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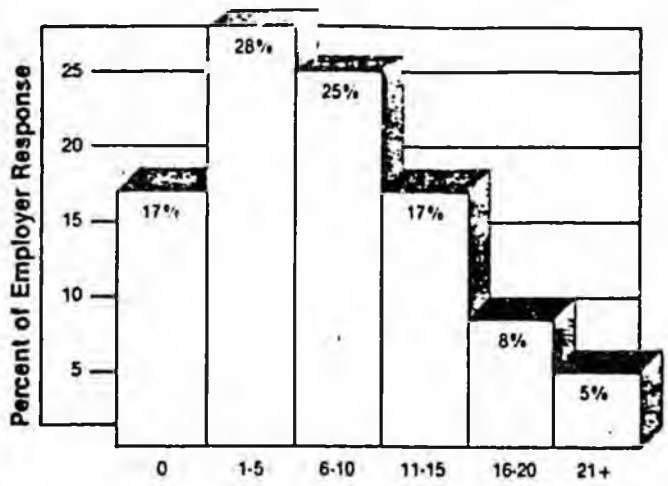
Handling Psychiatric Disability

Employers not only pay for mental health problems through increased absenteeism and health care costs, but also through psychiatric disabilities that require provision of short- and long-term disability and workers compensation benefits. The added financial burden of these income maintenance payments can be enormous.

The following chart shows the percentage of long-term disability (LTD) claims due to psychiatric conditions among survey respondents.



LTD Cases
(Percent with Psychiatric Causes)

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.

One-third of the survey respondents said they have a program to bring psychologically disabled workers back to work. Often times, these programs are also open to physically disabled workers. The most common employer sponsored return-to-work program is an incentive arrangement whereby the disabled individual can work part-time and continue to receive disability benefits while he or she readjusts to employment. During this trial work period, the disabled employee does not run the risk of losing his or her disability benefits and Medicare coverage until he or she is fairly certain about being able to remain on the job. In most instances, individuals are selected on a case-by-case basis for such a program.

In addition, two companies surveyed have identified an individual who is solely responsible for disability benefits. One company, Owens-Illinois, employs a "long-term disability coordinator," while Xerox has a physician "disability manager."

Independent medical examiners frequently are called upon to assess the status of disabled workers. Internal rehabilitation committees comprised of representatives from company benefits and corporate medical departments also have merged as oversight groups that deliberate on the potential for rehabilitation of specific employees.

As corporations become more aware of the high cost of disability, cost management techniques will be advanced that echo the efforts employed by business over the last decade to reduce overall health care costs.

Shape of Changes to Come

The benefit changes recorded by participants in this survey give some indication of what revisions can be expected from employers who have yet to act. A number of these companies, however, are waiting until there are more data available on the impact of changes in mental health coverage. The most common alteration planned for 1985 will deal with outpatient care: 8 percent of the companies surveyed intend to enhance incentives for outpatient use by decreasing employee coinsurance levels from the usual 50 percent to 20 percent.

Concerns about excessive use of mental health benefits have motivated 4 percent of the companies to reduce the lifetime maximum, and another 4 percent to propose a limitation on the number of outpatient visits. Goodyear, Deere and Company, and Bethlehem Steel are examples of companies surveyed that are working on development of a preferred provider organization, HMO or other type of prepaid, risk sharing program with mental health providers.

Such interest indicates corporate leaders are scrutinizing closely mental health costs. Many employers now realize that they are paying dearly for expenses associated with mental illness, and yet they have little understanding of what they have been purchasing. The recent employer movement towards collecting, analyzing and monitoring data has made this more apparent. In addition, corporations are recognizing that mental health services can be provided through a wide range of alternatives and are beginning to reflect these options in the design of employee benefits.

The WBGH mental health survey reveals several trends in mental health care coverage including:

- That corporations are becoming extremely concerned about high health care costs, absenteeism, disability costs, and lost productivity associated with mental health;
- That benefit managers are grappling with how to redesign reimbursement for mental health coverage to reflect new options in service delivery and alternative providers;
- That employers also have recognized utilization review is an imperative component of benefit design;
- That employers are continuing to broaden their EAPs to include more areas such as counseling for disabled employees and that EAPs will become more diffused as the movement gains momentum;
- That as companies invest more in their employees as human resources, they will continue to develop new mental wellness programs.

In short, corporate awareness of mental health costs is likely to culminate in the restructuring of reimbursement and the delivery of mental health services. ■

Adult mildly retarded persons and their parents: the relationship between involvement and adjustment. Applied Research in Mental Retardation 6:409–419, 1985
43. Brunn LC: Elderly parents and dependent adult child. Social Casework 66:131–138, 1985
44. Wilder DE, Teresi JA, Bennett RG: Family burden and dementia, in The Dementias. Edited by Meyeux R, Rosen WG. New York, Raven Press, 1983
45. Kanter J, Lamb HR, Loeper C: Expressed emotion in families: a critical review. Hospital and Community Psychiatry 38:374–380, 1987
46. Arieti S: Interpretation of Schizophrenia, 2nd ed, rev. New York, Basic Books, 1974
47. Hatfield AB: Coping effectiveness in families of the mentally ill: an exploratory study. Journal of Psychiatric Treatment and Evaluation 3:11–19, 1981
48. Lefley HP: Etiological and prevention views of clinicians with mentally ill relatives. American Journal of Orthopsychiatry 55:363–370, 1985
49. Wasow M: Chronic schizophrenia and Alzheimer's disease: the losses for parents, spouses, and children compared. Journal of Chronic Disease 38:711–716, 1985
50. Gubman GD, Tessler RC: The impact of mental illness on families: concepts and priorities. Journal of Family Issues 8:226–245, 1987
51. Harris M, Bergman HC: The young adult chronic patient: affective responses to treatment. New Directions for Mental Health Services, no 21:29–35, 1984
52. Myers G: When I am gone: estate planning. AMI Newsletter of Dane County, Wisconsin, April 1987, p 5
53. Hatfield AB: Psychological costs of schizophrenia to the family. Social Work 23:355–359, 1978
54. Herz MI, Endicott J, Spitzer RL: Brief versus standard hospitalization: the families. American Journal of Psychiatry 133:795–801, 1976
55. Noh S, Turner RJ: Living with psychiatric patients: implications for the mental health of family members. Social Science and Medicine (in press)
56. Hoenig J, Hamilton ME: The schizophrenic patient in the community and his effect on the household. International Journal of Social Psychiatry 12:165–176, 1966
57. Pearlin LI, Schooler C: The structure of coping. Journal of Health and Social Behavior 19:2–21, 1978
58. Gubman GD, Tessler RC, Willis G: The family's response to a mentally ill relative: the do's and don'ts of household living. Schizophrenia Bulletin (in press)
59. Lefley HP: Impact of mental illness in families of mental health professionals. Journal of Nervous and Mental Disease (in press)
60. Falloon IRH, Boyd JL, McGill CW: Family Care of Schizophrenia. New York, Guilford, 1984
61. Anderson CM, Reiss DJ, Hogarty GE: Schizophrenia and the Family. New York, Guilford, 1986
62. Group for the Advancement of Psychiatry: The Family, the Patient, and the Psychiatric Hospital: Toward a New Model. Report no 117. New York, Brunner/Mazel, 1985
63. Bernheim KF, Lehman AF: Working With Families of the Mentally Ill. New York, Norton, 1985
64. Goldstein MZ: Family Involvement in the Treatment of Schizophrenia. Washington, DC, American Psychiatric Press, 1986
65. Hatfield AB: The expressed emotion theory: why families object. Hospital and Community Psychiatry 38:341, 1987
66. Lamb HR: Treating the Long-Term Mentally Ill. San Francisco, Jossey-Bass, 1982
67. Bachrach LL: Asylum and chronically ill psychiatric patients. American Journal of Psychiatry 141:975–978, 1984
68. Kasl SV: Stress and health. Annual Review of Public Health 5:319–341, 1984
69. Jacobs SC, Mason JW, Kosten TR, et al: Bereavement and catecholamines. Journal of Psychosomatic Research 30:489–496, 1986
70. Intagliata J, Willer B, Egri G: Role of the family in case management of the mentally ill. Schizophrenia Bulletin 12:669–708, 1986

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

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Health insurance claims of families covered by Aetna's Federal Employees Health Benefit Program from 1980 through 1983 were analyzed to determine if any changes in total health care utilization and costs were associated with the initiation of mental health treatment. A total of 26,915 families in which at least one member received mental health treatment were compared with a randomly selected group of 16,468 families in which no member had received mental health treatment. Total health care costs for those receiving mental health treatment were significantly higher than costs for the comparison group. However, those costs dropped significantly after initiation of mental health treatment and continued to decline over the study period. The biggest declines occurred among persons age 45 and older, a finding that may have important policy considerations.

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

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

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

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

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

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

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

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

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

Research design

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

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

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

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

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

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

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

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

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

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

Comparison of the groups

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

The monthly per-person costs (in January 1980 dollars) for all health care for families with at least one member receiving mental health treatment were $158.82, compared with $91.85 for the random sample. Most of this difference was the result of inpatient treatment costs ($104.85 a month for the mental health treatment group versus $60.12 a month for the random sample). However, there were also differences between the two groups in ambulatory care and other costs over the four-year study period.

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

Mental health treatment costs and utilization

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

The cost of mental health care per person receiving care during the study period was $2,079 (January 1980 dollars), of which 63 percent was paid by Aetna as health insurance benefits. Inpatient care, though utilized by only 20 percent of the mental health patients, accounted for 60 percent of mental health treatment costs. The average length of inpatient mental health treatment was 32.2 days. More than half of the inpatient stays were 21 days or less, and almost a fourth were seven days or less. The average cost per admission was $3,887 (January 1980 dollars), and the average number of admissions per person utilizing inpatient care was 1.57. No data were available on whether the inpatient stays were in specialty facilities or general hospitals.

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

Pre-post patterns of medical care

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

The primary research question

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

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

These results are confirmed in the analysis of group 3, those with at least 12 months pre- and 24 months posttreatment data. This group provides clear evidence that the decline in cost and utilization continues in the second year following the initiation of mental health treatment. Total health care costs per month per person fell from $242 in the year before treatment to $214 in the first year after treatment began to $162 in the following year. These differences were statistically significant ($F=21.88$, $df=17,642$, $p<.001$). As with group 2, this drop was primarily the result of decreases in inpatient days per month per person from .63 to .52 to .39 days ($F=19.02$, $df=17,642$, $p<.001$) and inpatient costs per month per person from $167 to $133 and $106 ($F=13.95$, $df=17,642$, $p<.001$). Ambulatory care costs actually increased in the year following initiation of treatment (from $59.15 in the year before to $64.15 in the year after) due to the use of ambulatory mental health services, but they fell below the pretreatment level in the second posttreatment year ($42.29). These differences were also statistically significant ($F=60.59$, $df=17,642$, $p<.001$).

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

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

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

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

Longitudinal analysis of total health care costs

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

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

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

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

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

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

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

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

Conclusions

The results of this study provide confirmation of the findings of previous studies as well as provide new findings, previously unreported, concerning the question of the potential for mental health treatment to reduce other health care costs.

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

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

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

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

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

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

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

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

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

This study is not as subject to biases due to regional variations in general health or mental health care as is much other research, since the population of persons filing mental health treatment claims with Aetna is a national one, drawing on all 50 states. However, it is not necessarily geographically representative of either the U.S. population or the population of federal employees, since many factors influence the choice of health plans by government workers.

