

ALASKA LEGISLATURE COMMITTEE FILES 1987-1988 8672

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low. Some child and adolescent patients may be discharged earlier than they otherwise would have been ' cause of the lack of a payment source, and some may not receive treatment at all.

We conclude that there is a substantial amount of documentation that the costs of providing mental health and chemical dependency treatment to children and adolescents are substantially greater than the costs of adult treatment. Costs for treating children and adolescents appear to be 63 to 172 percent greater for mental health and 20 to 83 percent higher for chemical dependency. This difference was not considered when the benefit levels in Chapter 601 were set originally. These levels were set so as to be minimally adequate for adults. They are wholly inadequate for children and adolescents.

The SHPDA recommends that separate minimum benefit levels for children and adolescents be provided for in the statute. Based on discussions at our study group meetings, we recommend that benefit levels for children and adolescents for mental health treatment be as follows:

Inpatient and day or partial hospitalization	\$10,500 of which only \$3,000 could be used for day or partial hospitalization
Outpatient	\$ 2,000
Overall	\$12,500

The total available coverage of at least \$12,500 in coverage for children and adolescents, compares to \$9,000 for adults. The \$10,500 in inpatient and day treatment coverage would allow for a 20 to 25-day inpatient stay, if it were all used for inpatient care. As noted above, this is about the current average length of stay for inpatient mental health care of children and adolescents in Oregon. Many providers think this average should be considerably higher; and of course there will be children and adolescents who need longer-than-average stays. This inpatient coverage level is therefore considered to be barely adequate, even as a minimum, but it represents a substantial improvement over what is available now.

The proposed benefit level also allows for up to \$3,000 of the \$10,500 inpatient benefit to be used for day or partial hospitalization. It is hoped that this will provide an incentive for providers to move children and adolescents into this lower level of care, whenever this is feasible.

The minimum outpatient mental health benefit for children and adolescents is set at \$2,000, the same as for adults. The difference, however, is that all of this \$2,000 would be available for outpatient treatment of children and adolescents, no matter how much inpatient or day treatment is provided. For adults, this benefit is subject to the \$9,000 overall cap. If the \$9,000 is exhausted by adult inpatient and day treatment, the \$2,000 outpatient benefit would not be available.

The proposed \$10,500 inpatient level for mental health treatment of children and adolescents is 40 percent higher than the current \$7,500 level for adults.

For chemical dependency treatment of children and adolescents, the SHPDA recommends the following benefit levels:

Inpatient	\$ 6,000
Residential/day or partial hospitalization	4,500
Combined total for inpatient, residential, and day or partial hospitalization	\$ 9,000
Outpatient	1,500
Overall	\$10,500

The inpatient level is a third higher than the current adult level of \$4,500. The residential/day treatment level is 50 percent higher than the current adult level. The outpatient benefit level is the same as the current adult level, but, as with the benefits for mental health, this outpatient benefit will be reserved for children and adolescents, and could not be reduced on the basis of the amount of inpatient or residential care delivered. The recommended minimum overall benefit level of \$10,500 compares to \$6,000 overall currently for adults.

Using data from DCBSO, the SHPDA has estimated the overall cost impact of these benefit level changes. BCBSO reports that adolescents represented 35 percent of all group payments for hospital inpatient or residential care for mental health; and 19 percent of all hospital inpatient and residential chemical dependency treatment. Statistics for outpatient and freestanding residential treatment were not available, but we will assume that the percentage is the same. (Actually, the percentage is likely to be less, because there is likely to be less difference between adults and adolescents for length of time in treatment for outpatient care.)

Under SHPDA's proposal, the total exposure of insurance companies for child and adolescent coverage would increase by 39 percent for mental health care (from \$9,000 to \$12,500) and by 75 percent for chemical dependency (from \$6,000 to \$10,500). The inpatient benefit levels would increase by 40 percent for mental health care (from \$7,500 to \$10,500); and by 33 percent for chemical dependency (from \$4,500 to \$6,000).

From July 1984 through June 1985, BCBSO paid \$8,535,221 in group coverage for mental health care and \$2,965,576 in group coverage for chemical dependency. According to the state Insurance Division, BCBSO accounted for \$466 million out of a statewide total of \$1,256 million in insurance premiums in 1985, or 37 percent of the total. Because BCBSO had 517,235 group plan members in 1984-85, we estimate that there are about 1.4

million people statewide with group health insurance coverage (assuming that BCBSO represents 37 percent of the total).

From these statistics, we estimate that about \$8.1 million annually is currently being spent in Oregon on mental health care for children and adolescents, and \$1.5 million for chemical dependency.

We have no way of predicting what the mix of treatment settings would be under the new coverage levels; i.e., the percent that would go for inpatient care as opposed to residential or outpatient treatment. If the increased benefit levels for children and adolescents were to result in increased payments by insurance companies in proportion to the increases in the overall benefit caps, then total statewide payments for child and adolescent mental health services could increase by as much as \$3.2 million, or \$.19 per group policy member per month. Chemical dependency payments could increase by as much as \$1.1 million, or \$.07 per member per month. As noted earlier, total reimbursement by BCBSO for mental health and chemical dependency services was \$1.85 per member per month from July 1984 through June 1985. This would therefore represent a 14 percent increase in mental health and chemical dependency payments.

Costs may not increase in proportion to the increases in the overall benefit caps, however. We believe they are likely to increase at least as much as the increases in the inpatient portion of the benefit levels. As noted above, this would be a 40 percent increase for mental health and a 33 percent increase for chemical dependency. Under this scenario, payments for child and adolescent mental health services would increase by \$3.2 million, or \$.19 per member per month--the same as in the above calculations. Chemical dependency reimbursement, however, would increase by only about \$500,000, or \$.03 per group policy member per month. Overall, this would represent an increase of 12 percent in insurance company payments for mental health and chemical dependency services.

In summary, it is well documented that the cost of treating children and adolescents for mental health and chemical dependency is considerably higher than the cost of treating adults. This was not considered when Chapter 601 was originally drafted. Therefore, the SHPDA is recommending separate, higher minimum benefit levels be set in the statute for children and adolescents. We estimate that this will increase the cost to insurers for mental health and chemical dependency benefits by 12 to 14 percent, or about \$.22 to \$.26 per group policy member per month. The purpose of these increased benefit levels is that more treatment be delivered to children and adolescents than to adults. Providers should not use the higher benefit levels merely as a basis for charging higher per diem rates. This principle should be included in the statute as a policy statement.

Dual diagnosis

Current provisions of ORS 743.557(2) and 743.558(2) (Chapter 601, Sections 6 and 7) allow insurance companies to limit benefits for all settings to \$6,000 over 24 months for persons who need both mental health and chemical dependency treatment (so-called "dual diagnosis" patients).

People with only mental health needs can be reimbursed up to \$9,000. The \$6,000 level for multiproblem patients seems overly restrictive and gives providers an incentive for "gaming" the patient's diagnosis. However, insurers have pointed out that most chemical dependency patients can be said to have an associated psychiatric diagnosis; and that therefore de'tating this requirement might merely result in raising the overall benefit level to \$9,000 for both mental health and chemical dependency.

Rationally, dual diagnosis patients have needs which are at least as great as those of mental health patients. The SHPDA therefore recommends that the dual diagnosis benefit levels be increased so that they conform to the mental health benefit levels. This would mean an overall cap of \$9,000 instead of \$6,000 for adult dual diagnosis treatment; and an overall cap of \$12,500 instead of the current \$6,000 for children and adolescents with dual diagnoses.

The SHPDA shares the concerns of insurers that an increase in the dual diagnosis levels may cause some chemical dependency treatment programs to find dual diagnoses in increasing numbers of patients. For this reason, the SHPDA also recommends that dual diagnosis treatment be recognized in the statute as a separate type of treatment from either chemical dependency or mental health treatment, with separate utilization review and program approval criteria and standards.

It is difficult to estimate the cost impact of increased benefit levels for dual diagnosis treatment, because we do not have good statistics on the proportion of all mental health and chemical dependency patients who are dual diagnosis patients. A reasonable guess would be that 20 percent of all chemical dependency patients could have dual diagnoses. We also assume that all persons in mental health programs will be billed on the basis of mental health benefit levels, even though some of these people may also have dual diagnoses. Last, we will assume that payments for dual diagnosis patients will increase in proportion to the increase in the overall benefit levels; that is, a 50 percent increase for adults (\$9,000 ÷ \$6,000) and a 108 percent increase for children and adolescents (\$12,500 ÷ \$6,000). Because 16 percent of BCBSO's group coverage claims for chemical dependency were for adolescent treatment, we can weight the above the above figures and estimate that payments for dual diagnosis treatment will increase by 59 percent overall.

BCBSO spent \$2,965,576 on chemical dependency payments to group policy members from July 1984 through June 1985. As noted earlier, BCBSO represented 37 percent of all group insurance business in the state. It can therefore be estimated that about \$8 million is spent annually by insurers for chemical dependency treatment for group policy holders. If 20 percent of these payments are for dual diagnosis patients, then approximately \$1.6 million is currently spent by insurers annually on dual diagnosis patients with group policy coverage.

With the above statistics, we can estimate that the proposed increase in dual diagnosis benefit levels will cost insurers statewide about \$900,000, or \$.05 per member per month. This represents a three percent increase in insurance company payments for mental health and chemical dependency, based on BCBSO statistics.

Other benefit level issues

The SHPDA is proposing major changes in the mandated benefit levels only in the two areas described above--coverage for children and adolescents; and coverage for dual diagnosis patients. Other issues related to benefit levels have been raised at our work group meetings, however.

Some mental health service providers have advocated an increase in the benefit level for inpatient mental health services. Benefits for this setting were cut substantially by Chapter 601, on the assumption that the new \$7,500 benefit for a 24-month period would be adequate for most patients. At current hospital and physician charges, this amounts to payment for about a 15-day stay. Data collected by the Oregon Psychiatric Association from six hospitals in January and April, 1986, indicate that patient lengths of stay exceeded the inpatient benefit levels in 24 percent of the cases. Because the existing benefit level is adequate for 76 percent of patients, we do not consider this to be as high a priority as changing the child/adolescent and dual diagnosis benefits. The fact that 24 percent of all patients need more inpatient mental health services than the benefit levels cover is significant, however, and will eventually need to be addressed by the legislature.

The SHPDA is proposing a slight change in the residential chemical dependency level for adults. Data provided by residential treatment programs indicates that costs are generally somewhat higher than the \$3,000 minimum benefit currently provided for in the statute. Laurelhurst Manor, a residential program in Portland, estimated its costs for adults at \$3,750 per case. The Addiction Treatment Association recommended that the residential benefit level be increased to \$3,500. The SHPDA concurs with the ATA recommendation, because it is supported by data on actual program costs and because it will increase the incentive for residential as opposed to inpatient care. It's also a relatively minor change in the benefit levels. The SHPDA estimates that even if all adult patients in residential chemical dependency programs were to be reimbursed for the full \$500 increase in the benefit level, this would add only \$.04 per member per month to insurance company costs. Of course, not all patients will receive the maximum reimbursement level. Many will have lesser treatment needs, or will leave treatment before completion of the program, or will have their reimbursement reduced as a result of utilization review. The actual cost impact of this change is therefore likely to be considerably less than \$.04 per member per month.

Utilization review

One of the "cost containment methods" established by ORS 743.557 (10) and 743.558(8) (Sections 5 and 6 of Chapter 601) is utilization review by insurers to determine whether or not the level of care provided was appropriate. The statute does not mandate that such utilization review be done, but gives insurers explicit authorization to do such reviews if they wish. As noted earlier, most of the larger health insurers in the state now conduct such reviews. BCBSO has stated that its mental health and chemical dependency utilization review program resulted in

direct savings of \$246,430 due to level of care reductions in calendar year 1985.

Section 7 of Chapter 601 required the SHPDA to prepare an advisory, non-binding set of criteria for use by insurance companies for screening claims in terms of level of care and length of treatment. The SHPDA issued these model criteria on October 1, 1983; and also presented a detailed, specific example of these criteria for alcohol problems. In the fall of 1984, SHPDA participated, with BCBSO and a number of treatment providers, in two utilization review work groups organized by the Oregon Medical Association and the Oregon Association of Hospitals. These groups developed a simpler and less restrictive set of utilization review criteria, which were endorsed by SHPDA and BCBSO. The SHPDA is currently working with groups of providers and insurers to develop utilization review criteria for children and adolescents, and we plan to begin development soon of criteria for dual diagnosis patients.

Since Chapter 601 was enacted, providers have had a number of concerns regarding the utilization review process. Currently, the primary concern is that the statute requires that "Review shall be on a post-admission basis rather than by mandatory prior approval..." Although not all providers favor mandatory prior approval, they would like to be able to find out in advance whether an insurer would consider a particular admission to be appropriate.

SHPDA's work groups reached a consensus on recommendations regarding the utilization review process, which would address the above issue and several other concerns, and would give insurers more freedom of choice in the method of utilization review. Our recommendations are as follows:

1. Continue to allow insurers to do utilization review if they wish.
2. Continue the requirement that SHPDA issue model utilization review criteria, but require that SHPDA revise these criteria every two years, and strengthen existing language in the statute requiring that SHPDA consult with all affected parties.
3. Require that reviewers have experience and expertise in the particular area that they are reviewing (i.e., mental health or chemical dependency treatment).
4. Allow providers or patients to request prior approval or concurrent review for particular cases, and state that they are entitled to a timely response to such requests.
5. Give insurers the option of which type of review they wish to provide, so long as the review criteria are defined and made available to providers. Insurers who elect to require prior approval should make allowances for the admission of emergency cases.

Licensure and approval of programs

When Chapter 601 went into effect, coverage was mandated for certain settings of care that were not previously licensable in the state of

Oregon: residential and outpatient mental health and chemical dependency services; and inpatient drug abuse services. The statute requires that inpatient facilities, in order to be eligible for reimbursement, must be licensed by the Health Division, but individual programs within hospitals, such as mental health or substance abuse programs, need no special approval or certification beyond the hospital license. Outpatient and residential services must be "licensed, approved, established, maintained, contracted with or operated by the Mental Health Division" in order to be eligible for reimbursement (ORS 430.010(3) and (4); Chapter 601, Section 1).

Thus, there is an apparent inequity, in that freestanding outpatient and residential programs require the approval of the Mental Health Division or Office of Alcohol and Drug Abuse Programs in order to be reimbursed while hospital-based outpatient and residential programs do not.

Section 2 of Chapter 601 mentions Joint Commission on Accreditation of Hospitals (JCAH) accreditation as an alternative to licensure or approval for hospital-based programs, but does not require JCAH accreditation. Work group members have pointed out that other nationally-recognized standards are available, in addition to JCAH standards. These include the standards of the America Association of Partial Hospitalization (AAPH) and the Commission on Accreditation of Rehabilitation Facilities (CARF).

The SHPDA is therefore recommending that all outpatient, residential, and day or partial hospitalization programs, whether or not they are hospital-based, be required to have approval from either the appropriate state agency (Mental Health Division or Office of Alcohol and Drug Abuse Programs) or from one of the nationally-recognized accreditation bodies (JCAH, AAPH, or CARF) in order to be eligible for insurance reimbursement. For inpatient programs, health facility licensure by the Health Division would continue to be the only program certification required, as it is now.

The definitions of the various treatment settings in ORS 430.010 (Chapter 601, Section 1) currently define which programs are eligible for insurance reimbursement. These definitions were primarily intended to apply to state supported mental health and chemical dependency programs, however (county mental health programs and subcontractors). The multiple purposes of ORS 430.010 has caused some problems. Because the statute related to county mental health programs is referenced, in ORS 430.010, the Mental Health Division (MHD) has taken the position that outpatient programs must be recognized by the local county mental health program before they can receive approval for insurance reimbursement purposes. It is our understanding that this was not the intent of Chapter 601, and the SHPDA therefore recommends that the statute give the Mental Health Division and the Office of Alcohol and Drug Abuse Programs the authority to approve treatment programs for insurance reimbursement purposes, without requiring that they be a part of a county mental health program.

Two issues have also arisen in regards to inpatient health facility license requirements. First, the definitions of various types of health facilities in ORS 442.015(16) establish what the licensure categories will be. ORS 442.015(16)(a) defines the licensure category "hospital." ORS 442.015(16)(d) defines another licensure category called "special inpatient care facility," which includes facilities for the treatment of alcoholism. Medicare will reimburse only for a facility that is licensed as a "hospital." Therefore, facilities for the treatment of alcoholism are not eligible for Medicare reimbursement, because of the way that health facilities are defined in Oregon statute. It doesn't seem fair that a hospital-based alcoholism unit should be eligible for Medicare reimbursement while a freestanding "facility for the treatment of alcoholism" performing the same service should not. Therefore, the SHPDA is recommending that ORS 442.015(16) be revised so that "special inpatient care facility" becomes a subcategory of "hospital."

The second licensure issue relates to drug treatment facilities. As noted earlier, Chapter 601 for the first time mandated reimbursement for drug abuse services. For inpatient drug abuse services to be reimbursable, Chapter 601 requires that they be licensed by the Health Division. However, ORS 441.017 states that, "For purposes of licensing health care facilities, 'health care facility,' as defined in ORS 442.015, does not include...facilities established for treatment of drug abuse." Thus, the Health Division is prohibited by statute from licensing inpatient drug facilities. Alcohol treatment facilities are subject to licensure, and most such facilities also treat drug abuse. Technically, however, they are not licensed to treat drug abuse. ORS 441.017(3), which establishes the licensure exemption for drug abuse, should be repealed. There is no reason why inpatient alcohol treatment facilities should be subject to licensure, while drug facilities are not. Also, by allowing the Health Division to license drug facilities, the reimbursability of such facilities would be clarified.

Definition of "residential mental health"

Chapter 601 states that, "'Residential facility' 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" (ORS 430.010(3); Chapter 601, Section 1). The statute goes on to state that payment at the "residential" benefit level "...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" (ORS 743.558(5); Chapter 501, Section 6).

The term "residential facility" implies a freestanding, halfway house sort of program. In fact, this sort of residential facility is an accepted model for chemical dependency service delivery. However, no such facilities exist for mental health services. Providers believe that the most appropriate model for delivery of mental health services that are more than outpatient and less than inpatient is probably a day or partial hospitalization program. In such programs, patients do not stay overnight; and programs are likely to be associated with hospitals or other providers, rather than being freestanding.

Many providers and insurers have not realized that under Chapter 601, "residential" also means "day treatment." The standard meaning of the word "residential" implies to many people that it does not include day treatment. It is therefore advisable for the statute to clarify that the "residential" benefit level really applies to more types of services than just residential facilities. In order to clarify that this setting can involve more models of treatment than simply residential facilities, the SHPDA recommends that references to "residential facilities" in the statute be changed to "residential facilities and day or partial hospitalization programs."

Members of SHPDA's work groups have also advised us that the requirement that "residential" programs provide treatment at least four hours per day, four days per week, may be too restrictive. Apparently, day treatment programs sometimes provide fewer hours of care, or concentrate services over less than four days a week. It is therefore recommended that day or partial hospitalization be defined so that program approval or accreditation is required, but no specific hour-based standard is applied. Providers appear to agree, however, that genuinely residential programs should be defined as those in which patients stay overnight and participate in a structured program at least eight hours per day.

Services and providers covered

Providers have frequently raised questions about whether particular diagnoses or types of programs are covered under Chapter 601. Oregon statute does not define or mandate any particular policy on these issues. Insurance companies therefore have discretion. The SHPDA understands that insurance companies have generally refused to reimburse for Diagnostic and Statistical Manual (DSM-III) V code diagnoses, and it appears that they are allowed to do this under Chapter 601. It was the intent of the statute, however, that insurers should still cover the diagnoses they covered prior to Chapter 601 taking effect.

An issue raised in SHPDA's work groups is whether medical treatment should be charged toward the benefit levels in Chapter 601. It is our opinion that because reimbursement for mental health and chemical dependency is limited, treatment or diagnostic procedures primarily related to medical problems should not be charged to these benefits, even when the patient's primary diagnosis is mental illness or chemical dependency.

Detoxification services should continue to be covered under the substance abuse inpatient benefit levels. However, the statute should be revised to state that for both mental health and substance abuse services, ancillary medical or neurological diagnostic or treatment services that are concurrent with, but not directly related to a mental health problem or normal detox protocol will not be charged to the mental health or substance abuse benefit levels.

There have also been questions raised as to whether conditions which apply to private practitioners also apply to treatment programs approved under Chapter 601. Specifically, ORS 743.135 requires reimbursement for registered clinical social worker (RCSW) services, but only when the patient has been referred by a physician. It is our understanding

that this restriction was not intended to apply to organized programs which had been approved by the Mental Health Division or Office of Alcohol and Drug Abuse Problems. In such cases, it is the program which is being reimbursed, not the individual practitioner; and the program has had to meet various requirements in order to receive certification.

However, ORS 743.557(3) and 743.558(3) (Sections 5 and 6 of Chapter 601) start out by saying "Subject to the provisions of ORS 743.123, 743.128 and 743.135..." before going on to say that programs are eligible to receive payment for treatment. This could be interpreted as meaning that physician referral is required for RCSW services per ORS 743.135, even in an approved program. Although the SHPDA believes that this was not the intent, the issue should be clarified. We therefore recommend that these cross-references be deleted from ORS 743.557(3) and 743.558(3).

Groups covered under the mandates

Currently, Chapter 601 applies only to group health insurance policies written in the state of Oregon. Thus, many people have insurance coverage that is not subject to these mandates. Types of coverage which are not subject to Chapter 601 include self-insured groups, individual policies, blanket policies, policies written out of state, group or staff model health maintenance organizations (HMOs), Medicare and Medicaid.

As a general principal, the SHPDA believes that insurance mandates should apply as broadly as possible, so that everyone is playing by the same rules, and no one is put at a competitive disadvantage as a result of having to comply with the mandates. There are a number of practical and legal problems that prevent this, however.

The largest group which is currently not subject to insurance mandates is the self-insured. Businesses have increasingly been setting up their own insurance plans in order to gain better control over costs and utilization. A federal statute, the Employee Retirement Income Security Act of 1974 (ERISA), has been interpreted as preempting state regulation of self-insured groups. Unless future federal court decisions change this interpretation, or Congress amends ERISA, it does not appear that states can apply insurance mandates to self-insured groups.

Likewise, federal requirements govern what is covered under Medicare and Medicaid.

In some areas, however, it appears that action can be taken to make Chapter 601 more broadly applicable. ORS 750.055(1)(j) (Section 9, Chapter 601) states 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." Thus, the Kaiser and Eugene Clinic HMOs are exempted from the Chapter 601 mandates, although all other HMOs are not. Although Kaiser does provide treatment to its members for mental illness and chemical dependency, its coverage of mental health and chemical dependency services does not fully conform to the provisions of Chapter 601, particularly in regard to residential and inpatient

care. The SHPDA recommends that all HMOs be brought under Chapter 601's requirements.

The SHPDA is not recommending at this time that any other groups be brought under the Chapter 601 mandates. It may be advisable at some future time to include individual policies, blanket policies, or policies written out of state, but the SHPDA believes that more study is needed before any of these types of policies are made subject to Chapter 601.

Blanket policies are often of a limited or short term nature, although some groups such as university students are also sometimes covered under blanket policies. Research would have to be done on whether Chapter 601 should apply to all blanket policies or only certain types of blanket policies.

Practical problems would have to be resolved in order to bring out-of-state policies covering Oregon residents under the requirements of Chapter 601. Fundamental changes to the insurance code would be required to attempt covering all state residents regardless of group policy status. The insurance code currently covers policies--that is the group contracts--issued to employers--issued in Oregon. It is not a straightforward matter to claim Oregon jurisdiction over a contract issued to a multi-state employer headquartered in another state, possibly even issued by a company not licensed to do business in Oregon; and potential conflicts would occur if the state in which the group policy was issued had laws which applied to all coverage under the policy (as most states do) regardless of residence of the employees. In addition to the legal problems, practical difficulties and resulting costs of compliance would be introduced for multi-state employers and their insurers from the necessity of varying benefit plans by state. These difficulties would provide an added incentive for such employers to self-insure the health benefits, which would remove them from any state jurisdiction.

STATUTORILY REQUIRED REPORT

ORS 171.875 requires that: "Every proposed legislative measure that mandates a health insurance coverage, whether by requiring payment for certain providers or by requiring an offering of a health insurance coverage by an insurer or health care service contractor as a component of individual or group health insurance policies, shall be accompanied by a report that assesses both the social and financial effects of the coverage in the manner provided in ORS 171.880, including the efficacy of the treatment or service proposed. The report may be prepared either by the chief sponsor or by any other proponent of the proposed measure. The report shall be submitted with the proposed measure when the proposed measure is submitted for filing, and shall be in writing and be a public record."

ORS 171.880 lists a number of questions which must be addressed as a part of this report. We will attempt to answer these questions here, as they relate to the continuation of Chapter 601 and SHPDA's proposed revisions to that statute. ORS 171.880(1) asks five questions related to the social effect of the proposed measure, including:

To what extent is the treatment or service used by the general population of Oregon?

