the Board of Medical Examiners for the State of Oregon as provided under ORS 677.010 to 677.450; psychologists licensed by the State Board of Psychologist Examiners as provided under ORS 675.010 to 675.150; nurse practitioners registered by the Oregon State Board of Nursing as provided under ORS 678.010 to 678.410; or clinical social workers registered by the State Board of Clinical Social Workers as provided under ORS 675.510 to 675.610.

SECTION 5. Section 2, chapter 601, Oregon Laws 1983, is repealed.

SECTION 6. Section 10, chapter 601, Oregon Laws 1983, as amended by section 1, chapter 124, Oregon Laws 1985, and section 179, chapter 158, Oregon Laws 1987 (Enrolled House Bill 2409), is further amended to read:

Sec. 10. [*(1)*] Sections 7, 8 and 11, chapter 601, Oregon Laws 1983, are repealed on July 1, 1987.

[*(2) The amendments to ORS 743.557, 743.558 and 750.055 by sections 5, 6 and 9, chapter 601, Oregon Laws 1983, are repealed on july 1, 1987.*]

SECTION 7. ORS 743.145 does not apply to section 2 of this Act because section 2 of this Act constitutes a reenactment of ORS 743.557 and 743.558 or to ORS 750.055 because of its amendment by this Act.

SECTION 8. Section 2 of this Act and the amendments to ORS 750.055 (1)(k) of this Act apply to contracts entered into, renewed or extended on or after July 1, 1988.

SECTION 9. ORS 743.557 and 743.558 are repealed June 30, 1988.

SECTION 10. Paragraph (a) of subsection (23) of section 2 of this Act is not operative after June 30, 1991.

SECTION 11. ORS 748.555 is amended to read:

748.555. (1) The following provisions of the Insurance Code shall apply to fraternal benefit so-

cieties to the extent so applicable and not inconsistent with the express provisions of this chapter:

(a) ORS 731.004 to 731.026, 731.032 to 731.154, 731.162, 731.166, 731.170, 731.204 to 731.356, 731.378 to 731.434, 731.446, 731.450, 731.454, 731.504, 731.508, 731.512, 731.574 to 731.620, 731.640, 731.644 to 731.652, 731.804 and 731.844 to 731.992.

(b) ORS 732.245, 732.250, 732.320 and 732.325.

(c) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.570, 733.590 to 733.680 and 733.710 to 733.780.

(d) ORS chapter 734.

(e) ORS 743.003 to 743.012, 743.018 to 743.030, 743.039 to 743.054, 743.060, 743.069, 743.078, 743.084 to 743.108, 743.114, 743.116, 743.123, 743.350 to 743.370 and 743.558 (1985 Replacement Part) **mental or nervous conditions covered under section 2 of this 1987 Act.**

(f) ORS 744.005 to 744.265.

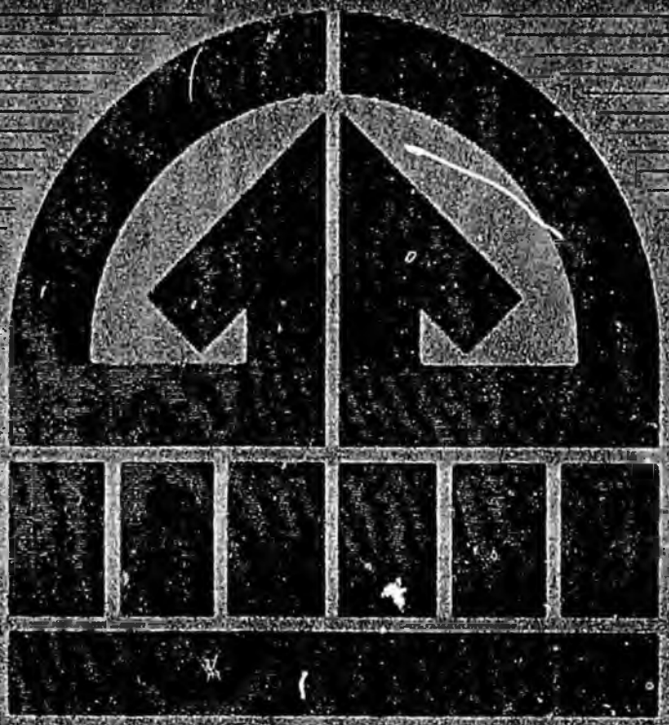
(g) ORS 746.005 to 746.140, 746.160, 746.180, 746.220 to 746.370 and 746.600 to 746.690.

(2) For the purposes of this section, fraternal benefit societies shall be deemed insurers and benefit certificates issued by such societies shall be deemed policies.

SECTION 12. If House Bill 3081 becomes law, on January 1, 1988, section 11 of this Act is repealed.

SECTION 13. This Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this Act takes effect June 30, 1987.

STATE LEGISLATIVE REPORT



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Human Resources Series

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by

Andrea Paterson

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MANDATED MENTAL HEALTH INSURANCE: A COMPLEX CASE OF PROS AND CONS

INTRODUCTION

On June 1, 1985, state legislatures across the country were still anxiously awaiting word from the U.S. Supreme Court on the legality of state laws requiring insurance companies to offer or provide minimum mental health benefits. Twenty-six states already had such laws; nearly all other states had considered them. Fifteen years of legislative action in this area was on hold.

The Court had yet to hand down its decision in the jointly heard case of Metropolitan Life Insurance Company v. Massachusetts and Travelers Insurance Co. v. Massachusetts. Specifically at issue was the legality of a Massachusetts law mandating certain minimum inpatient and outpatient mental health benefits in any group or individual insurance plan.

Metropolitan Life Insurance Company had charged that the state's mandated benefits law was in conflict with the federal Employee Retirement Income Security Act of 1974 (ERISA), which broadly preempts any and all state laws that regulate employee benefit plans. Massachusetts maintained that its mandated benefits law was protected by a key exception to ERISA's broad preemptive power: an exception that upheld the power of state laws regulating the business of insurance (1, p. 11).

In a different vein, the Travelers Insurance Company maintained that Massachusetts minimum benefits law was preempted by the federal National Labor Relations Act (NLRA) because it applied to benefit plans negotiated under collective bargaining agreements (1, p. 7). The state law, in effect, mandated certain terms of collective bargaining agreements by requiring the purchase of certain benefits, regardless of whether or not the parties involved wanted such benefits (2, p. 22). Massachusetts held that its law was not preempted by the NLRA because mandating minimum benefits did not upset the balance of power between the negotiating parties (2, p. 18).

On June 3rd, 1985, the Supreme Court upheld the Massachusetts law on both counts. Regarding the law's possible preemption by ERISA, the Court held that "if a state law regulates insurance, as mandated-benefits laws do, it is not preempted" (1, p. 21). Congress intended to preserve such state regulatory rights in exempting state laws governing the insurance industry from ERISA's preemptive power (1, p. 18). Regarding the law's possible preemption by the NLRA, the Court, citing the "purpose of Congress [as] the ultimate touchstone" (1, p. 22), held that Congress' intent in passing the NLRA was to establish "an equitable process for determining the terms and conditions of employment" (1, p. 28). The Court found no incompatibility "between federal rules designed to restore the equality of bargaining power and state. . .legislation that imposes minimal substantive requirements on contract terms negotiated between parties" (1, p. 29).

Across the country, legislative, professional and consumer advocates of mandated mental health insurance breathed a sigh of relief. Yet the Supreme Court decision stayed only the legal controversy surrounding these laws. Advocates and opponents alike maintain the fight is far from over. And while the Supreme Court decision has placed responsibility for mandating mental health benefits solidly back into the hands of the states, few state lawmakers would dispute the

fact that mandatory mental health benefits can be a hot political and economic issue to handle.

OVERVIEW: THE LONG-STANDING ARGUMENT BETWEEN THE INSURANCE INDUSTRY AND THE MENTAL HEALTH ESTABLISHMENT

In many state legislatures, controversy over mandated mental health insurance has largely reflected the traditional stand-off between the insurance industry and the mental health community over the necessity and appropriateness of minimum benefits laws. Points of contention between the two groups generally center on consumer choice in the free market system, potential increases in mental health services utilization and costs following a mandate, and the appropriateness of the legislative arena for deciding such an issue.

Consumer Choice in the Free-Market System. Opponents argue that mandates interfere with the market for mental health insurance and are unfair to consumers and industry alike. They maintain that mandates do the following:

- Deny employers and employees the right to choose the benefits they want. As such, the issue is not the ultimate desirability of mental health insurance, but the appropriateness of mandating such insurance when consumers have limited funds with which to buy all types of insurance coverage. The result is less consumer choice and higher premiums;

- Act as a regressive tax. As most employees pay for at least some portion of their health insurance, either through direct premiums or through decreased wages, a law that forces every employee--regardless of income--to purchase the same minimum benefits necessarily imposes a greater hardship on individuals with a lower income;

- Give an unfair advantage to insurance carriers not required to provide minimum benefits. One of the industry's toughest new competitors--Health Maintenance Organizations--are generally not covered by state mandates. In addition, individual insurance plans often are not covered;

- Encourage the trend toward self-insurance. As more companies find themselves required to purchase insurance packages containing unwanted mandated benefits, they will be more likely to self insure, thus side-stepping all federal and state regulation of employee insurance plans;

- Discourage industry from staying or locating in a state. As employers spend an average of 38 percent of their employee labor costs on benefits, a mandate that increases employee benefit costs will detract from that state's ability to attract or retain businesses (3, p. 9);

- Increase the number of uninsured employees. Small businesses may choose to drop their employee health insurance altogether if mandates increase the price of that insurance beyond an affordable point.