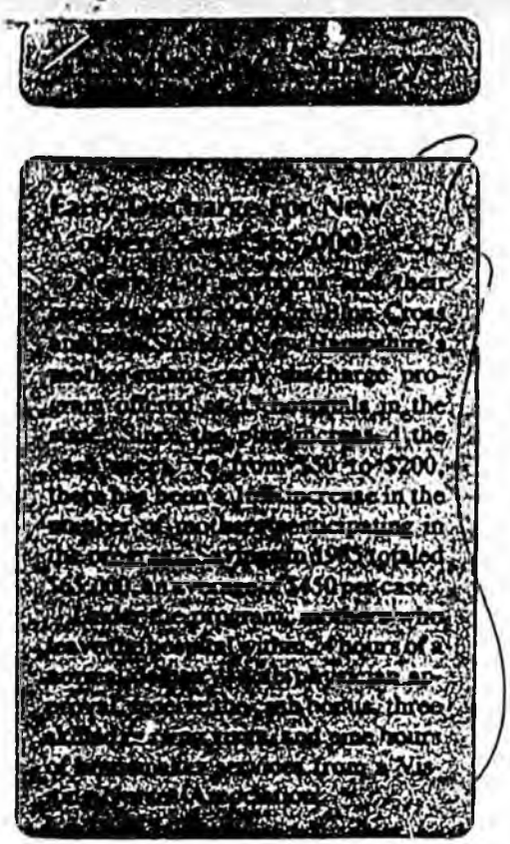
Roughly 60 percent of Aetna claimants receiving mental health treatment are age 45 and older. The study finding that older age groups have greater opportunity for cost reductions than younger groups is an important policy consideration. Older people tend to use more medical care services than those in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

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

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

References

1. Follette WT, Cummings NA: Psychiatric services and medical utilization in a prepaid health plan setting. Medical care 5:25–35, 1967
2. Jones KR, Vischi TR: Impact of Alcohol, Drug Abuse, and Mental Health Treatment on Medical Care Utilization: A Review of the Research Literature. Medical Care 17 (suppl), Dec 1979
3. Mumford E, Schlesinger HJ, Glass GV: Problems of analyzing the cost offset of including a mental health component in primary care, in Mental Health Services in Primary Care Settings: Report of a Conference, April 2–3, 1979. DHHS pub no (ADM) 83–995. Rockville, Md, National Institute of Mental Health, 1983
4. Mumford E, Schlesinger HJ, Glass GV: The effects of psychological intervention on recovery from surgery and heart attacks: an analysis of the literature. American Journal of Public Health 72:141–151, 1982
5. Mumford E, Schlesinger HJ, Glass GV, et al: A new look at evidence about reduced cost of medical utilization following mental health treatment. American Journal of Psychiatry 141:1145–1158, 1984
6. Schlesinger HJ, Mumford E, Glass GV, et al: 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 73:422–429, 1983
7. Kessler LG, Steinwachs DM, Hankin JR: Episodes of psychiatric care and medical utilization. Medical Care 20:1209–1221, 1982
8. Hankin JR, Kessler LG, Goldberg ID, et al: A longitudinal study of offset in the use of nonpsychiatric services following specialized mental health care. Medical Care 21:1099–1110, 1983
9. Goldberg EL, Comstock GW, Hornstra RK: Depressed mood and subsequent physical illness. American Journal of Psychiatry 136:530–534, 1979
10. Borus JF, Burns BJ, Jakobson AM, et al: Neighborhood health centers as providers of coordinated mental health care. Background paper, Conference on Provision of Mental Health Services in Primary Care Settings. Rockville, Md, National Institute of Mental Health, April 2–3, 1979
11. Campbell D, Stanley J: Experimental and Quasiexperimental Designs for Research. Chicago, Rand McNally, 1966
12. Cook T, Campbell D: Quasi-Experimentation: Design and Analysis Issues for Field Settings. Boston, Houghton Mifflin, 1979
13. Borus JF, Olendzki MC, Kessler L, et al: The "offset effect" of mental health treatment on ambulatory medical care utilization and charges. Archives of General Psychiatry 42:573–580, 1985



care, the report said, adding:

"With women accounting for two-thirds of the expected labor force growth, a more concerted effort by industry and the public sector is needed to assure quality child care.

"Child care is important for worker morale and productivity. It is also essential for the employment of welfare recipients. Child care facilities can provide a stimulating environment for younger children. This can be particularly beneficial for children from more disadvantaged surroundings."

Mr. Ong, who also is chairman and CEO of B. F. Goodrich Company, said the study was designed only to suggest what problems would arise in the next 15 years, "not to spell out our silver bullets to take care of the problems."

However, in a section on guidance for action toward the future challenge in labor market policy, the report did call for a national policy on child care "to identify the most appropriate responsibilities for the different levels of government."

No One Can Do All

It said that care of children during work hours has become a national issue, important to both men and women workers, with increases in single heads of households and two-wage-earner families.

The Alliance report said:

"No one sector can assume full responsibility and costs. Because many businesses already realize that worker attendance and productivity can be affected, they are providing information on available child care or assisting in expenses through benefit packages."

Businesses also need increasingly to consider flexible work schedules or greater part-time opportunities to meet needs of parents, stated the report.

"Since many needing child care, such as single heads of families, have lower incomes, governments must also respond. Options include tax incentives for business investment and income-based voucher programs for parents." □

Dropping Mental Health Coverage Can Be Costly

The cost of mental health benefits is high but the cost of not providing them may be even higher, according to the Washington Business Group on Health.

Speakers at the spring meeting of the National Association of Private Psychiatric Hospitals quoted the statistics on costs to employers of mental illnesses of employees and noted that those treating mental illness are responding to employer's cost concerns

associated with mental health benefits.

Dr. Howard Hoffman, of the Psychiatric Institute of Washington, D.C., referred to the study by the Washington Business Group on Health which reported that:

- Weirton Steel reports that 61% of its absenteeism is due to psychiatric problems.
- Kennecott Copper Company's "Insight" counseling program reports a 53% reduction in absenteeism and 55% hospital/surgical/medical reduction.
- The California Psychological Health Plan, a benefit plan added to some insurance policies, reports that users have a 20%-24% reduction in hospital/surgical/medical utilization.
- Blue Cross of Western Pennsylvania reports that for 136 persons who used insured outpatient psychiatric benefits, medical costs dropped from $16.47 to $7.06 per month.
- Group Health Association reports that users of mental health counseling benefits reduced their nonpsychiatric physician visits by 30.7% and lab/X-ray services by 29.8%.
- General Motors' alcoholism program reports a 49% reduction in lost work hours and a 29% reduction in disability costs.
- Bethlehem Steel has a 60% rehabilitation rate in its alcoholism program.
- Kimberly Clark's employee assistance program showed a 70% reduction in accidents for the year after participation compared with the year before.

Alternative Treatments

Speakers described psychiatric hospital responses to health care cost containment measures currently being taken by employers, insurers and other providers. Hospitals are developing alternative treatments such as outpatient treatment, day treatment and partial hospitalization as well as inpatient treatment. In addition, some hospitals work with local business health care coalitions and provide professional consultation, education programs and EAP resource services.

Flexibility Is Key

Dr. Hoffman said hospitals are developing flexible and creative approaches to meeting the needs and concerns of payors and employers shopping for services should be prudent buyers. When reviewing mental health benefits packages, employers should keep four points in mind:

- Substance abuse is not a single entity but encompasses many different problems and diagnoses.
- Caps on services are not all bad if there is an outlier appeal method.
- A creative exchange of benefits for less intensive services provides for flexibility.
- Child and adolescent illness is different from adult mental illness and needs different services. □

Stress Affects All Workers

The results of a recent nationwide survey shows that executives are not the only group of employees who are adversely affected by stress. The Panasonic Industrial Company and the Professional Secretaries International (PSI) polled 1,000 members and found that the stress faced by secretaries can contribute to absenteeism, diminished productivity, and any number of health problems.

The survey evaluated the impact of environmental conditions, such as job functions, work atmosphere, professional relationships, executive work habits, and office equipment.

Lack of communication is a major cause of secretarial stress. Of the 70% who reported too little communication with their

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Parity for Mental Health

Should there be "parity" or equality in coverage for mental illness in health insurance? Clear divisions have existed on this issue for some time. To providers and patient advocates, parity has symbolic as well as practical significance. In addition to enhancing patients' ability to pay for care and providers' ability to collect revenue for care, parity symbolizes acceptance by the medical profession and society at large of the legitimacy of mental illness and the value of mental health treatment. The American Psychiatric Association, for example, has drawn an analogy between stigmatizing the mentally ill and what they refer to as the "historical discrimination against the mentally ill in insurance plans."

Policy makers and most researchers, however, have rejected the call for parity on the grounds that equal insurance coverage would encourage excessive utilization. The research evidence has consistently shown, where health and mental health are compared, that the demand response for mental health care is greater than for most other health care. Principles of insurance design justify less coverage for services for which the "moral hazard" problem is more severe.

Parity: The Retreating Goal

Virtually all private and public insurance plans place special limits on coverage for mental health care. Less than ten percent of individuals covered by employment-related group health insurance have identical coverage for outpatient mental and physical health care. Medicare presently places strict limits on outpatient care and has special inpatient day limits in psychiatric facilities. Medicaid programs vary state to state; in many states mental health care is not a covered service or is subject to special restrictions.

In the past decade, the disparity between coverage for physical and mental illness has increased. Health cost inflation has eroded the real value of coverage denominated in dollars. Medicare pays $250 in total for outpatient mental health benefits (with 50 percent coinsurance). This can buy only about one-quarter of the care it could buy in 1965. Many states have mandated $500 or $1000 of insurance coverage. In 1976, Massachusetts mandated coverage of $500, which could purchase more than 14 visits to an office-based psychiatrist. Today the coverage is worth less than seven visits. Furthermore, cost-control efforts have led to benefit reductions specific to mental health in prominent health plans, including the nationally available plans for federal employees available from Blue Cross and Aetna.

Time of Reconsideration

Although the trend may appear to be moving away from parity in coverage, other changes in health care payment systems are giving cause for serious reconsideration of the perceived wisdom on the parity issue. Effective alternatives to patient cost sharing are being implemented and evaluated. As these innovative cost-control mechanisms become more effective, the need to impose cost sharing on patients to restrain utilization is diminished, and the case for using insurance primarily to protect patients against the financial risk of illness is strengthened.

Opportunities for significant restructuring of insurance coverage are greatest in the area of hospital care, because of recent changes in methods of reimbursement. Powerful supply-side incentives to limit utilization obviate the need for patient cost-sharing. In Medicare, *all* psychiatric discharges are paid by some form of prospective payment, fully prospectively in the case of nonexempt facilities on the basis of DRGs, and partially (roughly half) prospectively for exempt facilities paid under TEFRA. All but a handful of states use some form of prospective payment for psychiatric discharges in Medicaid. Contracting by private insurers is becoming the rule rather than the exception. In this environment, special limits on psychiatric discharges in these plans should be reconsidered.

Should Parity be the Goal?

Is it parity that should be sought? It is interesting that the mental health community has generally opposed parity on the reimbursement side in Medicare. The argument that mental health care should be treated like the rest of medical care was not persuasive when the rest of medical care was being paid prospectively on the basis of DRGs.

Health maintenance organizations (HMOs) are an example of near-parity for mental health. Although most HMOs explicity limit mental health visits to 20 per year, in fact, the real limit on use is what the clinicians at the plan decide the patient needs—very few patients reach 20 visits. In this sense, the limit on mental health care is the same as it is for other areas of health care. It is not at all clear that this instance of full parity is what we should want. When the provider is paid prospectively, mental health services seem to be one of the areas of heaviest management pressure to limit use.

In the case of payment system rules, equality with other medical care should not be the goal *per se*. The goal should be coverage that appropriately balances access to care and cost. We must ask, therefore, parity with what?

Health service researchers are likely to continue to argue that on the basis of distinct patterns of demand (and now supply) behavior, the reimbursement and financing system for mental health care should be different than for other medical care. Introduction of supply-side cost control policies makes the case for parity in payment systems stronger, to be sure. But leaving aside the question of parity, it is certainly true that changes in reimbursement methods put us in danger of cost overkill. It is time to lighten up on the demand-side controls on mental health care—particularly for hospital care—to provide more financial protection for the catastrophic expenses due to mental illness.

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FINAL REPORT

MANDATED HEALTH BENEFITS IN MARYLAND: A RESEARCH REPORT ON RELEVANT PUBLIC POLICY ISSUES

Prepared for

Blue Cross and Blue Shield of Maryland

Blue Cross and Blue Shield of the National Capital Area

November 1985

Excerpts (marked *)

(let me know if you want any other sections)

CENTER FOR HEALTH POLICY STUDIES

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MANDATED HEALTH BENEFITS IN MARYLAND: A RESEARCH REPORT ON RELEVANT PUBLIC POLICY ISSUES

Prepared for

Blue Cross and Blue Shield of Maryland

Blue Cross and Blue Shield of the National Capital Area

November 1985

Prepared by: Zachary Dyckman, Ph.D.
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MANDATED HEALTH BENEFITS IN MARYLAND:
A RESEARCH REPORT ON RELEVANT PUBLIC POLICY ISSUES

Introduction

The issue of the appropriateness and need for specific mandated health insurance benefits is a critical one in Maryland. It is likely that the Maryland legislature will be confronted with mandated benefit issues this year. It is the express desire of the Maryland General Assembly that decisions as to whether to expand, contract or change the structure of mandated benefits be made on the basis of reliable, accurate information on cost and benefit implications of specific mandate decisions. To this end, the House Economic Matters Committee has requested that Blue Cross and Blue Shield of Maryland, and Blue Cross and Blue Shield of the National Capital Area address a number of important questions concerning mandated health insurance benefits. This report is in response to those questions.

This report has been prepared by the Center for Health Policy Studies under the direction of Zachary Dyckman, Ph.D., for Blue Cross and Blue Shield of Maryland and Blue Cross and Blue Shield of the National Capital Area. The methodologies used to respond to the issues raised by the Committee include analyses based on existing published and unpublished research studies, computer runs of Blue Cross and Blue Shield claims cost files, information obtained from the Maryland Division of Insurance and other insurance industry sources and a special mandated benefit survey of Blue Cross and Blue Shield plans.

The report focuses on those benefits specifically mandated to be included in health insurance policies. Excluded from consideration in this report are benefits which are mandated to be offered to health insurance purchasers. Also excluded are mandated benefits for maternity coverage (mandated for larger groups by Federal statute), mandates for conversion rights and recently mandated benefits for in-vitro fertilization (no claims cost experience available).

Mandated Benefit Research Issues

Selected issues are discussed briefly here:

Issue: • What is the cost of health benefits mandated in Maryland?

1984 claims expenditure data (claims cost and administrative expenses combined) for Maryland Blue Cross and Blue Shield and National Capital Area Blue Cross and Blue Shield (Maryland contracts) were extracted from claims files and combined to

develop data for all Blue Cross and Blue Shield members in Maryland, excluding Federal Employee Benefit Plan and Medicare supplemental enrollees. The mandated benefit cost data are summarized below.