Statistics on the utilization of mental health and chemical dependency services were presented and discussed earlier in this report. It is impossible to estimate the total number of Oregonians who use mental health and chemical dependency services, because statistics are not reported for private practitioners and for many outpatient and residential programs. In 1985, 12,328 people were discharged from inpatient mental health and chemical dependency programs in Oregon, not including state or VA hospitals. Inpatient care represents only a small fraction of the total care delivered. BCBSO reported that from July 1984 through June 1985, it processed 18,398 claims for mental health and chemical dependency services. If BCBSO represents 37 percent of the private health insurance business in the state, then this would imply approximately 50,000 insurance claims statewide.

The President's Commission on Mental Health estimated in 1978 that approximately 15 percent of the United States population could benefit from mental health services. This would mean that in 1985, over 400,000 Oregonians were in need of mental health services. SHPDA's need determination rules, which are based on national studies of the prevalence of chemical dependency, estimate that 7 percent of the adult population and 19 percent of the adolescent population are problem drinkers. This would mean that in Oregon in 1985, about 135,000 adults and 53,000 adolescents were problem drinkers. The Governor's Council on Alcohol and Drug Abuse Programs has estimated that 12,000 adolescents in Oregon suffer from drug abuse.

In other words, mental illness and chemical dependency are serious problems in Oregon, affecting hundreds of thousands of Oregonians. Tens of thousands of Oregonians use treatment services each year.

To what extent is the insurance coverage already generally available in Oregon?

Chapter 601 has been in effect since July 1, 1984. This report seeks to justify the continuation and revision of already-existing coverage mandates. As noted earlier, prior to the enactment of Chapter 601, insurance coverage was generally available only for inpatient mental health and alcoholism services. Currently, coverage for children and adolescent and for dual diagnosis patients, although generally available, is believed to be inadequate. Most group policies cover mental health and chemical dependency services only up to the minimum levels required by Chapter 601.

What proportion of the population already has such coverage?

All individuals covered under group policies issued in Oregon are currently covered under Chapter 601. See answer above.

To what extent does the lack of coverage result in financial hardship in Oregon?

Because this report seeks to revise, rather than create, an existing insurance mandate, this question is not entirely relevant. However, children and adolescents and dual diagnosis patients are believed to currently have inadequate coverage for mental health and chemical dependency services. Some members of these groups may in fact experience financial hardship resulting from the inadequacy of their coverage. The Oregon Psychiatric Association estimated, based on a survey of six hospitals in January and April, 1986 that 43 percent of all children and adolescents receiving inpatient mental health services required more treatment than is covered under the existing benefit levels in Chapter 601. (As mentioned earlier, this is the case for only 24 percent of adult patients.)

In addition, if Chapter 601 were allowed to sunset, many Oregonians would either experience financial hardship in order to obtain needed mental health and chemical dependency services, or would forego such services. It is impossible to estimate how many persons would be affected, because we have no data on the financial status of mental health and chemical dependency patients, and we don't know what sort of insurance coverage would continue to be provided, if the mandates were no longer in effect. Outpatient, residential, and day or partial hospitalization services would be the most likely targets for reductions in coverage, so patients needing these services would be most affected.

What evidence exists to document the medical need in Oregon for the proposed treatment or services?

As detailed in the answer to the first question, above, it appears that hundreds of thousands of Oregonians are in need of mental health and chemical dependency services. This estimate is based on a number of authoritative studies on the incidence of mental illness and chemical dependency. Chapter 601 allows insurers to review claims to determine whether the level of care delivered was medically necessary. BCBSO has

been reviewing all claims for reimbursement since Chapter 601 took effect, and determined that some reimbursement was justified in all claims reviewed in 1985, although the amount of reimbursement was reduced in some instances.

ORS 171.880(2) asks five questions concerning the financial effect of the proposed measure, including:

To what extent is the coverage expected to increase or decrease the cost of treatment or services?

Changes in the minimum required benefit levels for mental health and chemical dependency services are proposed in only three areas: services to children and adolescents; services to dual diagnosis patients; and residential chemical dependency services. The costs of increasing these benefits was fully discussed earlier in this report. Overall, the increased benefit levels are expected to cost insurers no more than \$.35 per member per month. This is equivalent to a 19 percent increase in insurance company payments for mental health and chemical dependency services; and a 0.8 percent increase in insurance company costs for all health services.

To what extent is the coverage expected to increase the use of the treatment or services?

The proposed revisions to Chapter 601 are expected to have little if any effect on the utilization of services. The groups effected by the proposed benefit level changes already have coverage for mental health and chemical dependency services--the proposal is simply to increase the coverage to more adequate levels. The creation of insurance coverage for a particular type of service might be expected to result in the increased use of that service. As noted earlier in this report, the use of outpatient and residential programs for mental health and chemical dependency appears to have increased dramatically since Chapter 601 took effect. We do not expect any similar effect to result from the improvement of an existing benefit, however.

To what extent is the mandated treatment or service expected to be a substitute for more expensive treatment or services?

As detailed earlier in this report, Chapter 601 was originally enacted in order to provide coverage for lower-cost alternatives to inpatient mental health and chemical dependency services (i.e., outpatient and residential care). Costs to insurers of inpatient care appear to have in fact decreased since Chapter 601 took effect. The revisions to Chapter 601 which are currently being proposed do not change this situation, and do not create coverage for any new less costly alternative.

To what extent is the coverage expected to increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders?

There are no new areas of coverage being created by the proposed revisions to Chapter 601, so administrative expenses resulting from the proposed

revisions should not be substantial. However, all group policies issued in Oregon will need to be amended if the proposed changes are made. Insurance company claim personnel must also become familiar with the changes. Changes in levels of treatment for adolescents, eligible program definitions, and maximum benefit or provisions will raise many technical questions that must be analyzed. The associated costs of insurers will no doubt be passed on directly or indirectly to policyholders, but we have no way of estimating the magnitude of these expenses.

As noted earlier, the proposed improvement in the benefit levels for services to children and adolescents, dual diagnosis patients, and residential chemical dependency programs is expected to have an overall impact on insurance company costs of less than \$.35 per member per month. Insurance companies would need to increase premiums to policyholders by less than one percent, if at all, in order to cover these increased costs.

What will be the effect of this coverage on the total cost of health care?

The SHPDA believes that Chapter 601 has had the effect of reducing the total cost of health care to Oregonians. There is a substantial amount of documentation in the scientific literature of the fact that people who receive mental health and chemical dependency services subsequently experience large reductions in their overall medical care expenditures. Chapter 601 has allowed more people to gain access to such treatment.

In addition, Chapter 601, when it was originally enacted, incorporated several provisions aimed at reducing or controlling the cost of mental health and chemical dependency services. As discussed earlier, the utilization review provisions of Chapter 601 have resulted in direct cost savings to insurers. The fact that outpatient and residential services are now covered, instead of just inpatient services, has resulted in some extra costs to insurers for outpatient and residential services; but has also helped to ensure that services are delivered in the lowest cost setting appropriate to the patient. Costs have gone up only marginally, while many more people have been reimbursed for services they received. Costs to insurers for inpatient care have decreased as a result of Chapter 601; and costs of chemical dependency services have remained stable.

As mentioned earlier, the proposed increases in benefit levels for children and adolescents, dual diagnosis patients, and residential chemical dependency are expected to add slightly to insurance company expenses. In many cases, however, treatment is currently being received, but the patient is paying the portion of the bill which is not covered by insurance. In such cases, the proposed revisions will simply cause a shift in the payment source, from the patient to the insurer, rather than adding to the overall costs of health care.

In summary, Chapter 601 is designed to ensure that Oregonians have at least the minimum necessary insurance coverage for mental health and chemical dependency problems. While ensuring access to such services, it is also designed to ensure that such services are delivered only when medically necessary, and in the lowest cost setting which is appropriate.

SUMMARY OF RECOMMENDATIONS

As a result of its analysis and the advice of its work groups, the SHPDA is recommending a number of revisions to Chapter 601. These revisions have been explained and analyzed in detail in the section of this report titled "Issues and Problems Related to Implementation."

These recommendations have been incorporated into three bills: SB 30, SB 31 and SB 32. The first bill simply eliminates the current July 1, 1987, sunset date on Chapter 601. The second bill incorporates most of the substantive revisions to Chapter 601. The third bill incorporates our two recommendations relating to inpatient health facility licensure (recommendations number 9 and 10, below).

The SHPDA's recommendations concerning revisions to Chapter 601 are as follows:

1. The sunset on Chapter 601, currently July 1, 1987, should be repealed.
2. Because children and adolescents need longer lengths of stay and higher staffing ratios, they should have higher minimum benefit levels than adults. Minimum required benefit levels for mental health treatment of children and adolescents should be:

Inpatient and day or partial hospitalization	\$10,500 of which only \$3,000 could be used for day or partial hospitalization
Outpatient	\$ 2,000
Overall	\$12,500

3. For chemical dependency, the minimum benefit levels for children and adolescents should be:

Inpatient	\$ 6,000
Residential/day or partial hospitalization	\$ 4,500
Combined total for inpatient, residential, and day or partial hospitalization	\$ 9,000
Outpatient	\$ 1,500
Overall	\$10,500

4. The overall cap for dual diagnosis patients should be \$9,000 for adults and \$12,500 for children and adolescents, rather than \$6,000 as it is now. It should be clarified, for utilization review and program approval purposes, that dual diagnosis is a separate type

of mental health service from either chemical dependency treatment or mental illness treatment.

5. The minimum required coverage level for adult residential chemical dependency services should be increased from \$3,000 to \$3,500.
6. Recommendations related to utilization review by insurers are to:
 - a. Continue to allow insurers to do utilization review if they wish.
 - b. Continue the requirement that SHPDA issue model utilization review criteria, but require that SHPDA revise these criteria every two years, and strengthen existing language in the statute requiring that SHPDA consult with all affected parties.
 - c. Require that reviewers have experience and expertise in the particular area that they are reviewing (i.e., mental health or chemical dependency treatment).
 - d. Allow providers or patients to request prior approval or concurrent review for particular cases, and state that they are entitled to a timely response to such requests.
 - e. Give insurers the option of which type of review they wish to provide, so long as the review criteria are defined and made available to providers. Insurers who elect to require prior approval should make allowances for the admission of emergency cases.
7. Residential, day or partial hospitalization, and outpatient programs should be required to have approval from either the appropriate state agency (Mental Health Division or Office of Alcohol and Drug Abuse Programs) or from one of the nationally-recognized accreditation bodies (JCAH, AAPH, or CARF) in order to be eligible for insurance reimbursement. These requirements would apply whether or not the program is based in a hospital, but for inpatient programs, health facility licensure by the Health Division would continue to be the only program certification required, as it is now.
8. The statute should give the Mental Health Division and the Office of Alcohol and Drug Abuse Programs the authority to approve treatment programs for insurance reimbursement purposes, without requiring that they be a part of a county mental health program.
9. In ORS 442.015(16), "special inpatient care facility" should be a subcategory of "hospital," rather than a separate type of health care facility.
10. Drug abuse facilities should no longer be exempted from licensure requirements. ORS 441.017 should be revised so as to delete this exemption.

11. The definition of day or partial hospitalization should be re-defined to eliminate the current requirement that at least four hours per day, four days per week of care be provided. Program certification standards, rather than any hour-based standard, would be relied upon for such programs. Residential facilities, however, would be required to keep patients overnight and provide at least eight hours of structured programs per day in order to be eligible for reimbursement. Also, it should be clarified that day treatment, partial hospitalization and residential care are all included under the same benefit level. The statute should list each of these three types of care.
12. Detoxification services should continue to be covered under the substance abuse inpatient benefit levels. However, the bill should state that for both mental health and substance abuse services, auxiliary medical or neurological diagnostic or treatment services that are concurrent with, but not directly related to a mental health problem or a normal detox protocol will not be charged to the mental health or substance abuse benefit levels.
13. The cross-reference at the beginning of ORS 743.557(3) and 743.558(3) should be deleted. The intent of this change is to clarify that when reimbursement is paid to an approved program, conditions that would apply to private practitioners (such as physician referral to RCSWs) will not apply to the program.
14. The exemption of group and staff model HMOs in ORS 750.055 should be deleted.

Appendix A

62nd OREGON LEGISLATIVE ASSEMBLY—1983 Regular Session

Enrolled

Senate Bill 522

Sponsored by Senator KITZHABER (at the request of Vernice Paterson)

601

CHAPTER.....

AN ACT

Relating to health; creating new provisions; amending ORS 430.010, 430.021, 430.315, 743.557, 743.558 and 750.055; and prescribing an effective date.

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

SECTION 1. 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" 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 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 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 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 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 2. (1) If a residential program is offered by or through a health facility, it must be either approved by the Mental Health Division or accredited by the Joint Commission on Accreditation of Hospitals.

(2) If an outpatient program is offered by or through a health facility, it must be either approved by the Mental Health Division or accredited by the Joint Commission on Accreditation of Hospitals.

SECTION 3. ORS 430.315 is amended to read:

430.315. The Legislative Assembly finds alcoholism or drug dependence is an illness. The alcoholic or drug-dependent person is ill and should be afforded treatment for [his] that illness. 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. State agencies that purchase treatment for alcoholism or drug dependence shall develop criteria consistent with this policy in consultation with the Mental Health Division and the State Health Planning and Development Agency. In reviewing applications for certificate of need, the State Health Planning and Development Agency shall take this policy into account.

SECTION 4. ORS 430.021 is amended to read:

430.021. (1) The Mental Health Division is responsible for the administration of the state mental health programs and the mental health laws of the state.

(2) The division shall direct, promote, correlate and coordinate all the activities, duties and direct services for the mentally or emotionally disturbed, mentally retarded and developmentally disabled, alcoholic and drug-dependent persons; and promote, correlate and coordinate the mental health activities of all governmental organizations throughout the state in which there is any direct contact with mental health programs.

(3) The division shall develop cooperative programs with interested private groups throughout the state to effect better community awareness and action in the field of mental health, and encourage and assist in all necessary ways community general hospitals to establish psychiatric services.

(4) 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. State agencies that purchase treatment for mental or emotional disturbances shall develop criteria consistent with this policy in consultation with the Mental Health Division and the State Health Planning and Development Agency. In reviewing applications for certificates of need, the State Health Planning and Development Agency shall take this policy into account.

~~[(4)]~~ (5) The division shall establish, coordinate, assist and direct a community mental health program in cooperation with local government units and integrate such a program with the total state mental health program.

~~[(5)]~~ (6) The division shall promote public education in the state concerning mental health and act as the liaison center for work with all interested public and private groups and agencies in the field of mental health.

~~[(6)]~~ (7) The division shall accept the custody of persons committed to its care by the courts of this state.

SECTION 5. ORS 743.557 is amended to read:

743.557. 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) ~~[The policy may limit hospital expense coverage to treatment provided by the following facilities:]~~ 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.

[(a) A health care facility licensed as required by ORS 441.015.]

[(b) A health care facility accredited by the Joint Commission on Accreditation of Hospitals.]

[(c) A rehabilitation clinic and agency established, maintained, contracted with or operated by the Mental Health Division under ORS 430.260.]

(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.

[(3)] (6) Except as permitted by *[subsection (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 *[and the policy shall provide coverage, within the limits of this subsection, of not less than 80 percent of the hospital and medical expenses for treatment for alcoholism]*.

(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.

SECTION 6. ORS 743.558 is amended to read:

743.558. Every insurer offering group health insurance benefits shall *[offer]* 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.

[(1) In the case of benefits based upon confinement as an inpatient in a hospital, the period of confinement for which benefits are payable shall be at least 30 days in any calendar year.]

[(2) In the case of major medical expense coverage, benefits, after the applicable deductible, shall be at a 50 percent rate for covered expenses incurred by the insured while other than an inpatient in a hospital, and benefits shall be available for such expenses during any calendar year up to a maximum of \$500.]

SECTION 7. To facilitate implementation of the amendments to ORS 743.557 and 743.558 by sections 5 and 6 of this Act, the State Health Planning and Development Agency, with technical advice from the Insurance Commissioner, Health Division and the Mental Health Division, and with consultation from affected parties, shall draft, offer for public review, and revise for public distribution, no later than October 1, 1983, an advisory or model set of criteria for appropriate utilization of care in health facilities, residential facilities and outpatient services. These criteria shall be consistent with this Act, and shall not be binding on any insurer or

other party. However, any insurer may, at the time of contract negotiation or amendment, with the agreement of the parties to the contract, adopt the criteria, or similar criteria, with or without modification. In preparing criteria with regard to mental or nervous conditions, appropriate cross-referencing shall be made to the third edition of the Diagnostic and Statistical Manual.

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, exercise 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.

SECTION 9. ORS 750.055, as amended by section 22, chapter 649, Oregon Laws 1981, is further 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, 732.315 to 732.325 and 732.505 to 732.570.

(c) 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.

(d) ORS chapter 734.

(e) ORS 743.003 to 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 [743.558] 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 744.205.

(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.

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

SECTION 10. Sections 7, 8 and 11 of this Act and ORS 743.557, 743.558 and 750.055 as amended by sections 5, 6 and 9 of this Act are repealed on July 1, 1987, except that the amendment to ORS 743.558 (6) by section 6 of this Act is repealed July 1, 1985.

SECTION 11. This Act does not affect a policy issued before the effective date of this Act. However, this Act applies to a renewal or extension of an existing policy on or after the effective date of this Act as well as to a new policy issued on or after the effective date of this Act.

SECTION 12. Nothing in this Act applies to disability policies.

SECTION 13. This Act takes effect July 1, 1984.

Approved by the Governor July 29, 1983.

Filed in the office of Secretary of State August 1, 1983.

Enrolled Senate Bill 522

Appendix B

CHAPTER 124
Oregon Laws 1985
AN ACT

HB 2051

Relating to health planning; amending section 10, chapter 601, Oregon Laws 1983; and declaring an emergency.
Be It Enacted by the People of the State of Oregon:

SECTION 1. Section 10, chapter 601, Oregon Laws 1983, is amended to read:

Sec. 10. Sections 7, 8 and 11, chapter 601, Oregon Laws 1983, [of this Act] and ORS 743.557, 743.558 and 750.055 as amended by sections 5, 6 and 9, chapter 601, Oregon Laws 1983, [of this Act] are repealed on July 1, 1987, except that the amendment to ORS 743.558 (6) by section 6 of this Act is repealed July 1, 1985].

SECTION 2. 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 on its passage.

Approved by the Governor May 22, 1985

Filed in the office of Secretary of State May 23, 1985

NCSL MENTAL HEALTH PROJECT

Materials Check List Mandated Mental Health Insurance

Name: _____

Affiliation: _____ Telephone: _____

Address: _____
zip _____

Please check desired publications/articles/legislation and return form to NCSL.

Articles and Books

- ____ Frank, R.G., and Kamlet, M.S. "Direct Costs and Expenditures for Mental Care in the United States in 1980." Hospital and Community Psychiatry 36:2 (1985): 165-168.
- ____ Goldman, H.H.; Pincus, H.A.; Taube, C.A.; et a;. "Prospective Payment for Psychiatric Hospitalization: Questions and Issues." Hospital and Community Psychiatry 35 (1984): 460-464.
- ____ Lee, F.C., and Schwartz, G. "Paying for Mental Health Care in the Private Sector," Business and Health (October 1984): 12-16.
- ____ Levin, B.L., and Glasser, J.H. "A National Survey of Prepaid Mental Health Services." Hospital and Community Psychiatry 35:4 (1984): 350-355.
- ____ Runck, B. "State Mandates for Mental Health Insurance: What is Their Cost?" Hospital and Community Psychiatry 34:3 (1983): 207-208.
- ____ Scherl, D.J., and English, J.T. "Current Trends in Financing Psychiatric Services: The Initial Response of Psychiatry to Prospective Payment." Psychiatric Annals 14 (1984): 332-339.
- ____ Schlesinger, H.J.; Mumford, E.; Glass, G.V.; Patrick, C.; and Sharfstein, S. "Mental Health Treatment and Medical Care Utilization in a Fee-for-Service System: Outpatient Mental Health Treatment Following the Onset of a Chronic Disease." American Journal of Public Health 73:4 (1983): 422-429.
- ____ Sharfstein, S.S.; Muszynski, S.; and Arnett, G. "Dispelling Myths About Mental Health Benefits." Business and Health (October 1984): 7-11.
- ____ Sharfstein, S.S.; Muszynski, S.; and Myers, E. Health Insurance and Psychiatric Care: Update and Appraisal. Washington, D.C.: American Psychiatric Press, Inc., 1984.

— Taube, C.; Lee, E.S.; and Forthofer, R.N. "Diagnosis-Related Groups for Mental Disorders, Alcoholism, and Drug Abuse: Evaluation and Alternatives." Hospital and Community Psychiatry 35:5 (10984): 452-455.

Legislation Passed

— California (chap. 295) - Requires insurance policies that include coverage for inpatient care for nervous or mental conditions to provide coverage at general acute care hospitals, acute psychiatric hospitals, and psychiatric health facilities.

— Indiana (p.l. 258) - Requires all insurance policies that provide coverage for inpatient mental illness or substance abuse treatment to include coverage for such services provided by a community mental health center or by any licensed psychiatric hospital.

— Kentucky (chap. 482) - Requires all health insurance policies to offer coverage for inpatient and outpatient treatment of mental illness to at least the same extent as physical illness coverage.

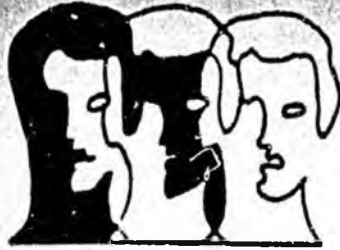
— Maryland (chap. 843) - Mandates that policies covering outpatient mental health benefits provide such coverage at 65% of the cost for the first 20 visits per calendar year or benefit period.

— Tennessee (SJR 310) - Creates a study committee on group insurance benefits for expenses arising from treatment for mental illness, alcoholism, and drug abuse.

— Texas (chap. 805) - Requires group health insurance policies to provide benefits for the necessary care and treatment of alcohol dependency that are not less favorable than for physical illness.

— Texas (SCR 62) - Authorized development of a plan for reimbursement of rehabilitative residential programs in lieu of more costly programs, as private insurers tend to favor hospitalization rather than community-based rehabilitative programs.

— Wyoming (chap. 45) - Provides for freedom of choice of practitioners in private health insurance policies.



MENTAL HEALTH PROJECT

National Conference of State Legislatures

**SELECT ENACTED LEGISLATION RELATING TO
MANDATED MENTAL HEALTH INSURANCE**

May 1987



**National Conference
of State Legislatures**

1050 17th Street • Suite 2100
Denver, Colorado 80265

MANDATED MENTAL HEALTH INSURANCE

SUMMARY OF LEGISLATION

During the past several years, a number of states have passed legislation relating to insurance coverage for mental health. At least two states, KENTUCKY (chap. 482) and TEXAS (chap. 805), passed legislation that requires mental health insurance coverage to be available under present law. Three states, INDIANA (p.l. 260), KENTUCKY (chap. 482), and MISSOURI (chap. 376), expanded the number of eligible service providers who could provide mental health services if an insurance policy offers mental health coverage. At least four states passed legislation to expand the minimum mental health benefits that are presently required by law, including ARKANSAS (act 236), MAINE (chap. 843 and chap. 633), MARYLAND (chap. 843) and WISCONSIN (chap. 29). CALIFORNIA (chap. 295), INDIANA (p.l. 258), MASSACHUSETTS (chap. 380), SOUTH DAKOTA (chap. 419), and WYOMING (chap. 45) expanded insurance mandates to include more mental health service providers or to include more insurance providers. Moreover, at least two states, ILLINOIS (p.a. 84-382) and TENNESSEE (SJR 310), are studying various aspects of mental health insurance during 1985 and 1986.

MANDATED MENTAL HEALTH INSURANCE
LEGISLATIVE SUMMARY

Arkansas

1985 Arkansas Acts, Act 236

Increases minimum coverage for psychiatric care under private health insurance group contracts of disability insurance from \$4,000 to \$7,000 per calendar year.

California

1985 California statutes, Chap. 295

Requires insurance policies that include coverage for inpatient care for nervous or mental conditions to provide coverage at general acute care hospitals, acute psychiatric hospitals, and psychiatric health facilities. This does not prohibit insurers from entering into alternate payment arrangements with providers or from restricting or modifying the choice of providers.

Illinois

1985 Illinois Laws, P.A. 84-382

Creates a Task Force for the study of Long-Term Care Insurance within the Department of Insurance to examine a private market approach to the provision of long-term care insurance. Findings and recommendations of the task force will be reported to the legislature and governor no later than December 31, 1986.

Indiana

1985 Indiana Acts, P.L. 258

Requires all insurance policies that provide coverage for inpatient mental illness or substance abuse treatment to include coverage for such services provided by a community mental health center or by any licensed psychiatric hospital.

1985 Indiana Acts, P.L. 260

Amends individual or group policy of accident and health insurance to entitle a health service provider in psychology for reimbursement of services.