Proponents argue that a mandate can restore to proper functioning the otherwise improperly functioning market in mental health insurance, as well as ensure minimum coverage for individuals who need, but are unable to afford mental health insurance. To this end, proponents maintain that two key problems keep the market in mental health insurance from functioning properly.

- The average mental health consumer is not well-informed about the need for and value of mental health insurance. It is estimated that the stigma associated with mental illness helps keep four-fifths of the individuals suffering from a mental disorder from seeking treatment (4, p. 3). Many individuals also have "unrealistic feelings of immunity to mental illness" (5, p. 34), stemming in part from a general "lack of understanding of mental illness, especially when compared to physical illness" (4, p. 3). Furthermore, many employees without mental health coverage are reluctant to ask their employers for such coverage, and employees with such coverage are reluctant to use it because they fear that they will jeopardize their jobs (5, p. 34). Finally, an individual's employer and family may undervalue mental health insurance because they benefit indirectly and in ways that cannot be readily quantified.

- The market in mental health insurance is kept from functioning properly by a phenomenon known as "adverse selection." Adverse selection refers to "the tendency of high-risk policyholders to choose insurance plans with coverage they are likely to use," and for low-risk policyholders not to choose these same plans (6, p. 208); thus it changes the nature of the "risk pool" created by insurance coverage of an illness. When only those high-risk individuals, who know they will use mental health insurance, select plans offering mental health coverage, there is no real risk pool created. As most of the individuals in the pool will take advantage of the mental health services, the costs of that care are not spread evenly over a larger, randomly-selected group reflective of the true risk of mental illness among the general population. As the costs of the mental health coverage climb toward the out-of-pocket care costs, the insurance plans offering mental health coverage often have to drop or decrease that coverage to remain competitive.

Proponents of mandated insurance also maintain that it improves shallow insurance coverage for those low-income employees who would not normally have the out-of-pocket resources for mental health care, but who might need it at some point in their lives to retain their jobs and well-being. Such individuals could use their insurance to defray the costs of mental health care following, for example, the unexpected death of a child or spouse or a traumatic divorce.

Potential Increases in Mental Health Services Costs and Utilization. On the issue of the effect of mandates on mental health care costs and utilization, each side charges the other with misinterpretation of research data and flawed research designs. Moreover, both sides cite studies and statistics that refute the other's "inaccurate" findings.

Opponents argue that mandates greatly increase the costs and utilization of mental health care, without a comparable increase in benefits to individuals and society.

- Blue Cross/Blue Shield of Massachusetts reported a 24-fold increase in outpatient mental health care costs following the implementation of that state's minimum benefits law. In addition, the number of individual therapy sessions almost tripled, making it the single most common procedure covered by Blue Cross/Blue Shield (7, p. 8).

- Minnesota Blue Cross/Blue Shield, between 1976 and 1980, reported a 115 percent increase in inpatient costs for psychiatric care and chemical dependency following the implementation of that state's mandate. Overall hospital charges in the state increased by only 58.2 percent during the same period (7, p. 8).

- In Kansas, Blue Cross/Blue Shield found that the state mental health mandate added "nearly five dollars per month to the average family contract"; in Maryland, Blue Cross/Blue Shield found the increase to be "between two and three dollars per month per family contract" (3, p. 5).

Opponents maintain that mandates produce this dramatic increase in costs and utilization for several reasons. First of all, without providing adequate provider incentives to control costs, they greatly expand provider markets.

- Minimum mental health benefit laws have been associated with average statewide increases of 7 percent in the number of psychiatrists and 32 percent in the number of psychologists (8, p. 207).

- In Wisconsin, the number of state-approved outpatient clinics, for the treatment of drug and alcohol abuse and mental illness, soared from under 40 to over 900 following the implementation of that state's minimum benefits law (9, p. 2)

Secondly, opponents maintain that the amount of mental health care that a consumer will use depends largely on the price of those services, so utilization can and often does skyrocket in situations of greatly increased access to mental health services.

- Between 1974 and 1981, under the liberal mental health coverage provided by the Blue Cross/Blue Shield federal employee benefits plan (FEB), the number of visits to a psychiatrist per 1000 individuals increased 34.1 percent. Yet the number of visits to psychologists, social workers and other nonmedical therapists rose over 300 percent. In 1981, the combined total for FEB subscribers was 922.5 visits per 1000 individuals (7, p. 7).

- A group of Philadelphia area employers, who reviewed hospital utilization by their employees, found that "intensity of hospitalization increases dramatically with availability of benefits. . . .[and] the patients with the more generous benefits have much longer lengths of stay" (7, p. 9).

Proponents argue that mental health costs and utilization stabilize over time, that direct savings will result if an individual in need receives appropriate mental health care, and that mandates can be implemented in such a way as to control unnecessary use of mental health services. Regarding the stable costs and utilization of mental health care over time, proponents cite such examples as the following:

- A 1982 study indicated that the percentage of federal employees receiving psychiatric benefits under both the Blue Cross/Blue Shield and Aetna federal employee benefit plans is relatively stable at around 1.5 percent of the total number of enrollees (6, p. 8).

Proponents insist that the insurance industry's claim of greatly increased costs is reflective of the fact that mandates force "insurers [to] pick up the tab that was once paid by the government and the users themselves (8, p. 207).

States presently pay 50 percent of the costs associated with mental health care, while the insurance industry pays only 12 percent. In contrast, states pay only 15 percent and private insurance dollars pay 28 percent of the costs of general medical care. The net increase in costs of a mental health mandate is estimated to be $1 to $2 per person for the general population (8, p. 208).

Proponents also claim that appropriate mental health care results in direct financial benefits to individuals, employers and society. They maintain that "attempting to establish a false dichotomy between mental and physical illness leads to a false economy in insurance coverage" (6, p. 8).

- Individuals suffering from mental disorders "will use their medical-surgical benefits to cover but not treat their diseases if they do not have access to mental health services" (4, p. 12).

- Mental health care can decrease the use of other--and often more costly--medical services. A Blue Cross/Blue Shield study of individuals diagnosed as having one of four chronic diseases, including certain types of heart disease, hypertension and diabetes found that "the inclusion of outpatient psychotherapy in medical care systems can improve the quality and appropriateness of care and also lower costs of providing it" (10, p. 428). In general, reductions in other medical costs resulting from the provision of appropriate mental health treatment range from 5 to 80 percent (8, p. 208).

- Sixty-six percent of the $237.6 billion that drug abuse, alcoholism and mental illness cost society in 1984 was paid out in indirect costs such as decreased job productivity and loss of employment (11, p. 16). An increase in direct expenditures for mental health care could thus produce a significant decrease in indirect costs; even minimal psychotherapy has often been attributed with creating "lessening absenteeism, increasing productivity and decreasing the number of on-the-job accidents (4, p. 7).

Finally, co-payments and co-insurance provisions as well as peer review of psychiatric claims can be effective in controlling excessive and unnecessary use of psychiatric services.

- A 1985 study found "employee insulation from cost" to be the greatest factor contributing to excessive health care costs (4, p. 9).

- More than 400 psychiatrists review mental health benefit claims, based on peer review guidelines developed by the American Psychiatric Association, for 24 national and local insurers across the country. Aetna Life and Casualty spent $20,000 on such peer review in 1981, and saved an estimated $2.4 million. Mutual of Omaha's estimated savings totaled $300,000 during its first year of formal peer review procedures (6, pp. 10-11).

Appropriateness of Legislative Arena for Deciding Insurance Questions. Opponents argue that the state legislature is simply not an appropriate place for questions of insurance coverage to be decided. They maintain that the insurance industry is in the best position to judge the most cost-effective and appropriate mental health benefits on a plan-by-plan basis.

Moreover, they maintain that mental health mandates often have proven to be more costly than mandates for other types of health care. In 1984, Maryland Blue Cross/Blue Shield reported that inpatient and outpatient mental health care

accounted for 60 percent of its expenditures per member month for mandated benefits. In addition to mental health, Maryland law requires coverage of prosthetic devices, alcohol rehabilitation, home health care, as well as services rendered by podiatrists, chiropractors and optometrists, to name a few (12, p. 14).

Opponents also charge that mandating one set of benefits that expands the market for one group of care providers sets a dangerous precedent for the next special interest group that hopes to increase the currency and utilization of its services through mandates. Finally, opponents maintain that legislative efforts to provide coverage for mental health care on a par with that provided for physical illnesses are misguided. The insurance industry generally defends its track record on mental coverage by insisting that mental illness is different from physical illness: "diagnoses are subjective, protocols of treatment are unclear, providers of services are more numerous and less well-trained than is true of medical conditions" (7, p. 1).

