ALASKA LEGISLATURE COMMITTEE FILES 1987-1988 8672
4752 HJUD SB 67

government in a state and certified or eligible for certification in psychiatry by the American Board of Psychiatry and Neurology;

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

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

(E) a clinical social worker who is

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

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

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

(A) in the outpatient department of

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

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

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

(B) by one or more of the following:

(i) a psychiatrist who is licensed by a state as a physician and certified, or eligible for certification, in

psychiatry by the American Board of Psychiatry and Neurology;

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

(iii) a psychologist licensed by a state;

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

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

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

(d) Except to the extent necessary to comply with AS 21.42.365, a [A] person may not practice or permit unfair discrimination against a person who provides a service covered under a group disability policy that extends coverage on an expense incurred basis, or under a group service or indemnity type contract issued by a nonprofit corporation, if the service is within the scope of the provider's occupational license. In this subsection, "provider" means a state licensed physician, dentist, osteopath, optometrist, chiropractor, or nurse midwife, naturopath, physical therapist, or occupational therapist.

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

Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the provisions contained or referred to previously in this chapter, the

following chapters and provisions of this title also apply with respect to service corporations to the extent applicable and not in conflict with the express provisions of this chapter and the reasonable implications of the express provisions, and for the purposes of the application the corporations shall be considered to be mutual "insurers":

(1) AS 21.03

(2) AS 21.06

(3) AS 21.09, except AS 21.09.090

(4) AS 21.18.010

(5) AS 21.18.030

(6) AS 21.18.040

(7) AS 21.18.120

(8) AS 21.21.321

(9) AS 21.36

(10) AS 21.69.400

(11) AS 21.69.520

(12) AS 21.69.600, 21.69.620, and 21.69.630

(13) AS 21.78

(14) AS 21.90

(15) AS 21.42.345 - 21 42.365 [AS 2 [illegible] AND 21.42.355]

(16) AS 21.89.040

(17) AS 21.89.060.

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

5-0356Ma
Ford

AMENDMENT #1

Offered in the HOUSE

By Collins

TO: HCS CSSB 67(Judiciary)

HANLEY

Page 1, line 29:

Delete "20"

Insert "50"

5-0356Ba
Ford

A M E N D M E N T

TO: CSSB 67(HESS)

Page 1, line 16:

Delete "shall offer"

Insert "must provide"

Delete "an option to receive"

Page 1, line 22, after "50":

Insert "hours of"

Page 1, line 24:

Delete "offering"

Insert "providing"

Page 1, line 29 through page 2, line 3:

Delete all material.

Reletter the following subsection accordingly.

Page 3, line 10:

Delete "in"

Insert "through"

5-0356Xa
Ford

A M E N D M E N T

Offered in the HOUSE

By Gruenberg

TO: HCS CSSB 67(HESS)

Page 3, line 9, after "Providers;":

Insert "the American Association for Marriage and Family Therapy;"

A M E N D M E N T

Offered in the HOUSE By Barnes

TO: HCS CSSB 67(HESS)

Page 3, line 9, after "Providers;":

Insert "the American Association of Pastoral Counselors;"

A M E N D M E N T

Offered in the HOUSE

TO: HCS CSSB 67(HESS)

Page 1, after line 27:

Insert a new subsection to read:

"(c) Notwithstanding (a) of this section, if the insured or subscriber is an employer who employed fewer than 20 permanent, full-time employees for each working day during each of at least 20 calendar workweeks in either the current calendar year or the preceding calendar year, the insurer, hospital, or medical service corporation is not required to provide the coverage specified in (a) of this section to the insured or subscriber but shall offer that coverage to the insured or subscriber as optional coverage."

Reletter the following subsection accordingly.

STATE OF ALASKA
1988 LEGISLATIVE SESSION

BILL VERSION: CS SB 67 (HESS)
PUBLISH DATE: _____

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: ...relating to insurance coverage for the treatment of a mental or nervous cond.
Sponsor: _____
Requestor: _____

Agency Affected: Health & Social Services
BRU: Community Mental Health Grants, Institutions and Administration
Components: Community Mental Health Grants, Alaska Psychiatric Institute

EXPENDITURES/REVENUES: (Thousands of Dollars)

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

FUNDING: (Thousands of Dollars)

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

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

see attached sheet

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

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

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

FISCAL NOTE

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

STATE OF ALASKA 1987 LEGISLATIVE SESSION
FISCAL NOTE

Bill Version: CS SB 67 (HESS)
Publish Date: 3-3-87

REQUEST:

Revision Date:
Title: "An Act Relating to Insurance Coverage of a Mental Health or Nervous Condi.
Sponsor: Faiks and Kertulla
Requestor:

Agency Affected:
BRU: Institutions and Administration
Components: Alaska Psychiatric Institute

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
REVENUE	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of Dollars)

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

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

See attached

Prepared by: Deborah K. Smith
Division:
Phone: 465-3370
Date: 1/27/87

Approved by Commissioner: Marie M. Munson
Agency: Dept. of Health & Social Services
Date: 3/18/87

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

CS SB 67 HESS

FISCAL NOTE

Payments to the Alaska Psychiatric Institute from 3rd party insurance are estimated to increase as a result of this bill. Community Mental Health Centers could expect additional revenue from 3rd party payors also. Data is not available from this Division to calculate the potential increase in revenue. Currently, 40% of our clients have some form of insurance.

STATE OF ALASKA

DEPARTMENT OF ADMINISTRATION
DIVISION OF RETIREMENT & BENEFITS
PLEASE REPLY TO:

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

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

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

STEVE COWPER, GOVERNOR

February 12, 1988

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

Dear Representatives Koponen and Ellis:

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

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

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

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

The increase in the PERS contribution rate (.20%) times the estimated FY 89 state PERS payroll ($479,549,872) equals:	$ 959.1
The increase in the TRS contribution rate (.15%) times the estimated FY 89 University of Alaska TRS payroll ($44,753,863) equals:	67.1
The increase in the TRS contribution rate (.15%) times the estimated FY 89 Department of Education TRS payroll ($5,613,930) equals:	8.4
	$1,034.6

02-34LH

Note: Please Include Your Social Security Number In All Correspondence & Requests Concerning Your Benefits.

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

The increase in the PERS contribution rate (.20%) times the estimated FY 89 political subdivision payroll ($329,744,333) equals:	$ 659.5
The increase in the TRS contribution rate (.15%) times the estimated FY 89 school districts' payroll ($319,882,344) equals:	$ 479.8
	$1,139.3

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

Sincerely,

Robert F. Stalnaker
Acting Director

RFS/bb/7

STATE OF ALASKA
1988 LEGISLATIVE SESSION

Bill Version: Work Draft HCSCSSB67(HESS)
Publish Date:

FISCAL NOTE

REQUEST:

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

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

EXPENDITURES/REVENUES: (Thousands of Dollars)

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

FUNDING: (Thousands of Dollars)

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

POSITIONS:

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

ANALYSIS: (Attach a separate page if necessary)

DRAFT

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

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

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

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

February 11, 1988

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

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

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

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

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

DRAFT

February 29, 1988

MAR 04 1988

Representative John Sund
House Judiciary Committee
Alaska State Legislature
P.O. Box V, (MS 3100)
Juneau ,Ak. 99811

I oppose

Dear Representative Sund:

Recently I sent a P.O.M. regarding SB 67 concerning mandatory insurance for mental health problems. The wording of the bill needs to be changed because it presently focuses on service providers with Master's degrees in Psychology, Social Work, or Nursing. Therefore, many other appropriate and qualified individuals are excluded from said insurance reimbursement. Ideally, there needs to be licensing for Master's level mental health therapists, so that the insurance bill could read that "any licensed provider" could be eligible for reimbursement. However, since there is no such licensing, the bill needs to include language such as "an equivalent degree" to assure that providers of services with Master's in Counseling, Marriage and Family Therapy, or similar degrees would be covered as well as those with Psychology, Social Work, and Nursing. It is not at all reasonable to focus on only three degrees as many other mental health providers are highly trained and appropriate therapists also.

I would appreciate your attention to this matter.

Sincerely,

Vivian C. Finlay

Vivian C. Finlay, M. Ed.,
Marriage, Family and Child Therapist.

P.O. Box 872433, Wasilla, Ak. 99687

cc: Senator Kerttula
Representatives: Fran Ulmer
Sam Cotten
Max F. Gruenberg, Jr.
Mike Navarre
Ramona L. Barnes
Robin L. Taylor
AkAMFT

February 29, 1988

Senator Kerttula
Alaska State Legislature
P.O. Box V
Juneau, Ak. 99811

Dear Senator Kerttula:

As a follow up to my phone conversation with Matt Fishel in your Wasilla office I would like to express my support for Senate Bill 423 which would provide for certification for Marital and Family Therapists. I believe that a hearing is needed on this subject so that the importance of certification and licensing may be discussed thoroughly.

I have been writing to members of the Alaska legislature since early 1984 on this subject of licensure for Marital and Family Therapists. I believe licensing is of critical importance to regulate the people who are "therapists" so as to assure adequate training and expertise, thereby giving consumers information to make informed judgements in seeking therapy services. Also if we presently had licensing the wording of legislative bills such as SB 67 would be less cumbersome; insurance reimbursement could be available to "licensed providers". However, since there is no licensing for Marital and Family therapists, we are excluded from the wording in such a bill.

As a Clinical member of the Alaska Association for Marriage and Family Therapists, and as a practicing therapist for the past 12 years (4 1/2 years in Alaska) I strongly support the need for licensing of Marital and Family Therapists. I have been licensed in the State of California as a Marriage, Family and Child Counselor since January 1980. I retain the license because I believe it helps the Alaskan public have confidence in my skills. I am required to obtain specific continuing education regularly in order to renew my license. I believe this is another valuable aspect of licensure.

I would appreciate your support of this bill and would like you to consider holding hearings on the subject.

Sincerely,

Vivian C. Finlay

Vivian C. Finlay, M.Ed.
Marriage, Family and Child Therapist, P.O.B. 872433, Wasilla, AK. 99687

cc: AkAMFT
Senator Paul Fischer
Representative John Sund, House Judiciary Committee

Montreal, site of APA's 1988 annual meeting, calls St. Joseph's Oratory the world's most important shrine to St. Joseph, Canada's patron saint. The basilica was begun through the efforts of Brother André, who was beatified in 1982. APA members have until April 2 to preregister for the annual meeting and save on fees. More information about the meeting is available by calling (202) 682-6100.

onally Disturbed Students Status as 'Handicapped'

sturbed students who or dangerous may not or an indefinite period school officials obtain n parents or a judge, ourt ruled in late Janu-

ıe majority in the 6–2 e William Brennan Jr. e Education of the ct of 1975 (EHA) pro- than four million dis- eceiving special edu- in the United States al" disciplinary ac- lisabled children, ap- 000 are considered to disturbed, the U.S. ducation estimates. igation of the 1954 *Brown* vs. *Board of* Supreme Court pro- n to be "perhaps the unction of state and ." Yet 21 years lat- bserved, Congress y to enact the EHA ls of American chil- t receiving appropri- ervices.

cording to Brennan, ildren "were simply special classes or shepherded through school until any disciplinary review proceedings have been completed, "unless the parents and state or local educational agencies otherwise agree."

By passing this legislation, Brennan asserted, "Congress very much meant to strip schools of the unilateral authority they had traditionally employed to exclude disabled students, particularly emotionally disturbed students, from school."

Concurring with Brennan's opinion were Chief Justice William Rehnquist and Justices Thurgood Marshall, By-

see "Students," page 11

Court Holds Bipolar Disorder Is Physical

In a decision that could have wide-ranging ramifications for psychiatry and the insurance industry, an Arkansas appeals court recently ruled that bipolar disorder is a physical, not mental, illness and should be reimbursed at whatever payment rate an insurer has established for covering the treatment of physical illnesses.