Kansas

1986 Kansas Session Laws, Chap. 174

Amends the coinsurance and deductible provisions of previous mandated benefits. Limits payment to \$1640 in any year and lifetime maximum of \$7500 and makes HMO's subject to mandated benefits, while exempting medigap policies. Also redefines the conditions for which coverage must be provided.

Kentucky

1986 Kentucky Acts, Chap. 482

Requires all health insurance policies to offer coverage for inpatient and outpatient treatment of mental illness for at least the same extent and degree as coverage provided for the treatment of physical illness. Coverage provision also applies to health maintenance organizations.

Maine

1986 Maine Laws, Chap. 633

Requires nonprofit health service plans and health insurers to offer the option of providing benefits for the victims of Alzheimer's disease.

1986 Maine Laws, Chap. 843

Alters the rate at which certain health insurance policies are required to provide benefits for the treatment of acute mental illnesses.

Maryland

1986 Maryland Laws, Chap. 843

Amended mandated health insurance benefits for outpatient mental health care. Mandates that policies covering outpatient mental health benefits provide such coverage at 65% of the cost for the first 20 visits per calendar year or benefit period. Thereafter, coverage reverts back to the 50% of the cost of benefits which the policy provides for other types of illness.

Massachusetts

1986 Massachusetts Acts, Chap. 380

Provides for reimbursement by insurance companies and others for services performed by certified clinical specialists in psychiatric and mental health nursing if the specialist is licensed and is providing services within the scope of the license.

Missouri

1985 Missouri Laws, Chap. 376

Provides extensive regulatory provisions relative to group and individual insurance. In part, measure mandates that group health insurance policies which provide coverage for treatment of alcoholism shall provide coverage whether the insured is in a hospital or in a residential or nonresidential facility certified by the Department of Mental Health.

South Dakota

1986 South Dakota Session Laws, Chap. 419

Revises certain insurance reimbursement provisions and provides peer review for psychologists. Adds psychology to the listing of professions eligible for reimbursement under any insurance policies.

Tennessee

Tennessee SJR 310, passed 1986

Creates a special joint study committee on group insurance benefits for expenses arising from treatment for mental illness, alcoholism, and drug abuse. The findings of the committee will be submitted to the legislature by January 1987.

Texas

S.C.R. 62 - 1985 Legislative Session - passed

Directs the Texas Department of Mental Health and Mental Retardation and the state Board of Insurance to develop a plan for reimbursement of rehabilitative residential programs in lieu of more costly programs, as the lack of adequate funding is a severe barrier to the expansion of community-based services and private insurers tend to favor hospitalization rather than community-based rehabilitative programs.

1985 Texas General Laws, Chap. 805

Requires all group health insurance policies or contracts, including all self-funded or self-insured plans, to provide benefits for the necessary care and treatment of alcohol dependency that are not less favorable than for physical illness generally. Does not apply to those self-funded or self-insured plans with 250 or less employees or members.

Wisconsin

1985 Wisconsin Laws, Chap. 29

In part, changes the mandated coverage of group insurance policies for nervous and mental disorders, alcoholism, and other drug abuse problems. Group

policies must now include the following coverage: total inpatient and outpatient treatment coverage up to \$7000; outpatient coverage up to \$1000 minus a copayment of up to 10%; and inpatient coverage must provide not less than the lesser of either the expenses of the first 3 days as an inpatient in a hospital, or the first \$7000 minus a copayment of up to 10%.

Wyoming

1985 Wyoming Session Laws, Chap. 45

Provides for freedom of choice of practitioners in private health insurance policies. Requires reimbursement for psychologists on the same basis as physicians.

STATE HEALTH REPORTS

MENTAL HEALTH, ALCOHOLISM, & DRUG ABUSE

Intergovernmental Health Policy Project

No. 20 (Special Feature)

January 1986

State Laws Mandating Private Health Insurance Benefits for Mental Health, Alcoholism, and Drug Abuse

Editors Note: This special feature of STATE HEALTH REPORTS ON MENTAL HEALTH, ALCOHOLISM, & DRUG ABUSE examines the current status of state laws mandating private health insurance benefits for mental health, alcoholism, and drug abuse, and the policy context from which they have evolved.

This REPORT was written by Adrienne Lang, Assistant Director for Government Relations at the American Psychiatric Association, from information provided by the Intergovernmental Health Policy Project. Special thanks are also due to Bill Butynski, Executive Director for the National Association of State Alcohol & Drug Abuse Directors, for providing an update on the status of the laws related to alcohol and drug abuse insurance benefits.

This REPORT represents an update of Private Health Insurance Benefits for Alcoholism, Drug Abuse and Mental Illness, a monograph published by IHPP in 1979.

A regular issue of STATE HEALTH REPORTS will be mailed to you very shortly.

I. INTRODUCTION

Traditionally, alcoholism, drug abuse and mental health were viewed as "different" from physical disorders. Causes were mysterious, cures rare and a social stigma was attached to victims. Frequently, the medical establishment treated only the physical problems related to these diseases, while neglecting the less tangible underlying problems.

Recent years have witnessed tremendous growth in public expenditures for alcoholism, drug abuse and mental illness as well as a lessening of the stigma associated with them, and an increase in practical treatment alternatives. Nonetheless, many private health insurers have not expanded their coverage to pay for comprehensive treatment of these diseases. Most private health insurance reimbursement for alcoholism, drug

abuse and mental health is limited to medically-oriented inpatient settings, and few companies pay for comparable benefits in outpatient settings or those staffed by non-medical personnel.

Because of the limited coverage available in the private marketplace, state governments have exercised their regulatory authority over the insurance industry to require expansion of such benefits.

Despite the opposition of health insurers, a number of state legislatures enacted laws in the 1970s requiring them to provide benefits for alcoholism, drug abuse and mental health. Other legislatures enacted less stringent versions of these same statutes, requiring only that health insurers "offer" such benefits to the policyholders at their option. The state laws were enacted for a variety of reasons: to encourage recogni-

tion and treatment of these diseases to the same degree as physical illnesses; to lessen the burden on public programs; to reduce utilization of other medical services because of pseudo-diagnoses or related physical diseases; and to improve the structure of treatment benefits.

This special feature of State Health Reports highlights some of the problems leading to state legislation in this area, analyzes specific provisions of a variety of state laws on the subject, and provides additional detail on costs (where available) and other issues surrounding this public policy question.

II. BACKGROUND

A. Prevalence and Costs

When discussing health insurance benefits for alcoholism, drug abuse and mental illness, it is helpful to consider the extent of these problems in the United States and the resources already devoted to them. According to a recent report prepared for the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) by the Research Triangle Institute¹, the economic burden of alcohol abuse, drug abuse, and mental illness in 1980 was an estimated \$190.7 billion. Alcohol abuse contributed to the major portion of these costs, estimated at \$89.5 billion. The costs of mental illness were estimated at \$54.2 billion and drug abuse at \$46.9 million.

For 1983, total costs to society for ADM of that total, disorders were estimated at \$249.2 billion; alcohol abuse contributed \$116.6 billion, drug abuse accounted for \$59.7 billion and the costs associated with mental illness were \$72.7 billion.

The study also indicated that employees with ADM problems are likely to be less productive than otherwise comparable workers. The reduced productivity impact due to alcohol and drug abuse was estimated to be \$50.6 billion and \$25.7 billion, respectively, or 56 and 55 percent of the total alcohol and drug abuse cost. The study said that reduced productivity due to mental illness was \$3.1 billion; that figure, however, represents only people reporting partial work disability due to severe emotional or chronic

disorders, and does not reflect the costs of the true prevalence of mental illness.

In comparison, mental illness costs \$18.5 billion due to lost employment (complete disability) of its victims, involving incapacitation either at home or in hospitals. Alcohol and drug abuse have lower costs for lost employment at \$4.1 billion and \$312 million respectively.

The ADAMHA study results also indicated that the combined costs for ADM treatment services in 1980 were \$31.6 billion, divided among mental illness (\$21.0 billion), alcohol abuse (\$9.5 billion), and drug abuse (\$1.2 billion). This represents direct health services provided to victims of ADM, including long and short hospitalizations, services from physicians and other sources.

Although the ADAMHA study did not address the issue of public versus private expenditures, other groups have made estimates in this regard. According to the American Psychiatric Association,² in 1980 total mental health care dollars were divided as follows:

- o 25 percent federal,
- o 28 percent state and local,
- o 12 percent insurance,
- o 35 percent private.

An interesting comparison is that in the same year for total medical care, insurance paid 26 percent, while state and local governments paid only 9 percent. Further, the insurance slice of the pie for mental health showed a decrease from 14 percent in 1971 to 12 percent in 1980.

According to a report prepared by the National Association of State Alcohol and Drug Abuse Directors, for FY 84, states contributed 49.5 percent (\$666.9 million) of total funds for alcohol and drug abuse treatment and prevention services, while federal programs contributed 20.7 percent (\$278.5 million), county or local sources 9.7 percent (\$130.1 million) and other sources such as private health insurance and client fees 20.1 percent or \$271.2 million³

B. Impact of the Federal Employee Retirement Income Security Act of 1974 on Mandated Benefit Statutes

A central question to state mandates of any type has been a legal one: do states have the power to require insurance companies to provide a minimum level of coverage, or would the federal Employee Retirement Income Security Act of 1974 (ERISA) pre-empt state laws?

Following enactment of the landmark mandated mental health benefits law in Massachusetts in (1974), the Metropolitan Life Insurance and Travelers Insurance Companies sued the Commonwealth of Massachusetts, contending that the statute violated Section 514(a) of ERISA, which provides that the federal law shall "supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan."

However, the Massachusetts Supreme Court held that the governing section of ERISA is 514(b), which states that ERISA shall not "be construed to exempt or relieve any person from any law of any state which regulates insurance." In June 1985 the U.S. Supreme Court upheld the lower court, finding that the Massachusetts mandated benefit law is a "law which regulates insurance" -- and that therefore there is no pre-emption.⁴

C. Support for Mandated Benefits

An anticipated benefit accruing from improved insurance coverage of alcoholism, drug abuse and mental illness is decreased utilization of medical services for other illnesses and avoidance of more costly levels of care. Patients with chronic illnesses or those recovering from certain surgeries benefit from psychiatric intervention, often with a decline in inpatient days and readmission rates. Admission costs for patients with alcoholism-related complications also improve with psychiatric care. But these outgrowths, called "offset costs," are plausible, but difficult to quantify with any precision.

The difficulty of measuring offsetting costs is evidenced by the widely ranging figures found by Jones and Vischi,⁵ that is, a 5 to 80 percent reduction in medical utilization in cases with psychiatric intervention. Mumford and Schlesinger⁶ have

devoted several studies to the measurement of offset costs. One research study of the effect of mental health treatment as part of post-operative/hospital care among heart attack and surgical patients found lower long-term costs of care for such patients (fewer complications, earlier discharges, fewer readmissions). A new Mumford and Schlesinger report⁷ on 58 studies of effects of outpatient psychotherapy on subsequent medical services showed 85 percent reporting a decrease in such services.

While findings such as these do provide some percentages and measurements, there are other offsetting factors not as easily calculated. McGuire and Montgomery⁸ say that "each of us has a financial stake in the treatment of mental illness." Their point is that the taxpayer and the fellow-employee are indeed paying for the mentally ill, the alcoholic or drug abuser through the criminal justice system, state institutions, absenteeism from the workplace, and unemployment. These very concerns, and the associated state and local pricetags, have been forceful in motivating state legislators to support mandated benefits as a way to shift some of these costs to the private sector.

State laws mandating health insurance coverage for alcoholism, drug abuse and mental illness could alter not only benefits structure but treatment patterns. A classic example is the "revolving door" syndrome of alcoholics who go through detoxification time after time, but receives no follow-up treatment because their insurance covers only the acute inpatient detoxification. Proponents of mandated benefits offer this example to illustrate that coverage of alcoholism treatment episodes not only provides needed therapeutic treatment, but also prevents more costly multiple detoxifications and chronic absenteeism.

D. Opposition to Mandated Benefits

The major opponents of mandated benefit laws are insurers and business/employer groups. Interestingly, unions also tend to oppose mandated benefits. Insurers maintain that mandates stifle competition and innovation; lead to a fragmented health care system; do not guarantee the provision of

necessary and appropriate care; and deny flexibility to employers.

Furthermore, the extent to which such mandates drive up employers' labor costs is concerning a number of state policy makers, who feel many companies may become discouraged from locating or remaining in a state with mandated mental health benefits. For example, New York's commissioner of insurance recently observed that "mandated benefits and increased provider coverage raise the cost of conducting business in New York, thus creating an additional incentive for an employer to abandon New York State. The insurance department recognizes this forces cost increases on employers and opposes all such legislation..." In addition, statutory mandates obstruct flexible benefit plans such as "cafeteria plans," that have become increasingly popular among employees and are designed to permit consumer choice of health care services.

It should be noted, however, that many employers have chosen to self-insure to avoid compliance with mandated benefits laws. Their reason, at least in part, is that ERISA preempts them from state laws regulating health insurance. It has been estimated that as much as 30 percent of the market is self-insuring and they are certainly doing so to avoid increases in their health insurance costs.

In sum, insurers and employers offer a multitude of philosophical and practical reasons for opposing comprehensive health insurance benefits for alcoholism, drug abuse and mental illness. Often, alcoholism and drug abuse are thought of as social problems requiring nonmedical care while mental illness is often perceived of as a disease without clear definition, diagnosis or treatment. Insurers claim it is actuarially difficult to measure risks without a predictable course of illness. The reason underlying all of these perceptions is costs, because health care follows the dollar.

III. PRIVATE HEALTH INSURANCE COVERAGE FOR MENTAL HEALTH CARE SERVICES

A. Overview

Private insurers and employers histo-

rically have not covered mental illness. The growth and development of the insurance industry during the 1930's and 1940's did not encompass either interest in nor coverage of mental illness. Traditional views held that mental illness and its treatment were different from physical illness. The stigma attached to mentally ill patients and their families combined with insurers' and employers' fears of unpredictable (presumed runaway) utilization and costs to make coverage scant. Some growth in benefits occurred following advances in treatment of the mentally ill, including the move away from long-term hospitalization, psychopharmacologic interventions, and new programs of outpatient therapies. Private health insurance was growing tremendously, and by the 1970s, the private sector was called on to share a portion of the financial burden of treating mental illness. At this time a number of state legislatures passed laws mandating mental health benefits in private insurance.

Fearing expensive costs for psychiatric care and regarding mental illness as a subjective disease, health insurers place special limitations on benefits, particularly on outpatient treatment. For example, the coinsurance rate for outpatient psychiatric care is generally 50 percent compared to the usual 20 percent for other illnesses. Several sources attribute the high coinsurance rates to earlier cost experience. When insurance companies initially offered outpatient major medical benefits, they made no distinction between mental and physical illness. As experience accumulated, they found that outpatient psychiatric services constituted a large portion of all ambulatory care costs.⁹

B. Existing Coverage

Coverage today has improved, in part due to state laws mandating benefits for the treatment of mental illness. The Health Insurance Association of America (HIAA), surveyed 36 of its companies and reported virtually all employees in the study (99 percent) had coverage for inpatient treatment of mental illness; of those with coverage, nearly 85 percent had inpatient benefits the same as for other covered conditions.¹⁰

An American Psychiatric Association (APA) survey of 300 private plans found that 100 percent of them provided some level of inpatient and/or outpatient coverage. The breakdown of this coverage shows:

- o 6 percent provided that same inpatient and outpatient coverage as for other conditions;
- o 59 percent provided the same inpatient coverage as for other conditions; reduced coverage for outpatient;
- o 3 percent provided the same outpatient coverage as for other conditions; reduced coverage for inpatient;
- o 31 percent provided reduced coverage for both inpatient and outpatient care.¹¹

The Bureau of Labor Statistics Level of Benefit Studies, which cover a far more comprehensive pool of employees, produced the following data:¹²

- o 99 percent had some level of inpatient coverage;
- o 94 percent had some level of outpatient;
- o 53 percent (a decrease of 5 percent since 1981) cover inpatient care on the same basis as other illness;
- o 7 percent cover outpatient coverage the same as for other illnesses.

The differences in coverage between mental and physical illness are usually explained by deductibles, coinsurance, and day/visit and/or dollar limitations. The APA survey found reduced inpatient benefits were most likely to be associated with small employee groups and Blue Cross-Blue Shield plans. On the outpatient side, while 98 percent of the surveyed plans provided coverage for outpatient mental illness care, only 10 percent provided benefits on the same basis as other illnesses and 90 percent on a reduced benefit basis. The reduced level outpatient benefits are explained by:

- o 69 percent with a higher coinsurance;
- o 35 percent impose maximum charges per visit;
- o 29 percent impose visit limits.

The majority of plans provided coverage at a 50 percent coinsurance rate; the most common "generous aggregate level of benefit coverage, greater than \$1,500 at the 20 percent coinsurance rate, was generally distributed equally," except for Blue Cross Blue Shield plans.¹³

The BLS studies found that the 94 percent covered for outpatient services: 20 percent have a limit on days or visits, 67 percent put a ceiling on dollars, and 53 percent impose major medical coinsurance limited to 50 percent.

C. Model Benefits

Model benefits for mental illness are more difficult to design than for alcoholism or drug abuse, because the latter illnesses have spawned more universal treatment regimens and protocols. The imprecise nature of mental illness, a key factor causing insurers not to cover its treatment, makes any model package elusive. Writers and researchers tend to propose descriptive models, rather than precise packages.

The National Institute of Mental Health contracted with GLS Associates, Inc., to develop model benefit packages as part of a comprehensive analysis of laws that mandate benefits. The GLS report describes three model benefit packages.¹⁴ Because the first, the "ideal" package of nondiscriminatory coverage (i.e., the same as for other illness), is not viewed as viable, it also offers two alternatives.

Alternative one places emphasis on outpatient coverage, restricting coverage of inpatient care to a set number of days, e.g., 30 days. Extended coverage would be provided for services rendered in both private offices and organized settings of care. Diagnoses to be covered under this plan would be generously defined, with limits placed on the number of psychotherapy visits to be covered per year. Those providers considered reimbursable would be the same as in the ideal benefit package, i.e., physicians and licensed psychologists in private offices, all certified/licensed providers in organized settings of care. Copayments and deductibles would be imposed at customary limits, e.g., 50 percent copayments; ceilings would be imposed upon

determination of reasonable costs.¹⁵

The advantages of this model cited in the report increased delivery sites/providers, utilization of outpatient rather than more costly inpatient treatment, and emphasis of the community mental health model. Disadvantages may include lack of coordination of a spectrum of mental health services, and lack of quality control and/or utilization review.

Alternative two, viewed by GLS as having support from providers and insurers, emphasizes inpatient care and catastrophic coverage. Details of this plan include "generous coverage on inpatient days, e.g., 60 days, with outpatient coverage limited to (1) services rendered in organized settings of care, and (2) services rendered in the private offices of psychiatrists or licensed psychologists when referred by a physician. Treatment for disabilities to be reimbursed under this plan would be limited to diagnoses listed in the ICDA code that are amenable to short-term treatment. The providers to be reimbursed in organized settings would be the same as in the other suggested plans, but would be restricted in office settings to physicians or psychologists via referral from other physicians. All providers would be subject to quality of care review by a multi-disciplinary team. Copayments and deductibles would be kept to a minimum level, e.g., 80/20 percent copayments, due to the presence of utilization and cost review mechanisms."¹⁶

D. Costs and Utilization

Both proponents of nondiscriminatory coverage of mental illness and of mandated benefits provide economic arguments supporting their views. Insurers generally agree that claims for mental illness are about 5 percent, of what total claims which is less than expected with the prevalence of mental illness.¹⁷ The GLS study summarizes national utilization patterns under group contracts:

- o There are between 3 and 8 inpatient psychiatric admissions per 1,000 covered persons per year.
- o The average length of stay for a psychiatric inpatient admission is between 10 and 22 days.

- o There are between 30 and 90 inpatient days per 1,000 covered persons per year.
- o There are between 4 and 20 persons per 1,000 eligibles utilizing outpatient services per year.¹⁸

These numbers are a reflection of availability of services and the stigma still attached to mental illness. The utilization of benefits cannot occur absent the benefit or under limitations.

Blue Cross and Blue Shield of Massachusetts studied the impact of that state's statute and found a sharp increase in payments for outpatient mental health claims in 1976, when the mandate was implemented. During the period 1977 through 1982, payments generally peaked in the second quarter, indicating greater utilization prior to meeting the maximum benefit allowance. Psychotherapy services accounted for the major category of payments (about 75%) for group and non-group plans.

The number of psychiatrists reimbursed under Blue Cross/Blue Shield plans has also grown steadily from 1974-1983. In addition, the number of psychologists and social workers practicing in the state has increased even more dramatically due to inclusion of their services under the mandate, so that by 1983, psychologists and social workers providing services under Blue Cross Blue Shield plans in Massachusetts outnumbered psychiatrists.¹⁹

The Center for Health Policy Studies reports the following primary findings regarding 1984 mandated benefit costs for Maryland Blue Cross and Blue Shield:

- o Mandated benefits per member month cost \$5.35, or 11.2 percent of total benefit costs of \$47.96 (for a statistically typical family contract of 3.3 persons annual mandated benefit cost is \$212 out of total benefit cost of \$1,899).
- o Mandated mental and alcohol rehabilitation benefits are \$4.12 per member month, or 8.6 percent of total benefit costs.
- o Mandated outpatient mental benefits are \$2.09 per member month, or 4.4 percent of total benefit costs and 27.2 percent

of total major medical benefit cost.

- o The major components of mandated benefit costs are outpatient mental, inpatient mental, podiatrist and psychologist services.²⁰

Blue Cross-Blue Shield, in testimony before the Maine legislature, said premium for mandated mental illness coverage increased by \$5/month to the average family contract in Kansas, \$2 to \$3/month in Maryland, and \$6/month in Massachusetts.²¹

Offset costs discussed in the introduction are an important component to consider when discussing the costs and utilization of mental illness benefits as are related costs, also discussed earlier. The National Institute of Occupational Safety and Health cites a "conservative" estimate of the costs of executive stress at more than \$19 billion; even its "ultraconservative" figure is more than \$11 billion.²²

In a future book on occupational stress, one corporate view of the need for a continuum of mental health care offers the following "bottom line": "The designing of health benefits is the most critical component of corporate mental health policy. It is through the availability of these benefits that workers and their families gain access to mental health services in the community."²³

E. Current Status of State Laws Mandating Private Health Insurance Benefits for Mental Health Services

Of the twenty-six states regulating mental health benefits in private health insurance policies, fourteen have "mandatory coverage" statutes, which require insurers to pay for mental health care in certain types of insurance policies. "Mandatory coverage" laws exist in Arkansas, Colorado, Connecticut, Maryland, Maine, Massachusetts, Minnesota, Montana, New Hampshire, North Dakota, Ohio, Oregon, Virginia, and Wisconsin. The remaining thirteen states (California, Florida, Georgia, Illinois, Kansas, Louisiana, ~~Massachusetts~~, Missouri, New York, Tennessee, Vermont, Washington, and West Virginia) require only that insurance policies "offer" such coverage at the policyholder's

option. Connecticut, Maryland, and Virginia, have laws with both mandatory and optional provisions.

Of the fourteen states with "mandatory" laws, Arkansas, Connecticut, Maryland, Massachusetts, and Virginia make the "mandatory coverage" applicable to individual as well as group contracts. The other nine laws affect group policies only.

Provisions in "mandatory coverage" laws pertaining to treatment setting are quite significant because this is an area where insurers typically have provided less coverage of mental illness, especially for outpatient care. Of the fourteen laws with mandatory coverage, the majority require treatment benefits for mental disorders be provided in both inpatient and outpatient settings.

Three states (Arkansas, Ohio, Tennessee) mandate coverage only for outpatient care. With regard to inpatient care, most states with mandatory benefits statutes require a minimum of 30 days in a general hospital or another approved facility such as a public-private mental hospital or community mental health center. Four states (Maryland, Montana, Virginia and Wisconsin) require at least 30 days of full hospitalization, while others such as Maine and Massachusetts require a minimum 60 days, and North Dakota, 70 days. Ohio's statute does not specify any inpatient benefit limits, while four states (New Hampshire, Minnesota, Georgia and Louisiana) mandate that mental health coverage be on a par (of equivalent value) with coverage for physical illness generally.

Partial hospitalization benefits are included under the provisions of 10 state statutes. In general, the number of days covered is usually twice the number of inpatient days allowed. Some states, such as Connecticut, have an exchange provision: if a partial hospitalization session costs less than 50 percent of one patient visit, then two sessions of partial hospitalization may be exchanged for one inpatient day; if the cost is greater than 50 percent, then one session of partial hospitalization may be exchanged for one inpatient day. North Dakota and Colorado have similar exchange provisions. Partial hospitalization is only

available as an option in Maryland, and partial hospitalization is included under outpatient benefits in Wisconsin.