Proponents argue that state mandates are an appropriate way to restore competition to a mental health insurance market otherwise riddled by the forces of adverse selection. They cite a long tradition of government intervention in improperly functioning markets--a tradition evidenced, for example, by the extensive body of federal and state anti-trust laws.

Proponents also argue that the insurance industry's power over mental health coverage has led to a history of employee health benefits in which "the human mind has been treated as a second class citizen" (4, apx. a). Employers often do not regard mental health benefits as essential in part because insurance companies generally refrain from promoting them.

In addition, insurance plans heavily favor inpatient care for mental health disorders, while rarely providing it at a level on a par with the coverage provided for physical illnesses. Moreover, proponents claim that the insurance industry's reliance on inpatient care for mental illness reflects a resistance to incorporating new methods of treatment for mental disorders, many of which rely on less-restrictive treatment settings.

- In 1983, the American Psychiatric Association found that, out of 300 insurance plans covering 33 million employees and their dependents, all provided coverage for inpatient care, but only 49 percent of the plans provided coverage on a par with other physical illnesses (6, p. 7). A 1985 update of that study indicated that the number of plans offering such comprehensive coverage had dropped to 48 percent (4, p. 5). Moreover, while 98 percent of the plans provided coverage for outpatient treatment, only 10 percent provided such treatment on the same basis as other medical conditions (6, p. 7).

Proponents maintain that mandated benefits requiring a mix of inpatient and outpatient services could help combat discrimination against the mentally ill in insurance coverage and provide individuals with an appropriate mix of inpatient, outpatient and partial-hospitalization services. Outpatient and partial hospitalization services have been proven to be a more cost-effective and therapeutic type of treatment for many mentally ill individuals, which can avert the potential harm of unnecessary inpatient hospitalization (5, p 38).

GENERAL LEGISLATIVE GUIDELINES: SPECIFIC STATE ISSUES IN MANDATING OR EXPANDING MENTAL HEALTH INSURANCE COVERAGE

Lawmakers must consider carefully the arguments both in favor of and against mandated mental health insurance in deciding to introduce such legislation or to support or oppose it. Specifically, state legislators should pay close attention to the key questions relative to mandating minimum mental health coverage.

What is the nature of the law? Are minimum benefits required or is the availability of such benefits mandatory? Minimum benefits packages can increase the costs of consumers' premiums and of insurance dollars paid for mental health care, so they generally incite fierce opposition from the insurance industry. Yet mandatory availability of mental health insurance coverage--often considered as a political compromise--can allow the forces of adverse selection to continue to operate, thus perpetuating the improper functioning of the mental health insurance market.

Who is covered? Insurance policies usually differentiate between those individuals who wish to improve their overall mental health and those who are ill as a result of a mental disorder; in general, insurance policies only cover treatment provided to the latter. In addition, most insurance policies limit the mental health services they cover so as to preclude any long-term treatment for mental illness. Costs of mental health care can go up considerably when more long-term treatment is brought under a mandate. Many argue, however, that those who do not receive appropriate mental health care, whatever the duration, will simply continue to use inappropriate medical services, drain the public mental health system and drive up the indirect costs of mental illness to society.

What types of treatment are covered? Minimum coverage generally applies to inpatient and outpatient services, while other laws may also require coverage of such services as partial-hospitalization. Inpatient care can often be necessary for mental disorders of an acute and intensive nature. It can be harmful, however, if treatment in such a restrictive setting is not clinically necessary. In addition, many state commitment laws restrict involuntary hospitalization to those cases in which the patient presents a clear and present danger to himself or to others. If clinically feasible, partial hospitalization and outpatient care are generally preferred treatment alternatives because they minimize the patient's dislocation and allow him or her to retain the use of natural support systems. In some localities, however, treatment settings and programs that offer accountable, commmunity-based outpatient and partial-hospitalization services are less readily available.

What coverage is provided? The problem with legislative determination of minimum levels of mental health coverage is that they tend to become maximum levels. Thus, those mentally ill who require more extensive treatment may not receive it. Still, select mandatory coverage in this area tends toward a norm.

- Most state laws mandate minimum inpatient care coverage of at least 30 days per year in a general or psychiatric hospital or some type of authorized mental health care facility; at least four states require inpatient care for psychiatric disorders to be of equal value with that provided for physical illnesses (13, p. 1.6). Many states that require coverage for partial hospitalization allow twice the number of partial hospitalization days as inpatient days (13, p. 1.7).

- State laws requiring or offering mental health benefits vary greatly with respect to outpatient treatment. Statutes can require coverage for a certain number of outpatient visits, for treatment provided up to a dollar limit or for some combination thereof. For example, Tennessee covers 30 outpatient visits per year; Georgia covers 48-50 visits per year, depending on the type of policy. Florida covers outpatient treatment up to $1,000; Massachusetts covers $500 per year. Minnesota provides for coverage of at least 80 percent of the first $750 of outpatient treatment; Vermont provides full coverage for the first five outpatient visits, and 80 percent of the treatment costs up to $500 after the first five visits.

What types of treatment settings are covered? Most state laws cover inpatient and outpatient care provided in traditional settings such as general or psychiatric hospitals or community mental health centers (CMHCs). Other laws cover additional community care providers such as free standing clinics. An increase in the number of treatment settings covered can increase utilization, but it can also help ensure appropriate treatment as well as use of the least restrictive--and least expensive--treatment setting.

Which mental health professionals are authorized to provide services? Many state laws cover only physicians and licensed psychologists. Others include such providers as clinical social workers and psychiatric nurses. Increasing the number of service providers can improve access and decrease the per unit cost of mental health care through increased competition among providers. Yet increasing the number of service providers can increase the total costs of mental health care as a result of increased utilization.

What cost containment mechanisms does the law contain? As with insurance coverage of physical illness, copayments and monetary caps can effectively limit unnecessary use of mental health services, but they can also discourage appropriate use of mental health services if they are too restrictive. Where copayments are specified, they are often 50 percent of the treatment costs once the appropriate deductible has been subtracted (13, p. 1.7). (The standard deductible for physical illness is 20 percent.) Provisions for peer review prior to reimbursement for services can effectively limit unnecessary provision of services by providers.

What types of policies are required to provide the minimum level of services? All mandated benefits laws cover group insurance policies; many cover individual policies as well. Requiring individual insurance policies to provide the minimum benefits necessarily ensures that such benefits are available. But it can also discriminate against and raise premium costs for a well-informed consumer who knows with a much greater certainty than a large corporation buying on behalf of its employees whether or not such benefits are necessary. Moreover, including both group and individual insurance plans can increase the trend towards self-insurance among employers and individuals.

THE STATES' RESPONSE IN RECENT YEARS

The following chart delineates the existing 26 state minimum benefits laws with respect to the type of mandate, the year passed and the services, policies and providers covered. In 1987, at least twenty-seven states are considering legislation that will mandate minimum mental health benefits, expand benefits level, service providers or insurance providers, or study various aspects of mental health insurance.

At present, 12 states require minimum benefits, 12 states require the availability of such benefits and two states require coverage for certain services and the availability of coverage for others. Connecticut was the first state to pass such a law in 1971; Georgia and Oregon were the most recent states to pass such legislation in 1984. The majority of the states passed their laws in the mid-to-late 1970s. The statutes in 23 states cover inpatient care, 24 cover outpatient care and nine cover partial hospitalization. (Wisconsin's law does not specify the types of services covered: it merely stipulates that coverage is provided for treatment of mental illness at usual and customary rates.) All 26 states cover group policies; nine cover individual policies as well. All cover services provided by a physician, 24 cover services provided by a licensed psychologist, 12 cover services provided by a licensed or clinical social worker and six provide coverage for additional service providers including psychiatric nurses, marriage and family counselors, licensed psychotherapists and pastoral counselors (see chart of state laws, p. 11).

FUTURE IMPLICATIONS AND DIRECTIONS

The track record of recent legislative attempts to pass mandated mental health legislation may or may not indicate that a plateau has been reached among the states that plan to adopt such measures. Many state lawmakers suspended their efforts in this area pending the Supreme Court's decision in Metropolitan Life v. Massachusetts. According to the National Mental Health Association, legislative interest in mental health mandates has risen considerably since the Supreme Court upheld the Massachusetts law.

Efforts among those states that already have mandates are largely focused on updating or expanding their laws. A number of states have considered legislation to expand the number of service providers covered by the mandate. In 1986, Maryland, Minnesota, and New Hampshire are all considering legislation to put Health Maintenance Organizations (HMOs) under their mandates. Massachusetts is considering legislation to include specialists in psychiatric and mental health nursing, Minnesota to include certified psychologists, and New Hampshire to include clinical social workers. In 1985, California, New York, and West Virginia considered, but did not pass, legislation that would have made mandatory the mental health coverage that is presently optional in all insurance policies. In 1986, Maryland decreased from 50 to 40 percent the copayment on outpatient mental health care (1986 Md. Laws, chap. 843).