After hearing testimony from several psychiatrists, the judge upheld a lower court ruling that ordered Blue Cross/Blue Shield to reimburse a policyholder for the treatment of bipolar disorder at the payment rate for coverage of physical disorders.

Under the insurance policy in question, as with most insurance policies, mental and nervous disorders were to be reimbursed at a lower rate than were physical illnesses and accidental injuries.

The father of a minor child, identified only as John Doe and Jane Doe respectively, filed suit against the insurance carrier after it refused to reimburse him to the extent he expected for the hospital treatment of his daughter's bipolar illness.

The Blues claimed that their definition of bipolar disorder as a mental illness was in line with similar classifications by Medicare, hospitals, and physicians throughout the country. Thus they were not remiss in refusing to reimburse Doe as they would have if the treatment was for a physical illness or an accidental injury.

One of the controversies in the case was whether the traditional classifica-

see "Bipolar," page 16

AMA Launches Drive to Change States' Malpractice Laws

In the caucuses and reference committees of the AMA House of Delegates, South Florida has been termed "the Beirut of the professional liability crisis."

Some specialists in that part of the country have been staggering under colossal malpractice premiums. Neurosurgeons in Florida's Dade and Broward counties, for example, may be required to

ida was $140,594—almost two and a half times the national average of $56,739.

Last year St. Paul Fire and Marine Insurance Company, the largest medical malpractice carrier in the country, requested a nearly 30 percent increase in its malpractice premium rates for Florida. But when the state's insurance department granted only a 17

Psychiatry news 3-4-88

Ps

VOL. XXIII No. 5 News

In This Issue

Second-class postage paid at Washington, D.C. and at additional mailing offices

Emotio Given S

Emotionally disti are disruptive or be suspended for of time unless sc permission from the Supreme Cour ary.

Writing for the decision, Justice W argued that the Handicapped Act c tects the more tha abled children rece cation services in from "unilateral" tions. Of these disa proximately 385,000 be emotionally dist Department of Educ

During the litigat landmark case, *Bro Education*, the Supr claimed education to most important funct local government." ' er, Brennan obser found it necessary to because thousands of dren were still not rec ate educational servic

At that time, accord many disabled childre 'warehoused' in spec were neglectfully shepl the system until they w to drop out."

Brennan pointed out EHA safeguards guar abled children the rig appropriate public edu "stay-put" clause. Th states that if a disabled disruptive, he or she st

continued from page 1

tion of bipolar (or manic-depressive) disorder as a mental illness was based on its symptoms or its causes and, if it was symptom based, did this reflect current thinking on how illnesses should be classified?

Several of the psychiatrists testifying as expert witnesses said that historically bipolar disorder has been labeled a mental or psychiatric illness, but that this is changing to reflect its causes rather than its manifestations.

At least five psychiatrists and psychologists testified about the nature and classification of bipolar disorder. All but one of them maintained that it is a biologically based illness.

Classification Changing

Several witnesses testified that classification of illnesses by symptoms rather than etiology is outdated, and that psychiatry was shifting its classification focus to one that is based more on the causes than the behavioral and emotional manifestations of psychiatric disorders.

Thomas Harris, M.D., a Little Rock psychiatrist, told the court that there is a movement throughout medicine to reclassify bipolar disorder as a physical illness because of "overwhelming medical research" pointing to its biological roots as a chemical or hormonal imbalance in the brain. "I think most laymen and. . .most physicians and most people in psychiatry now classify illnesses by cause or origin," he said, and although people with this illness display serious behavioral and emotional disturbances, its causes are clearly physical rather than mental in nature.

Another witness pointed out that in 1986 the Arkansas Psychiatric Society said that "[b]ipolar affective disorder is an illness whose origin is biological." The judge took the district branch's statement into consideration in his ruling, the decision indicates.

The judge rejected an argument by Blue Cross/Blue Shield that since psychotherapy is an important component of treatment of bipolar disorder, it is in the realm of mental rather than physical disorders.

In upholding the trial court decision that Blue Cross/Blue Shield should have reimbursed the plaintiff at its treatment rate for physical illnesses, the appeals court judge noted that in addition to the evidence about the biological basis of bipolar illness, the insurer's case was weakened by the fact that although classification manuals still consider it primarily a mental disorder, such manuals were not adopted or even referred to by Blue Cross/Blue Shield in the insurance policy in question.

Impact on Psychiatry

The impact on psychiatry of the Arkansas decision will be relatively minor unless courts in other states hand down similar rulings or extend the decision to illnesses such as schizophrenia and unipolar depression, for which there are biological components.

If this decision starts a judicial trend, however, the reaction of the insurance industry will in large part determine what the ramifications will be for psychiatrists and their patients.

If the Arkansas court's ruling becomes a precedent, or if the insurance industry is forced to reimburse for other psychiatric illnesses at the same rates as it does for other physical illnesses, the decision could raise sig-

see "Bipolar," facing page

nificant and complex issues "for psychiatry as a whole, particularly in how we conceptualize the illnesses we deal with," said Paul Appelbaum, M.D., chair of the APA Commission on Judicial Action.

More immediate ramifications may be on reimbursement patterns and may differentially affect psychiatrists who treat the most severe illnesses compared with those who generally treat less severe psychiatric disorders, he suggested.

APA Responds

To plan for how best to respond to the issues raised by this ruling, APA President-elect Paul Fink, M.D., announced at the January 29 meeting of the Joint Reference Committee that a work group to study the implications of the Arkansas decision will soon be appointed.

"The Arkansas case gives psychiatry an extraordinary window of opportunity," Fink told *Psychiatric News*. The task confronting psychiatry in light of the judge's ruling "is to use this decision in the best interest of all concerned, and we do this by helping people to understand that all major illnesses are physical, mental, and medical. All of these illnesses are biopsychosocial."

It is unfortunate, he added, that the judge chose to dichotomize psychiatric illnesses into separate categories of physical and mental disorders.

Fink emphasized that in light of its potential ramifications, psychiatrists must be "vigilant that insurance companies don't start to use [the Arkansas decision] to exclude psychiatric illnesses from coverage on a disease-by-disease basis." —K.H.

Trauma

continued from page 13

previously committed, he said. One child among the children of Chowchilla who were kidnapped and buried underground for 24 hours continued to blame the kidnapping on "mean things" said to the mother the morning before the abduction.

"The final theme," Segal said, "sometimes ends up sounding more like a sermon than science, but it has to do with the capacity, even during great suffering, of victims to turn outward, or in psychiatric terms to practice dereflection, from self-involvement to a sense of compassion and involvement with others. Those who didn't make it, indeed many of these who died in captivity, by the testimony of physicians and others who were there, gave up the ghost and did not turn outward to their fellow captives in a sense of communication and concern."

Implications

During a telephone interview Segal added, "I believe these findings have implications for the treatment of individuals who have undergone trauma and shattering crises of any sort. It may be important in treatment not only to help victims find sources of social support but to encourage attempts to find ways to reassert control and mastery over their existence, to rediscover meaning and purpose, to shed the mantle of self-blame and guilt, and to find vehicles for reaching outward to others rather than becoming ensnared in self-occupation and chronic victimhood."

STUDENT MEMBER REQUIREMENTS

Education

Current enrollment in a graduate program in marital and family therapy, or a course of study substantially equivalent, in a regionally accredited educational institution.

Professional Reference

Endorsements by two Clinical Members of the Association, attesting to suitable qualities of personal maturity and integrity for the conduct of marital and family therapy.

Student membership may be held until receipt of a qualifying graduate degree, or for a maximum of five years.

APPLICATION PROCEDURES

Applicants must apply for the highest level of membership for which they qualify.

All applicants for membership and transfer of status must submit the following:

- ☐ AAMFT application for membership
- ☐ Non-refundable processing fee
- ☐ Official transcripts of graduate and professional education (Exception: Associate Members who have previously met all educational requirements.)
- ☐ Endorsements by two AAMFT Clinical Members

Please note additional specific materials required for these categories:

Clinical membership

- ☐ Supervision reports completed by all supervisors, or
- ☐ Copy of a current state-issued MFT license or certificate recognized by the AAMFT Board of Directors

Student membership

- ☐ Current enrollment verification signed by the program coordinator/director at a regionally accredited educational institution.

For applications, please write:
AAMFT
1717 K Street, N.W.
Suite 407
Washington, D.C. 20006

For more information, please call:
AAMFT Membership Department
(202) 429-1825

Effective 7-86

MEMBERSHIP REQUIREMENTS

- CLINICAL MEMBER
- ASSOCIATE MEMBER
- STUDENT MEMBER

American Association
for
Marriage and Family
Therapy

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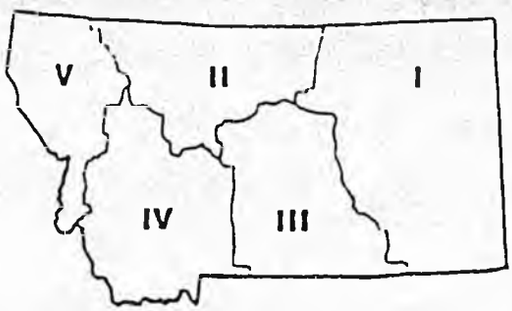

Montana Council of Regional Mental Health Boards, Inc.

2/21/86

Nancy Pease
House Research Agency
P.O. Box Y
Juneau, Alaska 99811-3100

Dear Nancy:

In 1983 the Montana legislature passed a law requiring group insurance benefits for mental health treatment. The enclosed materials were presented to the legislative committees and used as justification for passage of the law mandating insurance benefits for the treatment of mental illness.

Testimony also indicated that too often people were being inappropriately hospitalized for psychological services since health insurance plans pay for hospital benefits but not for outpatient mental health treatment. Obviously the incentive was to place people in an expensive hospital because the costs were paid by the health insurance company. Less expensive outpatient services were not a paid benefit so a client's doctor would order hospitalization.

After our phone conversation, I checked the trend in inpatient hospital admissions as reported to our mental health authority, the Department of Institutions. The information was gathered from reports by the Community Mental Health Centers. In fiscal year (FY) 83 there were 6358 mental health inpatient hospitalization units reported. In FY 84 there were 5999 inpatient units. In FY 85 there were 5518 inpatient units. As reported by the Community Mental Health Centers the downward trend in inpatient hospitalization since the passage of the law in 1983 is clear.

REGION I
EASTERN MONTANA COMMUNITY MENTAL HEALTH CENTER
1819 Main Street
Miles City, Montana 59301
(406) 232-2141

REGION II
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Holiday Village Shopping Center
P.O. Box 7036
Great Falls, Montana 59403
(406) 761-2100

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CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

STUDENT MEMBER REQUIREMENTS

Education

Current enrollment in a graduate program in marital and family therapy, or a course of study substantially equivalent, in a regionally accredited educational institution.

Professional Reference

Endorsements by two Clinical Members of the Association, attesting to suitable qualities of personal maturity and integrity for the conduct of marital and family therapy.

Student membership may be held until receipt of a qualifying graduate degree, or for a maximum of five years.

APPLICATION PROCEDURES

Applicants must apply for the highest level of membership for which they qualify.

All applicants for membership and transfer of status must submit the following:

- ☐ AAMFT application for membership
- ☐ Non-refundable processing fee
- ☐ Official transcripts of graduate and professional education (Exception: Associate Members who have previously met all educational requirements.)
- ☐ Endorsements by two AAMFT Clinical Members

Please note additional specific materials required for these categories:

Clinical membership

- ☐ Supervision reports completed by all supervisors, or
- ☐ Copy of a current state-issued MFT license or certificate recognized by the AAMFT Board of Directors

Student membership

- ☐ Current enrollment verification signed by the program coordinator/director at a regionally accredited educational institution.