Benefits for outpatient care also vary significantly from state to state. Fearing excessive costs associated with coverage for outpatient psychiatric care, most states have included specific limitations on such coverage, resulting in benefits that are far below those provided for physical illness. Thirteen states place a maximum dollar limit on outpatient benefits. For example, the Massachusetts law sets a maximum benefit at \$500 per year, while in New York it is \$700 per year. In 1985, Wisconsin increased its \$500 to \$1000 per year minus a copayment of up to ten percent. Other state laws mandate coverage for reasonable charges with copayments of up to 50 percent (Montana, Colorado) and a maximum dollar limit of not less than \$1000 per benefit period. Maryland's law mandates copayments of up to 50 percent of the benefits provided for other types of illnesses.

Meanwhile, coverage in New Hampshire (for major medical policies only) must contain deductibles and copayments on a par with those for other illnesses, with limits of not less than \$3,000 per person in any consecutive 12-month period, up to a lifetime maximum of \$10,000. Oregon's new statute provides an overall benefit that applies to both inpatient and outpatient mental health care of up to \$9,000 in any consecutive 24-month period, with different benefit limits for other services such as chemical dependency.

In terms of provider eligibility, more states across the nation have passed laws defining the terms for mental health provider reimbursement than have approved mandatory mental health benefits²⁴. A total of forty states have enacted laws defining under what circumstances, certain health providers (e.g., physician, psychiatrist, psychologist, clinical social worker, psychiatric nurse) are eligible for payment for services provided within the scope of their license, training and experience. Of the twenty-six states mandating mental health benefits, twenty-four have such reimbursement provisions. Wisconsin and North Dakota do not have this type of

statute. The majority of states limit private practice coverage to licensed or certified physicians, psychiatrists, and/or psychologists. All of the states include physicians and psychiatrists, while all but two with mandated benefit laws include reimbursement provisions for psychologists.

Furthermore, non-discrimination in reimbursement has also been extended to a variety of other mental health professionals. For example, eleven states reimburse certified clinical social workers, while Maine covers licensed/accredited psychiatric nurses, and Massachusetts and West Virginia include licensed psychotherapists. New Hampshire's law includes payment for licensed pastoral counselors, and Oregon extends payment to nurse practitioners.²⁵

**SUMMARY OF STATE MANDATES OF
MENTAL HEALTH INSURANCE COVERAGE**

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

MA: Mandated Availability
MBP: Mandated Minimum Benefit Package

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

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

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STATE	TYPE OF MANDATE	DATE	INPATIENT	PARTIAL HOSPITALIZATION	OUTPATIENT	POLICIES COVERED	ELIGIBLE PROVIDERS
Montana	MBP	1983	Under basic inpatient expense policies, benefits are no less than 30 days per year. Under major medical policies, no less than 30 days per year and if inpatient benefits are provided beyond 30 days, the durational limits, dollar limits, deductibles and copayments need not be the same as applicable to physical illness generally.	Not specified	Copayment no greater than 50% or the coinsurance factor applicable for physical illness generally, whichever is greater and the maximum benefit for mental illness, alcoholism and drug addiction in the aggregate during the benefit period may be limited to not less than \$1,000.	Group	Psychiatrist, psychologist, social worker, mental health treatment center.
New Hampshire	MBP	1973	Benefits on par with benefits for other illnesses for service in a licensed or general hospital. Major medical coverage may be limited to \$3,000 per individual and a lifetime maximum of \$10,000, per individual. Allowable days not specified.	Partial hospitalization is covered under major medical expenses but the extent of coverage is not specified. Allowable days not specified.	Benefits should be at least as favorable as those which apply to the benefits for the treatment of other illnesses. Non-major medical policies must cover 15 hours of care after the first 2 visits. Allowable days not specified.	Group	Psychiatrist, psychologist, licensed pastoral counselor, mental hospitals, licensed licensed or general hospitals, community mental health center, psychiatric residential program.
New York	MA	1977	30 days per year in a general or mental hospital.		\$700 per year deductibles and coinsurance on par with other benefits.	Group	Psychiatrist, psychologist, social worker.
North Dakota	MBP	1975	70 days per year for a licensed hospital. Each day of inpatient treatment shall be equivalent to 2 days of partial hospitalization.	140 days partial hospitalization per year. Benefits may also be provided for a combination of inpatient and partial hospitalization treatment.	Not specified	Group (more than 50 persons with 70% of group participating)	Psychiatrist
Ohio	MBP	1978	Not specified	Not specified	\$550 per year subject to reasonable deductibles and copays.	Group	Psychiatrist, psychologist, accredited hospital or community mental health facility.
Oregon	MBP	1984	No more than \$7,500 in any 24 consecutive month period for inpatient care and treatment in hospitals. No more than \$3,000 in any 24 consecutive month period in residential facilities. Within this \$3,000 limit, payment shall be made for either full-day supervised residential or part-day treatment.	Part-day treatment on an organized, formal, regularly scheduled basis consisting of at least 4 hours of structured treatment per day, for at least 4 days each week. Shall be no more than \$3,000 in any 24 consecutive period. Within this \$3,000 limit, payments shall be made for either part-day or full-day residential treatment. Part-day treatment less than 4 hours of treatment per day for at least 4 days each week, is covered as outpatient treatment.	No more than \$2,000 in any 24 consecutive month period.	Group	Psychiatrist, psychologist, nurse practitioner, clinical social worker, health facilities, residential facilities or inpatient services.

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STATE	TYPE OF MANDATE	DATE	INPATIENT	PARTIAL HOSPITALIZATION	OUTPATIENT	POLICIES COVERED	ELIGIBLE PROVIDERS
North Dakota	MBP	1975	70 days per year for a licensed hospital. Each day of inpatient treatment shall be equivalent to 2 days of partial hospitalization.	140 days partial hospitalization per year. Benefits may also be provided for a combination of inpatient and partial hospitalization treatment.	Not specified	Group (more than 50 persons with 70% of group participating).	Psychiatrist
Ohio	MBP	1978	Not specified	Not specified	\$550 per year subject to reasonable deductibles and copays.	Group	Psychiatrist, psychologist, accredited hospital or community mental health facility.
Oregon	MBP	1984	No more than \$7,500 in any 24 consecutive month period for inpatient care and treatment in hospitals. No more than \$3,000 in any 24 consecutive month period in residential facilities. Within this \$3,000 limit, payment shall be made for either full-day supervised residential or part-day treatment.	Part-day treatment on an organized, formal, regularly scheduled basis consisting of at least 4 hours of structured treatment per day, for at least 4 days each week. Shall be no more than \$3,000 in any 24 consecutive period. Within this \$3,000 limit, payments shall be made for either part-day or full-day residential treatment. Part-day treatment less than 4 hours of treatment per day for at least 4 days each week, is covered as outpatient treatment.	No more than \$2,000 in any 24 consecutive month period.	Group	Psychiatrist, psychologist, nurse practitioner, clinical social worker, health facilities, residential facilities or inpatient services.
Tennessee	MA	1974	Not mandated	Not mandated	30 visits per year copays and deductibles on par with physical illnesses.	Group, Individual	Psychiatrist, psychologist, community health center with an approved plan for quality assurance, accredited hospitals.
Vermont	MA	1975	45 days per year in a general or mental hospital.	45 day equivalents of active care per year.	100% of the first 5 visits and 80% thereafter up to \$500 per year.	Group	Psychiatrist, psychologist, licensed mental health professional, licensed general or mental hospital or community mental health centers.
Virginia	MBP/MA	1975	MBP: 30 days per year in a mental or general hospital includes benefits for drug and alcohol rehabilitation and treatment with respect to drug and alcohol rehabilitation only. There is an \$80 per day indemnity benefit and a lifetime coverage of 90 days.	Not specified	MA: \$500 per year with reasonable deductibles and coinsurance that are not less favorable than physical illnesses, except that the copayment not exceed 50% up to \$1,000 per benefit period.	Group, Individual	Psychiatrist, psychologist, licensed clinical social worker, mental health treatment center.
Washington	MA	1983					

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<u>STATE</u>	<u>TYPE OF MANDATE</u>	<u>DATE</u>	<u>INPATIENT</u>	<u>PARTIAL HOSPITALIZATION</u>	<u>OUTPATIENT</u>	<u>POLICIES COVERED</u>	<u>ELIGIBLE PROVIDERS</u>
West Virginia	MA	1977	45 days per year in a mental or general hospital; on par with illnesses in a general hospital.	Not specified	50% copayment up to \$500 per year, sessions cannot exceed 50 per year.	Group, Individual	Psychiatrist, psychologist, licensed or accredited general mental hospital, comprehensive health service organization, community center or clinic.
Wisconsin	MBP	1975	Not less than the lesser of either the expenses of the first 30 days as an inpatient in a hospital, or the first \$7000 minus a copayment of up to 10%.	Not specified	Up to \$1000 minus a copayment of up to 10%.		Psychiatrist, psychologist, hospital, residential facility, outpatient treatment facility.

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

MA: Mandated Availability
 MBP: Mandated Minimum Benefit Package

Produced for the APA National Education Program by GLS Associates, Inc., Philadelphia, PA, September 1983.





MANDATED MENTAL HEALTH INSURANCE

Bibliography

General

Blue Cross and Blue Shield of Massachusetts. Special Report: Outpatient Mental Health Benefits Payment Experience. Boston: Blue Cross and Blue Shield of Massachusetts, 1983.

Dyckman, Z, and Balicki, B. Selected Bibliography on State Mandated Mental Health Insurance: Research and Policy Issues 1973-1984. Rockville, Md.: National Institute of Mental Health, 1983.

Frank, R.G. Private Health Insurance for Mental Health Care: Coverage, Costs, and Policy. Baltimore: Johns Hopkins University, 1983.

GLS Associates, Inc. Analysis of State Programs Which Mandate Mental Health Benefits Under Private Health Insurance. Final Report. NIMH Contract 278-78-0040 (MH). June 29, 1979.

Levin, B.L., and Glasser, J.H. "A National Survey of Prepaid Mental Health Services." Hospital and Community Psychiatry 35:4 (1984): 350-355.

Levin, B.L., and Glasser, J.H. "A Survey of Mental Health Service Coverage within a Health Maintenance Organization." American Journal of Public Health 69 (1979): 1120-1125.

McGuire, T.G., and Montgomery, J.T. "Mandated Mental Health Benefits in Private Health Insurance." Journal of Health Politics, Policy, and Law 7 (1982): 380-406.

McGuire, T. and Montgomery, J. Mandated Mental Health Benefits in Private Health Insurance Policies: A Legal and Economic Analysis, Center for Health Studies Working Paper 40, Yale University.

Mitchell, Samuel A. Mental Health Services: The Case for Insurance Coverage. Federation of American Health Systems, February 1986.

Musynski, S.; Brady, J.; and Sharfstein, S.S. Coverage for Mental and Nervous Disorders: Summaries of 300 Private Sector Health Insurance Plans. Washington, D.C.: American Psychiatric Press, Inc., 1983.

National Association of Private Psychiatric Hospitals. Trends in Health Insurance Coverage for Mental Illness. Washington: National Association of Private Psychiatric Hospitals.

National Mental Health Association. "Survey: State Laws Concerning Mental Health Insurance Coverage." In For Ayes Only. Washington, D.C.: National Mental Health Association, 1983.

Patterson, D.Y., and Craig, T.J. "Health and Mental Health Care of the 1980s." Journal of the National Association of Private Psychiatric Hospitals 10 (1979): 12-18

Patterson, D.Y. "The Future of Health Maintenance Organizations." Hospital and Community Psychiatry 33 (1982): 746-749.

Financing/Costs

Craig, T.J., and Patterson, D.Y. "A Comparison of Mental Health Costs and Utilization under Three Insurance Models." Medical Care 19 (1981): 184-192.

Frank, R.G., and Kamlet, M.S. "Direct Costs and Expenditures for Mental Health Care in the United States in 1980." Hospital and Community Psychiatry 36:2 (1985): 165-168.

Frisman, L.K.; McGuire, T.G.; and Rosenbach, M.L. Cost Mandates for Outpatient Mental Health Care in Private Health Insurance. Unpublished manuscript. Boston University Dept. of Economics, 1984.

Hall, C.P. "Financing Mental Health Services Through Insurance." American Journal of Psychiatry 131 (1974): 1079-1088.

Hay Associates. "Hay Associates Model for Determining Cost of Mental and Nervous Care Insurance." Washington, D.C.: Hay Associates, 1981.

Lee, F.C., and Schwartz, G. "Paying for Mental Health Care in the Private Sector." Business and Health (October 1984): 12-16.

McGuire, T. Financing Psychotherapy - Costs, Effects and Public Policy. Cambridge, MA: Ballinger Publishing Company, 1981.

Manning, G., Jr., et al., the Rand Corporation. "Cost Sharing and the Use of Ambulatory Mental Health Services." American Psychologist, October 1984.

Runck, B. "State Mandates for Mental Health Insurance: What Is Their Cost?" Hospital and Community Psychiatry 34:3 (1983): 207-208.

Rupp, A.; Steinwachs, D.M.; and Salkever, D.S. "The Effect of Hospital Payment Methods on the Pattern and Cost of Mental Health Care." Hospital and Community Psychiatry 35 (1983): 456-459.

Sharfstein, S.S., et al. "The Impact of Third-Party Payment Cutbacks on the Private Practice of Psychiatry: Three Surveys." Hospital and Community Psychiatry 35:5 (1984): 478-481.

Prospective Payment

Eisenberg, B.S. "Diagnosis-Related Groups, Severity of Illness, and Equitable Reimbursement under Medicare." JAMA 251 (1984): 645-646.

Frank, R.G., and Lave, J.R. "A Plan for Prospective Payment for Inpatient Psychiatric Care." Hospital and Community Psychiatry 36:7 (1985): 775-776.

- Liptzin, B., Regier, D.A., and Goldberg, I.D. "Utilization of Health and Mental Health in a Large Insured Population." American Journal of Psychiatry 137:5 (May 1980): 553-558.
- Rupp, A.; Steinwachs, D.M.; and Salkever, S. "Hospital Payment Impacts on Acute Inpatient Care for Mental Disorders." A paper presented at the 110th Annual Meeting of the American Public Health Association in Montreal, November 1982.
- Schlesinger, H.J.; Mumford, E.; Glass, G.V.; Patrick, C.; and Sharfstein, S. "Mental Health Treatment and Medical Care Utilization in a Fee-for-Service System: Outpatient Mental Health Treatment Following the Onset of a Chronic Disease." American Journal of Public Health 73:4 (1983): 422-429.
- Sharfstein, S.S., and Taube, C.A. "Reductions in Insurance for Mental Disorders: Adverse Selection, Moral Hazard, and Consumer Demand." American Journal of Psychiatry 139:11 (1982): 1425-1430.
- Taube, C.A., editor. Mental Health Services Use and Demand: A Special Supplement. Health Services Research 21:2 (June 1986).
- Watts, C.A., and Scheffler, R.M. Demand for Outpatient Mental Health Services in a Heavily Insured Population: The Case of the Blue Cross and Blue Shield Associations FEHBP. Working papers. University of California, Berkeley: Institute of Business and Economic Research, 1984.
- Wells, K.B.; Manning, W.G., Jr.; Duan, N.; Ware, J.E., Jr.; and Newhouse, J.P. Cost Sharing and the Demand for Ambulatory Mental Health Services. Santa Monica, Calif.: The Rand Corporation, 1982.
- White, S.L. "The Impact of Mental Health Services on Medical Care Utilization: Economic and Organizational Implications." Hospital and Community Psychiatry 32:5 (1981): 311-319.
- Worthington, N., and Piro, P.A. "The Effects of Hospital Rate Setting Programs on Volumes of Hospital Services: A Preliminary Analysis." Health Care Financing Review 4 (1982): 47-66.

LEGISLATION INDEX DATA ENTRY FORM

Primary Subject H Crossfile A X Crossfile B ---- Crossfile C ----

State MD Chapter/Bill HJR 29 Year 87 Available N

Summary: 1987 Md. Laws, H.J. Res. 29

establishes the Governor's Task Force on Mandated Health Insurance Benefits to investigate the impact of mandated benefits on the people of Maryland and to develop a coherent policy and statutory structure of mandated benefits. The task force is to report to the governor and the Legislative Policy ~~Committee~~ Committee by November 1, 1987.

...be mandated to offer the option of benefits for home health care.

X

PA 1986 Pa. Laws, Act 89 (SB 293) establishes the Health Care Cost Containment Council and authorizes it to contract with a Mandated Benefits Review Panel to review legislative proposals for mandated health insurance coverage or health benefits. The panel is to report to the council about the social and financial impact and medical efficacy of each proposal. The council must report its recommendations about the proposals to specified legislative and executive branch officials.

PA 1986 Pa. Laws, Act 64 (SB 935) requires that insurance policies, excluding Medigap policies, and HMOs provide coverage for alcohol abuse and dependency and specifies that deductibles or copayments for the first instance or course of treatment can be no more than those imposed for

Mandated Mental Health Benefits in Private Health Insurance

Thomas G. McGuire, Boston University, and John T. Montgomery, Department of the Attorney General, Commonwealth of Massachusetts

Abstract. Eleven states mandate coverage of inpatient and outpatient mental health care in private health insurance. Health insurers have objected to these laws on the grounds that they interfere with consumer choice of health insurance benefits and are too costly. This paper analyzes the benefits and costs of mandates for psychotherapy. The potential benefits considered have to do with adverse selection in insurance markets and the offset effects of psychotherapy. Arguments based on economic efficiency are presented to justify the possible appropriateness of overriding individuals' choice of health insurance benefits. Mandates are estimated econometrically to increase the cost of psychotherapy in a state by about 10-20 percent. We conclude that mandates for mental health benefits in private health insurance may be reasonable state policy.

I. Introduction

Many states require insurers to include specified benefits in health insurance policies issued to their residents. Most common are mandated coverage for newborn care (37 states) and for physically handicapped and mentally retarded children (13 states).¹ Eleven states mandate coverage for inpatient and outpatient mental health care.² In general, state specification of the contents of health insurance policies has met some resistance

This research grew out of the authors' work in *Commonwealth of Massachusetts v. The Travelers Insurance Co. and Metropolitan Life Insurance Co.* (Suffolk Superior Court Action No. 355 98, 22 October 1980). The authors were expert witness and lead counsel, respectively, for the Commonwealth of Massachusetts. McGuire's work was partially supported by a grant from the Foundations' Fund for Research in Psychiatry (79-638). This article represents the opinions and legal conclusions of its authors and not necessarily those of the Department of the Attorney General of Massachusetts or of the Foundations' Fund for Research in Psychiatry. Opinions of the Attorney General are formal documents rendered pursuant to specific statutory authority.

We are grateful to AJ Klevorick and two referees for many helpful comments on an earlier draft.

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from insurers, firms, and organized labor; but among the specific categories of benefits, mandates for mental health care have generated by far the most controversy.

Massachusetts is a case in point. Since January 1976, Massachusetts has required insurers: (1) to pay for 60 days of inpatient care per year in mental hospitals; (2) to cover inpatient care in a general hospital for mental conditions at the same level as physical illness; and (3) to pay for outpatient benefits of \$500 per year when provided by a licensed facility, a licensed psychologist, or a physician who "devotes a substantial portion of his time to the practice of psychiatry."³ In a campaign to change the law, Blue Cross and Blue Shield of Massachusetts issued a series of special reports on the cost of coverage under the mandates.⁴ The Blues reported that their payments under group contracts for outpatient mental disorders rose from \$5.5 million per quarter in 1975 (before the mandate), to \$7.0 million per quarter in 1979.⁵ (This is a highly misleading estimate of the "cost" of the mandate, as we will discuss in more detail below). Other insurers in Massachusetts simply refused to offer the coverage. Metropolitan Life Insurance Company, and Travelers Insurance Company have only recently begun compliance with the statute under an injunction issued in a lawsuit filed by the Massachusetts Attorney General in June 1979.⁶

Mandates for mental health coverage have been subject to legal challenge in Maryland and New Hampshire. Other states are considering whether to implement or to remove mandates for mental health services. Given the emerging importance of state mandates in health policy, and special concerns about mandates for mental health care, it seems appropriate to consider whether mandates for mental health care represent good law and good policy.⁷

A state is constitutionally permitted to interfere with insurance contracts only if the regulation serves a legitimate state interest in the health and welfare of its citizens. (For a summary and evaluation of legal challenges to mandated mental health benefits, see Appendix A.) In the jargon of policy analysis, this might be cast as a question of the benefits—or perhaps of the relative costs and benefits—of the mandates. Courts are, of course, ill-equipped to make these comparisons; and indeed, in the absence of convincing evidence to the contrary, courts generally presume that legislative bodies have acted in the public interest. It is on the basis of this presumption that legal challenges to state mandates have failed.⁸

This paper discusses the benefits and costs of mandated mental health benefits independent of the presumption that the current policy in a state has special status. Section II presents the arguments why adverse selection in insurance markets, and external or offset effects of psychotherapy may justify mandates. Section III, based upon the experience of states

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with mandates, estimates the cost of mandated coverage for psychotherapy. Conclusions are drawn in Section IV.

II. The Benefits of Mandated Mental Health Insurance

The obvious effect of a mandate is to *force* people to buy insurance for mental health coverage. Why should the state force purchase of mental health coverage, when, without a mandate, an individual or group of individuals is free to negotiate its purchase with an insurer? If markets for mental health insurance coverage function well—in particular, if sellers of insurance price at cost, and if buyers of insurance are well-informed and accurately take into account the benefits to themselves and others in their decisions to purchase—then the policy of state interference with exercise of individual choice in insurance markets has little appeal. There are reasons to think, however, that markets for mental health insurance do not fully meet these exacting standards. Consideration of shortcomings in the market for mental health insurance, and how these relate to the case for mandated coverage, is the task of this section.

Two potential problems with markets for such insurance—both correctable by mandates—readily come to mind. The first is that individuals, or groups acting on behalf of individuals, may be ignorant of or unwilling to recognize the benefits of mental health services and insurance coverage. Prejudice against treatment for mental conditions has been widely noted.⁹ Mandates counter any tendency to undervalue mental health services. In a state with a mandate, the health insurance plan automatically “subsidizes” an individual’s purchase of mental health services. Second, many citizens may be concerned that everyone have access to mental health care. Mandates may reflect a general belief in a state that all should have the ability to pay for a minimum level of mental health services (whether or not they would choose to do so).

Although these two issues may be quite important for policy, little more can be said about them. Their importance is difficult to assess without evidence, first on the extent to which individuals are ignorant of or deny the benefits of mental health services, and second on the degree of concern for others’ access to mental health care. For the rest of this section, therefore, we discuss in detail two additional arguments for mandates for which more evidence is available. These arguments are based on the problem of adverse selection in insurance markets, and on the offset effects of psychotherapy.¹⁰

Adverse selection

Insurance is priced according to the average behavior of groups. Prices or premiums will be the same for all members of a union, residents of a

state, or some members of a smaller group; the fact remains that the insured are in good health, that the insurance premium

The premium is the sense that costs, including risks in the group premium, then risks. As a consequence to “buy coverage selection” its according to the average range

Note that the unwilling to pay incur by coverage too high because degrees of risk voluntary system

Adverse selection provided in a will be led to risk to be self-defeating. policyholders among the best. Raising the premium and to higher cost the insurer can at that premium efficiently risk-averse equals actuaries

Competition of adverse selection to some of trying to attract carrier’s policy lower premium as they desert original insurance cutting coverage pool, starting :

state, or some other group in which an individual is classified. Often, the members of a large group will be sub-classified for pricing purposes into smaller groups by age, sex, and health at the time they select a policy. But the fact remains that among, say, all Massachusetts males aged 40-50 in good health, there will still exist significant differences in the degree of risk that the insurer incurs with each individual policy, even though the insurance premium for each member of this group must be identical.

The premium charged to the good risks in a pool is thus "too high" in the sense that it exceeds the premium the insurer must charge to cover costs, including administrative cost and return on investment. For the bad risks in the group, the premium is similarly "too low." Coverage at this premium, then, is a bad buy for the good risks, and a good buy for the bad risks. As a consequence, in a voluntary system the good risks will decline to buy coverage more frequently than the bad risks. This gives "adverse selection" its name: in a voluntary system, when premiums must be set according to the behavior of groups, an insurer draws not the typical or average range of group members, but an "adverse selection" of the risks.

Note that the good risks may not be declining coverage because they are unwilling to pay a premium equal to the expected costs an insurer would incur by covering them. They are declining coverage at a premium that is too high because of the insurer's inability to discriminate fully among degrees of risk. The preferences of the good risks are frustrated by a voluntary system that presents them with inappropriate prices.