States are also beginning to act on quality assurance and utilization review. In 1985, the Oregon State Health Planning and Development Agency issued the first of two required reports evaluating the effectiveness of that state's 1984 benefits law, which mandated coverage for outpatient and partial hospitalization services and significantly reduced inpatient care coverage.

The statute allowed insurers two cost containment options, one of which was adopted by Blue Cross/Blue Shield of Oregon and seems likely to be adopted by other Oregon insurers: professional peer review of reimbursement claims, evaluated for both the level of care and length of treatment. While the report acknowledges certain problems with the existing statute, it does state that in Oregon "more people are currently receiving services for less money" than were previously. It notes that nominal increases in outpatient care costs have been offset by marked decreases in inpatient care costs for both Blue Cross/Blue Shield and SelectCare (14, p. 10).

States must remember, however, that much of the research relative to the impact of state minimum benefits has yielded conflicting evidence. Both the insurance industry and the mental health community dispute each other's statistics, citing flaws in research design and biased interpretation of data. Moreover, in 1984-85, the Baltimore, Maryland-based Center for Health Policy Studies undertook a major review of the literature relevant to mandated mental health insurance and made recommendations regarding further research. The report cited methodological inconsistencies in the research that had been done, such as differences in provider settings and the use of health insurance claims as research data, as cause for this conflicting evidence (13, pp. 1.12, 3.58). Thus state legislators must remember to evaluate the effectiveness of a minimum benefits law in light of the mental health system and resources within their own state.

Finally, the private sector also has begun to address more aggressively the issue of mental health care for employees. In deciding to support or oppose mandated mental health insurance, state legislators would want to weigh carefully any changes in the corporate world's overall approach to combating mental illness. For example, a 1984 survey of 64, mostly Fortune 500, companies with over 19 million employees indicated substantive changes in approach to mental health care:

- 19 percent had recently increased their lifetime or annual maximums for mental health coverage;
- 22 percent had recently enhanced their coverage for outpatient services, with an additional eight percent planning to increase outpatient coverage in the near future;
- 73 percent had developed Employee Assistance Programs (EAPs) to combat the problems associated with emotional problems and alcohol and drug abuse. While 30 percent of the EAPs still focused on alcohol and drug abuse intervention and treatment, 68 percent had broadened their scope to include short-term mental health treatment;
- 41 percent had implemented stress management programs (15, pp 15-16).

STATE MANDATORY MENTAL HEALTH INSURANCE LAWS

STATE	MANDATE TYPE: MANDATED BENEFITS PACKAGE	MANDATED AVAILABILITY	YEAR	SERVICES COVERED: INPATIENT	OUTPATIENT	PARTIAL HOSPITALIZATION	POLICIES COVERED: GROUP	INDIVIDUAL	ADDITIONAL PROVIDERS COVERED: PSYCHOLOGISTS	SOCIAL WORKERS	OTHER
AR	X		1979	X	X		X	X	X		
CA		X	1973	X	X		X		X	X	(1)
CO	X		1976	X	X	X	X		X		
CT	X		1971	X	X	X	X	X	X	X	
FL		X	1976/83	X	X	X	X		X		
GA		X	1984	X	X		X	X	X		
IL		X	1975	X	X		X	X	X		
KS		X	1978	X	X		X		X	X	
LA		X	1975	X	X		X		X	X	
ME	X		1983	X	X	X	X		X	X	(2)
MD	X		1974	X	X		X	X	X	X	
		X				X	X				
MA	X		1973	X	X		X	X	X	X	(2) (3)
MN	X		1975	X	X		X				
MO		X	1980	X	X		X	X			
MT	X		1983	X	X		X		X	X	
NH	X		1975	X	X	X	X		X		(4)
NY		X	1977	X	X		X		X	X	
ND	X		1975	X		X	X				
OH	X		1978		X		X		X		
OR	X		1984	X	X	X	X		X	X	(5)
TN		X	1974		X		X		X		
VT		X	1975	X	X	X	X		X		
VA	X		1975	X			X	X	X	X	
		X	1975		X		X		X	X	
WA		X	1983	--see note #6--			X		X		
WV		X	1977	X	X		X	X	X		(7)
WI	X		1975/85	X	X		X				

1) psychiatric nurses and licensed marriage, family and child counselors

2) psychiatric nurses

3) licensed psychotherapists

4) licensed pastoral counselors

5) nurse practitioners

6) Coverage provided for treatment at usual and customary rates, subject to reasonable deductibles and copayments, for services provided by a licensed physician, a licensed psychologist or a licensed community mental health agency.

7) licensed psychotherapists

NEW HAMPSHIRE CASE STUDY: THE PROS AND CONS OF EXPANDING EXISTING MENTAL HEALTH BENEFITS

New Hampshire's current mental health benefits law, passed in 1975 and implemented in 1977, requires certain minimum mental health coverage in all group insurance policies. The law differs from many state mandated benefits laws in that it differentiates between major medical and non-major medical insurance policies and contracts. Major medical policies must provide inpatient, partial hospitalization and outpatient services for mental illness on a par with other illnesses, with an annual limit of $3,000 and a lifetime limit of $10,000. Non-major medical policies must cover 15 hours of outpatient care, with the patient assuming the cost of the first two visits.

As a result of the law, the New Hampshire state hospital and the CMHCs have reaped substantial benefits from shifting costs.

- The state bills about $450,000 per year to private insurers for care provided in the New Hampshire State Hospital. This return on care provided to insured individuals helps defray the costs of that care and ensure that state funds are only used for truly catastrophic mental health problems that require long-term care and treatment of an acute nature (16).

- In 1986, New Hampshire's CMHCs will receive an estimated $4.5 million from private insurers for care provided in local settings and covered by the state mandate (16). These savings to the CMHCs are critical to ensure the availability of many community-based counseling and mental health care services that cannot be, by state law, paid for by state dollars. Without reimbursement from private insurers, these services might not exist. New Hampshire state law stipulates that state funds can be used only for the severely and chronically mentally ill, and for mentally ill elderly or children (16).

Blue Cross/Blue Shield of New Hampshire opposed the original law and opposes the currently proposed amendments to it. As reason for its past and present opposition, the insurer cites dramatic increases in its own costs for mental health care as well as the questionable effectiveness of the law's cost containment measures.

- Between 1977 and 1981, Blue Cross/Blue Shield increased by 245.4 percent the amount that it paid to the state's CMHCs for mental health care. During the same period, rates charged by the CMHCs increased 30 percent more than the rates charged by private psychiatrists (17).

- Inpatient claims have remained constant and the average length of stay in an inpatient psychiatric facility has gone up from 19 to 22 days (17).

- Eighty-two billing units of psychologists and pastoral counselors now qualify for reimbursement, as opposed to the 13 psychologists who qualified for reimbursement prior to the mandate, indicating a rapid growth in service providers following the mandate (17).

A number of legislative proposals are currently being considered in New Hampshire related to the state's mandated mental health law. These proposals include:

- Increasing the minimum outpatient coverage from 17 outpatient visits to 25 visits, with no more than a 50 percent copayment and an annual cap of $2500;

- Expanding the number of eligible service providers to include clinical social workers;

- Extending the mandate to include Health Maintenance Organizations (HMOs).

The state is also studying the possible implementation of some type of quality assurance or utilization review procedure to ensure that the mental health services provided under the mandate are necessary and of high quality.

The NCSL Mental Health Project conducted a technical assistance program for New Hampshire in January 1986 to help educate legislators and staff about the possible consequences of and alternatives to the proposed changes in the state's minimum benefits laws. Participating in the program was Dr. Richard Frank, mental health economist, Johns Hopkins University, Baltimore, Maryland. The suggestions provided to New Hampshire do not necessarily reflect those of NCSL or the National Institute of Mental Health.

ARGUMENTS FOR AND AGAINST THE PROPOSED CHANGES IN NEW HAMPSHIRE'S LAW

Increasing the mandate. Increasing the mental health benefits required can increase utilization and costs as well as the amount of the regressive tax that mandates impose on working individuals. Yet an increase in benefit levels will mitigate further the forces of adverse selection in the market for mental health insurance and transfer more of the costs for mental health care from individuals and the public sector to the private sector.

Increasing the number of eligible service providers to include social workers. Increasing the number of eligible service providers can increase the utilization and costs of mental health services and shift a greater percentage of the costs of mental health care to the private insurance industry. Yet an increase in the number of service providers can increase consumer access. In addition, including social workers could encourage more competition among existing service providers, thus decreasing the per unit cost of mental health care and increasing the quality of care since providers will need to ensure high quality care in order to retain their clients.

Including HMOs under the mandate. Including HMOs under the mandate would decrease their competitive edge against traditional insurance carriers already covered by the mandate and would spread the risk of mental health care costs over a greater number of individuals. Yet including HMOs could accelerate the trend toward self-insurance among those businesses and individuals striving to hold down their health care costs.