For applications, please write:
AAMFT
1717 K Street, N.W.
Suite 407
Washington, D.C. 20006

For more information, please call:
AAMFT Membership Department
(202) 429-1825

Effective 7-86

MEMBERSHIP REQUIREMENTS

- CLINICAL MEMBER
- ASSOCIATE MEMBER
- STUDENT MEMBER

American Association for Marriage and Family Therapy

The American Association for Marriage and Family Therapy (AAMFT), founded in 1942, is the professional association for the field of marital and family therapy. AAMFT offers professional contact and exchange of information, and serves the public interest through the advancement of the ethical practice of marital and family therapy. This brochure describes the requirements and procedures for becoming a Clinical, Associate, or Student Member of AAMFT.

CLINICAL MEMBER REQUIREMENTS

Education

Completion of a master's or doctoral degree in marital and family therapy from a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education, or a graduate degree from a regionally accredited educational institution and an equivalent course of study as defined by the AAMFT Board of Directors.

Applicants who have completed a program accredited by the Commission on Accreditation are considered to have completed all educational requirements. Coursework completed at institutions not accredited by the Commission is subject to review by the Membership Committee.

Meeting the educational qualifications consists of completion of a course of study substantially equivalent to the following curriculum. (Each course must be equivalent to a three-credit semester or four-credit quarter course.)

- ☐ Human Development (3 courses)
  Human development, personality theory, human sexuality, psychopathology, behavior-pathology.
- ☐ Marital and Family Studies (3 courses)
  Family development and family interactional patterns across the life cycle of the individual as well as the family. Courses may include the study of: family life cycle; theories of family development; marriage and/or the family; sociology of the family; families under stress; the contemporary family; family in a social context; the cross-cultural family; youth/adult/aging and the family; family subsystems; individual, interpersonal relationships (marital, parental, sibling).
- ☐ Marital and Family Therapy (3 courses)
  Communications; family psychology; family therapy methodology; family assessment; treatment and intervention methods; overview of major clinical theories of marital and family therapy such as: structural, strategic, transgenerational, experiential, object relations, contextual, systemic.
- ☐ Research (1 course)
  Research design, methods, statistics, research in marital and family studies and therapy.
- ☐ Professional Studies (1 course)
  Professional socialization and the role of the professional organization, legal responsibilities and liabilities, independent practice and interprofessional cooperation, ethics, and family law.
- ☐ Clinical Practicum (1 year, 300 hours)
  15 hours per week, approximately 8-10 hours in face-to-face contact with individuals, couples, and families for the purpose of assessment and intervention.

This course of study may be completed in a master's or doctoral degree program or subsequent to a graduate degree.

Applicants who have earned their first qualifying graduate degree prior to 1979 may establish coursework equivalency in the following manner:

- ☐ Workshops/Seminars—45 contact hours equals one three-credit semester or one four-credit quarter course
- ☐ Courses taught—one graduate level course taught equals one three-credit semester or one four-credit quarter course
- ☐ Extensive experience, publications, and educational qualifications in the field of MFT may be considered on a case-by-case basis.

Clinical Experience

Completion of 2 years of post-graduate work experience in MFT and supervision in accordance with the following established membership standards:

- ☐ Supervised clinical experience must follow receipt of the first qualifying graduate degree and the practicum required as part of the course of study;
- ☐ Supervision must be provided by AAMFT Approved Supervisors or supervisors acceptable to the Membership Committee; and,
- ☐ Successful completion of at least 1000 hours of face-to-face contact with couples and families for the purpose of assessment and intervention, and 200 hours of supervision of MFT, at least 100 of which are individual supervision, is required.

Applicants without previous graduate degrees who have completed programs accredited by the Commission on Accreditation may be credited with 500 hours of face-to-face contact and 100 hours of supervision, of which not more than 50 hours may be group supervision.

Licenses/Certificates

Applicants with a graduate degree and a state-issued MFT license or certificate recognized by the AAMFT Board of Directors are deemed to have complied with the educational and clinical experience qualifications for Clinical membership.

Professional Reference

Endorsements by two Clinical Members of the Association, attesting to suitable qualities of personal maturity and integrity for the conduct of marital and family therapy.

ASSOCIATE MEMBER REQUIREMENTS

Education

Completion of a master's or doctoral degree in marital and family therapy from a program accredited by the Commission on Accreditation, or a graduate degree from a regionally accredited educational institution and an equivalent course of study as defined by the AAMFT Board of Directors.

Meeting the educational qualifications for Associate membership consists of the completion of at least eight of the required courses and one year of clinical practicum as described under Clinical Member requirements.

Professional Reference

Endorsements by two Clinical Members of the Association, attesting to suitable qualities of personal maturity and integrity for the conduct of marital and family therapy.

Associate membership may be held until satisfactory completion of the requirements for Clinical membership, or for a maximum of five years.

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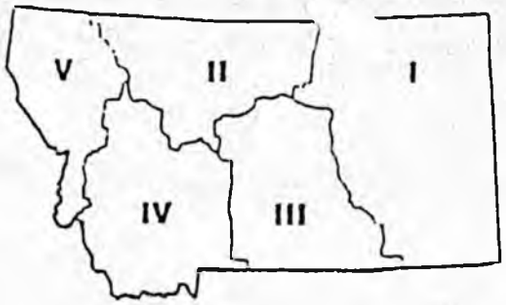

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As you might guess the health insurance industry is philosophically opposed to any mandated benefits. However, in private conversations with insurance providers they have indicated that mental health benefits are a low cost item. They also were paying for it anyway through increased utilization of hospitalization and other physical illness benefits. In fact, I am not aware of any insurance company that raised their premiums any significant amount. Most insurance providers did not even adjust their premium rate after the passage of the law.

I hope this information is of use to you and the members of the House committee. If I can be of further assistance please feel free to call on me.

Best regards,

Steve Waldron
Executive Director

Dispelling Myths About Mental Health Benefits

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

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

MENTAL HEALTH REPORT

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

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

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

This discrimination is bad for patients, for business, for mental health providers and, ultimately, for the community and taxpayers. Unequal coverage of psychiatric treatment has evolved primarily because of several prevalent myths about mental health benefits and care. In business' role as a formulator of health care policy, accurate information is essential to assure that employers make wise economic decisions about health care coverage for employees while providing for quality health care.

The 1960s and 1970s were decades of tremendous growth for mental health services, fueled by ever expanding public and private third party financial resources. From 1955 to 1977, the number of patients treated in inpatient and outpatient mental health facilities almost quadrupled, from 1.7 million to 6.4 million.

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

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

Restricting Benefits

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

Steven S. Sharfstein is deputy medical director and Sam Muszynski is director of the Office of Economic Affairs with the American Psychiatric Association. Grace-Marie Arnett is former executive director of the Washington Psychiatric Society and a professional journalist.

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

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

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

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

The Uncontrollable Costs Myth

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

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

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

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

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

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

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

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

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

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

The "Moral Hazard" Myth

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

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

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

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

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

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

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

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

The Cost-Effectiveness Debate

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

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

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

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

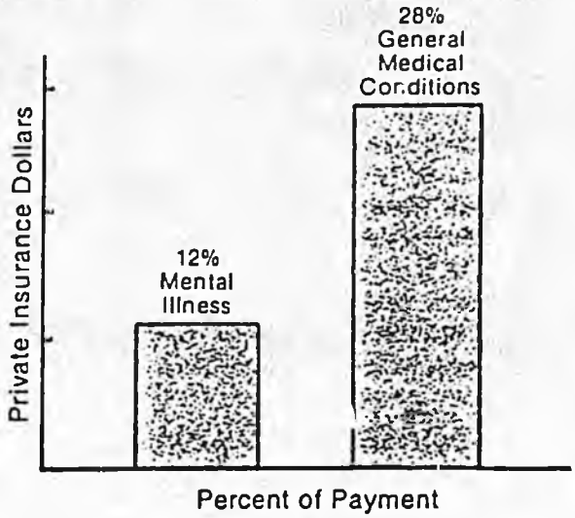
Yet some notable studies have been done which document the cost-effectiveness of psychiatric care in quantifiable terms. Among these was an extensive, three-part study reported in 1980 which found that the use of community based programs for the chronically disabled psychiatric patients greatly reduced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

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

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

Further, a 1983 study involving the Blue Cross-Blue Shield federal employees health plan showed a group of patients who began outpatient psychotherapy following diagnosis of chronic medical disease used 56 percent fewer medical services during the third year after diagnosis than a group with the same diseases who received no outpatient psychotherapy.[9]

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



The Accountability Issue

A final myth is that psychiatric treatment is nc accountable to insurance carriers. Utilization review i the form of peer review has become the cornerstone organized psychiatry's accountability to payers and co sumers. The goal of utilization review is to monitor t necessity and appropriateness of care, while peer revie is intended to improve the quality of care. Psychiatr peer review is carried out by psychiatrists and it concerned with utilization review, quality review, conti uing education, advocacy with third party payers f improved care and cost control.

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

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

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

The reported cost savings resulting from use c APA program are impressive. Aetna Life and Casu peer review costs in 1981 were about $20,000, a

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

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

Business Leadership Needed

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

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

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

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

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

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

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

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

Notes

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

2. S.S. Sharfstein, S. Muszynski and E. Myers, "Health Insurance and Psychiatric Care: Update and Appraisal" (Washington, D.C.: American Psychiatric Press, Inc., 1984).

3. K.B. Wells, W.G. Manning, N. Duan and J.P. Newhouse, "Cost Sharing and the Demand for Ambulatory Mental Health Services," R-2960-HHS (Santa Monica, Calif.: Rand Corporation, 1982).

4. J. Krizay, "Federal Employees' Experience as a Guide to the Cost of Insuring Psychiatric Services in the Various States," *American Journal of Psychiatry* 139:866-871, 1982.

5. S.S. Sharfstein et al, *op. cit.*

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FACT SHEET:
EQUAL INSURANCE
COVERAGE FOR MENTAL ILLNESS

Currently, 14 states regulate insurance coverage for treatment of mental and emotional problems by guaranteeing that benefits for mental illness are equal to benefits for physical illness. Most health insurance policies provide inadequate coverage for mental illness by limiting inpatient services and by providing no more than minimal outpatient services. Few, if any policies, cover partial hospitalization. Inadequate or untimely treatment of mental disorders is very costly in terms of the well-being of the individual, stability of the family and productivity in the work place. It may also result in costly and unnecessary hospitalization.

FACT: Over 50% of the patients who go to physicians have symptoms due wholly or in part to mental or emotional factors.

FACT: Some patients are forced to seek costly hospitalization because outpatient or partial hospitalization services are often not covered by their insurance.

FACT: Most current insurance plans provide incentives for inpatient care by paying only for inpatient care rather than for outpatient or partial hospitalization care.

FACT: Partial hospitalization is more effective than inpatient care in effecting client social adjustment and reducing family stress, and is comparable to inpatient care in preventing relapses.

FACT: The cost of partial hospitalization is usually one half, to one third the cost of inpatient care.

Equal insurance coverage for mental illness will decrease medical utilization and result in a cost-offset which should save consumers money.

FACT: Jones and Vischi reviewed 13 studies and found that decreased medical surgical utilization occurred in 12 of 13 ~~patients~~ STUDIES when mental health care was insured. Reduction in utilization ranged from 5% to 85% with a median reduction of 20%.

FACT: Blue Cross of Western Pennsylvania instituted psychiatric benefits and found a significant reduction in medical utilization - the monthly cost per patient was reduced 50%.

FACT: The University of Washington Health Services Center found a 41% reduction in the use of outpatient medical services by individuals receiving mental health services.

FACT: The Group Health Association of Washington D.C. found that patients with mental health coverage reduced their medical-surgical utilization by 30.7%.