BLUE CROSS AND BLUE SHIELD MANDATED BENEFIT COST IN MARYLAND, 1984

	Amount Per Member Contract Month	Amount Per Family Contract* Year	Percent of Total Benefit Costs
Mandated Benefits			
All Mandated Benefits	$ 5.61	$ 222.16	11.5%
Mental and Alcohol Rehabilitation	4.25	168.30	8.7
Outpatient Mental	2.19	86.74	4.5
Total Benefit Cost	$48.67	$1,927.33	100.0

*Assumes statistically average family of 3.3 persons.

The cost of Maryland mandated benefits, excluding maternity benefits and other selected mandates identified in the report, is 11.5 percent of total benefit cost. The aggregate cost of mandated benefits for 1,317,000 Blue Cross and Blue Shield members in Maryland is approximately $89 million, out of total benefit cost of $769 million.

Issue: • Which benefits mandated in Maryland are offered in states in which these benefits are not mandated?

The Center for Health Policy Studies conducted a survey of other Blue Cross and Blue Shield Plans. The primary purpose of the survey was to determine what benefits are commonly provided by Blue Cross and Blue Shield Plans for the benefits which are not mandated in their states but which are mandated in Maryland. Because the survey attempts to measure benefit levels which are determined by purchaser preferences rather than by state regulatory decisions, i.e., state mandates, Plans were surveyed in states which have relatively few (or no) mandated health insurance benefits.

Forty-two Blue Cross and/or Blue Shield Plans were selected for the survey from 34 states which were known to have few mandated benefits, based upon prior studies. A total of 34 Plans in 29 states responded to the survey questionnaire, for a response rate of 81 percent. Most surveyed Plans routinely

provide inpatient mental health, alcoholism and drug abuse benefits, with 30 days coverage the most common level of benefits. Similarly, most Plans routinely provide benefits for hospice care, prosthetic devices and home health care. These benefits are comparable to Maryland mandated benefits for these services. Few Plans provide benefits for in-vitro fertilization, a recently mandated service in Maryland.

Most of the Plans which routinely provide outpatient mental health benefits require 50 percent patient coinsurance, which is comparable to the Maryland mandate. However, most Plans had dollar limits on outpatient mental health benefits and/or limits on number of visits per year covered in addition to coinsurance requirements. The Maryland mandate precludes use of an annual limit on dollar benefits or number of visits unless comparable annual limits are used for other major medical benefits.

Issue: • Are mandated benefits hastening the trend toward self-insurance?

State mandated benefit laws regulate benefits provided under health insurance programs. HMO programs and employer self-insured health benefit programs are exempt from state mandated benefit laws. In 1982, more than one-third of all persons in the United States covered under health benefit programs were covered under programs exempt from mandates. This has increased to about 50 percent in 1985. It is estimated that health benefit programs covering 35 to 50 percent of Maryland residents are exempt from mandated benefits. Interviews with employers and administrators of self-insured programs indicate that the desire to avoid some or all Maryland mandated benefits is one of several primary factors inducing employers to move to self-insurance.

Issue: • What is the cost of health insurance in Maryland relative to other states?

Data are not available which would allow meaningful health insurance cost comparisons across states. Also, differences among states in health insurance costs are related primarily to factors other than mandated benefits. These include:

- historical utilization patterns
- historical provider prices
- existence of state rate regulatory programs
- competitiveness of the medical care market, possibly related to HMO market penetration

- number of persons covered under union agreements and specific benefits provided under these agreements

- relative number of large (costly) teaching hospitals in states.

As a result of these considerations, health insurance cost comparisons are not made across states.

It is useful, however, to compare provider supply across states, for those providers primarily affected by mandated benefits. Relative supply of mental health providers has been found to be highly correlated with mental health utilization and costs. Comparisons are made for practicing psychiatrists, psychologists and registered clinical social workers. Maryland ranks 4th, 3rd and 5th among all 50 states, in number of psychiatrists, psychologists and clinical social workers per 100,000 population, respectively. Maryland has between 52 percent and 120 percent more mental health providers, adjusted for population, than the United States as a whole.

These data indicate Maryland has a relatively abundant and possibly excess supply of mental health providers. The data also suggest that mental health care utilization and costs are higher in Maryland than in most other states.

Issue: • What are the estimated premium costs of selected benefits recently considered but not mandated in Maryland - Alzheimer's disease and increased benefit for outpatient mental health from 50 to 80 percent?

Alzheimer's Disease

Alzheimer's disease is a type of dementia primarily affecting the elderly which results in progressive loss of memory and other cognitive functions. There is no known method to halt or reverse the process. It is estimated that five percent of those over age 65 have Alzheimer's disease or related conditions, or approximately 20,000 persons in Maryland. Treatment often requires a mix of medical care and long-term care services.

Several important factors need to be evaluated, if mandated benefits are to be considered for Alzheimer's disease.

- Alzheimer's is diagnosed by an analysis of patient symptoms and through a process of elimination. It can be diagnosed definitively only after death.

- There are other chronic mental and physical debilitating conditions that require institutional care or extensive home care. Should Alzheimer's disease be singled out for mandated insurance coverage?

- Long-term custodial care is not covered under private health insurance programs. There has been, as of yet, no demonstration as to the feasibility of providing benefits for long-term care under private health insurance.

It is estimated that it would cost about $270 million to provide for the long-term care needs of Alzheimer's patients, assuming one-third require institutionalization and two-thirds require varying degrees of home care. This figure includes funds already being spent by Medicaid, self-pay and other sources for long-term care for Alzheimer's patients.

Increase in Outpatient Mental Health Benefits from 50 to 80 Percent

Outpatient mental health care, defined as mental health services provided in a non-inpatient setting by psychiatrists, psychologists, clinical social workers and others who may be licensed to perform such services in Maryland, is by far the largest expenditure category among all mandated benefits. It accounts for 4.5 percent of total benefit cost in Maryland, or approximately $35 million of total Blue Cross and Blue Shield benefit cost.

A number of factors are considered in developing a cost estimate for increased mandated benefits.

- Econometric studies indicate an elasticity of demand for mental health services of between one and two; i.e., a more than proportionate increase in utilization for a given decrease in effective price due to an increase in insurance benefits.

- It is well established in the research literature that claims cost and utilization experience under managed care HMO settings are irrelevant for projections of claims cost for mandated benefits in a fee-for-service environment. An offset factor, observed for selected types of patients in managed care settings, such as for patients recovering from heart attacks, has no relevance for projecting claims cost in a primarily fee-for-service setting.

- Maryland has a relatively abundant and possibly excess supply of mental health providers.

- Mental health and substance abuse treatment providers of all types are actively marketing in the electronic and print media. Utilization of services will be greater where providers have excess capacity than where supply-demand imbalances do not exist.

- Mental health claims cost can increase because: (1) a greater proportion of claims for services being used now will be covered under expanded benefits; (2) existing users will receive a greater quantity of services because of expanded benefits, due partly to provider induced demand; and (3) expanded benefits combined with increased provider marketing efforts will cause additional persons to use mental health services. Each of these is expected to occur as a result of an expansion of benefits from 50 to 80 percent, with factors (2) and (3) assuming greater importance after the initial year.

The following increases in claims cost are projected within two years after implementation of a change in mandated benefits from 50 to 80 percent:

- Existing claims will increase 60 percent from $2.19 to $3.50, simply as a result of greater benefits being paid for the same volume of claims.

- Substantial increases in utilization will occur for both existing and new users of mental health benefits. The projected combined effect is an increase in visits by approximately 100 percent within two years. As a result the $3.50 per member month will increase to $7.00, in addition to general inflation.

- For a typical family contract of 3.3 persons, annual premiums for outpatient mental health care are projected to increase from $86.74 to $277.20 in approximately two years, an increase of 320 percent.

In considering these projections, it is important to understand that the proposed increase in mandated benefits for outpatient mental health care is fundamentally different from previous mandated benefits. It substantially increases coverage for an already costly benefit, for which utilization is known to be highly responsive to reduced cost sharing. It could also serve as a major impetus to move to self-insurance and thus be exempt from all mandates.

MANDATED HEALTH BENEFITS IN MARYLAND:
A RESEARCH REPORT ON RELEVANT PUBLIC POLICY ISSUES

INTRODUCTION

The issue of the appropriateness and need for specific mandated health benefits (mandated benefits) is a critical one in Maryland. It is likely that the Maryland legislature will be confronted with mandated benefit issues this year. It is the express desire of the Maryland General Assembly that decisions as to whether to expand, contract or change the structure of mandated benefits be made on the basis of reliable, accurate information as to cost and benefit implications of specific mandate decisions. To this end, the House Economic Matters Committee of the Maryland General Assembly has requested that Blue Cross and Blue Shield of Maryland, Blue Cross and Blue Shield of the National Capital Area and health insurance companies operating in Maryland address a number of important questions concerning mandated health insurance benefits. These questions, restated and simplified somewhat from those expressed verbally at the Committee meeting on May 7, 1985, are listed in Exhibit 1 on the following page.

This report has been prepared by the Center for Health Policy Studies, under the direction of Zachary Dyckman, Ph.D., for Blue Cross and Blue Shield of Maryland and Blue Cross and

EXHIBIT 1

MARYLAND MANDATED BENEFITS RESEARCH ISSUES

- Are mandated benefits necessary? Are mandated benefits desirable from a public policy perspective?
- What is the cost of Maryland mandated benefits?
- Are mandated benefits hastening the trend toward self-insurance?
- What is the cost of health insurance in Maryland relative to other states?
- Which benefits mandated in Maryland are offered in states in which these benefits are not mandated?
- What would be the impact on individual purchasers and on individual members of groups of changing from mandated benefits to mandated offerings?
- How are employer health benefit decisions made? What is the process used by companies to determine which benefits to offer?
- What are the estimated benefit costs of selected benefits recently considered but not mandated in Maryland - Alzheimer's disease and increased benefit for outpatient mental health from 50 to 80 percent?
- How are decisions made concerning Blue Cross and Blue Shield coverage of new services and for determining whether a procedure is no longer "experimental"?
- What is the impact of mandated benefits on the availability of health insurance in Maryland?

Blue Shield of the National Capital Area. The commercial health insurance companies, in cooperation with the Health Insurance Association of America, have produced an independent report. The Center is a health policy research firm that conducts studies relating to health finance for the Health Care Financing Administration (administers Medicare), other Federal and state agencies, private health insurers and other purchasers of health care services. Dr. Dyckman served as project director for a recently completed study by the Center for the National Institute of Mental Health on the impact of mandated mental health benefits on the cost and utilization of health care services.

The methodologies used to prepare this report include analyses based on existing published and unpublished research studies, computer runs of Blue Cross and Blue Shield claims cost files, information obtained from the Maryland Division of Insurance and other insurance industry sources and a special mandated benefit survey of Blue Cross and Blue Shield plans. The specific research sources are identified in the discussion of each of the research issues.

Specific Mandated Benefits Examined

This report considers a wide range of health services for which benefits have been mandated in Maryland over the past decade. It focuses on those benefits specifically mandated to be

included in health insurance policies. Excluded from consideration in this report are existing benefits which are mandated to be offered to health insurance purchasers. Also excluded are mandated benefits for maternity coverage (mandated for larger groups by Federal statute); mandates for conversion rights; and the mandated benefit for in-vitro fertilization services (legislation was enacted earlier this year and no actual claims cost experience is available). The mandated benefits considered in this report are listed below.

STATUTE	BENEFIT	EFFECTIVE
Article 48A §354D & 470E	Nervous & Mental Mandates at least 30 days of inpatient care per calendar year or benefit period under all group and direct-billing contracts. Mandates a rate of payment for nervous and mental disorders under major medical of not less than 50% of the rate provided for other types of illnesses. Amended with the intent of adding extraterritorial applications for these benefits.	Before 1978 Amended 1981
Article 48A §490F	Alcoholism Rehabilitation Mandates that all group contracts include benefits for alcoholism rehabilitation (7 days emergency care or detoxification, 30 days inpatient care (Type C or D facility) and 30 outpatient	1980 Amended 1981

STATUTE	BENEFIT	EFFECTIVE
	Alcoholism Rehabilitation (Cont.) visits that can be limited to not less than $1,000 during any calendar year). Basic benefits may be limited to 120 days and visits combined in a covered person's lifetime.	
Article 48A §354L, 470K and 4770	Social Worker Mandates coverage for services provided by a licensed, certified social worker. Applies to group and direct-billing subscribers who reside or work in Maryland.	1978
Article 48A §354Q	Prosthetic Devices/Orthopedic Braces Requires payment of benefits under both group and direct-billing contracts for prosthetic devices and orthopedic braces.	1978
Article 48A §354E & 470G	Blood Products Prohibits the practice of excluding payment for blood products which would otherwise be covered under the group or non-group contract (does not apply to whole blood or concentrated red blood cells).	Before 1978
Article 48A §470J	Home Health Care Mandates benefits for at least 40 home care visits per calendar year or twelve month period. Home care providers include registered nurses, physical therapists, dieticians, etc. Applies to group and direct-billing contracts.	Before 1978 Amended 1982

STATUTE	BENEFIT	EFFECTIVE
Article 48A §354 & 489	Chiropractors Mandates that benefits for contractually included services be provided when rendered by a chiropractor licensed to render such services. Applies to group and direct-billing contracts.	Before 1978
Article 48A §354 & 490	Podiatrists Mandates that benefits for contractually included services be provided when rendered by a podiatrist licensed to render such services. Applies to group and direct-billing contracts.	Before 1978
Article 48A §354 & 477F	Optometrists Mandates that benefits for contractually included services be provided when rendered by an optometrist licensed to render such services. Applies to group and direct-billing contracts.	Before 1978
Article 48A §354 & 490A	Psychologists Mandates that benefits for contractually included services be provided when rendered by a psychologist licensed to render such services. Applies to group and direct-billing contracts.	Before 1978
Article 48A §354Y, 470T, 477Z	Coverage for Nurse Anesthetists Requires that insurers and nonprofit health service plans provide benefits whenever a covered service is rendered by a certified nurse anesthetist acting within the scope of a nurse anesthetist's license. Payment cannot be contingent on a nurse anesthetist's being employed by a physician. Defines a nurse anesthetist within the Health Occupation Article.	1984

STATUTE	BENEFIT	EFFECTIVE
Article 48A §354Z, 470U, 477AA, 490A-1	Coverage of Licensed Health Care Providers Requires that group and non-group contracts of a non-profit health service plan or commercial insurer provide benefits for covered services regardless of which provider renders the service, so long as the provider is licensed under the Health Occupation Article.	1979
Article 48A §354X, 470R and 477X	Cleft Lip and Cleft Palate Mandates benefits for in-patient and outpatient expenses arising from the management of cleft lip and cleft palate. Applies to group and direct-billing contracts.	1982

Outline Of The Report

The report is structured to be both relatively brief, yet comprehensive. Each issue forms a separate section of the report. Background material, technical discussions and supporting data are provided as appendixes to the report.