SOLUTIONS THAT COULD BRING PROS AND CONS INTO AN APPROPRIATE BALANCE

Increase the minimum coverage and the number of service providers in conjunction with other cost containment mechanisms. New Hampshire could move ahead with legislation designed to increase the minimum coverage required under the mandate and to expand the number of service providers if it made use of other cost containment measures that would offset the increased use of mental health services that such a dual increase in coverage and eligible service providers

would probably bring about. Examples of such containment measures that could be employed include:

- Increasing deductibles or copayment rates;

- Limiting increases in outpatient coverage to roughly 25 visits, after which the offset effects of mental health care on use of medical care tend to decrease.

Implement some type of vigorous utilization review and quality assurance programs. The state could also work to control upward pressure on utilization if it implemented some type of quality assurance or utilization review procedure. New Hampshire may wish to consult the American Psychiatric Association's guidelines for peer review of psychiatric claims and the American Psychological Association's guidelines for peer review of psychological claims. Such peer review programs have already been credited with saving millions of dollars nationwide.

Along this line, New Hampshire may want to consider bringing HMOs under the mandate, as they have both the administrative ability to control costs and the incentives to control utilization.

CONCLUSION

Since New Hampshire's experience with its present mental health mandate has been generally positive, the state would want to weigh carefully any possible amendments to the law before proceeding. Yet if the state decides to move ahead with proposed changes, it can move ahead with the knowledge that the present law will provide a solid foundation for further actions in this area.

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17) Clark P. Dumont, Director, Public Affairs, Blue Cross/Blue Shield of New Hampshire. Report to Greg Scanlen, Blue Cross/Blue Shield Association. April 1, 1983.

TECHNICAL ASSISTANCE PROGRAM TAPES AND BACKGROUND MATERIALS

Available through the NCSL Mental Health Project are edited tapes of the actual technical assistance program presented for New Hampshire in January 1986, as well as the background materials distributed at the New Hampshire program.

The tapes of New Hampshire's technical assistance program, entitled "Mandating and Expanding Mental Health Insurance Benefits: The Pros and Cons" feature keynote addresses by Dr. Richard Frank, Assistant Professor, Department of Health Policy and Management, Johns Hopkins University and Alexander Taft, Vice President of Public Relations and Legislative Liaison, Blue Cross/Blue Shield of New Hampshire.

Background materials relating to "Mandating and Expanding Mental Health Insurance Benefits: The Pros and Cons" include a summary of select state legislation, a bibliography and a checklist that interested legislators and staff may return for copies of legislation and bibliographic materials.

If you wish to receive loan copies of these tapes, or the background information distributed at the technical assistance program, please copy, complete and return the form below to the Mental Health Project, NCSL, 1050 17th Street, Suite 2100, Denver, Colorado 80265.

Name: _____

Title: _____

Address: _____

_____

Requesting New Hampshire background materials_____ tapes _____

MENTAL HEALTH PROJECT

PROJECT OVERVIEW

In June 1986, the National Institute of Mental Health (NIMH), U.S. Department of Health and Human Services, awarded a contract to the National Conference of State Legislatures (NCSL) to conduct technical assistance programs for state legislators on mental health policy issues from 1986 through 1989.

The goal of NCSL's Mental Health Project is to improve the decision-making ability of state legislators on mental health policy by providing specific assistance to chosen states and disseminating information regarding mental health issues.

During this three-year program, the Mental Health Project will respond to specific issue and format needs of legislators. Under the guidance of the Mental Health Advisory Committee, which is composed of legislators and other persons with mental health experience, Project staff will obtain assistance from expert consultants and state policymakers to provide a variety of services to states, including testimony, special workshops and seminars, and individualized assistance.

Based upon input from the state legislatures, five states will be chosen each year to receive technical assistance on state-specific mental health issues. Along with the programs, the Mental Health Project will develop background materials, audio tapes, and various publications for each issue area. These materials are available free of charge to requesting parties.

The mental health technical assistance programs offered during 1987-88 are:

Arkansas	Maximize federal funds at the state hospital and consolidate hospital facilities
Delaware	Determine the role of the psychiatric hospital in a youth mental health system
North Carolina	Develop coordination of care between the community and state hospital
North Dakota	Determine the role and function of the state hospital as community-based services are expanded
Utah	Determine the future role of the state hospital

The Mental Health Project Manager is Rebecca I. Craig, who may be contacted at NCSL's Denver office (303/623-7800). The acting federal project officer is Jacque Rosenberg, Policy and Planning Branch, National Institute of Mental Health (301/443-3657).

The National Conference of State Legislatures
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Department of Human Resources
OFFICE OF HEALTH POLICY
3886 BEVERLY AVENUE NE, SUITE 19, SALEM, OREGON 97305-1389 PHONE 378-4684

Memorandum

July 30, 1987

TO: Interested Persons

FROM: Wayne J. Wolfe, Acting Assistant Director
Office of Health Policy
Department of Human Resources

SUBJECT: Publications of the Former State Health Planning and Development Agency

The 1987 Legislature eliminated the State Health Planning and Development Agency through Senate Bill 343 and placed its responsibilities with the Director's Office of the Department of Human Resources. It is now known as the Office of Health Policy and will continue with its former duties of health planning and policy development, program and facility review, certificate of need and Office of Rural Health.

The Office of Health Policy will continue to make copies available of the policy papers and reports developed by the former State Health Planning and Development Agency.

Questions regarding these publications should be referred to the Office of Health Policy, 3886 Beverly Avenue, N.E., Suite 19; Salem, Oregon 97305; telephone 378-4684.

WJW:ah

SCOTT MANCHESTER, MSW

Certificate of Need Coordinator

Office of Health Policy

Department of Human Resources
3886 Beverly Avenue NE. Suite 19 Salem 97305 Phone 378-2959
1-800-255-7007

Second Report on

OREGON'S EXPERIENCE WITH REMODELING INSURANCE BENEFITS FOR MENTAL HEALTH AND CHEMICAL DEPENDENCY

Report to the 64th Oregon Legislative Assembly
on Implementation of Chapter 601,
Oregon Laws 1985

December 15, 1986

Oregon State Health Planning
and Development Agency
3886 Beverly Avenue, N.E., Suite 19
Salem, Oregon 97305-1389

VICTOR ATIYEH
GOVERNOR

State Health Planning and Development Agency

3886 BEVERLY AVENUE NE, SUITE 19, SALEM, OR 97305-1389 PHONE 378-4684

December 15, 1986

The Honorable Victor Atiyeh
Governor

The Honorable John Kitzhaber
President of the Senate

The Honorable Vera Katz
Speaker of the House

Mental illness and drug abuse are serious problems in the state of Oregon, directly affecting hundreds of thousands of Oregonians and indirectly affecting all of us. In recognition of these problems, the 1983 Oregon Legislature passed legislation aimed at assuring that Oregonians have access to cost effective mental health and chemical dependency treatment, by requiring that insurance policies cover such treatment.

The attached report fulfills the obligation of the State Health Planning and Development Agency (SHPDA) under Section 8 of Chapter 601, Oregon Laws 1983 (Senate Bill 522), by providing an analysis of Oregon's experience with mandated insurance benefits for mental health and chemical dependency which were created by that statute.

Chapter 601 provided insurance benefits for the first time for residential and outpatient mental health and chemical dependency services. Previously, coverage was mandated for only the most expensive setting for care--inpatient services. By providing coverage for less expensive services, and allowing insurance companies to screen claims to determine whether a less intensive setting would have been appropriate, it was hoped that Chapter 601 would result in more people receiving mental health and chemical dependency services, while at the same time containing costs.

This report finds that the statute seems to have achieved its intended effects. The service delivery system has undergone a restructuring that involves less emphasis on inpatient care and greater emphasis on outpatient and residential settings. The benefit levels created by the statute have resulted in many more people receiving treatment, while increasing costs to insurers by only about one percent.

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There have been some problems associated with the implementation of Chapter 601. Over the past 15 months, the SHPDA has sponsored a series of meetings which have involved over one hundred persons representing all groups with an interest in this statute. These work groups have identified issues associated with Chapter 601, and in many cases have reached agreement on solutions. The SHPDA is grateful to all of the work group participants for the many hours that they have contributed to this evaluation process and for their efforts to provide us with data on the impact of Chapter 601. As a result of this process, the SHPDA is making a number of recommendations for changes in the statute. Our recommendations are detailed in this report and are incorporated into three bills which have been pre-session filed for consideration by the 1987 Legislature: SB 30 , SB 31, and SB 32.

The most significant of our recommendations are that the sunset on Chapter 601 be removed; that minimum benefit levels for children and adolescents be improved; and that the statute no longer allow lower benefit levels for persons with both a mental illness and a chemical dependency problem than it provides for persons with a mental illness alone.

This agency believes that this report represents a balanced presentation of all the issues related to mental health and chemical dependency insurance benefits in Oregon. We believe that Oregon's experiment with achieving cost containment in mental health and chemical dependency services through reimbursement incentives has proven successful.

We hope that Oregon's Legislative Assembly will continue this program, but at the same time consider adjustments to some existing provisions as proposed in this report's recommendations.