27-50

Equality of insurance coverage for mental illness has significant benefits for business and industry.

FACT: Equitable Life initiated an emotional health program for employees and increased productivity by $3.00 for every $1.00 spent.

FACT: Kimberly-Clark began an Employee Assistance Program and realized a 70% reduction in accidents.

FACT: Kennecott Copper started an Employee Assistance Program and found a 6 to 1 benefit to cost ratio; a 52% improvement in attendance; a 74.6% decrease in weekly indemnity costs; and a 52.4% decrease in medical costs.

Currently most insurance policies have higher co-payments, more restrictions and lower limits for mental health care than are placed on physical illness. As a result, the mentally ill, and in some cases, the taxpayer, must bear a far greater burden for the cost of mental illness than for physical illness. Equality of insurance coverage for mental illness will ensure that the private sector shares in the cost of providing mental health, thus freeing limited state dollars to fund services for the chronically mentally ill.

FACT: Nationwide, public funding sources provide 51% of the funds for mental health care, compared with 42% of the funds for general health care.

FACT: Insurance coverage accounts for only 15% of the total expenditures for mental health care compared with 25% of the expenditures for general health care.

FACT: In 1980, fee collections in mental health centers in New Hampshire increased 100% since insurance coverage for mental health care was mandated in 1977.

Equal insurance coverage for mental and nervous conditions prevents unnecessary and costly hospitalization, benefits employers, reduces medical costs by reducing utilization and saves tax dollars.

Alcoholism Treatment and Total Health Care Utilization and Costs

A Four-Year Longitudinal Analysis of Federal Employees

Harold D. Holder, PhD, James O. Blose, MPP

This study examines the effect of alcoholism treatment services on overall health care utilization and costs for health insurance enrollees under the Federal Employees Health Benefit Program with Aetna Insurance Company, 1980 through 1983. Claims filed by 1697 treated alcoholics (and their family members) continuously enrolled with Aetna during the study period were examined. In the years prior to initial alcoholism treatment, alcoholics incurred gradually increasing total health care costs on the average. These costs rose dramatically in the six months prior to treatment, began to decline after treatment initiation, and continued to fall during several follow-up years. For alcoholics less than 45 years of age, costs eventually declined to a point comparable with the lowest pretreatment levels.

(*JAMA* 1986;256:1456-1460)

EARLIER studies have established that alcoholics have lower life expectancies and thus higher mortality rates at younger ages than nonalcoholic populations.[1-3] Regular heavy ingestion of ethanol increases the chances of physical illness and early death.

On the average, alcoholics consume medical care resources at a much higher rate than nonalcoholic individuals.[4,5] There have been few studies, however, of the way that alcoholism treatment affects overall health care utilization and costs. This relationship has become an important issue during the past decade as more insurance carriers, self-insured companies, and health maintenance organizations (HMOs) have covered and/or provided alcoholism treatment. Several studies have examined the impact of alcoholism treatment on medical care cost and utilization using data from prepaid plans or HMOs (H. Hunter, unpublished data, November 1978).[6] These have generally found a reduction in health care utilization or cost following alcoholism treatment. Holder and Hallan[9] report similar findings in a study of alcoholics in a fee-for-service population. Research in this area has been more thoroughly reviewed by Jones and Vischi[10] and Saxe et al.[11] While these studies consistently show decreases in overall health care utilization following alcoholism treatment, the generalizability of the findings can be questioned because of the possibility of self-selection in enrollment with HMOs.[12,13] Further, most of this research is based on relatively small numbers of cases concentrated in specific geographic areas.

The study reported herein provides further evidence regarding changes in general medical care utilization and costs following initiation of alcoholism treatment. This research sought to avoid several limitations of many prior studies[10] by the use of several design features: (1) a large, continuously enrolled treated alcoholic population (about 1700 subjects), (2) a geographically diverse population including cases from all 50 states, (3) longer pretreatment and posttreatment time periods, (4) use of multiple cost and utilization measures to corroborate any observed effects, and (5) use of a comparison group.

In addition to providing an opportunity to corroborate the findings of previous small regional studies with a sizable national data base, this research has the capacity to extend our knowledge in two directions: (1) The large number of cases permits some exploratory analyses to be conducted on alcoholics of differing ages; and (2) the long time period examined provides a longer and more detailed picture of the pretreatment cost patterns of alcoholics than has been possible.

RESEARCH APPROACH

The data for this study were derived from a review of all claims filed with the Aetna Life and Casualty Company during the calendar years 1980 through 1983 by all persons insured under the Federal Employees Health Benefit Program. As of September 1983, the Aetna plan covered 390 000 enrollees (federal employees and retirees) and about 980 000 beneficiaries in all. About half of all enrollees were aged 60 years or older. During the four-year

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study period, 2934 individuals filed claims for alcoholism treatment.

An alcoholic was defined as any person who had received medical treatment under a primary diagnosis of alcoholism. Aetna utilized a limited classification system for coding types of illnesses but did identify alcoholism diagnoses as a single group. Aetna did not utilize International Classification of Diseases codes during the time period covered by the study.

Since the primary purpose of the study was to examine longitudinal patterns of medical care, only those families that had continuous health insurance coverage with Aetna during the study period were used for analysis. Of all families with at least one alcoholic member, 1645 (57%) were continuously enrolled. Those dropped from the longitudinal analysis were demographically similar to the continuously enrolled families, and no temporal patterns in enrollment discontinuity were evident.

A randomly selected group of continuously enrolled families that had filed no claims for alcoholism treatment during the study period was chosen. This random sample was stratified by age to ensure that the age distribution matched that of families with alcoholic members. The sample size (N=3598) was twice that of the alcoholic family group. This group was used only to make comparisons with the alcoholic families regarding general medical care utilization patterns. It would be inappropriate to utilize such a comparison group for making inferences regarding the impact of alcoholism treatment.[14]

No statistically significant differences in demographic characteristics ($P<.01$) were found between the two family groups. Both had a mean family age of approximately 50 years. This similarity in age was the result of selecting an age-stratified comparison group. Mean family size was 2½ persons. Family composition was similar as well.

All medical care claims for both groups for services rendered during the period from January 1980 through September 1983 were analyzed. Claims for medical services received during the final quarter of 1983 were incomplete because many such claims would not be filed until early 1984. Costs were defined as unique charges for services submitted to Aetna by medical care providers. Although the cost measures used here are limited to services for which claims were filed with Aetna, the Aetna plan is rather inclusive, and these measures thus serve as fairly comprehensive indicators of overall health care utilization. Federal employees and annuitants can be insured under only one government-sponsored plan, including HMOs approved under the Federal Employees Health Benefit Program. While membership by Aetna enrollees or members of their families in other HMOs is possible, we consider it unlikely given the high average age of Aetna enrollees and the large number of retirees enrolled. All charges were adjusted to control for inflation during the study period using the Medical Care Index developed by the US Department of Labor as part of the Consumer Price Index. All cost figures cited herein are stated in January 1980 dollars.

Under the Federal Employees Health Benefit Program with Aetna, alcoholism treatment is explicitly covered under the surgical and medical expenses for mental disorders. There are two annual inpatient treatment benefit limits: $20 000 (high-option coverage) and $15 000 (low option). About 80% of the families in both the alcoholic and nonalcoholic study groups retained high-option coverage throughout the four-year period. Inpatient treatment is covered only if part of a program of therapy supervised by a physician who certifies that a follow-up program has been established. Inpatient care for detoxification alone without an associated therapy program is not covered by the plan. Outpatient treatment coverage includes the services of a physician or clinical psychologist. Services rendered by other providers are covered if they are supervised by a physician specializing in psychiatry. Annual outpatient treatment benefits are limited to $1000 (high-option coverage) and $750 (low option).

RESULTS

The total medical care utilization and costs of the two family groups were examined by calendar year. This family-based comparison ensures the broadest frame of reference, ie, all insured individuals are included. No statistically significant differences were found across calendar years within either group. The four-year average per capita monthly health care costs for families with an alcoholic member were $209.60, or almost 100% higher than comparable costs ($106.54) for families with no apparent alcoholic members (statistically significant at $P<.01$) (Fig 1). Most of this difference resulted from higher monthly inpatient costs ($164.50 per person) for the families with an alcoholic member. These figures include both general medical care and alcoholism treatment costs. When alcoholism treatment costs are omitted, the average per capita monthly health care cost of the alcoholic families was $180.88.

The mean age for the 1697 treated alcoholics was 51 years. The age distribution is shown in Fig 2, which shows that 85% were 35 and older and that more than 50% were more than 54 years old. About 65% were male. Treated alcoholics were located in all 50 states. Two thirds of those receiving alcoholism treatment were enrollees (employees or annuitants), 24% were spouses, and 11% were dependent children.

The primary form of alcoholism treatment was inpatient care, with an average length of stay of 21.7 days. Inpatient alcoholism care was received by 77% of the treated alcoholics and accounted for 95% of all alcoholism treatment costs. The utilization rate of the alcoholism benefit was low—less than 1% of covered individuals were treated for alcoholism in any given year. The estimated benefit cost for Aetna's alcoholism treatment coverage was $1.34 per covered individual per year. About 65% of all charges were paid under the plan.

Most of the inpatient care was concentrated in general hospitals (82% of inpatient admissions). Other forms of inpatient or residential care, such as specialized alcoholism hospitals (9.2%) and hospital-affiliated inpatient or alcoholism care centers (6.3%), were used less frequently. Outpatient care was concentrated in physicians (66.4%) and general hospitals (13.7%). Other outpatient providers included clinical psychologists (5.7%), specialized alcoholism hospitals (2.8%), and psychiatric social workers (3.0%).

No individuals exceeded the annual benefit limits for inpatient alcoholism treatment and the outpatient benefit limits were exceeded only rarely—in less than 1% of the cases. Benefit limits thus did not result in any significant underestimation of alcoholism treatment cost or utilization.

The pattern of overall medical care for treated alcoholics was analyzed using the first known alcoholism treatment event as a reference point. The date of first alcoholism treatment was determined based on the available claims data. While it is possible that some individuals had previously received alcoholism treatment, this is unlikely to be a significant problem.

Since alcoholics began treatment during each month of the study period, individuals had varying amounts of pre- and post-alcoholism treatment initiation data available for analysis.

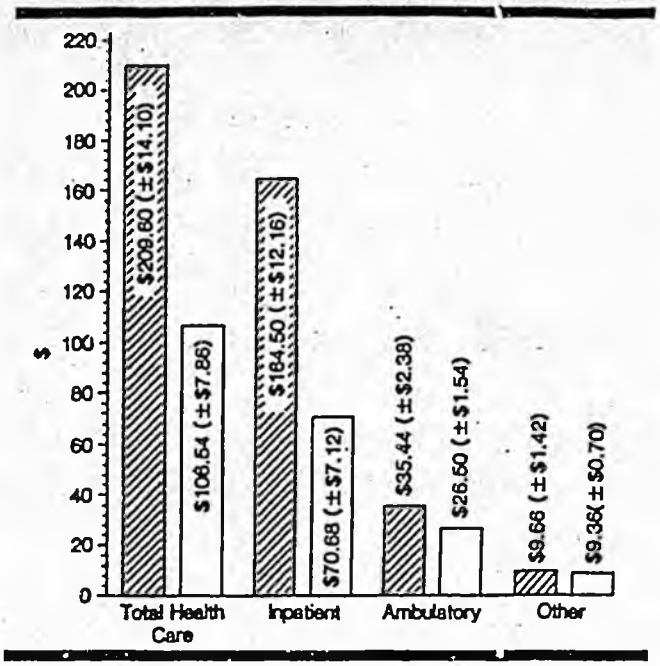

Fig 1.—Family health care costs (per capita monthly average), 1980 through 1983, for alcoholic (slashed bars) and nonalcoholic (solid bars) groups. Ninety-five percent confidence limits are given in parentheses.