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

STATUTE	BENEFIT	EFFECTIVE
Article 48A §354Z, 470U, 477AA, 490A-1	Coverage of Licensed Health Care Providers Requires that group and non-group contracts of a non-profit health service plan or commercial insurer provide benefits for covered services regardless of which provider renders the service, so long as the provider is licensed under the Health Occupation Article.	1979
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Outline Of The Report

The report is structured to be both relatively brief, yet comprehensive. Each issue forms a separate section of the report. Background material, technical discussions and supporting data are provided as appendixes to the report.

Research Issue: Are mandated benefits necessary? Are mandated benefits desirable from a public policy perspective?

This is a critical issue discussed briefly here to provide an appropriate framework for consideration of the specific issues discussed in this report.

As with most public policy issues confronting state governments, there are legitimate pros and cons to specific mandated health benefit proposals. By definition, mandated benefit laws force at least some health insurance purchasers to buy certain benefits that they would prefer to decline if this option were available. The market for health insurance has grown increasingly competitive, with Blue Cross and Blue Shield Plans, commercial health insurers, health maintenance organizations (HMOs), preferred provider organizations (PPOs), and third-party administrators offering a wide variety of health plans. A competitive economic market is an efficient mechanism to allocate resources: it works well to provide the products that purchasers want at a reasonable cost. Competitive forces will, within a short period, force out of the market those sellers which provide services that are not wanted or are inferior, or which sell their products at higher than competitive prices. Interference in the health insurance market should be considered only if there are overwhelming public policy arguments supported by objective, reliable data to support mandating specific benefits.

Some of the most important issues raised by both sides of the policy debate on mandated benefits are summarized below. Many of these issues are considered more fully later in this report.

Primary arguments raised by providers and other proponents of specific mandated benefits are:

- Specific health care services are needed by the public and are not covered, or are inadequately covered, under existing health insurance programs.
- Employers (and insurers) have biases against certain types of benefits (e.g., mental health services), because they are uninformed or for other reasons.
- Benefits for specific services (defined by types of service or provider) not now generally provided would result in reduced use of other health care services and would reduce overall health care costs.
- Some employers may not wish to purchase certain benefits, but the benefits are desirable from an overall public policy perspective.

Primary arguments often made by employers, unions, Blue Cross and Blue Shield Plans and commercial health insurers against specific mandated benefits are:

- Employers, unions, and insurers are informed and sophisticated buyers and sellers of health benefits; they have access to the most reliable information on the cost and performance of benefits for specific services.
- Employers can and to an increasing extent do exempt themselves from mandated benefits by using "self-insurance" programs. Costly mandates hasten this process.

- The primary forces behind specific mandated benefits are often providers who will economically benefit from mandates, rather than the public. Arguments as to cost effectiveness are often self serving and are not based on reliable, objective data.

- Health care benefits included in employer and union-employer sponsored benefit programs reflect the preference of those covered under the program. It is unfair to force groups to purchase unwanted benefits instead of benefits preferred by group members.

- Employer sponsored health benefit programs cannot cover all services. Some services are best financed through consumer self-pay, government sponsored programs, or other mechanisms.

- Multi-state employers and/or employers with union contracts face substantial administrative and employee relations problems in complying with state mandates. Sometimes, benefits are reduced in order to comply with specific provisions of state mandated benefit laws.

- Mandated benefits add to the cost of health benefit programs. The increased cost often results in reduced coverage for other, preferred medical care benefits. In extreme cases, increased cost results in higher labor costs which provide incentives to reduce the size of the work force, or to locate plants in other states, particularly for low-wage, high labor cost industries.

The relevance and importance of specific arguments for or against mandates varies with the nature of the mandated benefit under consideration. In general, mandated benefits have greater effects on cost to the extent that they affect costly or potentially widely used services, and they differ substantially from health care benefits currently offered by most employers.

Research Issue: What is the Cost of Maryland Mandated Benefits?

This is a basic but important question regarding mandated benefits in Maryland. While conceptually simple, the measurement of the cost to Blue Cross and Blue Shield of mandated benefits (claims cost and administrative expenses) is a complex undertaking, primarily because data are not easily retrievable by mandate categories. This is particularly true for outpatient mental health benefits and other benefits provided under major medical portions of health benefit programs, for which claims are often submitted directly by Blue Cross and Blue Shield members, rather than providers. The terminology included in many major medical claims for procedure descriptions, diagnoses and coding are often imprecise, causing difficulties in accurately classifying diagnostic and type of service information.

Blue Cross and Blue Shield Plans serving Maryland were able to develop 1984 claims expenditure data (includes claims cost plus administrative expense) for the following categories of mandated benefits:

Mental illness, inpatient

Mental illness, outpatient (home & office)

Prosthetic Devices

Alcohol Rehabilitation

Cleft Lip and Palate

Podiatrist

Social Worker

Chiropractor

Psychologist

Optometrist

Licensed Practitioner

Home Health Care

Nurse Anesthetist

Not included in the data are mandated benefits for maternity, for which Federal statutes in effect mandate benefits under most group contracts; for benefits which are mandated to be offered rather than provided; and mandated conversion type benefits. Claims expenditure data for each Plan include administrative costs, sometimes called retention, of approximately 10 percent, with administrative costs being higher relative to claims cost for medical-surgical and major medical benefits than hospital benefits (larger dollar cost per claim). Administrative costs are computed at a common rate for both group and individual coverage accounts. The study focuses on claims expenditures, sometimes referred to as benefit cost in this report, because subscription charges are set each year so that they are approximately equal to projected claims expenditures.

Approximately 1,317,000 persons are covered under Blue Cross and Blue Shield contracts in Maryland, excluding those covered under Federal Employee Benefit Programs and Medicare supplemental programs. Of these, 85 percent are covered by Maryland Blue Cross and Blue Shield and 15 percent by Blue

Cross and Blue Shield of the National Capital Area. Federal Employee Benefit Programs and Medicare supplemental health insurance programs are exempt from mandated benefit legislation.

Maryland Blue Cross and Blue Shield claims expenditures (not including National Capital Area Blue Cross and Blue Shield data for Maryland -- shown in Appendix A) are shown on a per member month basis in Exhibit 2. Most Blue Cross and Blue Shield health benefit programs include three interrelated benefit programs: hospital benefits, which cover primarily inpatient hospital expenses; medical/surgical benefits, which cover primarily surgical expenses and physician medical services provided in the hospital; and major medical benefits, which cover primarily medical services provided in the home and office setting and medical services not completely reimbursed under the hospital and medical/surgical benefit programs. Expenditures are shown for each mandated benefit category separately for hospital, medical/surgical and for major medical benefits, and for all benefits combined. In computing total claims expenditures, it is assumed, as is most often the case, that Blue Cross and Blue Shield accounts have all three benefits: hospital, medical/surgical and major medical benefits. Some accounts have hospital benefits from Blue Cross and Blue Shield and medical/surgical and/or major medical benefits from another carrier. In addition to claims expenditures for each mandate category, expenditure data are also shown for three summary categories of mandated benefits: mental health and alcohol rehabilitation, outpatient mental health, and

EXHIBIT 2

MARYLAND BLUE CROSS AND BLUE SHIELD
EXPENDITURES PER MEMBER MONTH,
COMBINED GROUP AND INDIVIDUAL CONTRACTS,
1984

EXPENDITURE CATEGORY	HOSPITAL	MED/SURG	MAJOR MED	TOTAL
Mental*	$ 1.47	$ 0.21	$ 1.53	$ 3.21
Prosthetic Device	0.04	0.01	0.35	0.41
Alcohol Rehab	0.34	0.00	0.00	0.34
Cleft Lip/Palate	0.01	0.00	0.00	0.01
Podiatrist	0.00	0.44	0.04	0.48
Social Worker	0.00	0.00	0.16	0.16
Chiropractor	0.00	0.00	0.17	0.18
Psychologist	0.00	0.01	0.40	0.42
Optometrist	0.00	0.00	0.00	0.00**
Licensed Practitioner	0.00	0.01	0.00	0.01
Home Health	0.13	0.00	0.01	0.14
Nurse Anesthetist	0.00	0.00	0.00	0.00**
Summary Categories				
Total Mandated Benefits***	1.99	0.69	2.67	5.35
Mental & Alcohol Rehab	1.81	0.23	2.09	4.12
Outpatient Mental****	0.00	0.00	2.09	2.09
TOTAL ALL CLAIMS (Mandated and Non-Mandated)	$26.99	$13.29	$ 7.68	$ 47.96

*Includes both inpatient and outpatient mental health benefits.

**Less than $.01 per member month.

***Maternity benefits excluded. If maternity benefits were included, total mandated benefit cost would be $6.33 per member month.

****Includes outpatient benefits for services provided by psychologists and social workers.

all mandated benefits combined. Mental health benefits include benefits for services provided by psychologists and social workers. Excluded from mandated benefit expenditures are maternity benefits and the other mandate categories excluded from our analysis, which were noted above. Exhibit 3 shows the same claims expenditure data, as a percentage of all claims.

The following are the primary findings regarding 1984 mandated benefit costs for Maryland Blue Cross and Blue Shield:

- 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)
- Mandated mental and alcohol rehabilitation benefits are $4.12 per member month, or 8.6 percent of total benefit cost.
- Mandated outpatient mental benefits are $2.09 per member month, or 4.4 percent of total benefit cost and 27.2 percent of total major medical benefit cost.
- The major components of mandated benefit cost are benefits for outpatient mental, inpatient mental, podiatrist and psychologist services.

The data shown in Exhibits 2 and 3 are for group and individual contracts combined. Approximately 10 percent of Maryland Blue Cross and Blue Shield members, excluding those covered under Federal government and Medicare supplemental contracts, are covered under individual (non-group) contracts. Mandated benefit claims expenditures for group and individual contracts are shown separately for group and individual contracts in Appendix A. Mandated benefit costs as a percentage of total

EXHIBIT 3

MARYLAND BLUE CROSS AND BLUE SHIELD
EXPENDITURES AS A PERCENTAGE OF ALL CLAIMS,
COMBINED GROUP AND INDIVIDUAL CONTRACTS,
1984

EXPENDITURE CATEGORY	HOSPITAL	MED/SURG	MAJOR MED	TOTAL
Mental*	5.45 %	1.56 %	19.87 %	6.68 %
Prosthetic Device	0.17	0.07	4.64	0.85
Alcohol Rehab	1.25	0.00	0.00	0.70
Cleft Lip/Palate	0.03	0.02	0.00	0.02
Podiatrist	0.00	3.31	0.57	1.01
Social Worker	0.00	0.04	2.02	0.33
Chiropractor	0.00	0.01	2.26	0.37
Psychologist	0.00	0.09	5.26	0.87
Optometrist	0.00	0.00	0.00	0.00**
Licensed Practitioner	0.00	0.05	0.02	0.02
Home Health	0.48	0.00	0.12	0.29
Nurse Anesthetist	0.00	0.00	0.00	0.00**
Summary Categories				
Total Mandated Benefits***	7.38	5.16	34.75	11.15
Mental & Alcohol Rehab	6.70	1.70	27.16	8.59
Outpatient Mental****	0.00	0.00	27.16	4.35

*Includes both inpatient and outpatient mental health benefits.

**Less than .001 percent of total benefit costs.

***Maternity benefits excluded. If maternity benefits were included, total mandated benefit cost would be 13.1% of all claims.

****Includes outpatient benefits for services provided by psychologists and social workers.

benefit costs are higher for individual contracts than for group contracts. However, data for individual contracts are not strictly comparable to data for group contracts, as benefit designs, levels of coverage, and proportions of members covered under all three benefit programs (hospital, medical/surgical and major medical) differ between group and individual contracts.

As noted above, approximately 15 percent of Blue Cross and Blue Shield enrollees in Maryland are covered by Blue Cross and Blue Shield of the National Capital Area. Mandated benefit cost data for Maryland group accounts of National Capital Area Blue Cross and Blue Shield, comparable to data shown in Exhibits 2 and 3 for Maryland Blue Cross and Blue Shield, are shown in Appendix A. Data for National Capital Area Plan's individual Maryland contracts are not available. Summary mandated benefit cost data for the National Capital Area Plan are shown in Exhibit 4, along with Maryland Plan data and combined Plans serving Maryland data.