Adverse selection can severely limit the amount of insurance coverage provided in a market. The insurer drawing an adverse selection of risks will be led to raise premiums to cover costs, a pricing strategy that is likely to be self-defeating. As premiums are raised in a voluntary system, some policyholders will drop their coverage. Those who do so will tend to be among the better risks of the group that chose coverage in the first place. Raising the premium thus leads to a further deterioration in the risk pool and to higher cost per insured. In the extreme, there may be no premium the insurer can set to cover costs for those who would choose coverage at that premium. This may be true even when all consumers are sufficiently risk-averse that they would buy coverage at expected cost, which equals actuarially fair premiums plus the usual industry loading charge.¹¹

Competition among carriers can further darken the picture in the presence of adverse selection. Suppose a carrier has been able to sell insurance to some part of a population. A competitor may adopt the strategy of trying to attract the good risks from among those who chose the first carrier's policy. This can be done by offering slightly less coverage at a lower premium. The good risks are more likely to find this attractive, and as they desert the original carrier they undermine the viability of the original insurance package. The first carrier may be forced to react by cutting coverage in order to avoid being stuck with the poorest risks in the pool, starting a new cycle of coverage reductions.¹²

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Adverse selection is present to some degree in all markets for insurance. It is more serious in some situations than in others. The essential ingredients for adverse selection are two. First, premiums must be set for a group, a condition which is virtually always met. Second, members of the group must differ in their degree of risk, they must *know* that they differ, and they must be prepared to act on their knowledge. This second ingredient is present in many of the categories of mandated coverage. Consider the most commonly mandated coverage, services to newborns. These expenses can be a significant financial risk, against which policyholders would presumably be willing to insure. The problem is that many people who are going to have children plan for it in time to select the most favorable coverage. Suppose one insurance company offers coverage for newborn care and a competitor does not. All those subscribers planning families (the "bad risks") will choose the first policy, while those who do not anticipate having children (the "good risks") will choose the competitor's policy. Any insurer venturing unilaterally into covering newborn care will attract a disproportionate share of the bad risks. The crucial second ingredient is present in coverage for mental health services as well: people differ widely in the likelihood that they will use mental health services, and many seem to have a good idea of the likelihood that they will use the benefit.

The problem of adverse selection presents itself in another way when the individual does not make a direct choice of health insurance coverage, but is included automatically in a group plan offered through employment. When employees know they differ in risk and pay the premium appropriate for the average group member, there is likely to be a substantial majority of members of the employee group opposed to mental health benefits, even if all employees would be in favor of coverage if the benefit were priced according to each individual's risk. Riders for mental health benefits may be rejected by representatives of the "good risk" majority asked to pay prices above their actuarial cost.

Evidence of adverse selection may appear when individuals are observed making choices among options for insurance coverage. Federal employees are served by the widest choice among health insurance options of any major group of employees in the U.S., and their behavior is one of the few sources of evidence for adverse selection. Federal employees choose among two Blue Cross/Blue Shield plans and an Aetna plan that are offered nationally, and, within any region, among local plans including health maintenance organizations. During the early 1970s both Aetna and Blue Cross/Blue Shield featured very generous coverage for outpatient psychotherapy, equal to coverage for ambulatory medical treatments. Aetna's plan, not confined to "usual, customary and reasonable" reimbursement levels, offered the most generous coverage. In a

review of its 1973. Aetna's federal employees received twenty visits for mental disorders. Many responded by year after Aetna's benefits going four years.¹⁴ outpatient psychotherapy fit. There can be no insurance coverage

Adverse selection by the state. It is for the service because no one is victimized by the state by forcing prevention of the coverage below a mandate. The state is taking steps to approximate the risk of each employee closely approximated by working

The mandate without its price of a market to be. Second, although it would have provided coverage must be paid by people. Thus some people they would ratify the fact that it would have been the mandate for risks. This is judged on efficiency that mandates will be

review of its claims experience for mental and nervous conditions for 1973, Aetna attributed its high costs to drawing an adverse selection of federal employees.¹³ Aetna's response to this was to impose a limit of twenty visits per year on its outpatient coverage for mental and nervous disorders. Many of the "bad risks" among federal employees apparently responded by leaving the Aetna plan and migrating to Blue Cross. In the year after Aetna's cut in benefits, Blue Cross saw the percentage of total benefits going for psychiatric care jump significantly for the first time in four years.¹⁴ More recently, Blue Cross has reduced its coverage for outpatient psychotherapy by increasing the coinsurance rate for this benefit. There can be no doubt that adverse selection led to a reduction in the insurance coverage for psychotherapy for federal employees.

Adverse selection presents an opportunity for constructive intervention by the state. It may well be that everyone would buy reasonable insurance for the service in question—for example, mental health care—but cannot because no insurance company could offer such insurance without being victimized by adverse selection. The government can improve the situation by forcing all insurers to offer a minimum level of coverage, and thus preventing them from competing to attract only the good risks by reducing coverage below this amount. Adverse selection changes the perspective on a mandate. Far from violating consumer sovereignty, the state may be taking steps to implement it.¹⁵ The state mandate may more closely approximate the result that would have occurred in a market had insurers been able to price their product in accordance with the appropriate degree of risk of each enrollee. Everyone may be "forced" to buy coverage more closely approximating that which they would have bought had markets been working well.

The mandate "solution" to the problem of adverse selection is not without its problems, however. First, how does one know, in the absence of a market test, that the state has mandated the correct level of benefits? Second, although mandated benefits may give people the coverage they would have purchased had markets been pricing efficiently, the mandated coverage must be financed by the usual system of pricing, where some people pay more than is justified by their likely costs and some pay less. Thus some people (the good risks) will feel imposed upon by this mandate: they would rather have the money than the coverage. This does not negate the fact that they are still getting the efficient coverage (that which they would have bought had prices been correctly set); but it does indicate that the mandate distributes the financing of that coverage in favor of the bad risks. This redistribution from the "healthy" to the "sick" cannot be judged on efficiency grounds, but only on political grounds: it is a redistribution that may not be objectionable. Finally, the intention of the mandates will be frustrated if people decline to buy health insurance after a rise

in premiums caused by mandates. Although it seems highly doubtful that the added cost imposed by a mandate would lead many individuals to forego insurance against health costs, mandates may be contributing to a trend toward self-insurance among large firms, since employer self-insurance plans are sheltered from direct state regulation by the Employee Retirement Income Security Act of 1974.

"Offset effects" of psychotherapy

For a market to work well, a consumer should take into account all of the benefits from purchase. If the consumer receives directly only part of the total benefits accruing to society, then he or she underestimates the social value of the purchase and may not buy "enough." In these circumstances, society may want to step in to encourage the individual to buy more, either by subsidizing purchase of the service or by requiring the individual to buy a certain amount.

There can be little doubt that the benefits and costs of treatment for mental illness extend beyond the individual "consumer" of mental health services—beyond the patient and his or her family. One obvious way in which some benefits of treatment for mental conditions are external to a patient is when others care about his or her well-being. But although compassion may play a large role in mental health policy, we will stress here another external benefit of mental treatment, the so-called "offset effect" resulting from mental health treatment and particularly from psychotherapy. Our society's system for funding medical and other social services means that every individual's decision about treatment has financial implications for many other people.

We pay collectively for treatment of mental illness. In 1975, 800,000 mentally ill were treated in mental hospitals, 900,000 in general hospitals, 350,000 in VA hospitals, 200,000 in nursing homes, and 13,000,000 by physicians other than psychiatrists, at a total cost of about \$15 billion.¹⁴ Mental illness is also dealt with by various social agents other than health personnel, including police and welfare agencies. Taxes support social services and VA hospitals; taxes and insurance premiums together pay for 90 percent of hospital expenses and 70 percent of physicians' charges. Even productivity lost due to mental illness is borne in part by all workers in the form of lower wages. It is simply incorrect to think that any individual can avoid paying part of the cost of mental illness. Our collective method of payment for most of health and social services builds in interdependencies. Each of us has a financial stake in treatment of others' mental illness.

An "offset effect" occurs when use of mental health services leads to a reduction in use of other health or social services. The existence of offset

effects can be between mental health and other social problems. Mental health problems and symptoms and patients' problems are often reciprocal. Little value is added by the solution on mental health who see a doctor problem, and their feeling compensated by the appropriate. The patient is trained to be a treatment of the illness may discussion of possible offset

Although offset effects have no interrelation to failed even to medical costs found evidence and mental health reduction in short-term problems. But for the existence of a well-established mental health utilization to most treatments

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effects can be anticipated based on the well-recognized interrelationships between mental health and general health, and between mental health and other social problems. Mechanic, for example, has observed: "[Mental health] problems are common and are often associated with physical symptoms and discomforts. . . . The distress associated with these patients' problems triggers a demand for medical services, and such patients are often recipients of intensive medical and surgical care that achieves little value."¹⁷ Epidemiological data reported by the President's Commission on Mental Health (PCMH) show that at least 6 percent of the people who see a doctor other than a psychiatrist have a primarily psychological problem, and many more have psychological problems contributing to their feeling of ill health.¹⁸ Sometimes these people are treated appropriately by their physicians, but sometimes the treatment is not appropriate. The PCMH concludes that most physicians are not adequately trained to be able to recognize and treat psychological problems. Direct treatment of the psychological problems and the psychological component of illness may lead to fewer demands on the rest of the health system. In discussion of mandates for coverage of \$500-\$1000 of services, it is the possible offset effects of short-term psychotherapy that are relevant.

Although offset effects seem highly plausible, their quantitative magnitudes have not been established. Indeed, in spite of the established clinical interrelation between health and mental health, the research literature has failed even to establish unambiguously the *existence* of an offset on other medical costs. In a thorough discussion of the literature, Jones and Vischi found evidence for offset effects in 24 of 25 studies of alcohol, drug-abuse, and mental health treatment, with magnitudes ranging from 5 to 80 percent reduction in medical utilization.¹⁹ Virtually all of those studies were of short-term psychotherapy. Near unanimity is rare in a research literature. But for the deficiencies in the research designs of these studies,²⁰ the existence of an offset effect of short-term therapy would be regarded as well-established. In addition, the research investigating offsets has, primarily, been confined to health maintenance organizations, community mental health centers, or clinics in industry. The response of medical utilization to psychotherapy provided in the fee-for-service sector, where most treatment occurs, may be different.²¹

In interpreting this evidence for offsets, it is important to keep in mind the different perspectives the scientist and the policymaker or legislator must bring to the question of evidence. Science is very conservative. For evidence to provide convincing support for a new idea, such as the idea that treatment for mental conditions reduces other health costs, the researcher is required to exclude other possible explanations for the effect by the use of "controls" in the study, and to reduce the possibility that the effect could have been the result of chance variation in the sample to less

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than 5 percent. If these criteria are not met, scientists remain skeptical of the hypothesis. This is appropriate when the activity in question is "hypothesis testing."

Legislatures, for their part, have less interest in hypothesis testing. They need to know if an idea is *likely* to be correct, rather than whether an hypothesis can be accepted within standards of scientific evidence. It would be a far too conservative approach to legislative action to require that all policies be demonstrated to be effective to the usual standards of scientific proof.

Adopting the perspective of the lawmaker, how likely is it that offset effects exist? First, before any explicit empirical tests of offset are considered, there are powerful reasons, related to the nature of physical and mental illness and the reasons people seek medical care, to expect offsets to exist. Second, although no one study fully meets scientific standards for research design, as a body of work the offset studies should probably be given considerable weight. Although design flaws generally had the effect of biasing findings in favor of finding an effect, other problems in these studies—notably problems associated with measurement error—tend to bias the results against a finding of offset.²² Efforts to improve research methodology should certainly proceed; but, in the meantime, it is reasonable to expect that psychotherapy leads to some reduction on other medical costs.

To sum up the discussion in this section, adverse selection and offset effects of psychotherapy may mean that too little insurance for mental health services would be purchased when choice of insurance is voluntary. In the case of adverse selection, this is because insurers are incapable of pricing insurance for mental health to reflect an individual's true expected cost. Premiums are "too high" for many people, inappropriately discouraging purchase. In the case of offset effects, the mandate, by providing insurance, serves to subsidize an individual's purchase of a service which yields financial benefits to others.

III. Costs of Mandated Mental Health Benefits

The most frequent argument against mandates for mental health benefits is that they would be costly. Of particular concern is the cost for coverage of outpatient psychotherapy. Research on the influence of insurance on demand for psychotherapy supports the fear that introduction of insurance coverage would lead to large increases in use of psychotherapy. In a review of the limited literature on financing and demand for mental health services, McGuire concluded that the price-elasticity of demand for

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psychotherapy is probably between one and two.²³ Research on the elasticity of demand for psychotherapy is of little direct help in estimating the costs of mandates, however, since a central feature of all mandates is a limit on the total coverage—usually \$500. A study of the outpatient mental health utilization of enrollees in the Blue Cross and Blue Shield Plan for Federal Employees found that cutting off coverage at 10 visits (corresponding roughly to \$500 of coverage) was a very effective check on demand, eliminating 74 percent of the covered visits.²⁴ Strict limits on coverage were probably made part of mandate legislation because of fear of large cost increases. In addition, strict limitations on coverage can be justified by reference to the literature on the effectiveness of psychotherapy, which provides stronger support for short-term therapy.²⁵

Specific estimates of the cost of mandates for mental health have, to date, been derived from the experience of insurance carriers. In 1979, Blue Cross and Blue Shield of Massachusetts covered about 3,000,000 persons and paid out about \$29,800,000 per year for outpatient psychotherapy. An estimate of the gross cost of the outpatient portion of the mandate to Blue Cross and Blue Shield, based on those figures, would be about \$10 per person per year. It has been difficult to put together comparable estimates for costs to third-party payers in other states. GLS Associates have recently completed a study of mandates for the National Institute of Mental Health, but they were unsuccessful in attempts to extract data on costs from insurers.²⁶

There are numerous reasons why it can be misleading to focus on costs to an insurer when evaluating the cost of a mandate. First, costs of psychotherapy are rising everywhere, with or without mandates, both because of increases in demand for psychotherapy and because of increases in the price of care. Some part of the cost increases seen in Massachusetts before and after the mandate would have occurred anyway, even if the mandate had not been imposed. General trends cannot be separated from impact of the mandate in data reported by a single insurer. Second, in addition to increasing costs, a mandate shifts the locus of the final payment for costs. There is a shift from out-of-pocket payments to payments by insurers, and a shift from the state (which may support mental health services in community agencies) to insurers. Although these shifts may be significant, they do not represent net increases in costs due to the mandates, only shifts in the way these costs are finally paid. Finally, focusing on a single insurer ignores any impact on cost of switches in contracts from one insurer to another after a mandate.

The true cost of the mandate is the increase in resources being used in a state because of the mandate. In the remainder of this section, we compare the experience of states with and without mandates in order to estimate the net increases in use of outpatient psychotherapy due to the

mandates. Our method takes advantage of the following relationship: if passage of a mandate has led to a large increase in the amount of psychotherapy consumed by a population, then there must have been a correspondingly large increase in the amount of psychotherapy supplied by mental health professionals, primarily psychiatrists and psychologists.

Table 1 compares the rates of growth in the numbers of psychiatrists and child psychiatrists in office-based practice between 1976 and 1978 in states that did and did not pass a mandate between 1974 and 1976. Although changes in the stock of providers will not be identical to changes in the flow of services, the two changes ought to be closely related. The purpose of the comparison is to see whether recent passage of a mandate is associated with unusually large increases in the number of psychiatrists. As the table shows, in states recently passing a mandate the rate of growth of psychiatrists was about 7 percent higher than in other states. This estimated difference is small, however, in relation to the general variance in growth rates, so it cannot be concluded with confidence that the passage of mandates had any effect on the growth in numbers of psychiatrists.

Table 1. Percentage Growth in Numbers of Psychiatrists and Child Psychiatrists in Office-Based Practice, 1976 to 1978

	Mean Percent Growth ^b	Standard Deviation
Group 1: States (7) putting mandates into effect between 1974 and 1976 ^a	31.1	38.5
Group 2: Other states (43)	23.6	31.9
All states	24.7	32.5

t-statistic testing difference of means between group 1 and group 2:
 $t = .526$, insignificant at 10% level in a one-tailed test.

a. Colorado (1976), Maryland (1974), Massachusetts (1976), Minnesota (1975), New Hampshire (1975), North Dakota (1975) and Wisconsin (1975). Connecticut passed a mandate in 1971, and is included in Group 2.

b. Differences in growth were reduced when states in each group were weighted by 1978 population. The results for this comparison were:

	Mean Percent Growth	Standard Deviation
Group 1	20.0	19.9
Group 2	15.7	15.0
All states	16.1	15.7

Source: AMA, *Physician Distribution and Medical Licensure in the U.S.*

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Table 2 makes a similar comparison for psychologists (actually, members of the American Psychological Association who identify themselves as health service providers).²⁷ Recent passage of a mandate is associated with a much higher growth in the number of psychologist health service providers—51 percent vs. 19 percent—and this difference is statistically significant. It is not surprising that supply of psychologists is more responsive to a mandate than supply of psychiatrists.²⁸ It is much more common for psychiatrists' services to be covered in health insurance policies in the absence of mandates; thus a mandate requiring coverage for services of both professionals will increase the amount of insurance coverage much more dramatically for the services of psychologists in the state. Also, the supply of psychologists as health service providers may be more responsive in the short run than is the supply of psychiatrists. Although

Table 2. Percentage Growth in Numbers of American Psychological Association Health Service Providers, 1976 to 1978, in States With Population 2,000,000 or Greater as of 1976

	Mean Percent Growth ^a	Standard Deviation
Group 1: States (5) putting mandates into effect 1974 and 1976 ^a	51.0	8.8
Group 2: Other states (27)	19.4	25.5
Groups 1 and 2	31.4 24.3	26.3

t-statistic testing difference of means between group 1 and group 2:
 $t = 2.44$, significant at the 5% level in a one-tailed test.

a. Colorado (1976), Maryland (1974), Massachusetts (1976), Minnesota (1975), and Wisconsin (1975).

b. When states were weighted by 1978 population, the results changed little:

	Mean Percent Growth	Standard Deviation
Group 1	49.9	8.0
Group 2	20.5	18.1
All states	23.7	19.6

Source: American Psychological Association. Human Resource Surveys for 1976 and 1978. The Human Resource Survey is a weighted sample of 10,000 psychologists. Weights and sample response are taken into account in our estimates of percent growth. Growth in small states cannot be reliably estimated from this information so they are dropped from the comparison. In addition, there is no data on psychologists in Florida for 1976 so this state was also not included.

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most psychologists who provide health services have training in clinical or counseling psychology, such specialization is not required to obtain a license or certification. Psychologists with other backgrounds and experience may shift into clinical practice as the opportunities there are widened by increased insurance coverage.²⁹ Unfortunately, data are unavailable to make this comparison for other mental health professionals who may provide psychotherapy under supervision of a psychiatrist, especially psychiatric social workers.

Mandates, are, of course, only one of the factors that influence the utilization and cost of psychotherapy within a state. In principle, one would want to estimate a system of equations for the demand and supply of psychotherapy, with the presence of a mandate in a state being one of the variables affecting demand. Estimation of such a system is beyond the scope of this paper.³⁰ We have, however, estimated reduced form equations for services of psychiatrists and psychologists, reported in Table 3. The dependent variable is the logarithm of hours of fee-for-service practice by psychiatrists and psychologists per 1000 (non-HMO) population in 1978. The logarithm form was chosen so that independent variables would have the same estimated percentage effect in every state. The independent variables are expected to influence the demand for psychotherapy, or the attractiveness of a state to providers (or in some cases both). There is, of course, no price variable in the reduced form.

Regression equations (2) and (4) were estimated with data for the 38 states with 1,000,000 or more people in 1978 (to eliminate states with unreliable estimates of psychologists' services). We will be primarily concerned with equations (1) for psychiatrists and (4) for psychologists. Equations (2) and (3) are presented for purposes of comparison.

The first thing to notice about the results in Table 3 is the high explanatory power of the regression equations, one important indication that the relationship specified between the dependent and the explanatory variables is a reasonable one. Percentage of the population living in metropolitan areas, percentage of the population with at least four years of college, per capita income, and the log of the number of psychiatric beds per thousand population are intended to control for the demand characteristics of individuals in a state and for the attractiveness of the state to mental health professionals. No specific interpretation is attached to the estimated coefficients for these variables. Notable, however, are the powerful impacts of high levels of education and unemployment on use of psychiatrists' services.³¹

Three reimbursement and regulation variables were included in the equations. They are the percentage of state population in the Federal Employees Health Benefits Plan (FEHB) or in the Civilian Health and Medical Plan for the Uniformed Services (CHAMPUS), whether the state

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had a freedom-of-choice (FOC) law in effect in 1978, and whether the state had a mandate in effect in 1978.

The FEHB and CHAMPUS plans together enrolled about 15 million individuals and featured (with the exception of some of the smaller carriers in the FEHB) generous coverage for outpatient psychotherapy in 1978. In the case of psychiatrists the estimated effect of this variable is near zero.

An FOC law requires an insurer offering coverage for mental health services to pay licensed or certified psychologists directly and independently of a physician for services psychologists are qualified to provide under state law. One might have predicted that an FOC law would lead to more psychologists' services in a state, and, because of potential competition between psychologists and psychiatrists, to fewer psychiatrists' services. This hypothesis is not borne out by the regression results shown in Table 3: the presence of an FOC law has a positive estimated effect on services of psychiatrists.³²

Our major interest is in the estimated effect of mandates. According to equation (1) of Table 3, mandates are associated with a 12 percent higher use of services of psychiatrists in fee-for-service practice. The t-statistic of 1.33 on this estimate is, however, not statistically significant by the usual standards. In the smaller sample of 38 states, the estimated impact of mandates is about 10 percent.

All three regulation and reimbursement variables—percent of population in FEHB or CHAMPUS, the existence of FOC law, and mandates—are estimated to have a positive effect on the use of psychologists' services in fee-for-service practice. The t-statistics are largest for the mandate variable, but even these indicate inaccuracy in the point estimates and only justify low levels of confidence in the hypothesis of positive effect of mandates. According to the estimated coefficients, the presence of a mandate increases the use of psychologists' services by 18–25 percent.

These results suggest two generalizations about the effects of mandates on the use of psychotherapy in fee-for-service practice. First, the impact of the mandates is greater on the practice of psychologists than on the practice of psychiatrists. The point estimates of the effect of mandates in equations (3) and (4) are roughly twice the point estimates in equations (1) and (2). This is as we would expect, since a mandate typically changes insurance coverage for psychologists much more than for psychiatrists. (It should be kept in mind, however, that these coefficients are not estimated precisely; the difference between the two estimates would not pass standard tests of significance.) Second, the mandate appears to increase the use of psychotherapy in fee-for-service practice about 10–20 percent (although this estimate, too, is not precise).³³

Table 3. Determinants of Use of Psychiatrists' and Psychologists' Services in Fee-for-Service Practice, 1978^a (t-statistics in parentheses)

Independent Variables	Psychiatrists		Psychologists	
	50 States	38 States ^b	50 States	38 States ^b
	(1)	(2)	(3)	(4)
Percent of population in SMSAs, 1976	.00623 (4.24)	.0283 (1.21)	.00309 (0.92)	-.000165 (0.05)
Percent of adult population with 4 yrs. college, 1976	.110 (6.78)	.112 (5.31)	.0600 (1.61)	.0683 (2.37)
Log of per capita income (in thousands), 1978	-.423 (1.36)	.438 (0.89)	1.12 (1.56)	1.58 (2.36)
Percent unemployed, 1976	.0806 (4.13)	.0660 (3.06)	.0614 (1.37)	.060 (2.03)
Percent of population in FEHB or CHAMPUS, 1978	-.00516 (0.58)	-.00129 (0.14)	.0175 (0.85)	.0137 (0.78)
FOC law (0,1), 1978	.147 (2.08)	.0648 (0.77)	.174 (1.07)	.123 (1.07)
Mandate (0,1), 1978	.123 (1.33)	.0918 (0.88)	.249 (1.18)	.180 (1.26)
Log of psychiatric beds per thousand, 1976	.105 (1.44)	.154 (1.72)	.104 (0.62)	.171 (1.40)
Constant	1.54	.143	-1.11	-1.78
R ²	.853	.866	.500	.756
F	29.84	23.38	5.13	11.23

a. The dependent variables are log of fee-for-service hours of psychologists and psychiatrists per 1000 non-HMO population, 1978. Sources for dependent and regulatory variables are given in Appendix B. More states can be used here than in Table 2 since the regressions did not use data from 1976.

b. States with 1,000,000 or more people, 1978.

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On average, Americans spent about \$9-10 per person per year on fee-for-service psychotherapy. The Alcohol, Drug Abuse and Mental Health Administration estimates that about \$1.8 billion was spent in 1980 for services of office-based psychiatrists and psychologists.³⁴ In addition, a small part of the \$1.6 billion spent for services at Community Mental Health Centers and other outpatient clinics was purchased on a fee-for-service basis.³⁵ Taking total expenditures on fee-for-service psychotherapy at about \$2.0 billion, and a U.S. population of about 220 million, we get roughly \$9-10 per capita. In absolute terms, then, a 10-20 percent increase in cost of psychotherapy due to a mandate corresponds to about \$1-2 per capita.

This \$1-2 is an estimate of the total net increase in use of resources due to the mandate. A number of points can be made about this estimate to clarify its meaning. From the point of view of an insurer, it overstates the new cost due to a mandate to the extent that some of the new cost is borne by individuals in the form of deductibles, copayments, or payments after limits have been exceeded. But probably more importantly, it understates the new cost to insurers to the extent that old costs are shifted by the mandate—either from existing users of service newly covered or from state budgets. The \$1-2 per person per year is thus not put forward as an estimate of the increase in premiums an insurer must charge.