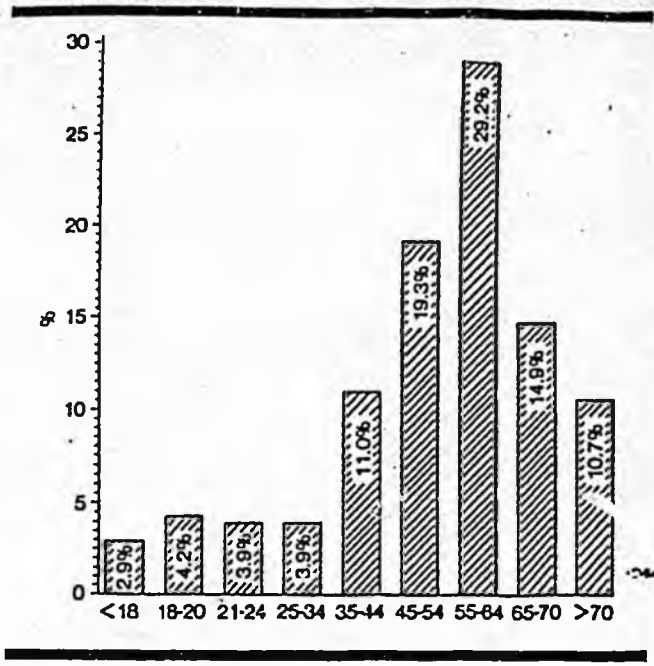

Fig 2.—Age of persons receiving alcoholism treatment.

Table 1.—Longitudinal Patterns in Total Health Care Cost and Utilization for Individuals With Available Data for 24-Month Pretreatment Period and 12-Month Posttreatment Period*

Variable	13-24-mo Pretreatment Mean	1-12-mo Pretreatment Mean	1-12-mo Posttreatment Mean	F	P
Total cost	$247	$398	$251	4.76	<.01
Inpatient cost	$192	$316	$191	4.11	.01
Ambulatory cost	$41	$49	$47	0.49	.61
No. of inpatient days	0.7	1.6	0.7	9.98	<.01
No. of inpatient treatment events	0.03	0.07	0.05	13.60	<.01

*N=344. First alcoholism treatment claim and its associated cost and utilization have been excluded.

Table 2.—Longitudinal Patterns in Total Health Care Cost and Utilization for Individuals With Available Data for 12-Month Pretreatment Period and 24-Month Posttreatment Period*

Variable	1-12-mo Pretreatment Mean	1-12-mo Posttreatment Mean	13-24-mo Posttreatment Mean	F	P
Total cost	$290	$242	$192	3.85	.02
Inpatient cost	$225	$188	$150	2.55	.07
Ambulatory cost	$48	$45	$35	2.31	.09
No. of inpatient days	1.2	1.0	0.6	4.73	<.01
No. of inpatient treatment events	0.06	0.05	0.04	6.46	<.01

*N=338. First alcoholism treatment claim and its associated cost and utilization have been excluded.

We tested for statistically significant changes in medical care cost and utilization using two groups of individuals having pretreatment and posttreatment periods of similar length: (1) persons for whom a full 24 months of pretreatment data and 12 months of posttreatment data were available and (2) persons with 12 months of pretreatment and 24 months of posttreatment data. Mean monthly cost and utilization for specific 12-month intervals were examined. Costs associated with the first alcoholism claim have been excluded from these and all subsequent analyses reported herein. Since initial alcoholism treatment usually involved an expensive inpatient stay, including these costs in the analysis tended to obscure the pattern of general medical care utilization. All subsequent costs for alcoholism treatment were included, however.

The total health care costs of group 1 (24 months of pretreatment and 12 months of posttreatment data, N=344) averaged $247 per month during the period from 13 to 24 months prior to treatment initiation and rose to $398 per month during the year immediately prior to treatment. This declined to an average of $251 per month during the year following treatment initiation (Table 1). Those in group 2 (N=338) had an average monthly total health care cost of $290 per month during the 12 months prior to treatment (Table 2). This declined to $242 per month during the first year following treatment initiation and then declined further to a monthly average of $192. Each of the mean comparisons was statistically significant at $P<.02$. These changes in overall monthly medical care are primarily the result of changes in inpatient utilization (Tables 1 and 2). While the longitudinal cost patterns of the two groups are similar, they appear to differ in average monthly costs for the 12-month pretreatment period. Some differences between groups should be expected due to stochastic variation.

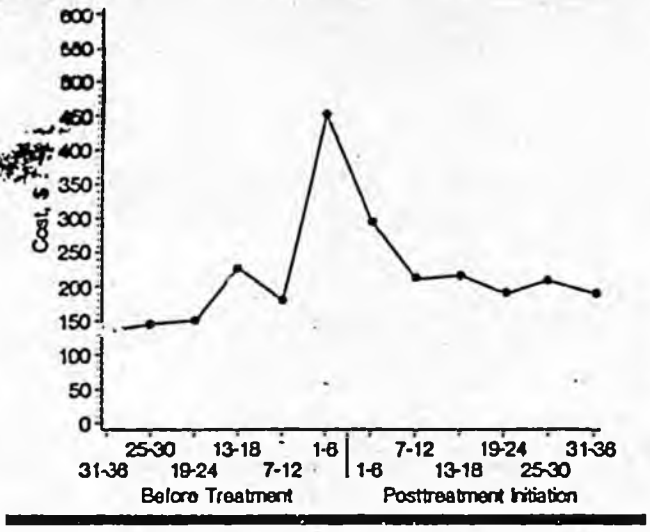

Fig 3.—Average monthly total health care costs for alcoholic individuals by six-month intervals (total population). Costs associated with first alcoholism treatment encounter were excluded.

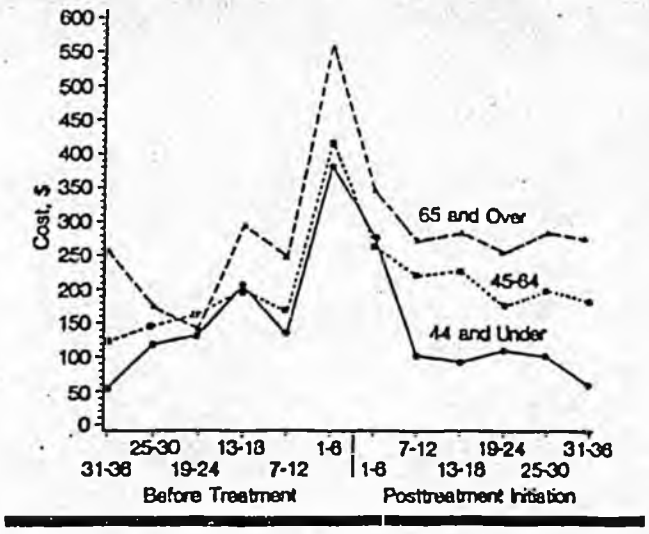

Fig 4.—Average total health care costs for alcoholic individuals by six-month intervals, by age group. Costs associated with first alcoholism treatment encounter were excluded.

Although the precise reasons for this particular difference are unclear, it is fairly certain that it is not due to a systematic discrepancy between individuals beginning treatment at different times. A comparison of the demographic characteristics of each of the four-year cohorts found no statistically significant differences. A cross-cohort comparison of average monthly costs also found no significant differences.

Taken as a whole, these results clearly indicate that mean monthly total medical care costs gradually increase before the initiation of alcoholism treatment, decline immediately following treatment initiation, and continue to decline at least into the second year.

These statistical analyses of specific subgroups were necessary to ensure that individuals were compared across similar time periods. However, overall patterns in monthly total medical care costs can also be examined by pooling the pretreatment and posttreatment data from all 1691 treated alcoholics to obtain a distribution of average monthly costs per individual during a six-year period (36 months before and after treatment initiation). A plot of this distribution is shown in Fig 3, using means for 12 different six-month intervals, where the midpoint on the horizontal axis is the start of alcoholism treatment. Monthly cell sizes always exceed 300 individuals.

This plot shows that, on the average, from 36 to 12 months before alcoholics begin alcoholism treatment their medical care costs gradually increase, with average monthly costs per person rising from approximately $130 to $179. During the year before treatment begins, however, total medical care costs rise much faster. The average monthly medical care cost rose to $452 in the six-month period before alcoholism treatment and to $1370 in the final month.

After treatment begins, total medical care costs drop fairly rapidly for about 12 months. This drop continues, though more slowly, during the next two years. Total health care costs averaged $294 per month during the six months following treatment initiation, but only $190 per month by the third post-treatment initiation year.

While this pattern of overall medical care costs was almost identical for both men and women, alcoholics of different ages showed distinct medical care cost patterns. We examined three age groups: less than 45 years, 45 to 64 years, and 65 years and older. Alcoholics in each age group followed the general patterns of the total group (Fig 4). Yet there was a clear association between age and the extent of the drop in medical care costs following the start of alcoholism treatment. By 36 months after the start of treatment, the average monthly total costs of those less than 45 years (N=440) had dropped to a level comparable with that experienced 36 months prior to treatment.

The middle age group (45 to 64 years old, N=823) is most like the model age of groups typically represented in previous studies of treated alcoholics. The health care costs of this group also dropped significantly following the start of alcoholism treatment, although they did not reach levels as low as those existing several years prior to treatment. The oldest group (N=434), which consisted primarily of retirees, experienced the highest overall medical care costs and showed the least convergence to the levels that existed prior to initiation of alcoholism treatment.

COMMENT

The results presented herein provide important confirmation of the findings of previous studies showing a decline in the health care costs of alcoholics following the initiation of treatment. No study of a single enrolled population can be definitive, given both the diversity of the alcoholic population and the diversity of populations enrolled under employee health benefit plans, as well as variances in types of coverage and services available in different regions of the United States. Nonetheless, this research is probably more generalizable than many previous studies based on smaller regional samples. Additionally, the long time period available for analysis allowed us to examine the pretreatment medical care cost patterns of alcoholics more thoroughly than has been possible in prior research. This examination identified more clearly the nature of the rapid increase in costs that occurs in the year immediately preceding initial alcoholism treatment. It appears that within the six months prior to the start of alcoholism treatment, the emotional and physical problems of the average alcoholic escalate. These worsening problems manifest themselves in the use of additional health care services. This sharp upward ramp is not unique to alcoholism but also occurs for other chronic diseases.[15]

Further, the large sample size permitted for the first time an exploration

the earlier we get people to treatment the better the results

of the possibility. that the effects of alcoholism treatment on health care could vary by age. Indeed, the findings indicate that this may be the case. Only for persons less than 45 years of age did posttreatment health care costs eventually decline to a level as low as that experienced several years prior to alcoholism treatment. While persons in older age groups also experienced declining costs after starting treatment, these costs did not decline to a point comparable with the lowest pretreatment levels. This is likely a result of the increasing medical care costs that accompany aging,[16] as well as potentially more serious alcohol-related health problems due to a longer period of chronic abuse.[17-19]

It is possible that some of the posttreatment decline in total medical care costs resulted from factors other than the treatment itself, particularly statistical convergence to the mean. While this factor may be operating for some individuals in the period immediately following treatment initiation, the longer-term decline in posttreatment costs is more likely the result of alcoholism treatment.

The effects of specific forms of treatment cannot be evaluated using these data. Rather, the findings are relevant to an actuarial concern for the extent of risk for increased benefit payments by a health insurance company, a self-insured employer, or an HMO. From this perspective, the aggregate reductions in total health care costs associated with alcoholism treatment in a situation where there is no direct control of the quality or type of alcoholism treatment are most relevant.