Sincerely,

Richard H. Grant

Richard H. Grant
Director

RHG:iu

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INTRODUCTION

This is the second report developed by the State Health Planning and Development Agency (SHPDA) to comply with Section 8 of Chapter 601, Oregon Laws 1983. A report was also prepared for the 1985 legislative session. The current report represents an update of the 1985 report. The statute was created by the 1983 legislative session through enactment of Senate Bill 522 of that session. It is still generally referred to as "SB 522"; however, in order to avoid confusion with the current session's bill numbers, the 1983 statute will be referred to in this report as "Chapter 601." Section 8 of this statute reads:

> "SECTION 8. The State Health Planning and Development Agency shall consult with the Insurance Commissioner and with all insurers, public and private providers and state agencies which implement policies under the authority of this Act, in order to prepare reports to the 1985 and 1987 sessions of the Legislative Assembly. The purpose of the reports shall be to:
>
> "(1) Describe the extent to which the options under this Act have been exercised.
> "(2) Identify savings and expenses attributable to the exercise of the options.
> "(3) Identify problems which interfere with, or arise from, exercises of the options, and evaluate alternative solutions to such problems.
> "(4) Recommend whether or not the approaches to cost containment, authorized as options under this Act, should be eliminated, continued or made mandatory; and whether or not they should be extended, on an optional or a mandatory basis, to other coverages under insurance policies written in Oregon.
> "(5) Recommend and describe desirable characteristics of other approaches to cost containment which may be appropriate for legislative action."

This report is also intended to fulfill the requirements of ORS 171.875 and 171.880, which require that any legislative measure proposing mandated health insurance coverage be accompanied by a report assessing the social and financial effects of that coverage.

Provisions of Chapter 601

Chapter 601 took effect on July 1, 1984. This statute made major changes in the requirements for coverage of mental illness and chemical dependency treatment by insurance companies.

The purpose of the law is to provide reimbursement incentives so that, "to the greatest extent possible, the least costly settings for treatment, outpatient services and residential facilities, shall be widely available and utilized except when contraindicated because of individual health care needs" (Chapter 601, Sections 3 and 4).

The provisions of the bill were expected to result in more people receiving treatment for mental illness and chemical dependency, while containing costs to insurers.

The entire text of the statute is included as Appendix A of this report.

The statute for the first time mandated that insurance companies cover residential and outpatient settings for mental health and chemical dependency. For mental health, policies are required to provide at least $2,000 in coverage for outpatient services over a 24-month period; and $3,000 for care in "residential" settings (which can include services such as intensive outpatient and day hospitalization, which are not strictly "residential"). Section 6 of Chapter 601 (which revised ORS 743.558) specifies the mental health coverages.

For chemical dependency, policies must include at least $1,500 in outpatient coverage and $3,000 in residential coverage over a 24-month period. The statute also for the first time mandated coverage of treatment for drug addiction, as well as alcoholism. Such coverage is specified in Section 5 of the statute (which amends ORS 743.557).

At the same time, coverage for inpatient mental health services was slashed from around $24,000 for 24 months (actually, 30 days treatment every 12 months) to only $7,500. Chemical dependency inpatient coverage remained the same (except that drug treatment was now included)--$4,500 in any 24-month period.

Maximums for overall reimbursement for all settings in a 24-month period were set at $9,000 for mental health and $6,000 for chemical dependency and combined mental health/chemical dependency problems.

The statute also allowed, but did not require, insurance companies to implement either of two "cost containment methods" (outlined in ORS 743.557(10) and 743.558(8), Sections 5 and 6 of the statute). One option, through which insurers could provide for a lower copayment for residential and outpatient services than for inpatient care, has not been widely implemented.

The other option, however, has been implemented by several insurers, including Blue Cross/Blue Shield. It involves review of claims for payment, by the insurer or a contractor, of the appropriateness of both the level of care provided and the length of treatment. An insurer who finds that treatment could have been provided in a residential setting, for example, rather than on an inpatient basis, may reimburse at the rate that applies to the lower cost setting.

The benefit levels and cost containing options established under Chapter 601 are summarized in Table 1, and contrasted with the situation prior to this statute's enactment.

Background

In developing this report, the SHPDA has relied on several reports that it issued in previous years.

Table 1

MANDATED HEALTH INSURANCE BENEFITS IN OREGON FOR CHEMICAL DEPENDENCY, INCLUDING ALCOHOLISM, AND FOR MENTAL OR NERVOUS CONDITIONS, BEFORE AND AFTER CHAPTER 601, OREGON LAWS 1983

Features	BEFORE		AFTER	
	Chemical Dependency Including Alcoholism	Mental or Nervous Conditions	Chemical Dependency Including Alcoholism	Mental or Nervous Conditions
1. Scope?	Alcoholism only	Diagnosed mental or nervous conditions	Other drug dependency as well as alcoholism	Diagnosed mental or nervous conditions
2. Statutory authority for reduced co-payments as a cost-containing incentive for use of outpatient, day, or residential treatment, rather than inpatient?	No	No	Optional in negotiated insurance contracts	Optional in negotiated insurance contracts
3. Statutory authority for more costly treatment to be subject to review against detailed criteria justifying need, as a cost-containing incentive?	No	No	Optional in negotiated insurance contracts	Optional in negotiated insurance contracts
4. Requirement for coverage in group policies?	Shall provide	Shall offer	Shall provide	Shall provide
5. Requirement for coverage in individual policies?	Shall offer	None	Shall offer *(alcohol only; and $4,500, as at present)*	~~Shall offer~~ *None*
6. Minimum overall benefit every 24 months?	$4,500	$25,000 (approximate)	$6,000	$9,000 (unless payments are asked for both chemical dependency and mental or nervous conditions, in which case an overall cap of $6,000 may be applied)
7. Minimum outpatient benefit every 24 months?	None	$1,000 (actually $500 every 12 months, with 50% co-payment)	$1,500, with the same co-payment as for any medical outpatient treatment; usually 20%	$2,000 (sunset after 2 yrs.) with the same co-payment as for any medical outpatient treatment; usually 20%
8. Minimum benefit for intensive part-day treatment or for round-the-clock non-medical residential treatment, every 24 months?	None	None	$3,000, with the same co-payment as for inpatient treatment	Up to $3,000, from the $7,500 for inpatient (see below), with the same co-payment as for inpatient treatment
9. Minimum benefit for round-the-clock inpatient treatment in which needs for nursing care and physician treatment may be met, every 24 months?	$4,500	$24,000 (approximate; actually, 30 days of hospitalization every 12 months; present rates around $400 per day)	$4,500, with the same co-payment as for any medical inpatient treatment	$7,500, with the same co-payment as for any medical inpatient treatment

7/6/83

In May 1982, the SHPDA issued a report called "The Growth of Hospital-Based Alcohol Treatment Programs: Overview and Implications." This report found that, at the time of its writing, "The treatment of alcoholism in general hospitals and specialized alcoholism treatment programs is sharply increasing in Oregon in particular, and the United States in general. At the same time, providers have shown little interest in non-hospital treatment, such as day treatment, outpatient care and residential care."

The report also found that clinical research has not indicated that inpatient care is any more effective, for most patients, than less restrictive and less expensive settings. "It is clear that some treatment is superior to no treatment, and differences in treatment methods apparently do not significantly affect long-term outcome. The implications for allocating our scarce human and financial resources should be to emphasize simpler and less expensive alcohol treatment programs that de-emphasize hospital care."

The report concluded with the following recommendations: "Oregon's mandated insurance law should be rewritten to require the use of less costly treatment modes such as outpatient and day treatment, except where inpatient care is clearly medically necessary... Health care professionals, problem drinkers, alcoholics and the public at large must be made aware that treatment in a residential setting and outpatient care is much less expensive than traditional hospital inpatient treatment, and just as effective."

Through the enactment of Chapter 601, the 1983 legislature in effect adopted these recommendations.

In March 1983, the SHPDA issued a report called "Mandated Health Insurance Benefits in Oregon," which analyzed the 14 health delivery mandates in Oregon statute in an attempt to determine the costs and savings to insurers and health care consumers.

The report concluded: "The results of this analysis indicate that the mandated health insurance benefits that have the largest fiscal impact are those related to coverage of four large-scale services: obstetrical care, newborn care, mental and nervous disorders, and the treatment of alcoholism" (emphasis added).

The report noted that research studies indicate that coverage of mental illness can create an offsetting of other medical expenditures. Recent studies have indicated that this is true of coverage for alcoholism treatment as well. Alcoholics and persons with mental illness who receive treatment for these problems use fewer medical services overall than those who do not.

The report also found that much of the costs related to alcohol treatment resulted because only coverage of inpatient care--the most expensive setting--was mandated. "A full continuum of care is optimal to meet the needs for alcoholism treatment in Oregon. The current system of reimbursement has not supported the development and maintenance of a wide range of effective treatment settings."

Chapter 601 creates reimbursement for a full continuum of care for both chemical dependency and mental illness. In addition to allowing people to receive treatment in the most appropriate setting for their own problem, this reimbursement system saves money over the old model, in which only the most expensive settings had to be reimbursed.