It should also be noted that this estimate applies to the effect of a mandate on the resource use in a single state enacting a mandate. For this "marginal" calculation, the supply of services is properly regarded as being highly elastic. (This is confirmed by the estimation of a price equation reported in footnote 33.) If either many states simultaneously or the federal government enacted a mandate law, it could be expected that due to a somewhat inelastic national supply curve, the impact of a demand increase after a mandate would be divided between more services and a higher price.

IV. Conclusions

The benefits and costs of mandates for mental health services are relevant to both the legality and the general advisability of the regulations. Mandates for mental health services may be beneficial by (1) overcoming ignorance and prejudice against treatment for mental conditions, (2) ensuring that everyone has an ability to pay for at least a minimum amount of mental health care, (3) correcting inefficiencies in insurance markets due to adverse selection, and (4) promoting offset effects of psychotherapy. There is evidence, reviewed here, that adverse selection inhibits the marketability of mental health coverage. We have also reviewed evi-

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dence that supports the existence of offset effects of psychotherapy. Our major finding with respect to costs is that mandates increase the net social cost of psychotherapy by about 10-20 percent, or about \$1-2 per capita in absolute terms. Notable, however, is that this small change in net cost may be associated with large changes in the burden of payment of final costs.

While a definitive comparison of costs and benefits is impossible at this time, it is clear nevertheless that mandated mental health benefits should be immune from legal attack. Mandates are not preempted by federal law (see Appendix A). And consideration of the costs and benefits of the mandates leads to the conclusion that insurers can not bear the burden of proof necessary to establish that no legitimate state interest is served by the mandates, or that the social costs outweigh the social benefits.

As a matter of public policy, the question of the advisability of state mandates for mental health services can not be answered so easily. The costs of the mandates seem "small"; but are the benefits great enough to outweigh these costs? We do not propose a final answer to this question. But, in light of our research, mandating a minimum level of coverage for mental health services in private health insurance does appear to be reasonable state policy.

State regulation of health insurance will take on increased importance as federal influence is reduced. Policy research, in service to public decision-making, should seek to clarify the nature of the favorable and unfavorable effects of state policies and, where possible, measure the importance of these effects. Our detailed consideration of one type of state regulation, mandated coverage for mental health benefits, illustrates that although progress can be made on both fronts, further work is needed. Estimates of the net costs and benefits should obviously be refined. In addition, our work has made clear that mandates may powerfully influence the distribution of the cost of mental health services. The shift in cost from state budgets (taxpayers) to third-party payers (insurers) is only one of the several transfers resulting from mandates. Distributional issues are clearly worthy of further attention.

Notes

1. Diana Walsh, "The Health Insurance Industry: Structural Changes in an Uncertain Environment," *Health Care Management Review* 53 (Summer 1980): 71-85.
2. Mary Lou Cooper, *Private Health Insurance Benefits for Alcoholism, Drug Abuse, and Mental Illness* (Washington, D.C.: Intergovernmental Health Policy Project, The George Washington University, 1979). In addition, eleven states require insurers to offer coverage for mental health services, chosen at the option of the policy holder. The implementation of this so-called "mandatory availability" varies widely. This paper is concerned only with mandated coverage.
3. *General Laws of the Commonwealth* 175, §47B.

4. Blue Cross Payment E to mandate Position P2 ciates, Inc. Under Priv. reports gen
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7. See J. G. L anisms" (R discussion (to state mar discussion (ing Psycho- Publishing.
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11. The result n selection rec 'Lemons': C Economics J. Riley, "J Journal of E
12. This "comp equilibrium of Market C Economy 81 "Equilibrium fect Informa C. Wilson, " Economics 7
13. "Mental anx as evidences effective dat parently has employees), 14% of the t- nervous exp selection") i and nervous Claims Undk

4. Blue Cross and Blue Shield of Massachusetts, "Special Report: Outpatient Psychiatric Payment Experience" (Boston: 1980). Blue Cross and Blue Shield are generally opposed to mandates for mental health care. See, for example, Group Hospitalization, Inc. "A Position Paper on Psychiatric Care Benefits" (Washington, D.C.: 1979). GLS Associates, Inc. "An Analysis of State Programs Which Mandate Mental Health Benefits Under Private Health Insurance"—NIMH contract # 278-78-0400 (MH), 29 June 1979—reports general industry resistance to mandates for mental conditions.
5. Blue Cross and Blue Shield of Massachusetts, "Special Report: Outpatient Psychiatric Payment Experience," pp. 1-2.
6. Superior Court Civil Action No. 35598, 22 October 1980, Suffolk County, Massachusetts.
7. See J. G. Larsen, "Mandated Health Insurance Coverage—A Study of Review Mechanisms" (Report to the Bureau of Insurance, State of Virginia, 1979), for a general discussion of some of the issues in mandated health insurance. The federal counterpart to state mandates is national health insurance, also a form of compulsory coverage. For discussion of many of the issues raised here in that context, see T. G. McGuire, *Financing Psychotherapy: Costs, Effects, and Public Policy* (Cambridge, Mass.: Ballinger Publishing, 1981).
8. See Appendix, note 10.
9. National Institute of Mental Health, "The Financing, Utilization and Quality of Mental Health Care in the U.S." (Washington, D.C.: 1976).
10. Another argument in support of mandates for mental health care is that private insurers, and especially Blue Cross and Blue Shield, are more responsive to established medical interests than to the desires of consumers. Mandates for mental health care generally increase insurance coverage for non-medical providers relatively more than for physicians (see Section III), and therefore might be opposed by medical interests. The line of thinking that health insurers are heavily influenced by medical interests is well established, though not universally accepted. See, for example, Federal Trade Commission, "Medical Participation in Control of Blue Shield and Certain Other Open-Panel Medical Prepayment Plans" (Washington, D.C.: 1979). That insurers must be forced to offer forms of coverage alternative to those most beneficial to physicians in private practice is the basis for Enthoven's influential analysis of health financing. See Alain Enthoven, *Health Plan* (Reading, Mass.: Addison-Wesley Publishing Co., 1980).
11. The result may not be to destroy the marketability of insurance altogether, but adverse selection reduces the amount of insurance purchased. See G. Akerlof, "The Market for 'Lemons': Qualitative Uncertainty and the Market Mechanism," *Quarterly Journal of Economics* 84 (August 1970): 488-500. For a useful survey, see J. Hirshleifer and J. Riley, "The Analytics of Uncertainty and Information—An Expository Survey," *Journal of Economic Literature* 17 (December 1979): 1375-1421.
12. This "comparative statics" discussion avoids the problem of existence and stability of equilibrium in insurance markets. For technical discussion, see M. Rothschild, "Models of Market Organization with Imperfect Information: A Survey," *Journal of Political Economy* 81 (November/December 1973): 1283-1308; M. Rothschild and J. Stiglitz, "Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information," *Quarterly Journal of Economics* 90 (November 1975): 629-649; and C. Wilson, "A Model of Insurance Markets with Incomplete Information," *Journal of Economic Theory* 16 (December 1977): 167-207.
13. "Mental and nervous expenditures are seemingly quite easy to predict [by the insured] as evidenced by the fact that most such expenditures commence within a few days of the effective date of the individual's coverage. The Indemnity Benefit Plan [of Aetna] apparently has the most liberal mental and nervous benefit [of any plan offered to Federal employees], as evidenced by the fact that persons who joined the plan in 1972 constituted 14% of the total lives insured as of May 1973; yet they incurred 21% of the mental and nervous expenses. In view of this high degree of antiselection [our term is "adverse selection"] it would seem that some action should be taken to reduce the plan's mental and nervous benefits." Aetna Life and Casualty, "Study of 1973 Mental and Nervous Claims Under the Government-Wide Indemnity Benefit Plan" (Hartford, Conn.: 1974).

14. See Guillette, M., "Is Psychotherapy Insurable?" (Hartford, Conn.: Aetna Life and Casualty).
15. This presumes consumers are risk-averse and that the moral hazard associated with this coverage is not so severe as to make the coverage unattractive at actuarially-based premiums appropriate for each individual. The degree of moral hazard with this coverage is discussed in the next section.
16. For breakdown of costs by sector, see Alcohol, Drug Abuse and Mental Health Administration, Office of Program Planning and Evaluation, "Alcohol, Drug Abuse, and Mental Health Services Under National Health Insurance: Alternative Levels of Benefits and Estimated Costs" (Rockville, Md.: 1979).
17. D. Mechanic, "Considerations in the Design of Mental Health Benefits Under National Health Insurance," *American Journal of Public Health* 68 (May 1978): 486.
18. President's Commission on Mental Health, *Report* (Washington, D.C.: 1978).
19. K. R. Jones and T. R. Vischi, "Impact of Alcohol, Drug Abuse and Mental Health Treatment on Medical Care Utilization," *Medical Care* 17 (December 1979): 1-82.
20. The most serious problem had to do with the nature of the control group, as Jones and Vischi emphasize (*ibid.*). Some studies used a "before-and-after" design, comparing medical utilization by the same people before and after psychotherapy. This design can be confounded by the "peaking" of all kinds of utilization in times of physical and emotional distress. Observed declines in medical utilization may well have occurred in the absence of psychotherapy. Other studies compared medical utilization of a group after psychotherapy with a matched population who did not choose psychotherapy. The problem with this design is that the groups are not really the same since the treatment group freely chose psychotherapy and the control group did not. Differences between the groups, rather than the psychotherapy itself, may account for differences in subsequent medical utilization.
21. Jones and Vischi (*ibid.*) do discuss one study in which treatment occurred in the fee-for-service sector, but this was done in West Germany more than thirty years ago. Armer's reports of the experience of The California Psychological Health Plan (not included in Jones and Vischi's review), in which groups of employees may receive psychotherapy from a "closed panel" of psychologists and psychiatrists in private practice, provides some evidence for offset effects. But the organization of this plan is again not fully representative of the general fee-for-service sector. See J. Armer, "Is Mental Wellness an Answer to the Runaway Cost of Health Care?" in *Mental Wellness Programs for Employees*, ed. Egdahl, Walsh, and Goldbeck (New York: Springer-Verlag, 1980).
22. The effects of "measurement error" on testing the effects of psychotherapy are discussed in McGuire, *Financing Psychotherapy: Costs, Effects and Public Policy*, pp. 63-71.
23. T. McGuire, "Financing and Demand for Mental Health Services," *Journal of Human Resources* 16 (Fall 1981): 501-522.
24. M. R. Van Korff and M. Kramer, "Mental and Nervous Disorders Utilization and Cost Study" (Washington, D.C.: National Institute of Mental Health and U.S. Office of Personnel Management, 1979), p. 28.
25. See McGuire, *Financing Psychotherapy*, esp. chapter 3, for discussion of the efficiency literature.
26. GLS Associates, "Analysis of State Programs Which Mandate Mental Health Benefits Under Private Health Insurance."
27. In 1977, 84 percent of licensed or certified psychologists were members of the American Psychological Association. See D. Mills, A. Wellner, and G. VandenBos, "The National Register Survey: The First Comprehensive Study of All Licensed/Certified Psychologists," in *Psychology and National Health Insurance*, ed. C. Kiesler, N. Cummings, and G. VandenBos (Washington, D.C.: American Psychological Association, 1979), p. 126.
28. The rate of growth in psychiatrists for states in group 1 of Table 2 is 16.1, and 16.8 for group 2.
29. In a survey of licensed or certified psychologists in ten states in 1977, 20 percent of health service providers with a current specialty of clinical psychology were originally trained in some other specialty. H. Dorken and J. Webb, "Licensed Psychologists in Health Care: A Survey p. 134.
30. For development "Pricing and Lc Boston Universi
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Care: A Survey of Their Practices," in *Psychology and National Health Insurance*, p. 134.

30. For development of such a full model in the case of psychiatrists see Richard Frank, "Pricing and Location of Physician's Services in Mental Health" (Ph.D. dissertation, Boston University, 1981).
31. It is interesting that the coefficient on the unemployment rate is positive and significant, suggesting a kind of Brenner-effect on utilization—see Brenner, *Mental Illness and the Economy* (Cambridge, Mass.: Harvard University Press, 1975). A causal interpretation of an estimated partial correlation between unemployment and use of mental health services is much more plausible in a time-series analysis (as in Brenner's work) than in a cross-sectional analysis.
32. One explanation for a positive estimated effect of an FOC law is that the presence of the law is endogenous to a model of use of psychotherapy and is positively correlated with unmeasured influences on demand or supply for psychotherapy.
33. The effect of mandates on the price of psychologists' services was investigated using price as the dependent variable in equations similar to those reported in Table 3. The estimated impact of mandates was only about \$0.01 on hourly fees for psychologists.
34. See McGuire, "Financing and Demand for Mental Health Services," Table 3.
35. In 1976, Community Mental Health Centers received about 11 percent of their funds from patient fees or private insurance plans. See T. McGuire, "Markets for Psychotherapy," in *Psychotherapy: Practice, Research, Policy*, ed. G. VandenBos (Beverly Hills, Calif: Sage Publishing, 1980), pp. 187-246.

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Appendix A: Legality of Mandated Mental Health Benefits

State legislation of mandated mental health benefits has been challenged on a number of constitutional grounds: (1) that enforcement of mandates violates the Commerce Clause of the U.S. Constitution; (2) that mandates violate the Due Process Clause of the Constitution; and (3) that mandates are preempted by federal legislation under the Supremacy Clause of the Constitution. This appendix will briefly outline the major underpinnings of these legal theories, and attempt to identify the policy considerations underlying the judicial treatment of the various constitutional arguments.¹

Commerce clause

Where insurance policies have been issued outside a state, as is frequently the case with group contracts providing benefits to residents of a number of states, insurers have asserted that the application of mandated benefit statutes violates the Commerce Clause of the U.S. Constitution. The Commerce Clause establishes the primacy of the Congress in the regulation of interstate commerce. Thus, where Congress completely occupies the field of matter in interstate commerce, there is often no room for any parallel state regulation. However, as early as 1869, in *Paul v. Virginia*,² the Supreme Court held that the business of insurance was not interstate commerce subject to federal regulation. In the wake of *Paul* and subsequent cases, a diverse network of state regulation developed. But the Supreme Court reversed itself in 1944, holding in *United States v. South-Eastern Underwriters Association*³ that the insurance business was subject to regulation by Congress under the Commerce Clause. In response to that decision, Congress enacted the McCarran-Ferguson Act in 1945,⁴ which expressly provides that regulation and taxation of the business of insurance shall be subject to the laws of the several states.

Subsequent to the enactment of the McCarran-Ferguson Act, the Supreme Court made it clear that the statute effectively operates to "sustain [state insurance legislation] from any attack under the Commerce Clause."⁵ The Court recognized that, as a result of the Congressional abdication in favor of the states, "uniformity of regulation . . . [is] not required in reference to the business of insurance."⁶

Despite the McCarran-Ferguson Act, insurance companies in recent cases challenging mandated-benefits legislation have sought to revitalize the Commerce Clause as a ground for attack on state insurance laws. In each of these cases, however, the courts have upheld the validity of the mandated-benefits statutes.⁷

Due process

Although the McCarran-Ferguson Act validated state regulation with respect to the Commerce Clause, it did not purport to define state authority in light of the Due Process Clause of the Fourteenth Amendment. The Due Process Clause is the touchstone of constitutional analysis of state insurance legislation which applies extraterritorially. Within the context of the due process considerations, it is well settled that a state may subject out-of-state insurance transactions to its laws where the state has a legitimate interest in regulation.⁸

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With respect to state insurance statutes that apply extraterritorially to out-of-state insurance companies and policies, the Supreme Court has said:⁹

A state has a legitimate interest in all insurance policies protecting its residents against risks, an interest which the state can protect even though the state action may have repercussion beyond state lines. . . . we [have] accorded great weight to the consequences of the contractual obligations in the state where the insured resided and the degree of interest that the state had in seeing that those obligations were faithfully carried out.

Under the due process principles enunciated by the Supreme Court, most state insurance legislation survives attack. Recent challenges to statutes mandating mental health coverage have not seriously pressed the due process argument. The courts in these cases have supported state mandates on the basis of the strong interest demonstrated by the states in providing treatment for mental and nervous conditions for their citizens.¹⁰

Federal preemption

The doctrine of federal preemption of state law under the Supremacy Clause of the U. S. Constitution has had a protracted history, marked by shifting attitudes toward the proper balance between state and federal authority.¹¹ Decisions of the United States Supreme Court in the last two decades suggest a narrow frame of reference. Federal law will preempt a state statute only where there is a clearly discernible Congressional intent to occupy the field for exclusive regulation by the federal government, or where the state act is in actual conflict with the applicable federal law;¹² preemption will also occur where Congress has expressly dictated that result.¹³

The first prong of the preemption test requires analysis of Congressional intent to occupy the field of regulation. Where the analysis involves an area of traditional state regulation, such as insurance, the courts are directed to "[assume] that the historic police powers of the states were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress."¹⁴ Local regulation is not to be "disturbed unintentionally by Congress or unnecessarily by the courts."¹⁵

If Congress has not occupied the field, the second step of the preemption analysis looks to a conflict with federal law. A conflict between state and federal law requires preemption where the state regulation is an "obstacle to the accomplishment and execution of the full purpose and objective of Congress."¹⁶ A conflict will arise most clearly where state and federal laws require mutually exclusive conduct. However, there is no preemption where both statutes are enforceable without impairment of federal dominance of the field.¹⁷ In fact, the Supreme Court has displayed a marked tendency in recent years to preserve local regulation in the face of a potential conflict with federal law.¹⁸

State mandates for health insurance have been alleged to be in conflict with two federal statutes: the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 101 *et seq.*; and the National Labor Relations Act (NLRA), 29 U.S.C. § 141 *et seq.* Virtually all employee health benefit plans are subject to ERISA, while the NLRA applies to plans that are the subject of collective bargaining.

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The Employee Retirement Income Security Act. The Employee Retirement Income Security Act of 1974, was enacted to correct widespread abuses in administration of employee pension and welfare plans.¹⁹ ERISA imposes on such plans minimum federal standards for reporting, disclosure, vesting, funding, and fiduciary duties.²⁰ Although all of the provisions of the act apply to pension plans, welfare plans are required only to observe the reporting, disclosure, and fiduciary standards.²¹

In establishing a new and detailed regulatory structure governing employee benefit plans, Congress decided to displace direct state regulation of such plans. The extent of federal preemption is delineated by Section 514 of ERISA, which creates a dichotomy between state laws that "relate to" an employee benefit plan and state laws that regulate insurance. Section 514(a) provides for general preemption of state law as follows:

Except as provided in subsection (b) of this section, the provision of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) and not exempt under section 4(b). This section shall take effect on January 1, 1975.

The broad preemption language of this section has generally led courts to preempt state laws that directly regulate employee benefit plans.²²

ERISA, however, does not appear to preempt mandated insurance benefit statutes that do not apply directly to employee benefit plans, despite the indirect regulatory effect of the statutes on plans that purchase insurance coverage on behalf of their members. The "savings clause" of ERISA expressly provides that state "insurance, banking, and securities" laws are preserved from the broad preemptive effect of S. 514(a). In construing this section, federal and state courts have uniformly upheld the state statutes.²³

In the leading decision on this issue, *Wadsworth v. Whaland*, the U. S. First Circuit Court of Appeals found that New Hampshire's mandated mental health benefit statute was not preempted by ERISA, even though the statute subjected plans that purchase insurance to indirect regulation. The court registered its strong support for the traditional national policy of state primacy in the regulation of insurance:²⁴

The plaintiff's interpretation would greatly diminish the state's primacy in regulating insurance. It would nullify all state insurance laws concerning group insurance when the group policy is issued to an employee benefit plan. We do not find, absent a clear statement of intent, that Congress meant to so restrict a state's authority to regulate insurance.

The *Wadsworth* Court directly acknowledged the anomaly created by ERISA, since the statute clearly preempts any state law that requires employers to provide mental health insurance or treatment services. However, the court correctly concluded that any policy conflict was best resolved by Congress. Indeed, some commentators believe a case such as *Wadsworth* demonstrates that Congress neither understood nor considered the broader implications of ERISA preemption.²⁵

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The National Labor Relations Act. The NLRA requires employees, employers, and labor unions to discuss wages and conditions of employment, and provides a "protected" climate for the bargaining process. It is clear that states may not interfere with this "protected" climate.²⁴ The NLRA, however, does not regulate the substance of the contract, nor does it undertake to regulate wages, hours, working conditions, or employee benefits.²⁵ Moreover, the act neither contains an express preemption provision, nor does it expressly or by implication supersede the dictates of the McCarran-Ferguson Act.

Although the NLRA represents a comprehensive federal scheme, the Supreme Court has recognized numerous limitations to its preemptive effect, stating that "[we] cannot declare preempted all local regulation which touches or concerns in any way the complex interrelationships between employees, employers, and unions; obviously much of this is left to the states."²⁶ The larger context of state laws of general applicability takes precedence over the NLRA.²⁷

Thus a number of specific exceptions to preemption by the NLRA have developed, including state action which is of peripheral concern to the NLRA²⁸ or which touches interests deeply rooted in local feeling and responsibility,²⁹ or local health and safety regulations which conflict with a collective bargaining agreement.³² Mandated mental health statutes are of general applicability, and are not directed specifically at the collective-bargaining process. Therefore, the state and federal courts have rejected the claim that the NLRA preempts these state statutes.³³

Appendix B: Sources of Data

Psychiatrists' hours were computed as the product of the number of psychiatrists and child psychiatrists in office-based practice in 1978 times the average number of hours worked by psychiatrists in 1978, reported on a regional basis. Source: *AMA Physician Distribution and Medical Licensure in the U.S., 1978.*

Psychologists' hours were defined as the sum of the number of psychologists in individual private practice times the mean hours per week providing health services for that group; plus the number of psychologists (not in individual private practice) providing fee-for-service psychotherapy less than 20 hours a week times 10 hours per week; plus the number of psychologists (not in individual private practice) providing fee-for-service psychotherapy more than 20 hours a week times 30. Number of psychologists in all categories are estimates. Source: *American Psychological Association Human Resource Survey, 1978.*

Percent of population in FEHB or CHAMPUS is estimated as follows. The distribution of FEHB coverage was assumed to be similar to the distribution of federal employment, taken from U.S. Bureau of the Census, *Employment and Earnings in States and Areas (6744-5)*. Family size of federal employees was assumed to be the average for the state. The distribution of the total of 9,123,000 CHAMPUS eligible individuals was made according to the distribution of the number of claims received by CHAMPUS for November 1980. Source: American Psychological

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Association, CHAMPUS project, directed by William L. Claiborn. We are grateful to Will Claiborn for information and advice for computing these estimates.

FOC laws were not in effect in the following states in January 1978: Alabama, Alaska, Arizona, Delaware, Florida, Georgia, Idaho, Indiana, Iowa, Kentucky, Missouri, Nevada, New Hampshire, Pennsylvania, Rhode Island, South Carolina, South Dakota, Vermont, West Virginia, Wisconsin, Wyoming. Source: Personal communication from Herbert Dorken.

Mandates were in effect in 1978 in the following states: Colorado, Connecticut, Maryland, Massachusetts, Minnesota, New Hampshire, North Dakota, Ohio, Wisconsin. Source: Mary Lou Cooper, "Private Health Insurance Benefits for Alcoholism, Drug Abuse and Mental Illness," (Washington, D.C.: Intergovernmental Health Policy Project, The George Washington University, July 1979), pp 25-27.

Notes to Appendices

1. It should be emphasized that these are the arguments that have been advanced in opposition to mandates. They do not necessarily represent our judgment about the best possible set of arguments to be made. It is not the intention of the authors to provide a comprehensive analysis of the constitutional issues implicated by mandated benefits legislation.
2. 8 Wall 168, 19L. Ed 357 (1869).
3. 322 U.S. 533 (1944).
4. 15. U.S.C. §10 *et seq.*
5. *Prudential Insurance Co. v. Benjamin*, 328 U.S. 408 (1946); *Group Life & Health Insurance v. Royal Drug Co.* 435 U.S. 903 (1979).
6. *Id.* at 431
7. Contrast *Insurer's Action Council v. Markham*, 490 F. Supp 921 (D.C. Minn., 1980)—where the court correctly holds that the Minnesota Comprehensive Health Insurance Act is immune from Commerce Clause attack—with *Metropolitan Life Insurance Company v. Wayland*, New Hampshire Supreme Court, 28 December 1979, in which the court holds that New Hampshire's mandated mental health benefits statute does not impose an impermissible burden on interstate commerce. Even assuming, as the New Hampshire Court did, that the Commerce Clause is applicable to insurance regulation, it is clear that, absent conflicting federal legislation, the states may exercise their general police powers to regulate matters of local concern, even though interstate commerce is affected. Such legislation will be struck down only where the burden on commerce is clearly excessive in relation to the purported local benefits. *A & P Tea Co. v. Cottrell*, 424 U.S. 366 (1976). See also *Wadsworth v. Wayland*, 562 F.2d 70 (1st Cir 1977), *cert. denied*, 434 U.S. 1044 (1978).
8. *Osborn v. Ozlin*, 310 U.S. 53 (1940); *Hoopstun Canning Co. v. Cullen*, 318 U.S. 313 (1943); *Watson v. Employer's Liability Assurance Corporation*, 348 U.S. 66 (1954). In addition to a legitimate state interest, these cases require that the state must also have sufficient contacts with the transaction to justify state action.
9. *Travelers Health Association v. Virginia*, 339 U.S. 643, 647-48 (1950).
10. *Wadsworth v. Wayland*, 562 F.2d 70 (1st Cir. 1977), *cert. denied*, 434 U.S. 1044 (1978); *Metropolitan Life Insurance Company v. Wayland*, New Hampshire Supreme Court, 29 December 1979; *Commonwealth of Massachusetts v. Travelers Insurance Company and Metropolitan Life Insurance Company*, Suffolk Superior Court (No. 35598) 22 October 1980 (currently on appeal); *Insurer's Action Council v. Markham*, 490 F. supp. 921 (D.C. Minn., 1980).
11. See "The Preemption Doctrine: Shifting Perspectives on Federalism and the Burger Court," *Columbia Law Review* 75 (1975): 623.