Mandated benefit costs for the National Capital Area Plan's Maryland enrollees are higher than for the Maryland Plan enrollees, both in terms of dollars and as a percentage of total benefit cost. Mandated benefit cost per member month for Blue Cross and Blue Shield of the National Capital Area is $6.83, or 13.0 percent of total benefit cost. Mental and alcohol rehabilitation benefits, and outpatient mental health, respectively, are 9.4 percent and 5.2 percent of total claims cost.

The last two columns of Exhibit 4 show the combined Maryland mandated benefit cost experience for Blue Cross and Blue Shield Plans serving Maryland. The cost of mandated benefits represents 11.5 percent of the total benefit cost of Blue Cross and Blue Shield enrollees in Maryland. For the total estimated 1,317,000 Blue Cross and Blue Shield enrollees in Maryland, excluding those enrolled under Federal government and Medicare supplemental contracts, total cost of mandated benefits in 1984 is estimated at $88.7 million out of total benefit cost of $769.2 million. Mental and alcohol rehabilitation mandated benefits represent 8.7 percent of total benefit cost, while outpatient mental benefits represent 4.5 percent of total benefit cost.

An additional cost often overlooked in the discussion of cost of mandated benefits is implementation cost. Discussions with administrative staff of the Blue Cross and Blue Shield Plans serving Maryland indicate that the process of implementing a mandated benefit is a complex, costly task, involving many different operations. Attached as Appendix C is a description of the various tasks and associated costs required to implement the most recent mandate enacted in Maryland, benefits for in-vitro fertilization. Thirty-two discrete tasks are identified with a combined first year implementation cost of $108,000. This is the direct cost to a single carrier of implementing a single mandated benefit. There are additional indirect costs that are not included in this estimate, such as cost of responding to

EXHIBIT 4

BLUE CROSS AND BLUE SHIELD PLANS SERVING MARYLAND
CLAIMS EXPENDITURES PER MEMBER MONTH,
COMBINED GROUP AND INDIVIDUAL CONTRACTS
1984

	Maryland BC-BS*		Nat. Cap. Area BC-CS* Maryland Experience		Combined** BC-BS Maryland Experience	
	Amount	Percent	Amount	Percent	Amount	Percent
All Mandated Benefits	$ 5.35	11.2%	$ 6.83	13.0%	$ 5.61	11.5%
Mental and Alcohol Rehab.	4.12	8.6	4.97	9.4	4.25	8.7
Outpatient Mental	2.09	4.4	2.74	5.2	2.19	4.5
Total Benefit Cost	$47.96	100.0	$52.66	100.0	$48.67	100.0

*Maryland Blue Cross & Blue Shield data includes group and individual cost experience.
Blue Cross and Blue Shield of the National Capital Area data includes only Maryland group experience.

**Combined experience computed by using .85 and .15 weights, respectively for Maryland and National Capital Area Plan claims expenditures.

subscriber and provider inquiries related to benefit provisions and restrictions. In addition to implementation costs experienced by Blue Cross and Blue Shield, large employers operating in multiple states may experience additional costs and administrative and provider relations problems. These relate to required preparation of revised benefit brochures, and problems relating to lack of uniformity of benefits for employees in different states and of confusion about the new benefit provisions and limitations.

APPENDIX D

ANALYSIS OF MENTAL HEALTH PROVIDERS BY STATE

ANALYSIS OF MENTAL HEALTH PROVIDERS BY STATE

This section compares the supply of mental health providers in Maryland with all other states and with geographically adjacent states. The information provided is relevant to the question about the cost of health insurance in Maryland relative to other comparable states. A comparison of health insurance costs among states would be more dependent upon factors such as the competitiveness of the medical care market (including HMO market penetration), the existence of state rate regulatory programs, and the relative number of large, costly teaching hospitals in the state than upon the effects of mandated benefits, however. Consequently, the impact of mandated benefits is more appropriately addressed in terms of mandated provider supply and effects upon actual cost of mandates.

The impact of mandated benefits in relation to provider supply is examined here for several reasons. First, existence of an adequate supply of providers assures accessibility of mental health services to those in need of treatment. If no shortage of providers exists, the importance of mandates for assuring accessibility to services is decreased. Second, the impact of a mandate increasing coverage levels for mental health services will be more dramatic if the state has relatively more numerous providers. If an excess supply of providers exists, the impact of a mandate for 80 percent coverage of outpatient services will lead to greatly increased utilization and costs. Finally, the

existence of mandates for mental health insurance can affect the growth of provider supply in states. Knesper et al. (1984) found that the distribution of psychiatrists, psychologists, and social workers across U.S. counties was significantly and positively associated with the availability of liberal mental health insurance benefits (including insurance laws). It was estimated that the elasticity of psychiatrists with respect to insurance availability was 0.42, or a 10 percent increase in insurance availability was associated with a 4.2 percent increase in psychiatrists per 100,000 population. Continued growth in provider supply in areas with existing adequate supply would be less desirable from a policy perspective than encouraging providers to locate in less well-served areas.

Exhibit 1 illustrates the numbers of patient care psychiatrists by state and per 100,000 population in 1983. Maryland was found to have 18.6 patient care psychiatrists per 100,000 residents, a level 72 percent higher than the national average of 10.8 per 100,000. Only Connecticut, Massachusetts and New York had higher psychiatrist/population ratios than Maryland. These data were obtained from the American Medical Association's annual publication Physician Characteristics and Distribution in the U.S., 1983 Edition, a source widely used by the Federal government and others in research projects.

Numbers of doctoral psychologists providing health/mental health services by state and per 100,000 population in 1983 are

EXHIBIT 1

NUMBERS OF PSYCHIATRISTS PROVIDING
PATIENT CARE BY STATE AND
PER 100,000 POPULATION
1983

STATE	PSYCHIATRISTS*	PSYCHIATRISTS/ 100,000 POPULATION	STATE RANK
Alabama	140	3.5	46
Alaska	25	5.2	38
Arizona	234	7.9	23
Arkansas	111	4.8	41
California	3,762	14.9	5
Colorado	425	13.5	7
Connecticut	724	23.0	3
Delaware	70	11.6	9
Florida	833	8.0	22
Georgia	411	7.2	27
Hawaii	129	12.7	8
Idaho	25	0.3	50
Illinois	1,087	9.5	16
Indiana	265	4.8	42
Iowa	158	5.4	37
Kansas	236	9.7	15
Kentucky	227	6.1	32
Louisiana	308	6.9	29
Maine	101	8.8	20
Maryland	801	18.6	4
Massachusetts	1,332	23.1	2
Michigan	850	9.4	17
Minnesota	296	7.1	28
Mississippi	92	3.6	45
Missouri	374	7.5	26
Montana	30	3.7	44
Nebraska	87	5.5	36
Nevada	47	5.2	39
New Hampshire	98	10.2	14

EXHIBIT 1 (Cont.)

STATE	PSYCHIATRISTS*	PSYCHIATRISTS/ 100,000 POPULATION	STATE RANK
New Jersey	845	11.3	10
New Mexico	121	8.6	21
New York	4,158	23.5	1
North Carolina	107	1.8	49
North Dakota	33	4.8	43
Ohio	827	7.7	25
Oklahoma	172	5.2	40
Oregon	243	9.1	18
Pennsylvania	1,325	11.1	11
Rhode Island	98	10.3	13
South Carolina	194	6.0	33
South Dakota	19	2.7	47
Tennessee	266	5.7	34
Texas	1,068	6.8	30
Utah	103	6.4	31
Vermont	75	14.3	6
Virginia	571	10.3	12
Washington	384	8.9	19
West Virginia	111	5.7	35
Wisconsin	376	7.9	24
Wyoming	12	2.4	48
ALL U.S.	25,287	10.8	

*Psychiatrists engaged primarily in patient care

Source: American Medical Association, Physician Characteristics and Distribution in the U.S., 1983 Edition, Chicago.

presented in Exhibit 2. Maryland had 28.9 doctoral psychologists per 100,000 population, compared to the national average of 19.0 per 100,000. Maryland ranked third among all 50 states in psychologist supply, after Massachusetts and New York. Psychologists providing health/mental health services deliver physical and mental health care, or provide services adjunct to educational, rehabilitation, and vocational services, as opposed to those whose primary activity consists of education or research. The relatively high number in Maryland may be partially due to the large number of psychologists employed in federal agencies, such as the National Institute of Mental Health. Data are based on the 1983 American Psychological Association Census of Psychological Personnel, the most extensive attempt in over a decade to enumerate psychologists.

Exhibit 3 presents information on numbers of registered clinical social workers for 1985. Maryland has a level of 7.7 clinical social workers per 100,000, which is 120 percent higher than the national average of 3.5 per 100,000. Connecticut, Massachusetts, New Hampshire, and New York had higher social worker/population ratios than Maryland. Clinical social workers provide assessment, diagnosis, treatment (including psychotherapy and counseling), client-centered advocacy, consultation and evaluation. Registered clinical social workers must be members of the Academy of Certified Social Workers (ACSW), or be licensed

EXHIBIT 2

DOCTORAL PSYCHOLOGISTS PROVIDING
L HEALTH SERVICES BY STATE
PER 100,000 POPULATION
1983

DOCTORAL PSYCHOLOGISTS*	PSYCHOLOGISTS/ 100,000 POPULATION	STATE RANK
404	10.2	44
103	21.4	12
664	22.3	10
216	9.3	48
6,371	25.3	7
852	27.1	6
864	27.5	4
90	14.9	34
1,478	14.1	36
807	14.1	37
214	21.0	14
137	13.9	39
1,892	16.5	26
673	12.3	42
289	10.0	45
478	19.7	19
331	8.9	49
397	8.9	50
228	19.9	18
1,243	28.9	3
876	44.6	1
1,358	15.0	32
881	21.3	13
291	11.3	41
746	15.0	33
133	16.6	25
258	16.1	28
165	18.4	22
231	24.1	9

EXHIBIT 2 (Cont.)

YCHOLOGISTS/ 100,000 POPULATION	STATE RANK
20.1	17
17.8	24
30.7	2
14.4	35
11.2	43
15.9	29
14.0	38
20.9	15
18.8	20
20.7	16
9.6	46
15.9	30
16.3	27
13.8	40
21.9	11
27.2	5
17.9	23
18.7	21
9.1	47
15.1	31
24.2	8
9.0	

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EXHIBIT 3

NUMBERS OF REGISTERED CLINICAL SOCIAL WORKERS BY STATE AND PER 100,000 POPULATION
1985

STATE	CLINICAL SOCIAL WORKERS*	SOCIAL WORKERS 100,000 POPULATION	STATE RANK
Alabama	23	0.6	48
Alaska	29	6.0	8
Arizona	66	2.2	26
Arkansas	23	1.0	44
California	704	2.8	18
Colorado	72	2.3	21
Connecticut	244	7.8	4
Delaware	11	1.8	31
Florida	236	2.3	22
Georgia	85	1.5	34
Hawaii	22	2.2	27
Idaho	9	0.9	47
Illinois	749	6.5	6
Indiana	122	2.2	28
Iowa	85	2.9	16
Kansas	82	3.4	14
Kentucky	37	1.0	45
Louisiana	181	4.1	11
Maine	18	1.6	33
Maryland	333	7.7	5
Massachusetts	483	8.4	3
Michigan	340	3.8	12
Minnesota	137	3.3	15
Mississippi	12	0.5	49
Missouri	86	1.7	32
Montana	12	1.5	35
Nebraska	37	2.3	23
Nevada	11	1.2	40
New Hampshire	82	8.6	2

EXHIBIT 3 (Cont.)

STATE	CLINICAL SOCIAL WORKERS*	SOCIAL WORKERS 100,000 POPULATION	STATE RANK
New Jersey	430	5.8	9
New Mexico	20	1.4	36
New York	1,525	8.6	1
North Carolina	88	1.4	37
North Dakota	8	1.2	41
Ohio	275	2.6	20
Oklahoma	75	2.3	24
Oregon	77	2.9	17
Pennsylvania	239	2.0	29
Rhode Island	53	5.6	10
South Carolina	37	1.2	42
South Dakota	9	1.3	39
Tennessee	56	1.2	43
Texas	316	2.0	30
Utah	22	1.4	38
Vermont	32	6.1	7
Virginia	155	2.8	19
Washington	100	2.3	25
West Virginia	19	1.0	46
Wisconsin	178	3.8	13
Wyoming	2	0.4	50
ALL U.S.	8,201	3.5	

*Clinical Social Workers registered with National Association of Social Workers (NASW). Membership in NASW is a prerequisite to becoming a certified social worker.

Source: NASW Register of Clinical Social Workers, 1985, and unpublished summaries of NASW statistics.

or certified in a state at a level at least equivalent to ACSW standards. Data presented were obtained from the National Association of Social Workers, based on those who apply for listing in their register.

Numbers of mental health providers (including psychiatrists, psychologists, and social workers) are summarized in Exhibit 4 for Maryland, adjacent states and all U.S. Maryland ranks in the top five states for numbers of psychiatrists, psychologists, and social workers per 100,000 population, while only one adjacent state, Delaware, ranks in the top ten for any of these providers (ninth in psychiatrists). The District of Columbia was excluded from all tables in this section, because its small size and central city environment make its provider supply incomparable to other states. It should be noted, however, that some Maryland residents in the Washington metropolitan area are likely to use providers within the District of Columbia, further increasing the effective supply of providers accessible to Maryland residents.