The SHPDA also issued two previous reports on Chapter 601. The first was entitled "Oregon Senate Bill 522, 1983, Implementation: Quarterly Progress Report #1." This report was published on October 1, 1983, and reissued June 28, 1984. Its primary purpose was to fulfill the requirements of Section 7 of the statute by presenting "an advisory or model set of criteria" for possible use by insurance companies in screening claims for appropriateness of setting and length of stay under the major cost containment option of the statute.

The SHPDA also issued a report to the 1985 legislature on "Oregon's Experience with Remodeling Insurance Benefits for Mental Health and Chemical Dependency," which was the first report required by Section 8 of Chapter 601. The current report is the second report required by Section 8. The 1985 report found that the statute appeared to be having its intended effects. Costs to insurers resulting from mental health and chemical dependency claims had gone down. More programs for residential and outpatient treatment had opened, and there was some evidence that more people were receiving treatment.

The report made several recommendations for changes to the legislation, however, in order to clarify the statute's intent and to correct inequities. These changes were incorporated into SB 10 and HB 2051 in the 1985 session.

HB 2051 simply extended the sunset date on outpatient mental health coverage from July 1, 1985, to July 1, 1987, so as to conform to the sunset date for the rest of the statute. This bill passed by wide margins in both the House and the Senate, and is included as Appendix B of this report.

SB 10 proposed some changes to statutory language and adjustments to the minimum benefit levels. It passed in the Senate by a vote of 22 to 6, but did not reach the House until the last week of the session and was still in committee upon adjournment.

The current report updates our previous report to the 1985 legislature, and makes a number of recommendations for changes to the statute. These recommendations have been incorporated into three bills: SB 30 , SB 31, and SB 32. The most important of our recommendations is that ORS 743.557 and 743.558 should be continued, and that the current sunset date of July 1, 1987, should be repealed.

The development of this report

Section 8 of Chapter 601 requires the SHPDA to "consult with the Insurance Commissioner and with all insurers, public and private providers and state agencies which implement policies under the authority of this Act," in order to develop this report to the legislature.

In order to meet this requirement, the SHPDA developed work groups on child and adolescent and general issues; and on chemical dependency and mental health treatment. All parties with a known interest in the legislation were invited to participate, and as the work groups progressed, a number of other organizations and individuals expressed an interest and became involved. The mailing list for these work groups now includes 107 persons and groups, representing a number of insurance companies, mental health and chemical dependency treatment providers, professional associations, state agencies, and the business community.

The work groups began meeting in October, 1985, and met nine times through December, 1986. The groups were intended to:

1. Help the SHPDA collect data on Chapter 601, in terms of its cost and its impact on providers, insurers, and patients.

2. Help the SHPDA to search the professional literature for data on optimum program design, staffing levels, and costs.

3. Identify problems or concerns related to the implementation of Chapter 601.

4. Discuss these problems and, to the extent possible, develop a consensus on solutions.

The work groups accomplished all of these tasks. Of particular importance is the fact that the work groups acted as a forum for discussion between providers of care and insurers. Both sides gained an understanding of the other's perspective, and as a result consensus was reached on most issues.

It should be emphasized that the recommendations in this report are SHPDA's recommendations--not the work groups'. When the work groups were able to reach a consensus, the SHPDA adopted that position. But when a consensus was not reached, the SHPDA is responsible for the recommendations which are incorporated in this report. We attempted to make a recommendation that balanced the different viewpoints represented in the work groups. Individual work group members may disagree with some individual recommendations; but all work group members support most of the recommendations, and all support the idea that mental health and chemical dependency benefits should not be allowed to sunset.

IMPACT OF CHAPTER 601

When Chapter 601 was enacted, it was expected to have these principal results:

1. The development of a continuum of care for the treatment of mental health and chemical dependency services. By mandating insurance coverage for all settings, rather than just the more expensive inpatient setting, it was anticipated that patients would have more access to less restrictive settings; that more residential, day treatment and outpatient programs would be created; and that some inpatient programs might close.

2. Shifting of patients (where appropriate) from inpatient to outpatient or residential levels. In addition to the development of a full spectrum of services, it was expected that Chapter 601 would cause a shift in the service system, so that proportionately less services were provided at the inpatient level and more services were provided in less expensive residential and outpatient settings.

3. As a result of this shift in the service system, it was anticipated that an overall reduction in the costs of mental health and chemical dependency treatment would be achieved, enabling more people to obtain services. During the 1983 legislative session, the SHPDA estimated that this statute would save $371,520 per biennium in state employee health care costs alone.

In our 1985 report, we stated that it appeared that these results were being achieved, but that the statute had been in effect for too short a time to enable any firm conclusions. The statute has now been in effect for 2 1/2 years, and our data now largely confirm the conclusion of our earlier report. The statute has had its intended effects of enabling more people to receive care and of increasing the availability of alternatives to inpatient care. The costs to insurers of inpatient care have gone down, although costs of mental health outpatient services have increased somewhat, as a result of many more people receiving treatment. The data to support these findings are outlined below.

Impact on the service system

Since Chapter 601 took effect, a number of new outpatient and residential programs have opened. Nine new outpatient mental health programs (including two hospital-based programs) have opened or have received approval from the Mental Health Division. One new hospital-based mental health day treatment program has opened. Thirty-five new outpatient chemical dependency programs have been approved by the Office of Alcohol and Drug Abuse Programs (including eight hospital-based programs). Ten residential chemical dependency programs (including five in hospitals) have opened. It should be noted that not all of these programs represent new providers; some are already existing programs which simply received approval for a new type of service, or received approval in order to qualify for insurance reimbursement. When a provider received approval for more than one type of service, they have been counted twice in the statistics above.

Utilization of inpatient mental health and chemical dependency programs has not changed greatly since Chapter 601 took effect. Table 2 indicates that use rates (patient days per 1,000 population) for psychiatric inpatient units has declined slightly since the statute took effect, but that inpatient chemical dependency unit use rates have continued to increase. It appears that inpatient chemical dependency use has not increased as quickly since Chapter 601 passed as it did in previous years, however.

Use rates for inpatient chemical dependency units increased by 32 percent from 1980-81 to 1982-83 (when the new statute was passed). Use rates for inpatient mental health units increased by four percent during this time period. In the two years following enactment of the new statutory provisions, however, the inpatient chemical dependency use rate increased by only 12 percent; and the inpatient mental health use rate declined by seven percent. Please note that these statistics represent only the use of dedicated inpatient mental health and chemical dependency units. Some people will have received inpatient treatment for mental health and chemical dependency problems outside of established specialty programs.

This agency has data only on the utilization of inpatient and hospital-based services. We have no statistics on the use of outpatient and residential programs. However, it is reasonable to assume that the substantial growth that has occurred in the number of approved programs has also meant growth in the number of people receiving treatment. Data from the Bankers Life Company support this assumption. In the year and a half before Chapter 601 took effect, 7.7 percent of Bankers Life's total claims were for mental health treatment and 1.6 percent were for chemical dependency. In the year and a half after Chapter 601 took effect, these figures rose to 9.0 percent and 1.9 percent, respectively. Claims for outpatient treatment increased substantially more than claims for inpatient treatment. On a proportionate basis, claims for outpatient mental health treatment increased by 23 percent and claims for outpatient chemical dependency treatment increased by 100 percent.

Obviously, utilization patterns for mental health and chemical dependency services are influenced by more than just the insurance reimbursement mandates. Some hospitals have been anxious to get into such services because they see an unmet need; because such services are not yet subject to DRG-based payment by Medicare; and because "unbundling" and diversifying services is a currently popular marketing strategy. Some of the new outpatient and residential programs were started because of county RFP's or for other reasons. Some of these new programs are targeted at the indigent and not at those with insurance coverage. Nevertheless, this agency believes that the growth in outpatient and residential programs is motivated, at least in part, by the increased availability of insurance reimbursement for these services.

The available data therefore indicate that Chapter 601 achieved its intended effects in terms of increasing the availability of less expensive alternatives to inpatient care; and of bringing more people into treatment.

Table 2

Use of Dedicated Inpatient Mental Health and Chemical Dependency Units in Oregon, 1981 - 1985

	1984-85	% Change	1983-84	% Change	1982-83	% Change	1981-82	% Change	1980-81
Oregon population	2,675,800	0.6	2,660,000	0.9	2,635,000	(0.8)	2,656,185	(0.2)	2,660,735
Mental health units:									
Beds	412	1.2	407	(0.2)	408	0.0	408	(0.7)	411
Patient days	86,219	(4.1)	89,880	(1.7)	91,426	0.8	90,723	2.4	88,601
Patient days/1,000 pop.	32.2	(4.7)	33.8	(2.6)	34.7	1.5	34.2	2.7	33.3
Chemical dependency units:									
Beds	352	13.2	311	5.8	294	37.4	214	13.8	188
Patient days	66,776	9.2	61,152	4.3	58,641	19.9	48,914	8.9	44,904
Patient days/1,000 pop.	25.0	8.7	23.0	3.1	22.3	21.2	18.4	8.9	16.9

SOURCE: SHPDA, Annual Reports for Oregon Hopitals and Special Inpatient Care Facilities. Most data are reported for years starting October 1 and ending September 30, although some facilities report statistics for a different time period. Population estimates from Center for Population Research and Census, Portland State University.