12. *Florida Lime*
13. Where Congl effect, the Su the intent to See *Jones v.*
14. *Rice v. Sant*
15. *Jones v. Rail*
16. *Hines v. Dav*
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21. An employe heretofore o organization or maintain through the benefits, or ment, or va centers, sch §1002(1).
22. E.g., *Hewle* 502 (9th Cir Act which c *Agsalud*, 44 50 U.S.L. W Care Act re also *St. Pa* Minn., 1980 Rather em insurance
23. See cases preempting mandate th court concl
24. 562 F.2d at
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12. *Florida Lime and Avocado Growers v. Paul*, 373 U.S. 132 (1963).
13. Where Congress has explicitly indicated that a statute should have some preemptive effect, the Supreme Court has carefully examined the statutory scheme and required that the intent to preempt a particular concurrent state regulation be "clear and manifest." See *Jones v. Rath Packing Co.*, 430 U.S. 519, 525 (1977).
14. *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947).
15. *Jones v. Rath Packing Co.*
16. *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941).
17. *Florida Lime and Avocado Growers, Inc. v. Paul*.
18. For example, in *Goldstein v. California*, 412 U.S. 546 (1973), the Court held that the states' right to regulate unauthorized phonographic reproduction was not preempted by federal copyright statutes which do not expressly regulate such reproduction. The Court found that exclusive federal power arose over matters "necessarily national in import," *id.* at 544, but that no preemption by federal copyright law would occur except where the statutes are absolutely contradictory and repugnant. See also *New York State Department of Social Services v. Dublino*, 413 U.S. 405 (1973); *Kargman v. Sullivan*, 552 F.2d 2, reconsideration denied, 558 F.2d 612 (1st Cir. 1977).
19. ERISA was the culmination of twelve years of investigation into pension and welfare plan abuses which had deprived many workers of their earned benefits. ERISA replaced the Welfare and Pension Plans Disclosure Act, 29 U.S.C. §1001 *et seq.* (1958). For a discussion of the history of federal legislation governing employee benefit plans, see Chadwick and Foster, "Federal Regulation of Retirement Plans: The Quest for Parity," *Vanderbilt Law Review* 28 (1975): 641; Snyder, "Employee Retirement Income Security Act of 1974," *Wake Forest Law Review* 11 (1975): 219.
20. ERISA is analogous to the Securities Act of 1933, 15 U.S.C. §77 (a) *et seq.*, since it relies, to a great extent, on disclosure requirements to police the activities it was designed to regulate. The Securities Act imposes no substantive regulation on the kind or quality of securities traded on the exchanges. ERISA likewise does not contain any regulation of the kind or quality of benefits.
21. An employee welfare benefit plan is defined as "any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship, or other training programs, or day care centers, scholarship funds, or prepaid legal services . . ." ERISA §3(1), 29 U.S.C. §1002(1).
22. E.g., *Hewlett Packard Co. v. Barnes*, 425 F. Supp. 1294 (N.D. Cal., 1977), *affd.* 527 F.2d 502 (9th Cir., 1978)—preempting the California Knox-Keene Health Care Service Plan Act which directly regulated the terms of employee benefit plans; *Standard Oil Co. v. Agsalud*, 442 F. Supp. 695 (N.D. Calif., 1977), *affd.* 633 F.2d 760 (9th Cir., 1980), *affd.* 50 U.S.L.W. 3212 (6 October 1981)—preempting the Hawaii Comprehensive Health Care Act requiring employers to provide employees with a prepaid health care plan. See also *St. Paul Electrical Workers Welfare Fund v. Markham*, 490 F. Supp. 931 (D.C. Minn., 1980). The statutes in these cases did not mandate the terms of insurance policies. Rather employers were required to provide enumerated benefits whether through the insurance mechanism or self-insured employee benefits.
23. See cases cited at note 10 *supra*. The *Wadsworth* Court recognized the anomaly of preempting direct regulation of employers and benefit plans while permitting the state to mandate the terms of insurance policies purchased by employers or benefit plans. The court concluded that this was a policy issue best addressed by Congress. 566 F.2d at 78.
24. 562 F.2d at 70.
25. "Note, ERISA Preemption and Indirect Regulation of Employee Welfare Plans Through State Insurance Laws," *Columbia Law Review*, 78 (1978): 1536; Okin, "Preemption of State Insurance Regulation by ERISA," *Forum* 13 (1978): 652-679.

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26. *Lodge 76, International Assoc. of Machinists and Aerospace Workers v. Wisconsin Employment Relations Comm.*, 427 U.S. 132 (1976).
27. *Terminal Railroad Association of St. Louis v. Brotherhood of Railroad Trainmen*, 318 U.S. 1, 6 (1942).
28. *Motor Coach Employee v. Lockridge*, 403 U.S. 274, 289 (1971).
29. This is so even if one part of a state's protective legislation might become "the subject of a demand" so affecting interstate commerce that federal agencies would have to be invoked to deal with it. *Terminal Railroad Association of St. Louis v. Brotherhood of Railroad Trainmen*, 318 U.S. 1, 7 (1942).
30. *Massachusetts Electric Company v. Massachusetts Commission Against Discrimination*, 375 Mass 160, 375 N.E. 2d 1192 (1978)—upholding a regulation requiring employers to provide benefits for pregnancy-related disabilities. The court recognized that these benefits were a mandatory subject of collective bargaining, but nevertheless concluded that the regulation was a peripheral concern of the NLRA.
31. *Farmer v. United Brotherhood of Carpenters*, 430 U.S. 290 (1977).
32. *Local 24, International Brotherhood of Teamsters v. Oliver*, 358 U.S. 283 (1958).
33. See note 10 supra.

Cost-Benefit Prospect Reassessment

Richard W.

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Dispelling Myths About Mental Health Benefits

BY STEVEN S. SHARFSTEIN, SAM MUSZYNSKI AND GRACE-MARIE ARNETT

The case is made that mental health coverage is cost-effective and controllable.

Insurance coverage for mental health care always has lagged behind that of coverage for other medical care, and today, private insurance coverage for psychiatric illness is only half as available as coverage for other medical problems.

The American Psychiatric Association, in 1983, surveyed health insurance benefits provided by a cross section of major private sector employers. The 300 plans in the study sample covered 33 million workers and dependents employed in such corporations as IBM, General Motors and Exxon plus numerous mid-sized and smaller companies. The survey showed all of the plans provided some level of inpatient coverage for mental illness, but only 49 percent of the insured were protected for mental illness expenses on the same basis as any other illness. The remaining 51 percent of insured individuals were covered at a reduced level. Ninety-eight percent of the plans had some coverage for outpatient expenses for mental illness treatment. But, again, only 10 percent of the plans provided these benefits on the same basis as outpatient coverage for other medical conditions.¹

An earlier study of 455 major insurance programs, conducted in 1980 by Hewitt Associates, a benefits consulting firm, also found equal outpatient coverage for mental disorders in only 10 percent of the plans.

This discrimination is bad for patients, for business, for mental health providers and, ultimately, for the community and taxpayers. Unequal coverage of psychiatric treatment has evolved primarily because of several prevalent myths about mental health benefits and care. In business' role as a formulator of health care policy, accurate in-

MENTAL HEALTH REPORT

formation is essential to assure that employers make wise economic decisions about health care coverage for employees while providing for quality health care.

The 1960s and 1970s were decades of tremendous growth for mental health

services, fueled by ever expanding public and private third party financial resources. From 1955 to 1977, the number of patients treated in inpatient and outpatient mental health facilities almost quadrupled, from 1.7 million to 6.4 million.

There also was a major shift in the type of care delivered, with inpatient care declining sharply while outpatient care increased tenfold, primarily because of federal funding of community mental health centers.

The emergence of an accessible mental health treatment system in the U.S. depended upon joint private and public financing. Through these investments, the private and the public sectors have demonstrated over the last two decades the importance of mental health care. But concerns over the costs of this care have arisen in tandem with alarm over the nation's soaring total health care bill. As a result, a last in-first out policy is being adopted by health insurers with regard to psychiatric coverage, whose growth traditionally has lagged behind that of other medical coverage.

Restricting Benefits

Today, psychiatrists have approximately twice the number of patients with no health insurance as other physicians, and those patients with insurance have greater limits on their psychiatric benefits than for medical care. Mental health coverage has been curtailed in a number of plans, including those under the Federal Employees Health Benefits Program (FEHBP). Some carriers, beginning in 1981, imposed strict limitations on the amount of mental health care federal employees and their dependents may receive under the plans. The Blue Cross-Blue Shield federal employees plan, for example, in 1982 imposed a 50-visit limit on outpatient mental health treat-

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...and a 60-day limit on inpatient care annually, whereas in the past treatment was limited only by medical necessity.

Decades of clinical experience and research have shown, however, that mental and physical illness cannot be separated without impeding effective treatment. Psychiatric problems often are presented as physical complaints while somatic diseases initially may be experienced as emotional symptoms. Restrictions on mental care coverage cannot prevent individuals from obtaining some kind of care, although that care may not be the most appropriate for their illness. There is good evidence that attempting to establish a false dichotomy between mental and physical illness leads to a false economy in insurance coverage.

"Restrictions on mental care coverage cannot prevent individuals from obtaining some kind of care, although that care may not be the most appropriate for their illness. There is good evidence that attempting to establish a false dichotomy between mental and physical illness leads to false economy in insurance coverage."

For example, an executive under great stress may experience headaches, abdominal pain, fatigue and depression. Unless accessible psychiatric diagnosis and care are available, this executive might have to undergo costly medical and diagnostic testing and specialty consultations. It is cost-effective to treat this person with psychiatric interventions.

In addition, because of the essentially cognitive nature of psychiatry, especially as it involves psychotherapy, because psychiatrists can treat only a limited number of patients each day, and because fewer of their patients are insured, psychiatrists' earnings are near the bottom of the income scale compared with other physicians. So while psychiatrists contribute little to soaring health care costs, insurance coverage for their patients, nonetheless, is often the first to be cut.²

The Uncontrollable Costs Myth

Psychiatric care will not be reimbursed equally along with other medical treatments, however, until some of the myths considered unique to psychiatry are addressed. There are four commonly held myths that may account for discriminatory treatment of psychiatric coverage.

The first such myth is that costs of psychiatric treatment are uncontrollable and unpredictable. Opponents of comprehensive psychiatric coverage suggest that providing benefits with no limits on the number of days for inpatient treatment or the number of visits for outpatient care would bankrupt an insurance carrier because of the influx of new patients who would seek these services. Actual ex-

perience shows these concerns to be invalid.

Data from the Blue Cross-Blue Shield federal employee health plan, for example, which had no artificial limits on mental health coverage from 1967 to 1981, aside from the same deductibles and copayments for general medical care, indicate that mental health costs are stable over time. After an initial jump in costs immediately following the introduction of broader psychiatric benefits between 1967 and 1969, mental health care accounted for 7.2 percent to 7.7 percent of the total benefits paid from 1970 to 1981.

In 1971, the Rand Corporation began a health insurance study that enrolled 7,500 persons at six sites across the country in 14 different insurance plans having patient copayments ranging up to 95 percent, with a maximum dollar expenditure of \$1,000 per family. The Rand study found that expenditures for mental health care constituted only about 5 percent of the total health care costs for all insurance plan enrollees.

It was further determined that when insurance pays more of the bill and the patient less, people use extra psychiatric care at about the same rate as they use extra care from other medical specialists. The researchers found that between 7.1 and 9.6 percent of the population studied used mental benefits; this calculation embraces visits to general practitioners and internists whenever a psychotropic medication or a mental health reason was involved in the visit. Only a small percentage of the individuals (0.4) saw clinicians more than 40 times a year. The Rand study underscores the stability over time of costs for mental health care under insurance.³

Health economist John Krizay has done studies that also suggest that costs level out over time or show a plateau effect. In a 1982 study, for instance, he analyzed the experiences of the two insurers participating in the FEHBP — Blue Cross-Blue Shield and Aetna — on a state-by-state basis and translated these data into per capita utilization rates and costs in constant dollars. He noted that in almost all states the total percentage of enrollees who received psychiatric benefits under these plans was around 1.5 percent of total enrollment, indicating that the availability of insurance financing does not cause excessive utilization.⁴

Many of the restrictions on insurance coverage for psychiatric care appear to stem largely from concern about the costs of long-term custodial care or intensive psychotherapy. The standard treatment regimen for intensive psychotherapies involves a minimum of three therapy sessions a week. Experience with the FEHBP, which placed no annual restrictions on the number of outpatient visits for more than a decade, has shown that the number of persons receiving intensive psychotherapeutic treatment ranged from 0.9 percent of all psychiatric outpatients treated in 1971 to 1.1 percent in 1973. The cost for treatment for this population during the same time period ranged from 8.7 percent to 10.3 percent of the total cost of physicians' treatment of mental disorders.⁵

The availability of coverage limited only by medical necessity for intensive psychotherapy during the early

1970s did not seem to cause any appreciable increase in the number of people using this form of treatment. It is clear that in this system, which offered a comprehensive benefit — the full range of mental health services — that the number of people utilizing intensive psychotherapy remained consistently low. This seems a self-stabilizing factor mitigating against threats of exorbitant overutilization of the benefit.

Still, misconceptions about the excessive duration and costs for all psychiatric care have prevailed, and unwarranted discriminations against both inpatient and outpatient psychiatric care in general have persisted. The growing body of data and coverage experience suggests that these concerns and resultant discriminations need to be reviewed. A look at the larger picture of utilization of mental health benefits in comparison to use of other medical services indicates, too, that even with unlimited access to psychiatric care, use is predictable and the portion of the total health dollar consumed is modest.

The "Moral Hazard" Myth

Another myth is that mental health care costs are unstable because of the "moral hazard" which is especially applicable to psychiatric coverage. "Moral hazard" describes the case in which the services demanded for treatment of an illness depend, in part, on the price of these services. Since insurance lowers the price to consumers, more services may be used than if the consumer were required to pay the entire medical bill.

Arguments for restricting mental health benefits focus on the assumption that liberal coverage encourages unnecessary and excessive use. Supporters of this view cite data such as this: Among outpatient users of mental health care in the federal employees Blue Cross-Blue Shield plan, 9 percent accounted for 45 percent of the total cost. Likewise, in the Michigan Blue Cross plans, the highest utilization group of persons, consisting of 10 percent of the users with mental disorders, accounted for over 60 percent of the charges.

But that someone with insurance may be more likely to initiate medical care, and once under care, be likelier to opt for more extensive treatment is not a phenomenon exclusively found in the mental health area. General medical literature also has documented the fact that insurance encourages utilization of physician services. The 1981 Rand study, for example, reported that 1 percent of utilizers of medical care in the 7,500 sample accounted for 28 percent of the total expenditures.

Another study, "Insurance Effects on Employer Group Dental Expenditures," published in the June 1984 issue of *Medical Care*, further illustrates this point. The study found consumers spend more on dental care when they have dental insurance, and 81 million Americans have this type of coverage. Specifically, the study's findings indicate that total outlays for covered dental service are 36 percent higher for employees whose group insurance requires no cost sharing than for workers whose group insurance covers only 80 percent of the costs of basic dental services.

There is no established consensus about the extent of the impact of insurance on use of psychiatric services. Nonetheless, it is unwarranted to assume that this is a phenomenon unique to mental health care and, therefore, that specific benefit limitations to control for moral hazard are justified. The distribution of higher users of mental health benefits seems, if anything, to be less extreme.

According to a National Center for Health Statistics survey of ambulatory care conducted between May 1973 and April 1974, less than 20 percent of all physician visits are for problems considered "serious" or "very serious" by physicians. Nonetheless, 61 percent of all visits concerned problems for which the same patient had been seen by the same physician before, and, in roughly the same percentage of cases, the patient was instructed to return for yet another visit.

The demand for medical services, in other words, has little to do with "seriousness" in terms of clinical judgment. Relief from discomfort or anxiety is the most common motive for seeking medical advice. Thus it is both impossible to design a health insurance program around a concept of "seriousness," and illogical to apply a "seriousness" doctrine to coverage of psychiatric services alone. In that same vein, it is inappropriate for carriers to provide open-ended coverage for various nonpsychiatric conditions while restricting coverage for mental disorders. Yet, a recent study by Roche Products, Inc. showed more than 90 percent of psychiatrists stated they seldom or never see patients who primarily are seeking self-improvement.⁶

"There is no established consensus about the extent of the impact of insurance on the use of psychiatric services. Nonetheless, it is unwarranted to assume that this is a phenomenon unique to mental health care. . . . The distribution of higher users of mental health benefits seems, if anything, to be less extreme."

Lengthy inpatient care and intensive outpatient treatments are important and valid approaches in psychiatric care, just as open heart surgery is an important and valid method of treatment for cardiac patients.

The Cost-Effectiveness Debate

A third myth is that mental health care is not cost-effective. When benefits for mental health care are expanded and the stigma associated with receiving treatment for mental conditions decreases, an initial increase in insurers' costs attributable to psychiatric care is likely to occur. However, with psychiatric problems no longer masked under other diagnoses, and with early detection and ap-

appropriate treatment of these conditions, it also is probable that such costs will be offset partly by reduced expenditures for care of other illnesses.

Over the past few years there has emerged a body of evidence that spending for psychotherapy produces savings elsewhere through increased employee productivity, reduced absenteeism and lower costs for other medical care. There is wide and growing acceptance in private industry that it is worthwhile to invest in providing mental health services to employees as corporations can recoup some of the costs of this coverage in other areas.

Increasing medical care expenditures has made evidence of cost-effectiveness essential. In psychiatric treatment, however, results are not as quantifiable as in other medical disciplines. What is the dollar value of relief from incapacitating depression or anxiety, for instance? How can one measure the benefits to a child who is no longer beaten by an alcoholic father or calculate the advantages of a patient's increased capacity for intimate relationships?

Yet some notable studies have been done which document the cost-effectiveness of psychiatric care in quantifiable terms. Among these was an extensive, three-part study reported in 1980 which found that the use of community based programs for the chronically disabled psychiatric patients greatly reduced the need for hospitalization, lengthened community tenure and enhanced community adjustment. A rigorous cost-benefit analysis determined that benefits outweighed costs by about \$400 per individual.⁷

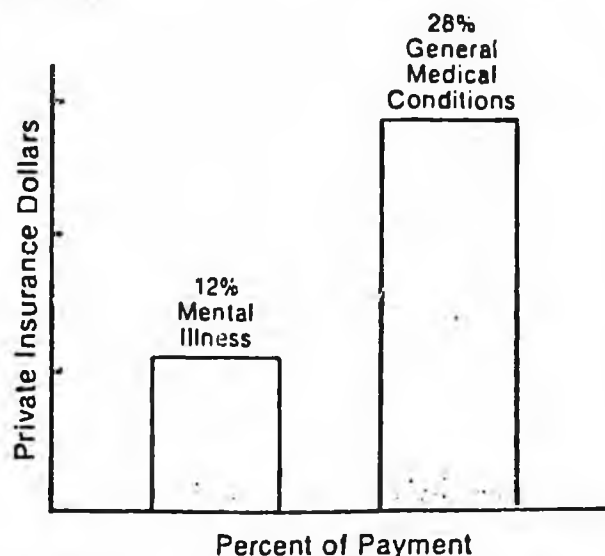
"...As companies look for areas to trim costs, psychiatric benefits often are the first to go, further eroding the real insurance provisions of their coverage. This is especially true where psychiatric benefits for catastrophic illness are eliminated to provide for more predictable routine dental care, for example."

A 1980 study looked at the issue of costs and benefits from a broad societal perspective. The focus was on the impact of the psychoactive medication lithium on the costs generated by manic depressive psychoses. Their conservative estimate of the 10-year savings was \$4.2 billion, that is, \$2.9 billion in unexpended treatment costs plus \$1.3 billion in productivity gains.⁸

Further, a 1983 study involving the Blue Cross-Blue Shield federal employees health plan showed a group of patients who began outpatient psychotherapy following diagnosis of chronic medical disease used 56 percent fewer medical services during the third year after diagnosis than

a group with the same diseases who received no outpatient psychotherapy.⁹

These studies clearly show that treatment for mental illness is cost-effective and can be measured directly in terms of savings from nonutilization of other medical services.



The Accountability Issue

A final myth is that psychiatric treatment is not accountable to insurance carriers. Utilization review in the form of peer review has become the cornerstone of organized psychiatry's accountability to payers and consumers. The goal of utilization review is to monitor the necessity and appropriateness of care, while peer review is intended to improve the quality of care. Psychiatric peer review is carried out by psychiatrists and it is concerned with utilization review, quality review, continuing education, advocacy with third party payers for improved care and cost control.

Unfortunately, many insurance carriers have chosen to put strict limits on psychiatric care rather than implement peer review procedures.

The American Psychiatric Association has developed peer review services to give employers the option of providing psychiatric care limited only by medical necessity, thereby enhancing their opportunity to achieve savings through cost avoidance in other areas of medical care. The APA's peer review program was established in the early 1970s and expanded in 1976 at the behest of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), the health insurance program for military families. Panels of psychiatrists are organized in each of the APA's district branches or chapters.

More than 400 psychiatrists nationwide now review mental health benefits claims for a total of 24 national and local insurers. Three psychiatrists review each case, basing their evaluations on guidelines in the *Manual of Psychiatric Peer Review*, which is regularly revised by the APA. In 1982, the APA conducted 5,000 reviews for CHAMPUS and 965 reviews for other third party payers.

The reported cost savings resulting from use of the APA program are impressive. Aetna Life and Casualty's peer review costs in 1981 were about \$20,000, and its

estimated savings were \$2.4 million. Mutual of Omaha Insurance Company estimated a savings of about \$300,000 during its first year of participation in the program. CHAMPUS reports that peer review has led to "outright savings" of \$5 million a year since it began participating three years ago. In addition, savings in costs of medical care avoided as a result of peer review may be three to four times greater than the direct savings. Peer review has been effective in assuring that necessary and appropriate care is delivered.

The APA program is recognized by many third party payers as a responsible effort by the psychiatric community to deal with significant issues of accountability. Mental health benefits require special attention by claims reviewers because of the essential task of protecting patient confidentiality in order for the treatment process to work. The APA's peer review program makes this service available by utilizing careful, professional reviewers in a system that assures accountability and confidentiality.

Business Leadership Needed

It has been predicted that 90 percent of health care services in 1990 will be delivered through contract arrangements between providers and third party payers and their intermediaries. Already systems are evolving to change the economics of health care delivery. There is increased cost sharing to heighten consumers' awareness of cost, and there is more competition between plans for premium dollars. Diagnosis related groups (DRGs) are altering dramatically medical services paid through Medicare and are being adopted rapidly by numerous other all-payer systems.

The extent to which business takes the lead in making choices and helping the medical and other health professions to set the course for health care delivery may well determine the success or failure of the evolving systems to provide quality care at reasonable prices to employers and employees. Some crucial issues must be addressed in this process. One is that as more and more people are covered by insurance the original definition of insurance is weakening. Increasing limits on psychiatric coverage mean that employees are less likely to be protected against the onset of a catastrophic mental illness. Also, as companies look for areas to trim costs, psychiatric benefits often are the first to go, further eroding the real insurance provisions of their coverage. This is especially true when psychiatric benefits for catastrophic illness are eliminated to provide for more predictable routine dental care, for example.

A second issue is that because of prevalent myths about mental health benefits, access to private psychiatric insurance coverage is limited and, consequently, more of the burden for this care falls to the public sector, especially state mental health programs. Only 12 percent of the payment for treatment of mental illness comes from private insurance dollars, compared with 28 percent of the payment for treatment of general medical conditions. States pay almost 50 percent of the cost of mental health care while paying less than 15 percent of the cost of other medical treatments.

This shift in the financial burden of mental health care to the public sector creates especially serious problems for the mentally ill in times of budget cutbacks by all levels of government. Patients receive less care and sometimes no care at all. The untreated show up on the streets as the homeless and in the jails and courts.

The public sector has a responsibility to care for the 28 million Americans who reported in a 1982 Robert Wood Johnson Foundation survey that they had serious trouble obtaining medical treatment. An estimated one million of these people were refused treatment for financial reasons and had no where else to turn but to public facilities. If these facilities are crowded with employees and their dependents whose employers have eliminated catastrophic psychiatric care from their health insurance packages, then the poor and near-poor are left with no place to go for mental health care.