The primary conclusions supported by this information include the following:

- Maryland ranks very high in mental health provider supply, among the top five states in psychiatrists, psychologists, and clinical social workers.

EXHIBIT 4

SUMMARY OF MENTAL HEALTH PROVIDERS IN MARYLAND,
ADJACENT STATES AND ALL UNITED STATES

STATE	PSYCHIATRISTS		PSYCHOLOGISTS		SOCIAL WORKERS	
	Per 100,000 Population	U.S. Rank*	Per 100,000 Population	U.S. Rank*	Per 100,000 Population	U.S. Rank*
Maryland	18.6	4	28.9	3	7.7	5
Virginia	10.3	12	17.9	23	2.8	19
Pennsylvania	11.1	11	18.8	20	2.0	29
Delaware	11.6	9	14.9	34	1.8	31
West Virginia	5.7	35	9.1	47	1.0	46
ALL U.S.	10.8		19.0		3.5	
Ratio of Maryland to All U.S.	1.72		1.52		2.20	

*Ranking of state in number of providers per 100,000 population in comparison to all 50 states.

Sources: American Medical Association, Physician Characteristics and Distribution in the U.S., 1983 Edition, Chicago;

J. Stapp, A. M. Tucker, G. R. VandenBos, Census of Psychological Personnel: 1983, Draft 1985, American Psychological Association:

NASW Register of Clinical Social Workers, 1985, and unpublished summaries of NASW statistics.

- Accessibility to mental health providers is substantially greater for residents of Maryland relative to adjoining states and to the U.S. as a whole. It is likely that geographic accessibility problems are relatively minor too, given the relatively small s. and urban nature of the state.

- An increase in mandated mental health benefits would cause the already adequate provider supply to grow further, by a factor of about 3 to 5 percent for each 10 percent increase in benefits.

- From a policy-making perspective, encouragement of continued growth in mental health provider supply in Maryland is a less than desirable goal, given that the state already has among the highest levels of these providers in the nation.

Adult mildly retarded persons and their parents: the relationship between involvement and adjustment. Applied Research in Mental Retardation 6:409–419, 1985
43. Brunn LC: Elderly parents and dependent adult child. Social Casework 66:131–138, 1985
44. Wilder DE, Teresi JA, Bennett RG: Family burden and dementia, in The Dementias. Edited by Meyeux R, Rosen WG. New York, Raven Press, 1983
45. Kanter J, Lamb HR, Loeper C: Expressed emotion in families: a critical review. Hospital and Community Psychiatry 38:374–380, 1987
46. Arieti S: Interpretation of Schizophrenia, 2nd ed, rev. New York, Basic Books, 1974
47. Hatfield AB: Coping effectiveness in families of the mentally ill: an exploratory study. Journal of Psychiatric Treatment and Evaluation 3:11–19, 1981
48. Lefley HP: Etiological and prevention views of clinicians with mentally ill relatives. American Journal of Orthopsychiatry 55:363–370, 1985
49. Wasow M: Chronic schizophrenia and Alzheimer's disease: the losses for parents, spouses, and children compared. Journal of Chronic Disease 38:711–716, 1985
50. Gubman GD, Tessler RC: The impact of mental illness on families: concepts and priorities. Journal of Family Issues 8:226–245, 1987
51. Harris M, Bergman HC: The young adult chronic patient: affective responses to treatment. New Directions for Mental Health Services, no 21:29–35, 1984
52. Myers G: When I am gone: estate planning. AMI Newsletter of Dane County, Wisconsin, April 1987, p 5
53. Hatfield AB: Psychological costs of schizophrenia to the family. Social Work 23:355–359, 1978
54. Herz MI, Endicott J, Spitzer RL: Brief versus standard hospitalization: the families. American Journal of Psychiatry 133:795–801, 1976
55. Noh S, Turner RJ: Living with psychiatric patients: implications for the mental health of family members. Social Science and Medicine (in press)
56. Hoenig J, Hamilton ME: The schizophrenic patient in the community and his effect on the household. International Journal of Social Psychiatry 12:165–176, 1966
57. Pearlin LI, Schooler C: The structure of coping. Journal of Health and Social Behavior 19:2–21, 1978
58. Gubman GD, Tessler RC, Willis G: The family's response to a mentally ill relative: the do's and don'ts of household living. Schizophrenia Bulletin (in press)
59. Lefley HP: Impact of mental illness in families of mental health professionals. Journal of Nervous and Mental Disease (in press)
60. Falloon IRH, Boyd JL, McGill CW: Family Care of Schizophrenia. New York, Guilford, 1984
61. Anderson CM, Reiss DJ, Hogarty GE: Schizophrenia and the Family. New York, Guilford, 1986
62. Group for the Advancement of Psychiatry: The Family, the Patient, and the Psychiatric Hospital: Toward a New Model. Report no 117. New York, Brunner/Mazel, 1985
63. Bernheim KF, Lehman AF: Working With Families of the Mentally Ill. New York, Norton, 1985
64. Goldstein MZ: Family Involvement in the Treatment of Schizophrenia. Washington, DC, American Psychiatric Press, 1986
65. Hatfield AB: The expressed emotion theory: why families object. Hospital and Community Psychiatry 38:341, 1987
66. Lamb HR: Treating the Long-Term Mentally Ill. San Francisco, Jossey-Bass, 1982
67. Bachrach LL: Asylum and chronically ill psychiatric patients. American Journal of Psychiatry 141:975–978, 1984
68. Kasl SV: Stress and health. Annual Review of Public Health 5:319–341, 1984
69. Jacobs SC, Mason JW, Kosten TR, et al: Bereavement and catecholamines. Journal of Psychosomatic Research 30:489–496, 1986
70. Intagliata J, Willer B, Egri G: Role of the family in case management of the mentally ill. Schizophrenia Bulletin 12:669–708, 1986

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

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Health insurance claims of families covered by Aetna's Federal Employees Health Benefit Program from 1980 through 1983 were analyzed to determine if any changes in total health care utilization and costs were associated with the initiation of mental health treatment. A total of 26,915 families in which at least one member received mental health treatment were compared with a randomly selected group of 16,468 families in which no member had received mental health treatment. Total health care costs for those receiving mental health treatment were significantly higher than costs for the comparison group. However, those costs dropped significantly after initiation of mental health treatment and continued to decline over the study period. The biggest declines occurred among persons age 45 and older, a finding that may have important policy considerations.

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

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

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

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

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

Dr. Holder is director of the Prevention Research Center in Berkeley, California, and lecturer in the School of Public Health at the University of California. Mr. Blose is a senior analyst at the Human Ecology Institute in Chapel Hill, North Carolina. Dr. Holder's address is 2532 Durant Avenue, Berkeley, California 94704. This research was conducted under contract no. ADM 281–83–0011 with the National Institute of Mental Health.

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

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

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

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

Research design

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

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

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

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

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

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

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

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

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

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

Comparison of the groups

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

The monthly per-person costs (in January 1980 dollars) for all health care for families with at least one member receiving mental health treatment were $158.82, compared with $91.85 for the random sample. Most of this difference was the result of inpatient treatment costs ($104.85 a month for the mental health treatment group versus $60.12 a month for the random sample). However, there were also differences between the two groups in ambulatory care and other costs over the four-year study period.

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

Mental health treatment costs and utilization

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

The cost of mental health care per person receiving care during the study period was $2,079 (January 1980 dollars), of which 63.4 percent was paid by Aetna as health insurance benefits. Inpatient care, though utilized by only 20 percent of the mental health patients, accounted for 60 percent of mental health treatment costs. The average length of inpatient mental health treatment was 32.2 days. More than half of the inpatient stays were 21 days or less, and almost a fourth were seven days or less. The average cost per admission was $3,887 (January 1980 dollars), and the average number of admissions per person utilizing inpatient care was 1.57. No data were available on whether the inpatient stays were in specialty facilities or general hospitals.

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

Pre-post patterns of medical care

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

The primary research question

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

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

These results are confirmed in the analysis of group 3, those with at least 12 months pre- and 24 months posttreatment data. This group provides clear evidence that the decline in cost and utilization continues in the second year following the initiation of mental health treatment. Total health care costs per month per person fell from $242 in the year before treatment to $214 in the first year after treatment began to $162 in the following year. These differences were statistically significant (F=21.88, df=17,642, p<.001). As with group 2, this drop was primarily the result of decreases in inpatient days per month per person from .63 to .52 to .39 days (F=19.02, df=17,642, p<.001) and inpatient costs per month per person from $167 to $133 and $106 (F=13.95, df=17,642, p<.001). Ambulatory care costs actually increased in the year following initiation of treatment (from $59.15 in the year before to $64.15 in the year after) due to the use of ambulatory mental health services, but they fell below the pretreatment level in the second posttreatment year ($42.29). These differences were also statistically significant (F=60.59, df=17,642, p<.001).

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

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

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

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

Longitudinal analysis of total health care costs

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

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

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

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

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

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

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

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

Conclusions

The results of this study provide confirmation of the findings of previous studies as well as provide new findings, previously unreported, concerning the question of the potential for mental health treatment to reduce other health care costs.

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

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

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

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

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

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

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

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

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

This study is not as subject to biases due to regional variations in general health or mental health care as is much other research, since the population of persons filing mental health treatment claims with Aetna is a national one, drawing on all 50 states. However, it is not necessarily geographically representative of either the U.S. population or the population of federal employees, since many factors influence the choice of health plans by government workers.

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

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

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

References

1. Follette WT, Cummings NA: Psychiatric services and medical utilization in a prepaid health plan setting. Medical care 5:25–35, 1967
2. Jones KR, Vischi TR: Impact of Alcohol, Drug Abuse, and Mental Health Treatment on Medical Care Utilization: A Review of the Research Literature. Medical Care 17 (suppl), Dec 1979
3. Mumford E, Schlesinger HJ, Glass GV: Problems of analyzing the cost offset of including a mental health component in primary care, in Mental Health Services in Primary Care Settings: Report of a Conference, April 2–3, 1979. DHHS pub no (ADM) 83–995. Rockville, Md, National Institute of Mental Health, 1983
4. Mumford E, Schlesinger HJ, Glass GV: The effects of psychological intervention on recovery from surgery and heart attacks: an analysis of the literature. American Journal of Public Health 72:141–151, 1982
5. Mumford E, Schlesinger HJ, Glass GV, et al: A new look at evidence about reduced cost of medical utilization following mental health treatment. American Journal of Psychiatry 141:1145–1158, 1984
6. Schlesinger HJ, Mumford E, Glass GV, et al: 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 73:422–429, 1983
7. Kessler LG, Steinwachs DM, Hankin JR: Episodes of psychiatric care and medical utilization. Medical Care 20:1209–1221, 1982
8. Hankin JR, Kessler LG, Goldberg ID, et al: A longitudinal study of offset in the use of nonpsychiatric services following specialized mental health care. Medical Care 21:1099–1110, 1983
9. Goldberg EL, Comstock GW, Hornstra RK: Depressed mood and subsequent physical illness. American Journal of Psychiatry 136:530–534, 1979
10. Borus JF, Burns BJ, Jakobson AM, et al: Neighborhood health centers as providers of coordinated mental health care. Background paper, Conference on Provision of Mental Health Services in Primary Care Settings. Rockville, Md, National Institute of Mental Health, April 2–3, 1979
11. Campbell D, Stanley J: Experimental and Quasiexperimental Designs for Research. Chicago, Rand McNally, 1966
12. Cook T, Campbell D: Quasi-Experimentation: Design and Analysis Issues for Field Settings. Boston, Houghton Mifflin, 1979
13. Borus JF, Olendzki MC, Kessler L, et al: The "offset effect" of mental health treatment on ambulatory medical care utilization and charges. Archives of General Psychiatry 42:573–580, 1985

SEATTLE P-I, WED. 2/10/88

Health care costs of employers soar

The Associated Press

NEW YORK — The cost of providing health care benefits to employees jumped to an average of $1,985 per worker last year as employers hunted for ways to curb costs, a survey said yesterday.

A poll of 2,016 corporate and government employers found that their costs rose 7.9 percent last year, or an average $128 per employee, said A. Foster Higgins & Co., which conducted the survey. The average cost had risen 7.7 percent in 1986.

Nearly one-fifth of the employers surveyed said their health costs soared 20 percent or more, according to Higgins, a New York-based benefits consultant. Six percent of the employers said they were hit with cost jumps exceeding 30 percent.

"Increases in the actual price of medical care supplied by doctors, hospitals and other providers is the fundamental reason for the plan cost hikes," said David Rahill, who directed the study, which looked at employers with a total of 13 million employees.

Higgins, a subsidiary of Johnson & Higgins, surveyed employers ranging from American Telephone & Telegraph Co. to the village government of Winnetka, Ill.

For public sector employers, health care benefit costs averaged $2,071 per worker, while the cost averaged $2,364 per worker for benefits in work places that are at least 50 percent unionized.

The economy-of-scale theory seemed not to apply. For employers with 5,000 or more workers, benefits averaged $2,100 per worker last year, compared with $1,962 for employers with fewer than 5,000 workers.

Overall, health benefit costs made up 9.7 percent of the payroll pie, up from 8.9 percent in 1986, an increase that Rahill called "disturbing."