Random assignment to treatment and "no treatment" conditions to control for motivation to seek care is not possible in studies of this type. In any case, it is unlikely that a "no treatment" alcoholic group randomly selected from the same enrolled population could be diagnosed and ethically denied care. Further, enrollees who are motivated to seek alcoholism treatment are the ones most likely to experience reductions in health care utilization and cost. The health policy question is not whether alcoholism treatment can bring about a reduction in total health care under controlled conditions but whether such treatment as actually rendered to a large population that is motivated to seek care can result in reduced overall health care costs. The results of this study provide further evidence that this question should be answered affirmatively.

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Effect of Mandated Drug, Alcohol, and Mental Health Benefits on Group Health Insurance Premiums

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There exists within the health care sector a considerable controversy over the issue of how to meet the costs of providing care for mental illness, alcoholism, and drug dependency. A major issue in this debate is the trend towards legislative mandates to include certain minimum benefits for mental illness, alcoholism, and drug dependency in insurance plans offered by insurers and health maintenance organizations. At this writing, over twenty states mandate some form of these benefits and such legislation is under consideration in a number of other states.

There is significant reluctance on the part of many insurers and health maintenance organizations to embrace any form of mandatory benefits. The insurers and health maintenance organizations have expressed the belief that provision of such benefits should be the choice of the individual or group purchaser.

The care providers for such illnesses, and other advocates of such care, contend that the social stigma and general denial systems of these illnesses prevent a groundswell of demand for such benefits by the public. They further contend that employers who are aware of this public perception do not feel meaningful pressures to voluntarily provide or expand benefits of this nature.

Against this background, a chorus of claims and counterclaims has arisen from both camps. Central among these claims are four issues which this report attempts to explore. They are:

(1) A number of insurers and health maintenance organizations claim that mandating benefits for mental illness, alcoholism, and drug dependency will dramatically increase premium costs for health care protection and be disruptive to the health care delivery system.

(2) Some insurers and health maintenance organizations indicate that mandating these benefits will accelerate a trend by employers towards self-insurance as a means of avoiding the impact of the mandates, since at this time there is a legal question as to whether self-insured plans must comply with most existing legislation.

(3) Many insurers and health maintenance organizations also contend that individuals and employers faced with the increased costs of health coverages because of mandated benefits will severely curtail or terminate their existing group insurance programs.

(4) A number of providers of care for mental illness, alcoholism, and drug dependency claim that mandating such benefits will lead to significantly increased utilization of such benefits. While conceding that this increased usage may result in modest increases in costs for such protection, they contend that there will be an offset in savings through less general medical and hospital services utilization.

It is the purpose of this paper to explore these four issues by reviewing the actual health insurance experience in six states which have had mandated benefits in some form for a period of time. The six states reviewed in our report are Arkansas, Connecticut, Maryland, Massachusetts, Oregon, and Wisconsin. These states were selected for their many diverse characteristics to provide balance to the report. They differ in region, population, economy, and other important social measurements. Their mandated benefits were incepted at different points in time and differ widely in structure.

Methodology

The relatively short period of time since Wisconsin enacted the first mandated health insurance legislation in 1972 has made it difficult to obtain hard data on claim experience on mental health, alcohol, and drug claims in post-mandated benefit periods as contrasted to pre-mandated benefit periods. In the absence of such data, we conducted our study by contacting sources located in the six study states who had been actively involved in the pricing, administration, and marketing of large numbers of group health insurance plans during both pre-mandated and post-mandated periods. No individual coverage experience was studied.

A total of thirty-one sources were

> . . . in some states legislation requires inclusion of the mandated benefits in all group insurance provided in the state.

contacted. All of the sources responded. These sources administered 84,500 plans in the study states covering a total of 8,822,100 participants. The sources have access to very significant data from both a quantitative and qualitative standpoint. The major carrier responded in each state. The largest national private carrier responded in each state. A national actuarial consulting firm responded for all states. A large national employer with locations in five of the six states responded for those five states. The balance of the responses were from major group insurers and independent agents located in the states studied. The respondents' answers were recorded exactly as given; however, it is obvious the respondents tended to round their numerical responses.

We have utilized data on mandated legislation that is aged for several years. This was done to present a mandated benefit structure for each state that would track as closely as possible with the period studied. The period studied was from the effective date of the mandates to a point thirty-six months after the mandates became effective. There may well be differences in the mandated benefits illustrated in the study and some legislation now in place.

Certain clarifications as to terminology are important. In questioning the experience of the respondents as to cost history, the respondents were asked not only if premiums increased but if premiums would have decreased in the absence of the mandated mental health, alcohol, and drug dependency benefits. This is important because respondents indicated some leveling of costs in recent years due to cost containment programs. We are also aware that it might not be desirable politically or from a marketing standpoint for an insurer to acknowledge cost increases for mandated benefits. It would not be difficult for the insurer to make internal rate adjustments to reach desirable pricing levels.

In regard to "mandated benefits," the term has a different meaning in different states. For example, in some states legislation requires inclusion of the mandated benefits in all group insurance provided in the state. In other states, the insurer or health maintenance organization must provide the benefit as an option for an employer to elect. In yet a third arrangement, an employer has the option, by written refusal, to waiver the mandated benefits.

It should be noted as a point in interest, there are many other mandated benefits that do not deal with mental illness, alcohol, or drug abuse issues which are in place in the states we studied.

It should be noted that in accessing the move from insured to self-insured health plans by employers, we measured the movements that were solely attributable to mandated benefits or where mandated benefits were the major causative factor in the respondents' view. This is important because there are two points to consider in evaluating the movement of plans from insured to self-insured status. The first point relates to the size of the group involved. The respondents indicated that a group of less than 100 participants was not generally appropriate for self-insurance. This fact has particular significance in that the number of employers with less than 100 employees generally significantly outnumbers those employers with more than 100 employees. The second point is that mandated benefits are only one of the reasons, according to respondents, that such plans change status.

Table One
Mandated Benefits in Place
During Period Studied

Arkansas

Drug—No benefits in legislation during period studied.

Alcohol—No benefits in legislation during period studied.

Mental Health—There are no minimum benefits specified for inpatient treatment. Reimbursement for services in a licensed outpatient psychiatric center on a par with those for health care services in a hospital. Minimum for both inpatient and outpatient of $4,000 per year. Employer must sign waiver to delete these benefits from coverage.

Connecticut

Drug—There were no drug benefits during the period surveyed.

Alcohol—For Group and Individual plans the benefits provide for 45 days inpatient coverage in a hospital or residential facility.

Mental Health—Inpatient benefits provide for at least 60 days full hospitalization or 120 sessions of partial hospitalization in a hospital (whether or not operated by the State) in any calendar year.

Outpatient benefits provide a deductible on a par with that for other illnesses. 50% copayment with mandated maximum benefit of up to $1,000 in any calendar year. Availability of additional benefits, up to a maximum of $1,000 at option of group policyholder with deductible or copayment provisions on a par with those for other illnesses.

Maryland

Drug—Inpatient benefits cover 21 days; there is a $1,000 outpatient benefit with 80% copayment.

Alcohol—For Group plans only, the benefits provide 7 days detoxification; 30 days residential; 30 outpatient visits for at least $1,000 with a lifetime limit of 120 inpatient days and outpatient visits combined.

Mental Health—Inpatient benefits provide at least 30 days full hospitalization in any calendar year or benefit period. Mandates optional availability for partial hospitalization. Where a patient lives at home part of the time and spends some time in a treatment program.

Outpatient benefits provide copayment of up to 50% of the benefits provided for other types of illness.

Effect of Mandated Drug, Alcohol, and Mental Health Benefits on Group Health Insurance Premiums

Massachusetts

Drug—There were no drug benefits during the period surveyed.

Alcohol—For Group and Individual plans and Health Maintenance Organizations the benefits provide for 30 days inpatient and $500 outpatient coverage.

Mental Health—Inpatient benefits provide at least 60 days full hospitalization in a licensed/accredited public/private mental hospital in any calendar year. Benefits and limitations on a par with those for other illnesses.

Outpatient benefits provide up to $500 per year for services furnished by a comprehensive health service organization, a licensed/accredited hospital, an approved mental health center, and other mental clinics or day care centers with furnished mental health services or services provided by a licensed psychotherapist, psychologist, or clinical social worker.

Oregon

Drug—There were no drug benefits during the period surveyed.

Alcohol—For Group plans only, the benefits provide for $6,000 per 24-month treatment period with mix of inpatient, residential, and outpatient and with usual copayments and deductibles.

Mental Health—General: Maximum overall benefit of up to $9,000 in any 24-consecutive month period (unless payments are for both chemical dependency, including alcoholism, in which case an overall benefit cap of $6,000 may be applied.) Deductibles and copayments on a par with those for other illnesses.

Except as noted above, inpatient benefits provide for not less than $7,500 in any 24 consecutive month period for full hospital or other health facility within the dollar limit for inpatient.

Except as noted above, outpatient benefits provide not less than $2,000 in any 24 consecutive month period.

Wisconsin

Drug—For Group plans only, the benefits provide 30 days inpatient coverage and the first $500 of outpatient treatment.

Alcohol—For Group plans only, the benefits provide 30 days of inpatient coverage; and the first $500 of outpatient coverage.

Mental Health—Inpatient benefits provide at least 30 days full hospitalization in any calendar year in approved public or private hospitals. Benefits on a par with those for other illnesses. Partial hospitalization included under outpatient coverage.

Outpatient coverage provides not less than $500 in any calendar year, including partial hospitalization. (State may adjust the dollar limit every two years.) Benefits on a par with those for other illnesses.

Table Two

Study Results—By Individual States

States and Plans Surveyed	Increase in Premium	Insured-Self-Insured	Plans Terminating	Offsetting Cost Reductions
Arkansas	None - 0	None	None	None - 33%
Groups—6,420	1-5% - 0			Significant - 0
Participants	5-10% - 100%			Too early
619,700	10-15% - 0			to determine - 67%
Connecticut	None - 75%	None	None	None - 40%
Groups—16,400	1-5% - 25%			Significant - 20%
Participants	5-10% - 0			Too early
1,565,000	10-15% - 0			to determine - 40%
Maryland	None - 42%	None	None	None - 29%
Groups—13,750	1-5% - 0			Significant - 0
Participants	5-10% - 58%			Too early
1,295,600	10-15% - 0			to determine - 71%
Massachu-	None - 40%	None	None	None - 75%
Grou-	1-5% - 40%			Significant - 0
Parti-	5-10% - 0			Too early
	10-15% - 20%			to determine - 25%
	None - 33%	None	None	None - 33%
-ps—1,060	1-5% - 0			Significant - 33%
Participants	5-10% - 67%			Too early
822,400	10-15% - 0			to determine - 34%
Wisconsin	None - 25%		None	None - 50%
Groups—5,830	1-5% - 0	None-88%		Significant - 28%
Participants	5-10% - 75%	Modest-12%		Too early
755,000	10-15% - 0			to determine - 22%

Summary

Composite Results for All Sources

(1) 35% of the sources indicated there was no measurable premium increase in the plans they covered attributable to the inception of mandated benefits.[1]

11% of the sources indicated tha-

(1) Some 22 sources provided both statistical data and background information. A number of organizations had sources reporting in more than one state. One source omitted a question due to premium tracking difficulty. Further details regarding this study are available to interested readers from the authors.

> Without exception the respondents indicated there had been no plan terminations due to mandated mental health, alcohol, and drug benefits.

they had experienced premium increases in the 1–5% range in the plans they covered attributable to the inception of mandated benefits.

50% of the sources indicated that they had experienced premium increases in the 5–10% range in the plans they covered attributable to the inception of mandated benefits.

3% of the sources indicated that they had experienced premium increases in the 10–15% range in the plans they covered attributable to the inception of mandated benefits.