Impact on costs

As noted in the "Introduction" section of this report, Chapter 601 established two "cost containment methods" which could be used by any insurer. These were first, establishment of a lower percentage copayment for residential or outpatient services than for inpatient services; and second, review of claims for payment to determine whether the level of care and length of treatment were appropriate. Based on the agency's survey of insurers two years ago and SHPDA's contacts with insurers over recent months as part of our work groups on this issue, it appears that few (if any) insurers have set copayments lower for residential or outpatient care than for inpatient treatment. However, most of the major health insurers in the state are now conducting utilization review on mental health and chemical dependency claims, as allowed by Chapter 601.

Insurers have achieved substantial savings as a result of this utilization review. Blue Cross/Blue Shield of Oregon (BCBSO) has carefully tracked its costs under Chapter 601. In calendar year 1985, BCBSO reduced payments for 26 percent of the claims it received for mental health and chemical dependency treatment, because utilization review indicated that the level of care received was inappropriate. In nearly all of these cases, payment was reduced from the inpatient level to the residential level. BCBSO reports that it saved $246,430 as a result of these level of care reductions, or about $ .48 per group policy member ($ .04 per member per month).

BCBSO is the only insurance carrier which has provided data which can be used to compare insurance company costs per member per month for mental health and chemical dependency treatment before and after Chapter 601 took effect. In this agency's survey of insurers two years ago, BCBSO reported that before Chapter 601, it paid an average of $1.34 per member per month for mental health and chemical dependency treatment. Of this total, $1.18, or 88 percent, was for inpatient treatment. Mental health treatment accounted for $ .89 per member per month and chemical dependency treatment accounted for the remaining $ .45.

BCBSO now reports that from July 1984 through June 1985 (the first year of implementation of Chapter 601), its total costs for mental health and chemical dependency payments for group policies was $1.85 per member per month. This is a 38 percent increase over the amount reported prior to Chapter 601 taking effect. This compares to a 3.8 percent increase in overall medical care costs during this time period. Only $ .94 out of the $1.85 total (51 percent) was for inpatient treatment. This represents a 20 percent decline in the cost of inpatient treatment per member per month to BCBSO, since Chapter 601 took effect. Payment for outpatient and residential treatment, which was only $ .16 per member per month before Chapter 601 took effect, has risen to $ .91 per member per month.

Mental health treatment accounted for $1.37 per member per month; while chemical dependency treatment accounted for the remaining $ .48 per member per month. The chemical dependency figure is only a slight increase over the $ .45 per member per month reported prior to Chapter 601 taking effect.

Thus, BCBSO's costs for mental health and chemical dependency benefits increased by $ .51 per member per month in the year after Chapter 601 took effect. Because the average monthly payment to BCBSO group policy members was about $42 in 1984-85, this time, this amounts to about a one percent increase in total costs. BCBSO appears to be purchasing substantially more services for its money, however, because its costs of inpatient treatment have gone down. A slight increase in overall costs appears to have allowed many more people to receive treatment in outpatient and residential settings which are substantially less expensive than the inpatient care which had previously been covered. BCBSO says that it has not had to raise its premiums as a result of Chapter 601.

To summarize, the "cost saving" effects of Chapter 601 appear to be mixed. Overall, BCBSO costs for mental health and chemical dependency services increased by $ .51 per member per month after Chapter 601 took effect. Nearly all of this increase appears to be attributable to mental health outpatient coverage. Costs of inpatient treatment for BCBSO have decreased under Chapter 601, and costs of chemical dependency treatment have remained about the same.

Although comprehensive data from before and after Chapter 601 took effect are not available from any other insurer, we have no reason to believe that the BCBSO data are atypical, and according to the Insurance Division, BCBSO accounts for 37 percent of all health insurance premiums statewide.

Summary

It is the SHPDA's conclusion that in general, Chapter 601 did what is was supposed to do: get more people into treatment in a more cost effective manner. Costs to insurers appear to have increased, but not dramatically. The increase appears to be largely attributable to increased payments for outpatient mental health services. The costs of other types of services has remained stable or declined. The number of people receiving insurance reimbursement for mental health and chemical dependency services appears to have increased; and a shift in the service system has occurred so that more outpatient and residential services have become available. The rate of growth in the use of inpatient services has declined.

ISSUES AND PROBLEMS RELATED TO IMPLEMENTATION

Although Chapter 601 is generally accomplishing what it was intended to do, there have been problems and controversy associated with certain aspects of its implementation. In some cases, fine tuning of the statute appears to be necessary to correct problems.

Areas of concern that have been discussed in meetings of SHPDA's work groups include:

Sunset of the legislation

Section 10 of Chapter 601 sunsetted the legislation as of July 1, 1987. It is our understanding that this was done because the legislature wanted to evaluate how the legislation had worked and what impact it had. As noted earlier, it is our conclusion that the legislation has had its intended effects of making mental health and chemical dependency services more accessible, while at the same time containing costs. Those attending our work groups meetings, including insurance company representatives, providers of care, other state agencies, and representatives of the business community, unanimously agree that this legislation should be continued. It is therefore SHPDA's recommendation that this sunset date be removed.

Coverage of children and adolescents

When Chapter 601 was enacted in 1983, the required minimum benefit levels for mental health and chemical dependency were set at what was considered to be the minimum necessary level for adult care. The people involved in drafting the bill did not consider the needs of children and adolescents. Members of the SHPDA study groups agree that children and adolescents have significantly different needs from adults. They need longer lengths of stay, and higher ratios of staff to patients.

A search of the scientific literature revealed few studies on appropriate program design for child and adolescent treatment. Studies that were available, however, seemed to indicate that effective programs could have as low as 28 to 35 day lengths of stay for both mental health and chemical dependency. Some studies reported far longer lengths of stay, but none reported shorter stays.

In Oregon, however, lengths of stay for all types of hospital care are lower than the national average. Our overall average length of stay for all inpatient psychiatric services was only 10 days in 1985, compared to the 59 day national average reported by the National Association of Private Psychiatric Hospitals for 1984.

According to the Oregon Psychiatric Association, the average length of stay currently in Oregon for children and adolescents is 22 days for inpatient psychiatric care, compared to 10 days for adults (based on a survey of six hospitals in January and April, 1986). BCBSO reports that claims it received for inpatient mental health care from July 1984 through June 1985 had average lengths of stay of 13 days for adolescents, compared to only eight days for adults. Aetna reported 21 days for

adolescents, versus nine for adults, based on its 1985 inpatient mental health claims. Thus, lengths of stay for children and adolescents appear to be over twice as long as for adults for inpatient mental health services.

Charges reported by insurance companies for inpatient mental health services are also substantially higher for children and adolescents than for adults. BCBSO reports an average charge for inpatient and residential or day mental health treatment of $4,800 for adolescents from July 1984 through June 1985, 63 percent higher than the $2,949 reported for adults. Bankers Life reported an average charge of $18,672 for inpatient mental health treatment of adolescents in 1985 (including physician fees), compared to $7,379 for adults (or a 153 percent difference). Aetna reported inpatient mental health treatment charges of $10,775 for adolescents, compared to $3,962 for adults in 1985, a difference of 172 percent.

For inpatient chemical dependency treatment, a difference also exists between adolescents and adults, although it is not as great as for mental health care.

On SHPDA's "Annual Reports for Oregon Hospitals and Special Inpatient Care Facilities" for October 1984 through September 1985, three facilities reporting inpatient chemical dependency services for children and adolescents had an average length of stay of 27 days for such services. This was 50 percent higher than the 18-day overall average for all inpatient chemical dependency units in the state. Insurance companies reported similar length of stay differences for inpatient chemical dependency based on their claims data. BCBSO reported average stays of 17 days for adolescents versus 13 days for adults from July 1984 through June 1985. Aetna reported 26-day average stays for adolescents and 15 days for adults in 1985.

CareUnit Hospital of Portland, which does over one-fourth of all inpatient chemical dependency treatment in the state, has reported that in May 1986, its adolescent program had over two clinical and nursing staff for each patient, compared to a one-to-one staffing ratio in its adult program.

CareUnit reported costs per stay of $5,314 for its adolescent inpatient program in May, 1986; 50 percent higher than the $3,543 reported for adults. BCBSO reported average inpatient and residential program claims from hospitals of $3,213 for adolescents and $2,537 from adults from July 1984 through June 1985, a 27 percent difference. Bankers Life reported average charges in 1985 of $5,689 for adolescents versus $4,759 for adults for inpatient chemical dependency services. Adolescent charges were 20 percent higher than adult charges. Aetna reported average inpatient chemical dependency charges of $6,318 for adolescents and $3,460 for adults in 1985--an 83 percent difference.

Because there are no specific minimum coverage levels for children and adolescents in state statute, and no insurers (to our knowledge) provide higher benefits for children and adolescents than for adults, it may be that the cost and length of stay differences cited above are artificially