"Continued increase could hamper the ability of American business to compete with lower-cost labor markets," he said, adding that higher costs could even spur companies to consider moving their operations.

Rahill said the study underscored the need for more stringent cost-control efforts. Only 30 percent of employers surveyed managed either to hold costs constant or reduce them last year, the survey found.

Higgins' survey found that 61 percent of the employers did not require employees to help foot the bill on individual coverage. But 88 percent did require their employees to pay a deductible. A third of the employers said they raised deductibles in the last two years.

Source: A. Foster Higgins & Co.

The Associated Press

Compilation by HIAA staff

AVERAGE LENGTH OF STAY
FOR PHYSICAL CONDITIONS AND
FOR PSYCHIATRIC CONDITIONS OR DIAGNOSES

Average length of stay for physical conditions, obtained from the American Hospital Association for 1984, is 7.3 days.

I have two sources for average length of stay for psychiatric diagnoses. The first source is from the Commission on Professional and Hospital Activities. This is data which is received from general, non-Federal, short-term hospitals. This is defined as a medium stay less than 30 days. This excludes data from psychiatric hospitals.

The length of stay for these diagnoses are:

paranoid schizophrenia - 15.1 days
acute schizophrenic episode - 15.4 days
childhood psychoses - 24.2 days
major depressive psychoses - 17.2 days
other effective psychoses - 16.4 days
miscellaneous psychoses - 11.6 days
anxiety states - 6.9 days
neurotic depression - 12.6 days
miscellaneous neuroses - 10.3 days

miscellaneous mental disorders - 13.6 days

The next figures I am going to quote were given to me over the phone by Bertie Firestone from the National Institute of Mental Health. These are average length of stay figures obtained from private psychiatric hospitals. These again are given by certain diagnoses.

Average length of stay for:

any alcohol related admission - 20 days
any drug related admission - 19 days
organic disease - 17 days
effective disorders - 20 days
schizophrenia - 18 days
other psychoses - 20 days
anxiety disassociative - 14 days
personality disorder - 17 days

This concludes the information that I was able to obtain about average length of stay. I did attempt to get data from the American Psychiatric Association, but they declined to give me any information about length of stay figures.

Company Practices In Mental Health Coverage; Plan Design Limits Reflect Increases In Cost, Use

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Employees are using mental health benefits more often, according to "Company Practices In Mental Health Coverage," a study by Hewitt Associates. About half of the 293 companies surveyed experienced an increase in mental health claims since 1983, while only 8% experienced a decrease. Although the number of companies that were able to track claims costs was small (28), costs increased each year from $118 in 1984 to a projected costs of $169 in 1987 per employee.

The complete study includes company practices in mental health and employee assistance programs and may be purchased from Hewitt Associates, 100 Half Day Road, Lincolnshire IL 60015. Attn: Cathy Schmidt.

Health care benefits have been subject to dramatic changes during the past five years. An increasing number of employers are concerned with one area of benefits that has been considered uncontrollable--mental health coverage.

Hewitt Associates surveyed 293 companies of various sizes and industry types to find specific prevalence patterns for mental health benefits and company-sponsored employee assistance programs. This report highlights the survey findings for the mental health benefits.

Surveyed companies were almost evenly distributed between manufacturing (49%) and nonmanufacturing (51%) industry classifications. In terms of the number of employees, 15% employed less than 1,000, 46% covered from 1,000 up to 5,000, 16% covered between 5,000 and 10,000, 19% between 10,000 and 50,000, and only 4% employed more than 50,000 employees.

Companies were almost evenly divided also in their reasons for offering mental health coverage. Moral obligation and competitive practice were the two most common responses as cited by 37% and 35%, respectively. Cost management for overall medical plan (15%), employee demand (6%), part of medical plan (4%), employee productivity (1%), and all others (2%).

Design And Usage

More than three-fourths of the companies have made no major design changes to inpatient or outpatient limits within the past two years. For the 288 companies surveyed, 80% did not change inpatient limits and 76% made no changes in the outpatient limits. However, 11% reported that they are planning changes within the next 12 months. Anticipated changes include limiting the number of inpatient days, adding or limiting annual and/or lifetime dollar limits, and overall evaluation of mental health coverage due to increasing claims costs.

In terms of utilization, 33% of the 197 companies said they have not been able to track use of the mental health benefit. Of those able to compare changes in use since 1983, just over half have seen an increase.

Design Features

Employers have ranked use of mental health benefits high on the list of health plan services that are difficult to control. The most common method used to control use places some type of special limit on plan benefits. Ninety-three percent of companies combined inpatient and outpatient limits (lifetime and/or annual) for mental health and substance abuse coverage. Of those plans, 71% had specific coverage limits for both mental health and substance abuse under the medical plan.

Specific limits for outpatient mental health benefits only was reported by 19% of the surveyed plans, and inpatient benefits were treated as any other illness under the medical plan. Seven percent reported specific limits for inpatient substance abuse only and inpatient mental health was covered as any other illness. Specific limits for inpatient mental health was reported by 3% of the companies surveyed and inpatient substance abuse is covered as any other illness.

More than half (54%) of the companies combined inpatient/outpatient limits expressed either as an annual or lifetime maximum; some companies had both. Annual dollar maximums were included in the plans of 22% of those companies with limits that ranged from

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

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June 3, 1987

MEMORANDUM

TO: Representative Niilo Koponen

ATTN: Lisa McLaren

FROM: Jay Livey
Legislative Analyst

RE: Mental Health Insurance Laws in Other States
Research Request 87.307

You asked that we: 1) determine the extent to which other states regulate the coverage of mental health services under health insurance policies sold within the state; 2) identify the types of mental health providers that are eligible to be reimbursed under the mental health coverage in other states; and 3) discuss the impact to mental health services in Alaska associated with designating specific mental health providers to be eligible for reimbursement from insurance claims.

Mental Health Insurance in Other States

The attached chart identifies the states which regulate mental health benefits in private health insurance policies. Thirteen states (Colorado, Connecticut, Maryland, Maine, Massachusetts, Minnesota, Montana, New Hampshire, North Dakota, Ohio, Oregon, Virginia and Wisconsin) have laws which require insurers to include mental health services as part of certain insurance policies sold in the state. Thirteen states (Arkansas, California, Florida, Georgia, Illinois, Kansas, Louisiana, Missouri, New York, Tennessee, Vermont, Washington and West Virginia) require only that insurance policies "offer" mental health coverage at the policy holder's option.

Mandated Coverage. Of the states which mandate mental health coverage, four states (Connecticut, Maryland, Massachusetts and Virginia) require coverage for individual as well as group policies. The type of mandated coverage specified in state insurance laws varies considerably. Colorado, Connecticut, Maine, Maryland, New Hampshire and Oregon specify coverage of inpatient services, partial hospitalization and outpatient services. Massachusetts, Montana, Virginia and Wisconsin specify inpatient and outpatient coverage only while Ohio and Minnesota specify only outpatient coverage. North Dakota specifies coverage for inpatient services and partial hospitalization but not for outpatient services.

Mental health providers eligible to receive insurance reimbursement under mandated coverage include psychiatrists in all thirteen states, psychologists in 12 states and social workers in six states. It should be noted, however, that the licensing requirements vary among states with regard to the qualifications required of these mental health providers. In virtually all of these states, mental health services offered in a licensed hospital or community mental health center are covered under mandated insurance policies.

Mandated Availability. Of the thirteen states which mandate availability of mental health coverage as a policy option, nine states specify that only inpatient and outpatient coverage be offered. Two states, Florida and Vermont, specify that in addition to inpatient and outpatient coverage, partial hospitalization should also be offered. Tennessee offers only outpatient coverage while Washington statutes do not specify services to be offered.

In twelve of these thirteen states--Georgia does not specify the types of providers eligible for insurance reimbursement--psychiatrists and psychologists are designated as professionals eligible for insurance reimbursement. In addition, five states specify social workers or other counseling professionals as eligible providers.

Provision of Mental Health Services in Alaska

Under Alaska law, three types of mental health professionals are licensed by the State: psychiatrists (AS 08.64), psychologists and psychological associates (AS 08.86). It is unlawful for an individual who is not so licensed to practice psychiatry or psychology or to generally advertise his or her services as relating to psychiatry or psychology. However, this does not preclude other types of health professionals from providing counseling services, e.g., drug and alcohol counsellors and family counselors.

Any hospital other than federal hospitals must be licensed by the State. A hospital is defined as any "institution or establishment, public or private, devoted primarily to providing diagnosis, treatment, or care over a continuous period of 24 hours each day for two or more unrelated individuals suffering from illness, physical or mental disease, injury or deformity, or any other condition for which medical or surgical services would be appropriate." Alaska has two hospitals licensed as psychiatric hospitals, Alaska Psychiatric Institute (API) and Charter North. In addition, Fairbanks Memorial, Providence and Mt. Edgecumbe are licensed to provide psychiatric services.

Community mental health centers established under AS 47.30 do not require a State license, but their operations must conform to State law and department regulations. Currently, there are 27 community mental health centers in Alaska. (See Table 1 for a summary of the community mental health centers in the state.)

Table 1 also includes the staffing characteristics of the community mental health centers as of October 1986. As the table indicates, eight mental health centers have medical doctors on staff. Of the centers without an M.D., eight have a PhD psychologist on staff (although two of these individuals were not licensed by the State) and 11 centers were staffed by an individual with a Masters degree. Within this latter group, one individual with a Masters degree was licensed as a psychological associate.

TABLE 1
COMMUNITY MENTAL HEALTH CENTERS IN ALASKA

		---------STAFFING INFORMATION---------		
LOCATION	NUMBER OF COMMUNITIES SERVED	MEDICAL DOCTOR	PSYCHOLOGIST	PSYCHOLOGICAL ASSOCIATE
Anchorage	3	yes	yes	yes
Fairbanks	8	yes	no	no
Wasilla	6	yes	yes	yes
Juneau	7	no	yes	yes
Kenai	4	yes	yes	no
Ketchikan	6	no	yes	no
Bethel	35	yes	no	no
Kodiak	6	no	yes	yes
Nome	16	no	no	no
Homer	8	yes	yes	yes
Sitka	2	no	yes	no
Barrow	7	no	no	no
Dillingham	26	yes	no	no
Kotzebue	12	no	no	no
Dutch Harbor	11	no	yes	no
Valdez	1	no	no	yes
Seward	5	yes	yes	yes
Prince of Wales	4	no	no	no
Galena	7	no	yes	no
Cordova	2	no	yes	no
Tok	7	no	no	no
Haines	3	no	no	no
Copper Center	10	no	no	no
McGrath	3	no	yes	no
Aniak	9	no	no	no
Fort Yukon	7	no	no	no
Tanana	8	no	no	no

Notes: Staff information provided as of October 1986.
Source: Alaska Department of Health and Social Services, Division of Mental Health.

Prepared by the House Research Agency, June 1987.

Table 2 provides a geographical distribution of licensed mental health providers in the state. As the table indicates, the licensed mental health providers are located predominantly in the larger communities in the state although Homer, Dutch Harbor, Seward, Petersburg and Glenallen all have a licensed provider.

TABLE 2
GEOGRAPHIC DISTRIBUTION OF LICENSED MENTAL HEALTH PROVIDERS IN ALASKA

COMMUNITY	PSYCHIATRISTS	PSYCHOLOGISTS	PSYCHOLOGICAL ASSOCIATES
Anchorage	30	44	7
Fairbanks	4	19	1
Wasilla	0	2	2
Homer	0	2	0
Cordova	0	1	0
Kodiak	0	1	0
Juneau	2	5	1
Ketchikan	0	4	0
Kenai/Soldotna	0	4	0
Sitka	0	3	0
Dutch Harbor	0	1	0
Seward	0	1	0
Kodiak	0	2	1
Petersburg	0	0	1
Glenallen	0	0	1
Out of State		13	0
Total	36	102	14

Source: Psychiatrist information from personal communication with the Alaska State Medical Association. Other data from Department of Commerce and Economic Development, Division of Occupational Licensing.

Prepared by the House Research Agency, June 1987.

Mental Health Insurance in Alaska

As Tables 1 and 2 indicate, there are areas of the state in which no providers could be reimbursed by insurance companies if reimbursement were restricted to licensed psychiatrists and psychologists. (Although psychological associates are licensed by the State, they must work under the direct supervision of a psychologist or psychiatrist.) Based on staffing patterns present in October of 1986, nine community mental health centers serving 84 rural communities do not have a licensed mental health provider on staff. As Table 2 indicates, these same communities have no private practitioners who could provide reimbursable services.

Expanding the definition of reimbursable providers to include master level practitioners would allow all community mental health centers to provide reimbursable services. According to the Division of Mental Health, as of October of 1986, all community mental health centers were staffed by an individual with at least a Master in Social Work (MSW) degree or Master of Arts (MA) degree in psychology.

One suggestion that has been made with regard to expanding the scope of reimbursable services in the state is to license mental health programs rather than mental health providers. Under this licensing format, community mental health centers which provide the required standards of service would be licensed by the State and be eligible for insurance reimbursement. Depending upon the licensing standards adopted, a community mental health center could be eligible for reimbursement even if the staff did not include a provider eligible to offer reimbursable services. The Division of Mental Health is currently investigating this approach.