(2) 98% of the sources indicated there had been no change from insured to self-insured status due solely to the mandated benefits in the plans which they administered.

2% of the sources indicated changes from insured to self-insured status due solely to the mandated benefits in the plans which they administered.

(3) None of the sources in our study states indicated that there had been any plans terminated due to the implementation of mandated benefits.

(4) 14% of the sources indicated they had experienced measurable cost reductions in other areas since the implementation of mandated benefits in plans which previously did not offer coverage in the mandated benefit areas or offered limited coverage in those areas.

43% of the sources indicated there had been no offsetting cost reductions in other coverage areas since the inception of mandated benefits.

43% of the sources indicated that it was too early to determine if there had been savings in other coverage areas since the inception of mandated benefits.

Observations

The composite figures indicate a consistency of response throughout the six states studied despite their aforementioned differences.

Premium Increases

We found no dramatic premium increases in the states studied due to mandated mental health, alcohol, and drug benefits. Some respondents indicated that a reason for this was that although individual claims for the mandated benefits may be significant, the number of claims for these benefits as a percentage of the total claim exposure was not significant in their experience. Another reason given for the moderate premium increases is that many plans already had benefits in place for mental health, alcohol, and drug abuse which approached, equaled, or exceeded the mandated benefits. The major carrier reported premium decreases in two states after mandated benefits were enacted. We believe it fair to assume that in many cases the premium increases indicated were the result of prospective rate increases by the insurers as opposed to rate adjustments based on actual experience. The respondents, in large numbers, indicated they simply had no hard claims figures on the mandated benefits being studied. It is interesting to note that a major carrier estimated claims made for substance abuse (not including mental health) were less than one-half of one percent of total claims. Another area not dealt with in our study but of considerable interest is the effect of costs occasioned by the involvement of family members in the treatment of substance abuse patients. It has been indicated that health care providers seeking reimbursement for family services are assigning nervous or mental health diagnosis such as "adolescent adjustment disorder" or "stress" to the family members (Science Management Technology Study 1981.)

Trend to Self-insurance

The two percent of the respondents reporting plans changed solely due to mandated benefits indicated only five plans were actually changed. The respondents reported a modest trend to self-insurance in plans of over one hundred lives; however, reported that mandated benefits were a minor consideration in that trend. Cash flow, plan design flexibility, and elimination of premium taxes in states where they exist, were cited as the main reasons for the movement to self-insurance. Future legislative efforts at the federal level could impact on this area if "qualified plans" were dealt with in regard to mandated benefits as contrasted to the current state approach which deals primarily with insurers and health maintenance organizations.

Plan Terminations

Without exception the respondents indicated there had been no plan terminations due to mandated mental health, alcohol, and drug benefits.

Offset Savings

No conclusion as to whether meaningful offset savings had been experienced could be reasonably determined from the sources' responses. The respondents differed more on this question than any other. It was interesting to note that those sources reporting offset savings were associated with the administration of plans with large numbers of participants. These respondents note that outpatient costs had increased with utilization after mandates, however, inpatient costs had decreased and the total of outpatient and inpatient costs had decreased. A reason cited for this result was that many participants no longer had to enter a hospital in order to receive benefits for mental health, alcohol, or drug abuse. Another factor to be reckoned with over time is the shift in costs resulting from previous misdiagnosis of drug, alcohol, and mental health claims. It is not uncommon for the family physician to label these claims differently in order to allow the patient to avoid stigma and discrimination, and to obtain reimbursement where none is provided under drug, alcohol, or mental health.
(I/R Code No. 3250.00)J

Barbara Browne is an officer in The Browne Company, a Washington-based national insurance and tax planning firm. Prior to her association with the firm, Ms. Browne was

Effect of Mandated Drug, Alcohol, and Mental Health Benefits on Group Health Insurance Premiums

Office Manager for Aetna Life and Casualty in Cleveland, OH.

Raymond F. Browne is an officer in The Browne Company. He attended the University of Maryland. Mr. Browne's articles have appeared previously in this Journal and other publications. Enrolled to practice before the Internal Revenue Service, he has lectured before professional groups throughout the country on tax planning.

Susan T. McLaughlin received her BA at the University of Toronto, MAT at Reed College, MSUP at Columbia University, and EdD at Harvard. Dr. McLaughlin is a healthcare consultant in Washington, DC.

Cynthia D. Wagner received her BA in Economics from Chatham College in 1975. Ms. Wagner is Vice-President for Comprehensive Benefits Service Co., Inc. Prior to this affiliation she was Vice-President, Sales in the group division of United States Life Insurance Co.

References:

"Private Health Insurance Coverage for Alcoholism and Drug Dependency Treatment Services: State Legislation That Mandates Benefits Or the Offering of Benefits for Purchase," National Association of State Alcohol and Drug Abuse Directors, Special Report, July 1983.

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"Mandated Mental Health Benefits Under Private Insurance: A Review of State Laws," Center for Health Policy Studies, 5865 Robert Oliver Place, Columbia, MD 21045.

"Formal Policy Statement on Youth Alcohol and Drug Problems Adopted By The American Bar Association On July 10, 1985."

"A Study of Effectiveness of the Texas Legislation for the Coverage of Alcoholism and Drug Abuse," prepared by Rudd and Wisdon—1985.

U.S. POSTAL SERVICE
STATEMENT OF OWNERSHIP,
MANAGEMENT AND CIRCULATION
(Required by 39 U.S.C. 3685)

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9. For completion by nonprofit organizations authorized to mail at special rates *(Section 423.12 DMM only)* The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes has not changed during preceding 12 months.

10. Extent and nature of circulation	*Average No. Copies Each Issue During Preceding 12 Months*	*Actual No. Copies of Single Issue Published Nearest to Filing Date*
A. Total No. Copies Printed (Net Press Run)	42,265	42,582
B. Paid Circulation		
1. Sales through Dealers and Carriers, Street Vendors and counter sales	None	None
2. Mail Subscription	39,751	41,220
C. Total Paid Circulation *(Sum of 10B1 and 10B2)*	39,751	41,220
D. Free Distribution by Mail, Carrier or Other Means Samples, Complimentary, and Other Free Copies	248	205
E. Total Distribution *(Sum of C and D)*	39,999	41,425
F. Copies Not Distributed		
1. Office Use, Left Over Unaccounted, Spoiled after Printing	2,266	1,157
2. Returns from News Agents	None	None
G. Total *(Sum of E, F1 and 2—should equal net press run shown in A)*	42,265	42,582

I certify that statements made by me above are correct and complete.
F. Robert Titus, Mgr. Support Svcs.

Honorable John Sond - Please let me know when the hearing will be on SB. #67. I will Testify if I'm by the conference in Anc. Thank you so much for your interest

Samaritan Counseling Center of Alaska

Expressing the love of God via counseling.

4502 Cassin Drive, Anchorage, Alaska 99507 • (907) 563-4325

Raymond Norman Fedje, Ph.D., D.D.
Executive Director

February 26, 1988

Ref.: L-K-1008

3661 Hazen Dr.
Anc Ak 99515
(907) 344-6478

Allen & Nancy Price
3661 Hazen Circle
Anchorage, AK 99515

Senator Jan Faiks
P.O. Box V
Juneau, Alaska 99811

Reference: CS FOR SENATE BILL NO. 67 (HESS)

Dear Senator Faiks:

On behalf of our Board of Directors and staff (please see the attached list), I am writing to you regarding Senate Bill No. 67 (HESS) asking for inclusion of Pastoral/Christian Counseling Centers, such as the Samaritan Counseling Center of Alaska.

We are suggesting as an amendment to Sec. 8.B.IV, line 14 through 18 or as an additional paragraph (v), the following be added:

> A PASTORAL COUNSELING CENTER WHERE STAFF PROVIDERS HAVE AN ACCREDITED DEGREE IN COUNSELING OR PSYCHOLOGY AND WORK UNDER THE DIRECT SUPERVISION OF A LICENSED PSYCHOLOGIST OR PSYCHIATRIST (M.D.).

This past year we served 652 clients for a total of 6,071 therapy hours. Our staff is supervised by W.A. Cassell, M.D., F.A.P.A., License No. AA1533, with Dr. O. Matsutani, consulting psychiatrist, and Dr. Nancy E. Sydnam, M.D., as our consulting medical officer. Being included in the bill would make it less of a burden for our clients to rely on their insurance for sessions given within the context of Pastoral Psychotherapy especially during our economically difficult times.

We do not receive state, federal or local funds for these services, so this would be most helpful to the Center in meeting the needs of the community.

Should you have particular questions, I would be happy to appear before your committee or answer questions for you.

Your consideration and suppport for this inclusion would be appreciated.

Sincerely yours,

SAMARITAN COUNSELING CENTER OF ALASKA

Raymond Norman Fedje, Ph.D.
Executive Director

RNF:iw

Enclosures

Alaska State Legislature

Committees:

Chair-State Affairs
V. Chair-Judiciary
Telecommunications
Special Ethics
Legislative Council
Finance Subcommittee
for the University of Alaska
Joint Committee
on Economic Recovery

P.O. Box V
Juneau, Alaska 99811
(907) 465-4947

REPRESENTATIVE FRAN ULMER

March 1, 1988

Allen Price
3661 Hazen Circle
Anchorage, AK 99515

Dear Mr. Price:

Thank you for your note regarding Senate Bill 67 and requesting amended language to include a pastoral counseling center.

I have shared a copy of your letter with the Committee and have requested that you be notified by committee staff when the bill will be heard.

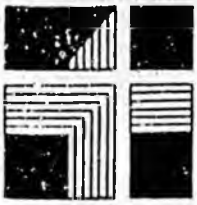
Thank you for sharing your concerns.

Sincerely,

Fran Ulmer, Vice Chair
Judiciary Committee

cc: Representative John Sund, Chair
w/attachment

2-26-88 Vice Chair Person - Please let me know when hearing is on SB #67. I feel Addition of this material is important to Alaska
Thank you so much Allen Price



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3661 Hazen Cir
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(907) 344-6078

Raymond Norman Fedje, Ph.D., D.D.
Executive Director

February 26, 1988

Ref.: L-K-1008

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P.O. Box V
Juneau, Alaska 99811

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Anchorage, AK 99515

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Sincerely yours,

SAMARITAN COUNSELING CENTER OF ALASKA

Raymond Norman Fedje, Ph.D.
Executive Director

RNF:iw

Enclosures

PUBLIC OPINION MESSAGE

DEAR: REPRESENTATIVE SUND

NAME: BEATRICE ROSE
TITLE:
ADDRESS: 2263 KISSEE COURT
CITY: ANCHORAGE ZIP: 99517
PHONE: 243-4806
BILL NO: SB 67
SUBJECT: HEALTH INSURANCE FOR MENTAL CONDITIONS
MESSAGE: MENTALLY ILL PEOPLE DO HAVE A DISEASE AND DESERVE TREATMENT. INSURANCE COMPANIES INFLATE THE COST BY NOT REIMBURSING THERAPY GIVEN BY CLINICAL SOCIAL WORKERS WHO CHARGE LESS THE PSYCHIATRIST. I URGE YOU TO VOTE FOR SB 67 AMENDED TO INCLUDE SERVICES OF CLINICAL SOCIAL WORKERS.

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SWACKHAMMER
WALLIS

PUBLIC OPINION MESSAGE

DEAR: REPRESENTATIVE SUND

NAME: JERRY MCCUTCHEON
TITLE:
ADDRESS: 121 W 11TH AVE
CITY: ANCHORAGE ZIP: 99501
PHONE: N/R-
BILL NO:
SUBJECT: STATE BAILOUTS
MESSAGE: FINANCE THOSE WHO USED POOR JUDGEMENT AGAINST THOSE WHO USED PRUDENT JUDGEMENT. BAILOUTS ABSORB THE AVAILABLE MIONEY FOR PUBLIC PROJECTS WHICH COULD HAVE PRODUCED JOBS AND, IN TURN, KEPT MORE PEOPLE IN THEIR HOMES WHICH WOULD PRODUCE MORE JOBS. BAIL OUT MONEY ENDS UP IN FEDERAL HANDS AND LEAVES THE STATE OF ALASKA.