It is imperative that business stand up to this challenge to provide insurance coverage in its truest sense for its employees to obtain private psychiatric treatment so that the state can provide adequate care to those with no other alternatives.

With accurate information to dispel myths about whether psychiatric costs are controllable, the need for psychiatric treatment, the cost-effectiveness of such care and accountability to carriers, business should be prepared to lead the revolution into the next century to assure employees receive full, affordable and high quality health care. ■

The opinions expressed in this article are those of the authors and do not reflect the official position of the American Psychiatric Association.

Notes

1. S. Muszynski, J. Brady and S.S. Sharfstein, "Coverage for Mental and Nervous Disorders: Summaries of 300 Private Sector Health Insurance Plans" (Washington, D.C.: American Psychiatric Press, Inc., 1983).
2. S.S. Sharfstein, S. Muszynski and E. Myers, "Health Insurance and Psychiatric Care: Update and Appraisal" (Washington, D.C.: American Psychiatric Press, Inc., 1984).
3. K.B. Wells, W.G. Manning, N. Duan and J.P. Newhouse, "Cost Sharing and the Demand for Ambulatory Mental Health Services," R-2960-HHS (Santa Monica, Calif.: Rand Corporation, 1982).
4. J. Krizay, "Federal Employees' Experience as a Guide to the Cost of Insuring Psychiatric Services in the Various States," *American Journal of Psychiatry* 139:866-871, 1982.
5. S.S. Sharfstein et al, *op. cit.*
6. *Psychiatric Viewpoints Report: Health Insurance and the Practice of Psychiatry*, Roche Products, Inc. 1983.
7. L.L. Stein, M.A. Test and B.A. Weisbrod, "Alternative to Mental Hospital Treatment: I-Conceptual Model, Treatment Program, and Clinical Evaluation; II-Economic Benefit-Cost Analysis; III-Social Cost," *Archives of General Psychiatry* 37:392-397, 1980.
8. A. Reifman and R.J. Wyatt, "Lithium: A Brake in the Rising Cost of Mental Illness," *Archives of General Psychiatry* 37:385-388, 1980.
9. H.J. Schlesinger, E. Mumford, G.V. Glass, C. Patrick and S.S. Sharfstein, "Mental Health Treatment and Medical Care Utilization in a Fee-For-Service System," *American Journal of Public Health* 73(4):422-429, 1983.

State Mandates for Mental Health Insurance: What Is Their Cost?

Bette Runck

Reductions in public financing of mental health services have forced policy makers at all levels of government to turn their attention to private insurance plans. Of particular interest are state mandates requiring minimal inpatient and outpatient mental health benefits in private health insurance policies.

Connecticut was the first state to pass such a law, in 1971 (1). Since then, ten other states have followed suit, and several more are considering similar mandates. Insurance companies, citing large cost increases, have vigorously opposed such measures. Some even refused to offer the coverage until court orders forced their compliance.

Now a Boston economist has demonstrated that such mandates cost society little. Other evidence suggests that the mandates may provide indirect benefits to offset their cost.

In a study comparing the experience of states with and without mandates, Thomas G. McGuire (2) of Boston University found a 10 to 20 percent increase in the use and cost of outpatient mental health services as a result of the

mandates. McGuire's findings contrast sharply with insurance company reports of the cost of coverage under the mandates. In Massachusetts, Blue Cross and Blue Shield reported that they paid out 14 times more for outpatient mental health care in 1979 than they did in 1975, before the state's mandate went into effect—a 1,300 percent increase.

While not refuting the insurers' claims of greater cost, McGuire provides a different perspective on them. Insurers consider only the increased cost to them, but McGuire looks at the cost to society as a whole. The insurance company figures reflect the fact that, with mental health benefits, insurers pick up the tab that was once paid by the public and users themselves.

Figuring the costs

Although legislated benefit packages differ from state to state, most cover at least 30 days of inpatient care in a private mental hospital, a general hospital, or a state hospital (1). Outpatient benefits in most states have deductibles comparable to those for other major medical benefits, copayments no greater than 50 percent, and a minimum coverage of \$500 worth of expenses per year after deductibles and copayments.

The argument over the cost of mandates focuses on the provision of outpatient benefits because most private health insurance plans already have at least limited inpatient mental health coverage (2). Before the McGuire study, the only available data on the additional cost of such benefits came from insurers, but even that was sparse.

In a recent article in the *Journal of Health Politics, Policy, and Law*, McGuire and John T. Montgomery, an attorney formerly with the Massachusetts Department of the Attorney General, argue that it is misleading to focus on the cost to insurers when evaluating the cost of a mandate (2). First, they point out, the cost of outpatient care has risen with or without a mandate. When looking at costs before and after a mandate, it is difficult to separate out that inflationary trend. Second, a mandate shifts some out-of-pocket and state costs to insurers. "Although these shifts may be significant," note McGuire and Montgomery, "they do not represent net increases in costs due to the mandates, only shifts in the way these costs are finally paid." A further reason why the cost reported by one insurer may be misleading is that it does not account for the possibility that contracts may have been shifted from one insurer to another.

To arrive at what he believes to be a truer cost of a mandate for mental health benefits, McGuire compared the rates of growth in numbers of mental health practitioners in states with and without mandates. He assumed that if the passage of a mandate leads to an increase in the amount of psychotherapy consumed, then there must be a corresponding increase in the amount supplied. McGuire further assumed that the flow of services would be closely related to the number of service providers.

He found that while the growth in the number of psychiatrists was about 7 percent higher in states with mandates than in those without, the corresponding figure for psychologists was much higher—32 percent. McGuire does not find this difference surprising. In the absence of mandates, psychiatrists' services are more commonly covered in health insurance policies than are psychologists'; under the mandates, psychologists' services are typically covered.

After calculating the growth rates of mental health practition-

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ers, McGuire factored out the proportion of growth that could be attributed to the mandates. The use of the services of psychiatrists in fee-for-service practice increased by about 10 to 12 percent. For psychologists identified as health service providers, the increase was 18 to 25 percent. For all fee-for-service practice, the increase was about 10 to 20 percent. Translated into dollars, the increase comes to \$1 to \$2 a person in the general population.

The mandates' advantages
Providing affordable mental health care to a large number of people is, of course, the principal benefit of the mandates. But why is it necessary for the state to step in and force people to buy such coverage? McGuire and Montgomery present four answers to that question.

First, they note that there is widespread prejudice against treatment for mental disorders, which causes mental health benefits to be undervalued. Second, states may choose to use the mandate mechanism to assure that most state residents have the ability to pay for at least a minimum amount of mental health care.

Third, and perhaps most important, mandates do away with the problem of so-called adverse selection. This term refers to the tendency of high-risk policyholders to choose insurance plans with coverage they are likely to use. As the cost of those plans goes up, low-risk policyholders often choose other plans. Then the plan that offered the coverage may drop it to remain competitive.

"Adverse selection changes the perspective on a mandate," write McGuire and Montgomery. "Far from violating consumer sovereignty, the state may be taking steps to implement it." Nevertheless, they note, the effect of mandates is to distribute the cost of mental health care to all policyholders, with good risks paying too much and poor risks paying too little. "This redistribution from the 'healthy' to the 'sick' cannot be judged on efficiency grounds, but

only on political grounds; it is a redistribution that may not be objectionable," according to McGuire and Montgomery.

The intention of the mandates may still be frustrated, however, if they contribute to a trend toward large firms offering their own insurance; employer self-insurance plans are not subject to direct state regulation.

Offset effects

"Offset effects" of mental health care are the fourth argument McGuire and Montgomery offer in favor of mandates. The use of mental health services may reduce the costs to society of health and social services, police, and reduced productivity.

McGuire and Montgomery cite an analysis by Jones and Vischi (4), who found evidence for offset effects in 24 of 25 studies of alcohol, drug abuse, and mental health treatment; in these 24, reductions in medical use ranged from 5 to 80 percent.

As Jones and Vischi caution, problems in the design of these studies make the evidence tenuous. However, McGuire and Montgomery point out that legislators often cannot wait for impeccable scientific proof but must act on available evidence. The existence of offset effects is intuitively sound and also supported by the evidence at hand.

McGuire and Montgomery's analysis of the mandates, which includes a discussion of unsuccessful challenges to their legality, falls short of definitive conclusions about whether the mandates are good social policy in the long run. Their research does lead them to conclude, however, that mandating a minimum level of coverage for mental health services in private health insurance appears to be "reasonable state policy."

Not the perfect solution

Steven Sharfstein, M.D. (3), deputy medical director/assistant to the medical director of the American Psychiatric Association and a longtime student of insurance trends,

believes that although mandates offer important public health and economic advantages, they have their limitations. Most serious is that minimum levels of coverage tend to become the maximum coverage available—"floors become ceilings."

Fifteen states have chosen to encourage mental health coverage without actually requiring it. They have passed laws mandating insurance companies to at least offer such coverage; the decision to buy it is left up to policyholders or their group representatives. In those states, actual purchase of benefits has been low. According to the Philadelphia firm of GLS Associates, Inc., which did a study of all the mandates for NIMH in 1979, there are several reasons for this low number of purchases (1). Among them are that mental health benefits are expensive, decisions are often made by group purchasers who opt for more popular benefits (such as dental care), and insurers do not actively sell this coverage.

Research such as McGuire's may help to change public perceptions about the ultimate cost of buying mental health coverage. "It is important to have creative economists like McGuire look at the objective facts in controversial issues such as the cost of psychiatric care under insurance," says Sharfstein. "We no longer have to rely on the statements of the insurance companies themselves."

References

1. GLS Associates, Inc: Analysis of State Programs Which Mandate Mental Health Benefits Under Private Health Insurance. Final report, NIMH contract 278-78-0040 (MH). June 29, 1979
2. McGuire TG, Montgomery JT: Mandated mental health benefits in private health insurance. *Journal of Health Politics, Policy, and Law* 7:380-406, 1982
3. Sharfstein SS, Taube CA: Reductions in insurance for mental disorders: adverse selection, moral hazard, and consumer demand. *American Journal of Psychiatry* 139:1425-1430, 1982
4. Jones KR, Vischi TR: Impact of alcohol, drug abuse, and mental health treatment on medical care utilization. *Medical Care* 17:1-82, 1979

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Paying for Mental Health Care in the Private Sector

BY FREDERICK C. LEE AND GAIL SCHWARTZ

Employers are looking to cut costs through benefit redesign and alternative providers.

Mental health benefit, service, and delivery issues have become increasingly important to benefit managers of large corporations. Although few employers

have developed a sophisticated data system that allows them to fully comprehend the nuances of this field, many have identified real concerns through increased scrutiny of benefit payments. This new sensitivity to costs is matched by heightened awareness of the need for benefit redesign which also is responsive to the expanding emotional support requirements of today's workers.

The Washington Business Group on Health (WBGH), in a recent survey, documented current corporate thinking on the use of alternative providers and settings as a strategy for containing costs and improving mental health care delivery. The survey also looked at what limits are being placed on mental health coverage and why.

There are a number of reasons why employers have become concerned about mental health issues. The federal government as overseer of Medicare has focused attention on mental health benefits with its emphasis on financing this care in a cost-effective fashion. Likewise, the Federal Employees Health Benefit Program (FEHBP), in concentrating on use of psychiatric benefits, has alerted private sector companies to economic problems created by mental health care coverage. States also have stirred attention with limitations imposed on Medicaid and state employee mental health benefits. Company benefit managers have extended considerable time analyzing the value of providing incentives for outpatient care, including mental health treatment, in lieu of inpatient care. In examining ways of reducing employer health costs, benefit managers also

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have become conscious of the merit of promoting mental wellness. A cultural change has occurred whereby employees are not nearly as covert about their need for and use of mental health services. This trend, in turn, has prompted expansion of worksite mental health programs including counseling, employee assistance programs (EAPs) and stress reduction classes.

Lastly, as employers have become better watchdogs of their benefit programs through the collection of utilization and charge data, they realize that considerable resources are being consumed by mental health episodes of care or inattention to psychiatric problems. In analyzing annual claims, benefit managers often discover that incidents of inpatient psychiatric care represent several of their top 10 most costly benefit payments.

Surveying the Trend Setters

For all these reasons, employers have increased their concern about the use of mental health services by employees. Through its survey, WBGH has tracked the efforts of member companies which have changed or contemplate revising their mental health benefits and in-house services. The survey of 64 large, mostly Fortune 500 corporations, asked about their overall approach to mental health coverage, including trends in services provided, benefits offered, changes implemented and costs accrued for a beneficiary population of 19 million.

The survey results depict the moves made by the employers who are trend setters in health care cost management and who, in the years ahead, are likely to be emulated by thousands of other large and small companies.

Data collected on these companies' general health care expenditures for 1982 and 1983 revealed that respondents spent an average of \$1,312 per capita in 1982 vs. \$1,422 in 1983, reflecting an average per capita increase of 12 percent. Fifty-seven percent of the companies experienced an increase of between 10 and 20 percent.

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Companies that reported per capita cost increases of more than 15 percent do not necessarily differ from those which have experienced smaller increases.

All the companies sampled are major employers in various types of industry including heavy manufacturing, pharmaceuticals, insurance, automobile, energy, hotels, financial services, computers and retail operations. These companies employ a variety of cost management strategies that include efforts to moderate mental health costs. It is clear from analysis of the survey data that the escalating costs of health care are not typical of just one or a few industries.

Wide Spectrum of Modifications

Companies selected for this survey have adopted an interesting range of changes in mental health coverage that reflects their efforts to cope with use of services. Some of the changes represent nothing more than an effort to stay even with cost of living and inflation factors. For example, 19 percent of the companies, including Boeing and Warner Lambert, increased either their annual or lifetime dollar maximum for mental health benefits. Eight percent of the corporations cut their lifetime maximum, however, on the premise that their responsibility of providing for care of an employee or dependent who may be chronically ill should only go so far. Twenty-one percent of the companies have increased employee cost sharing, requiring greater deductibles or coinsurance. But 6 percent of those surveyed reduced the cost sharing burden on employees and, more importantly, 22 percent of the companies enhanced their reimbursement for outpatient mental health services.

Some of the more innovative changes reported included the expansion of mental health benefits by 3 percent of the companies to cover day treatment hospitals, the offering of EAP services to employees who enrolled in a health maintenance organization (HMO), the extension of coverage by 3 percent of the companies for outpatient alcohol and drug programs (like Proctor & Gamble and ALCOA), and the use of flexible benefit programs to isolate employees requiring more extensive mental health coverage.

Three percent of the companies resorted to a defined compensation policy for outpatient care, setting an annual dollar limit with no restriction on the charge per visit or selection of provider. Five percent of the employers limited the number of visits per year on an outpatient basis and 5 percent required preadmission certification before inpatient psychiatric admission. Sixteen percent limited the number of inpatient days covered. For example, 3 percent of the employers set an inpatient limit of 120 days, 8 percent had a 60-day limit, 2 percent, a 45-day limit and 3 percent, a 30-day limit. One company, Chevron, altered both the number of outpatient visits and the rate of coinsurance at the same time. Now this company's employees will receive an 80 percent copayment (up from 50 percent), but the limit on outpatient mental health care visits annually has been reduced from 40 to 20.

Employers and other purchasers of health care are exploring the use of alternative health care providers who

may provide care more cost-effectively. This is especially true in mental health because of the diversity and sheer numbers of alternative providers. Corporations have begun to directly reimburse a variety of mental health professionals. The majority of employers sampled have always reimbursed psychiatrists and psychologists. Currently, 92 percent of employers reimburse for psychologists. In addition, 41 percent reimburse for social workers. Furthermore, corporations have almost doubled (to 34 percent) their use of psychiatric nurses since surveyed by WBGH in 1982.

Corporations employ psychologists more often than psychiatrists, although the tasks these providers perform are comparable regardless of their training. Twenty percent of the companies surveyed have full-time psychologists and 10 percent employ psychologists as part-time consultants.

"Many companies have begun to restructure benefit plans to incorporate alternatives to inpatient psychiatric coverage. Despite this trend, there is little available data to substantiate associated cost savings. Twenty percent of the survey respondents... said they have begun reimbursing for day treatment centers and 14 percent are reimbursing for night [hospitalization]...."

The WBGH survey also examined whether companies use specific individuals as "gatekeepers" to steer employees into appropriate mental health treatment settings. Twenty-seven percent of the respondents reported having a staff person responsible for identifying individuals in need of mental health treatment, 39 percent had someone referring patients to other providers, 25 percent had an employee monitoring ongoing treatment, and 27 percent had an individual overseeing psychiatric long-term disability cases. In most cases, these various tasks are being performed by the same individual. Triage duties were shared by the following: nurse, medical or counseling department staff member, physician, psychiatrist, EAP coordinator, plant personnel director, benefit manager, administrator or psychologist. In two cases, these functions were filled by a manager of disability services and a long-term disability coordinator.

Many companies have begun to restructure benefit plans to incorporate alternatives to inpatient psychiatric coverage. Despite this trend, there is little available data to substantiate associated cost savings. Twenty percent of the survey respondents, such as Aetna, said they have

begun reimbursing for day treatment centers and 14 percent are reimbursing for night hospitals which allow patients to work during regular employment hours. A few companies have also added extended care facilities to their plans.

Coverage for inpatient psychiatric care remains, however, the most generous mental health benefit offered by employers. There has been some benefit redesign in this area, with 33 percent of companies reporting that they have set a lifetime maximum on dollar outlays for psychiatric inpatient care. Of these companies, 29 percent have set the level at \$20,000 to \$25,000. Otherwise, no real trend in redesign of inpatient psychiatric coverage has become apparent. No company yet has introduced a maximum dollar limit per episode of care, and only 8 percent of the surveyed corporations imposes a maximum daily reimbursement for inpatient care. None of the companies with a daily cap has established dollar limits. Instead, the employers stipulate reasonable and customary or semiprivate room restrictions. One employer, The Continental Group, Inc., did introduce a limit for inpatient days in excess of 60, committing to a reimbursement rate of \$100 per day or 50 percent of the hospital charge, whichever is less.

Seventy percent of the companies have stop-loss coverage built into their plans. More than two-thirds of employers with a stop-loss provision have a specific inpatient psychiatric clause. The average recorded inpatient psychiatric stop-loss was \$1,590. But limits ranged from \$500 to \$5,000.

"A number of medium and large sized companies have developed EAPs. The impetus for this movement has been employer recognition of the costs, absenteeism and loss of productivity associated with emotional problems, alcoholism, drug abuse and mental illness.... Some employers are finding EAPs to be a viable, cost-effective option."

Employers also relied on coinsurance as a cost management strategy to control inpatient psychiatric benefits use. Fifty-five percent of the employers had an 80-20 cost sharing provision; one-fourth still had first dollar coverage.

Outpatient coverage, as noted earlier, remains an area of concern for employers. Respondents to the WBGH survey have implemented some conventional limitations to protect against induced demand. Although research has yet to indicate the most appropriate benefit design for

checking unnecessary outpatient use, the three most commonly employed strategies have been: placing a maximum limit on annual payment per employee for outpatient services; restricting the number of reimbursable outpatient visits per year; and imposing a dollar limit on reimbursement per visit. Fifty-six percent of the companies surveyed limit yearly reimbursement for outpatient mental health services to between \$1,500 and \$2,000 per employee, with the average limit being \$1,723.

Eight percent of the companies rely on a separate deductible for mental health services, but the bulk of the respondents choose to offer coinsurance restraints. Thirty-two percent of the employers pay less than 50 percent coinsurance, another 51 percent pay exactly half of the copayment, and 6 percent pay more than half of the provider's charge. The remaining 11 percent have adopted a graduated cost sharing strategy in which employee coinsurance requirements increase with the number of outpatient visits. For example, at Ford Motor Company the employee pays 20 percent of the cost of the first five visits, on up to 100 percent for more than 15 visits per year. One company even has adopted a graduated copayment level based on the diagnosis, an intervention many other companies may view as too controversial to attempt, because it interjects benefits managers into medical practice decisions. Only 21 percent of the employers have limited the number of annual outpatient visits. Of this group, five percent have set restrictions of 100 and 140 days per year, 5 percent have constrained use to an average of 23 days, and 11 percent selected either 50 or 52 days as the maximum reimbursable limit.

Utilization Review Limited

Many of the companies surveyed have adopted utilization review programs for general medical care, but the provision of separate mental health care review is less common. Thirty-seven percent of employers polled said they carry out concurrent inpatient psychiatric review. The first program of this kind among respondents was established in 1982. Only 11 percent of the corporations, including Armco, Goodyear and IBM, perform concurrent review of outpatient mental health care utilization. The same number of employers, among them LTV and Digital, reported implementing preadmission review as a gate-keeping function for potential inpatient psychiatric episodes.

One example from the survey demonstrates how the business community has collaborated with providers to make needed mental health care available while maintaining control over costly, inappropriate use of resources. The St. Louis Area Business Health Coalition has joined with a local, federally sponsored peer review group and the Eastern Missouri Psychiatric Society to create a concurrent inpatient psychiatric review program which begins this month. The program took 16 months to develop and relies on certain established criteria in determining appropriateness of care.

Reviews of care will be charted and the aggregate data analyzed. The program will charge \$2.50 per admission. A conservative estimate by the business coalition

is that the program will reduce inpatient psychiatric care by 5.38 days per stay which could result in a \$1,614 savings per admission. Despite the importance of this effort, the time spent developing this program underscores the fact that such proposals cannot be drawn up and implemented overnight.

Variations in EAPs

A number of medium and large sized companies have developed EAPs. The impetus for this movement has been employer recognition of the costs, absenteeism and loss of productivity associated with emotional problems, alcoholism, drug abuse and mental illness. More recently, corporations have realized that long-term psychotherapy is not the only option for employees with mental health problems. Some employers are finding EAPs to be a viable, cost-effective option.

Seventy-three percent of the companies surveyed by WBGH have EAPs, most of which were developed in the last eight years. The majority of EAPs employ a combination of health care professionals, and other types of staff. There were no significant patterns to these combinations. The following table gives a breakdown of the different professionals and paraprofessionals used in the EAPs of the survey respondents.

Type of professional/paraprofessional	Percent of EAPs in which professional/paraprofessional is represented.
Counselors	21%
Volunteers	2
Licensed Clinical Social Workers	26
Nurse	14
Master of Counseling	5
Psychologist	14
Psychiatrist	7
Master of Social Work	4
Physician (other than Psychiatrist)	4
Lawyer	2
Management Representative	5
Others	20

Over the past several years, EAPs have broadened their focus beyond their initial emphasis on alcohol and drug abuse. A number of EAPs have incorporated assistance in coping skills, family counseling and financial planning. Of the EAPs surveyed, 68 percent have comprehensive missions, while 30 percent are oriented solely around alcohol and drug abuse intervention and treatment.

The majority (67 percent) of employers house EAPs in their corporate medical departments, 24 percent put EAPs under their personnel departments, and the remaining 9 percent of employers have established independent EAPs or put that responsibility under the health and safety divisions.

Companies have dealt differently with the issue of who on an EAP's staff should initially identify employees to determine appropriateness of care. WBGH's analysis shows that psychiatrists are rarely involved in making this determination: they do so in only 4 percent of the EAPs

reviewed. Psychologists make this judgment in over one-fifth of the EAPs (22 percent). Licensed certified social workers do the initial screening in almost a third (29 percent) of EAPs, while counselors screen EAP clients in 18 percent of the programs. In the remaining companies, the designation is made by some member of the medical department, a registered nurse, or the EAP manager.

"Employers...[also] pay for mental health problems through...psychiatric disabilities....For 30 percent of the companies surveyed, psychiatric disabilities comprised more than 11 percent of their caseload. These employees frequently have severe mental health problems which make it difficult for them to work full-time."

In establishing EAPs, employers make an investment in their work force and assume new responsibility for their employees' mental health. But critical policy questions have to be resolved prior to implementation: Which employees should be eligible? What types of problems should be considered? Should EAP resources be limited to employees? Should they be broadened to include employees, dependents and retirees? Fifty-two percent of the companies surveyed offer their EAP services to their employees, dependents and retirees; 32 percent of the companies exclude retirees from EAPs, but make their programs available to employees and dependents; and 16 percent of employers make their EAP programs available only to employees. Where an EAP is restricted to employees, the company clearly views its responsibility as limited to cases where job performance is affected by mental health problems.

Of the total number of persons seen by EAPs, the majority (58 percent) were seen for screening and referral only, while the remainder actually were treated by EAP staff. The overwhelming majority (over 90 percent) of cases were self-referred, while the remainder were referred by supervisors or management, union representatives, fellow employees, or the medical department. Once an employee visited an EAP he or she most often was referred to in-house staff. Alcohol treatment centers and drug abuse programs were the other common referral sites.

Forty-one percent of the companies surveyed have a stress management program. Sixty-five percent of these employers house their stress management program within the EAP and the remaining 35 percent have put stress management under the corporate medical department, health and safety division, or employee services. Sixty-two percent of respondents stated their EAPs also work with disabled employees.