It has also been suggested that although many rural areas do not currently have eligible providers, the market incentives created by mental health insurance legislation would cause providers to move into the underserved areas. This scenario assumes that there are a significant number of individuals in the underserved areas who would be covered by insurance policies and who would seek mental health services. Steve Caverly, acting director of the mental program at the Yukon-Kuskokwim Health Corporation (YKHC), noted that in the Bethel area, this assumption was not necessarily accurate.

Mr. Caverly noted that, in Bethel, there are a significant number of individuals who are covered under group insurance plans. However, this is not true in the villages that are within the YKHC service unit. He doubts that the YKHC program could collect sufficient revenue from insurance companies to offset the expense of hiring a psychiatrist or psychologist if the employment of these providers were necessary to bill insurance companies. However, he did note that the program currently bills for medicaid and some private insurance so that a billing procedure already exists.

Mr. Caverly identified two technical problems with regard to the types of practitioners eligible for insurance company reimbursement. First, he noted that it is very difficult for the mental health programs in the rural areas to attract and retain psychiatrists and psychologists, even if sufficient funds are available to pay them. Turnover of these professionals is high in the rural areas and recruitment is a time-consuming process. Consequently, it is likely that for significant periods of time a community mental health center may not have either a psychiatrist or psychologist on staff even if this were the desired staffing level. If insurance coverage is discontinued during the time that one of these providers is not on staff, clients may choose to discontinue services rather than make higher out-of-pocket payments.

A second problem is associated with determining the appropriate level of service for the client. Mr. Caverly noted that, in some cases, clients are better served within their home communities. Many community services can be most efficiently provided by practitioners other than psychiatrists and psychologists. However, if these services are not reimbursable because they are not offered by an eligible provider, a client may choose an inappropriate level of service (such as inpatient treatment in Anchorage) because it is covered by his or her insurance policy.

If you have any questions or want additional information, please contact this agency.

Attachments

SUMMARY OF STATE MANDATES OF MENTAL HEALTH INSURANCE COVERAGE

STATE	TYPE OF MANDATE	DATE	INPATIENT	PARTIAL HOSPITALIZATION	OUTPATIENT	POLICIES COVERED	ELIGIBLE PROVIDERS
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 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.

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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	1984	30 days per year under an individual policy and 60 days per year under a group policy.	Not specified	45 visits per year under an individual policy and 50 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.
Louisana	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 social worker in consultation with a physician.
Maine	MBP	1983	At least 30 days per year with a 20% co-payment 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 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	1975	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 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
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 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					
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	1979	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.

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Source: State Health Reports, Intergovernmental Health Policy Project, No. 20 (Special Feature), January 1986.

JAN. 1988

ITEM II-A-4

STATE MANDATES OF PSYCHIATRIC INSURANCE COVERAGE

Mental health benefits are required in insurance mandates in 27 states. Mandated benefit packages (MBP) are required in 14 states; mandated availability (MA) is required in 13 states. Details of the insurance mandates are presented in the following tables.

SUMMARY OF STATE MANDATES OF MENTAL HEALTH INSURANCE COVERAGE

STATE	TYPE OF MANDATE	DATE	INPATIENT	PARTIAL HOSPITALIZATION	OUTPATIENT	POLICIES COVERED	ELIGIBLE PROVIDERS
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 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.

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STATE	TYPE OF MANDATE	DATE	INPATIENT	PARTIAL HOSPITALIZATION	OUTPATIENT	POLICIES COVERED	ELIGIBLE PROVIDERS
Georgia	MA	1984	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 50 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.
Louisana	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 social worker in consultation with a physician.
Maine	MBP	1983	At least 30 days per year with a 20% co-payment 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 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	1975	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 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
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 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					
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.

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Source: State Health Reports, Intergovernmental Health Policy Project, No. 20 (Special Feature), January 1986.

(2)

Memo: Rep. Niilo Koponen - House HESS
Attn: Lisa McClaren

Re: SB 67-
Clinical Social Workers as providers

Date: 2/8/88

From: Marsha Schneider, MSW, ACSW
Executive Director
Alaska Chapter
National Assoc. of Social Workers

NASW recommends that clinical social workers be included as qualified providers of mental health services without regard to place of employment. Specifically, Sec. AS 21.42 [page 4, line ## 14] include a new section to read . . .

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

(b) ~~certified~~ certification by a national professional organization offering certification of clinical ~~Social Workers~~.

These organizations currently include:

(1) NASW ~~Clinical~~ Register of ~~Clinical Social Workers~~;
(2) National Registry of Health Care Providers;
(3) American Board of Examiners in Clincal Social Work.

At the present time our estimate is that there is approximately 15-20 clinical social workers currently on the NASW Register that are in private practice that would be included as additional providers under this bill. (1)

The next Register will be open in September of 1988. To be eligible ~~es~~ a for certification under ~~The~~ The NASW Register of Clinical Social Workers a social worker must meet the following requirements:

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

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

(3) Has at least 2 years of f-t exper. or 3000 hours of direct practice within the last 10 years.

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

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

(3) Please be aware that this standard is very stringent (see Vendorship Report, page 4). Without licensing of social workers by the State of Alaska, this high standard must be ~~was~~ maintained because there is no mechanism to assure that qualifications are met by practitioners. Additionally, there is the problem of consumer protection and accountability. Because certification currently requires membership either in NASW or the Society of Clinical Social Work Practice (SIC) in Alaska, there are internal grievance committees that can handle ethics complaints.

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

Thanks for your assistance.

(3)

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EXPER: 73- Asst Prof University of Alabama Birmingham; 80-83 Bryce Hospital Social Work Supervisor; 74-77 Brewer-Porch Childrens Center Social Worker

Tuskegee Institute

SMITH, ELSIE M.* LCSW/AL ACSW
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SPEC: AD; A; MIN
EXPER: 74- Dir Spec Prgm Tuskegee University; 72-74 Dir Campus Individual Development Ctr; 61-72 Outpt Soc Wkr Tuskegee Mtl Hlth Ctr

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EDUC: MSW 70 U Alabama, University AL
SPEC: AD; Gen Prac
EXPER: 82- Veterans Admin Med Ctr

ALASKA (Total 20)

Anchorage

ANDERSEN, ELLEN M.* ACSW
US Public Health Service
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EDUC: MSW 72 U Michigan, Ann Arbor MI
SPEC: C
EXPER: 78- Sr Soc Wkr US Public Health Service; 77-78 Soc Wkr Bureau of Indian Affairs; 75-77 Pottawattamie Child Guidance Ctr

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REGNO: 024144 *CERT:* RN, AK; RN, CA
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EDUC: MSW 82 U Houston, Houston TX
SPEC: AD; Eat Dis; Mar/Dvc; Med Con; Gen Prac
EXPER: 84- Executive Director Ctr for Chdn & Parents; 82- Clinical Social Worker Private Practice

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EDUC: MSW 75 Washgtn U/GW Brown, St Louis MO
EXPER: 78- Private Practice; 76-78 Ped SW Yale-NH Hosp Yale Sch of Med

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Social Services Dept, 2801 DeBarr, Anchorage AK 99508
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REGNO: 001202
PRAC: I; GR; FAM
EDUC: MSW 69 U North Carolina, Chapel Hill NC
SPEC: AD; Med Con; Dth/Dyg; Sub Ab
EXPER: 82- Soc Svc Director Humana Hosp; 73-80 Clinical Soc Wkr NC Mem Hosp; 71-72 Sr Soc Wkr Queen Ellz II Hosp

CRAIG, HELEN S. ACSW
Langdon Psychiatric Clinic
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REGNO: 017326
PRAC: FAM; I
EDUC: MSW 74 U Illinois, Urbana IL
SPEC: A
EXPER: 77- Langdon Psychiatric Clinic; 74-77 Involvement Centers of Wisconsin; 74-74 Mattoon Community Mental Health Center

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DHEW-PHS-IHS
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REGNO: 011872
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EDUC: MSW 68 U Denver, Denver CO
SPEC: AD
EXPER: 68- Clinical Social Worker Alaska Native Med Ctr

DUKE, VERONICA M.* ACSW
State of Alaska
State of Alaska, 2900 Providence Drive, Anchorage AK 99508
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REGNO: 000842
PRAC: I
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EXPER: 72- Chf Soc Wkr Alaska Psych Inst Program Manager; 70-72 Psych Soc Wkr Alaska Psych Inst; 56-60 Psych Soc Wkr State of MO

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PRAC: I; CP; GR; FAM
EDUC: MSW 76 Washgtn U/GW Brown, St Louis MO
SPEC: AD; Fam Vio; Gen Prac; Mar/Dvc; Med Con
EXPER: 85- Social Worker Div of Fam & Youth Svc; 83-85 Psych Providence Hospital; 78-82 Psych Malcolm Bliss Mtl Hlth Ctr

GARVIN, JOHN C., DR ACSW
Good News Counseling
2008 East 38th Avenue, Anchorage AK 99508 *PH:* (907) 561-4799B
REGNO: 020429
PRAC: I; CP; GR; FAM
EDUC: PhD 76 U Pittsburgh, Pittsburgh PA; MPH 73 U Pittsburgh, Pittsburgh PA; MSW 71 U Pittsburgh, Pittsburgh PA
SPEC: A; AD; Chd/ Sex Ab; Dth/Dyg; Gen Prac
EXPER: 86- Director Good News Counseling of Alaska; 84-86 Director Samaritan Counseling of Alaska; 75-84 Director Alaska Childrens Services Executive

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PRAC: I; GR; FAM
EDUC: MSW 62 U Michigan, Ann Arbor MI
SPEC: C; A; AD; Gen Prac; Med Con
EXPER: 73- Soc Svc Spec Alaska State Sch for the Deaf; 70-73 Soc Wk, Alaska Chdns Svc Ctr for Chdn & Parents; 66-70 Dir Therapeutic Svc Jesse Lee Home

Eagle River

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PRAC: I; FAM
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SPEC: A
EXPER: 83- Private Practice; 80-83 The Collective A Feminist Therapy Center; 77-80 Alaska Womens Resource Center Therapy Prgm

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EDUC: MSW 63 U Utah, Salt Lake City UT
SPEC: C; AD
EXPER: 82- ADCO CPC Fort Richardson AK; 75-82 Soc Wkr VA Center Hot Springs SD; 67-75 Psych Soc Wkr MO Div Mtl Hlth

PUGH, RICHARD G.* CCSW/UT*
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EXPER: 85- Elmendorf USAF Regional Hospital

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PRAC: I; FAM; GR; CP
EDUC: MSW 80 Smith Col, Northampton MA
SPEC: AD; A; C; Gen Prac; Chd/ Sex Ab
EXPER: 85- Supervisor Resource Ctr for Parents & Children; 84- Private Practice; 81-84 Clinician Fairbanks Comm Mtl Hlth Ctr

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EDUC: MSW 78 U Utah, Salt Lake City UT
SPEC: MIN; A; AD; Gen Prac; Sub Ab
EXPER: 84- Consultant Applied Behavioral Ecology; 83-85 Director Mental Health Tanana Chiefs; 80-82 Director Autism Teaching Center

PATRICK-RILEY, COLLEEN C.* ACSW
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PRAC: FAM; I; CP; GR
EDUC: MSW 79 U Washington, Seattle WA
SPEC: C; AD; Chd/ Sex Ab; Mar/Dvc; Gen Prac
EXPER: 83- Director Fairbanks Counseling & Adoption; 79-83 Social Worker Jesse Lee Home AK Chdns Svcs

SCOLLAN, ELIZABETH L.* ACSW
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PRAC: I; FAM; CP; GR
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SPEC: C; AD; A; Chd/ Sex Ab; Gen Prac
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SPEC: A; C; Mar/Dvc; Gen Prac; Chd/ Sex Ab
EXPER: 84- Clinical Social Worker Private Practice; 80-84 Counselor Resource Ctr Parents & Children; 77-80 Organizer NYC Commission Human Rights

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EXPER: 86- Clinician Fairbanks Counseling & Adoption; 82-83 Clinician Fairbanks Community Mental Health; 82-82 Lecturer Dept of Psych Univ of Alaska

Kodiak

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PRAC: I; CP; FAM; GR
EDUC: MSSW 75 U Missouri, Columbia MO
SPEC: AD; A; Gen Prac; Mar/Dvc; Dth/Dyg
EXPER: 75- Clinician III Kodiak Is Mental Health Ctr

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REGNO: 022251
PRAC: I; FAM; GR; CP
EDUC: MSW 70 VA Commonwealth U, Richmond VA
SPEC: C; A; AD; MIN; Sub Ab
EXPER: 83- Psych Soc Wkr Kodiak Island MHC; 78-83 Forensic Soc Wkr St Elizabeth Hospital

Nome

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EDUC: MSSW 57 Columbia U, New York NY
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EXPER: 83- Clinician III Norton Sound CMHC Nome AK; 82- Private Practice Overview Clinic Nome AK; 82-83 Director Extended Care SE CO Fam/MHC

PROFESSIONAL SOCIAL WORK RECOGNITION

Vendorship Report

June 1987

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

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TABLE OF CONTENTS

I. INTRODUCTION

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

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

As more health insurance policies include mental health benefits, and as budgets for agencies decrease, clinical social workers in all settings are steadily exploring with clients the use of health insurance to help defray the cost of clinical social work services. The use of insurance payments (also called "third-party payments") is thus of vital interest to all clinical social workers.

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

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

II. GENERAL PERSPECTIVES

A. On Third-Party Reimbursement

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

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

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

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

B. On Securing Recognition

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

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

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

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