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FRANK	FURNACE	FAIKS
GOLL	GRUENBERG	FANNING
GRUSSENDORF	HANLEY	FISCHER
HERRMANN	HOFFMAN	HALFORD
HUDSON	KOPONEN	HENSLEY
LARSON	MARTIN	JONES
MENARD	MILLER	JOSEPHSON
NAVARRE	PEARCE	KELLY
PETTYJOHN	PHILLIPS	KERTTULA
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ULMER	WALLIS	UEHLING
ZAWACKI		ZHAROFF

OK Lumber Company, Inc.
Building Supply Center & Hardware

P. O. BOX 10449
FAIRBANKS, ALASKA 99710
(907) 457-6270
FAX (907) 457-3122

March 14, 1988

Senator John Binkley
Representative Mark Boyer
Senator Faiks
Representative Menard,

Ref:SB363 and HB 403 (the same)
Ref: SB67 and HB 440

Sirs and Ms.;
75% of the small business in this state of Alaska in 1986 have voted against this type of insurance! Do you not pay attention to what we have to say via the NFIB (National Federation of Small Business)

If we have a drug and alcohol problem, then it's our personal responsibilty to take care of it.. IT IS NOT THE RESPONSIBILITY OF THE TAXPAYERS to take care of our vices! If one plays with fire..he or she had better be prepared to be burned! Vote against this program.Senator Binkley and Representative Boyer, I urge you to listen to the taxpayers and those small business's that keep the taxpayers and you employed. Vote against this type of insurance.

Senator Faiks. I urge you to vote against this bill you have your name tagged to. This is still a free country, but with the legislation you people are trying to put into being..it soon won't be!

Rep. Menard, So now you all got your way with pregnancy coverage; letting the government stick its nose into peoples private affairs, Now you have to cover the other side that can't get pregnant! What next? Insurance to cover the mongrel stray dog that made your dog pregnant? And of course, then an insurance to cover the cat that can't have a litter of kittens?

To all of you, are we in a free country? Are we to be subjected and liable for everyones vises and personal affairs? I urge you to take responsible action, and cool down your desires to become A SOCIALIST GOVERNMENT! Read your history books..Socialism does not make a strong country!

Sincerely yours,

Angie Kruckenberg

Copies to all who represent me in Alaska

OK Lumber Company, Inc.
Building Supply Center & Hardware

P O BOX 10449
FAIRBANKS, ALASKA 99710
(907) 457-6270
FAX (907) 457-3122

March 11, 1988

Ref: Workmans Comp article, as in todays Newsminer, inclosed.

To my representatives, legislators, senators, and to all those who represent me in my Government.

Sirs/Ms.;

In reference to paragraph 1 and 2. This is the main problem of the high costs of insurance. Is there any paper trace by the state, upon the insurance carriers, of the employers claim costs that are in reserves? And is there any paper trace of the insurance carriers ever returning these amounts back to the employer? ***see exhibit 1***

In my case, and I am inclosing my total history of claims in this letter. I can show you where the reserve amounts have sat dormat, as a cost to me, while the insurance company collected interest, and charged me higher costs in the high risk pool, while these funds were not used. **exhibit 2***

I am complainly highly because this one case, (JUNE 13. 1985) of an employee who broke an ankle when he said he fell off the trailer bed, with no witnesses. The Coastal people told me he stepped out of the truck and broke his leg. Flippo tells me he stepped off the end corner of the trailer between it and the truck. When Coastal called me about it, I immediately called Humana Hospital where they took him, to request a blood test, as he seemed very "funny acting" when he left my office. I was told that they could not do that. This was the man's third trip to Anchorage for us and he knew that this was just a temporary situation.

We all know that 1985 in Alaska took a nose dive as far as the economy goes, and MANY employees used workmans compensation for their means of support in this declining era. If each case was thoughly investigated during this time period, you would see MASSIVE FRAUD by employees, the medical association and the legal professions. They all wanted to live in the manner that they became accustomed to during the BOOM years! (And we have only 3 fraud investigators in the entire State!)

It was later, upon getting back all the references and the inquirys into his history that I found out that he had lied on his application with me. He wrote that he had NEVER been in an accident. (when in fact he had three with his past employer, "Wickland Oil Transport" 1st one not chargable to him. 2nd one could have been avoided by himself. In the 3rd one he killed several people! And in this one he collected workmans compensation from the state of California! YET ON HIS APPLICATION FORM HE TELLS ME HE HAD NEVER EVER COLLECTED COMPENSATION! AND HE SAYS HE NEVER HAD AN ACCIDENT! (This was told to me by telephone by his ex-boss Gerry Heifner for whom he worked from 6/78 to 3/85) I have his payroll files in my office and will send you all pages if you request.

I have talked to each of my insurance agents and NO ONE WOULD INVESTIGATE THIS CASE! In 1987 I had someone investigate where he lives and what he does. He lives in a high income area, a very elaborate home, with swimming pool and emmensities that many people would desire. He manages a condominion or apartment complex, and it would not surprise me if he isn't a partner in it.

With a figure of almost half a million dollars on this case, I was told 1st by Dorthy Ronning, of Dawson Insurance (1985 agent), and then by Kathy, 1986 and 1987 agent at James and Associates, in Seattle, Ws. that the amount is TOO LITTLE FOR THE INSURANCE COMPANY TO INVESTIGATE! — now deceased

Sure, why should they investigate? It will only cost them money...when in fact all they have to do is "set aside a reserve" for this account..against my account, add it to the many other employer "reserve" accounts in the same situation, CALL A MEETING WITH THE STATE OF ALASKA GOVERNMENT, tell our state people that they (THE INSURANCE COMPANYS) have to have MORE MONEY! SO UP GOES THE INSURANCE RATES FOR WHATEVER % THEY ASK FOR; And all the time all these reserves (listed as additional claim costs) are sitting in their bank accounts drawing more interest!

OF COURSE THE MORE THEY CAN SHOW AS TO HOW HEAVY THE CLAIMS ARE, THE MORE PREMIUM THAT THEY CAN CHARGE US!!

Have you people who are representing us looked at this side of the coin? Please do, if you haven't! I don't know how long we employers will last at the rate it is going now!

Why isn't it possible for employers to get a history of employees on the following:

1. Driving records, every state.

2. Proof of medical certificates, and Doctors address on same. see attached. ***exhibit 3***The doctor's name is not signed as an "MD!" And no address to check it out for my protection as an employer!

3. Workmans compensation records, every state.

4. The permission to request another physician's examination if something seems to appear fraudulent. And when it is shown as fraudulent (my case, 4/1/78 John Balsh. another Doctor wrote me that this injury was not due to his work at our place, but a prior problem he had.) see #5 below.

5. Cooperation from the state and/or insurance company for investigation, if an employer finds there are abuses here.

6. Every employer to receive from his carrier, a loss claim record of injured employees without the hassel of going though his agent, who sometimes does not want to bother. It's almost like they want to keep it a secret! Plus, many self employed people have no knowledge of what to ask for to protect themselves, to be aware of what is going on in their workmans comp account.

If these above items were possible, these types of people would not go from state to state, taking advantage of their employers with accidents coverage by workmans compensation. Nor would it be allowable for doctors to dig up 30 and 40 year old childhood injuries, and add it to a simple scratch, protect it by a band-aid, and expand a $100. workmans comp visit, into over $100,000. of costs. Inclosed is a picture of this injured employee, 7 hours after the accident, at a company picnic on July 22, 1986.**exhibit (4)** This band aid injury tacked on a claim cost of $112,000. to my account!

With only 3 fraud investigators in the state, how do I as an employer protect myself from this kind of problem?

There should be limits set to the costs charged by the medical profession and the legal profession. Present method makes it easy and lucrative for them, because it is a workmans compensation injury. See copy of different cost scales for this chiropratic clinic attached.***exhibit 5*** I am sure if medical clinics were checked, you would see similar differences as I show you here, but with only 3 fraud investigators in Alaska, its very easy to "get away with it".

Again, how can employers protect themselves of this? We are not ever told or given reports of what is going on with the injured employee! It is our premiums that pay for this, we employers of all people should be allowed to know!

In the past 15 years, we have had over 700 employees on our payroll. Per my OSHA records. I had 42 accidents: 27 with No Days Lost. 9 with a total of 13 days lost. 1 with 2 weeks lost. 1 with 42 days lost. 1 with 3 months lost. 1 fraud that was caught. 2 still outstanding, both fraudulent, but still collecting.

1973 4/2 accidents.	1974 4 accidents.	1975 1 accident.
1976 1 accident	1977 1 accident	1978 2 accident
1979 NO ACCIDENTS.	1980 2 accidents.	1981 1 accident.
1982 8 accidents.	1983 4 accidents.	1984 NO ACCIDENTS
1985 6 accidents	1986 11 accidents	1987 3 accidents.

If I had cooperation of suspicious cases, the entire cost of workmans compensation claims for this firm for 15 years, would be less than the premium that I paid in this 1 year for 1987. See attached 1987 total premium cost. exhibit (6)

If we cannot get proper audit controls of the insurance companys showing the ACTUAL claims paid, instead of the fictious reserve* accounts being added to the claim costs, thus throwing an inflated amount of claim costs upon the employers, of which they base the employers premiums costs; I'd like to suggest the following:

Is it possible to drop all insurance carriers, let the state start from scratch, and underwrite the workmans compensation insurance, with adequate investigators, and set limits on each and every injury what ever it may be, (example; a finger worth 1000., an arm 50,000. etc.) If this method were used, it would not be, as lucrative to sacrifice the finger or arm for Workmans compensation funds. Doctors on the other hand would only receive a set amount for that finger or arm. And the legal profession would not be so "sue happy" if there was a maximum amount in place.

And then perhaps, by the employers track and safety records, the state would allow them to have certain limits by which they could self-insure. In addition, have a state fund, (collected from all employers to cover certain catastrophic injuries that are reviewed by a board and thoroughly investigated.)

Also, make it mandatory that every employer would get at least a quarterly report of all costs that occur in that employers claim record.

Thank you for hearing me out. Please advise if anything in these areas can be corrected.

Sincerely yours,

Angie Kruckenberg

begin arriving late Saturday even-

(See GAMES, Page 5)

most recent recession failed to [illegible] the gains of the boom that [illegible] Games corporation.

Legislator problem: to cut worker comp rates or revise state law

By LARRY PERSILY
Associated Press Writer

JUNEAU—Legislators disagree on whether the state should force insurance companies to lower worker's compensation rates or just revise the compensation law and hope for a rate decrease.

Opposition to mandatory rate reductions also is coming from insurance companies and the state insurance director.

The Senate last month passed a major rewrite of worker's compensation laws, but the House Labor and Commerce Committee chairman said Thursday the bill is inadequate and he wants to change it.

The Senate bill (SB322) does not require insurance companies to lower their rates. The bill was drafted with help from a statewide labor and management task force.

A proposed House substitute would require companies to decrease their rates by 6 percent for 18 months.

"We're asking worker's to agree to some compromises . . . and in that process one of our primary goals is to reduce rates," said Rep. Dave Donley, Labor and Commerce chairman.

The Anchorage Democrat said, "The Senate bill fails to address many legitimate public concerns and is a mediocre product that does not adequately or fairly address the issues hundreds of Alaskans have asked us to address."

Senate Labor and Commerce Committee Tim Kelly said he is nervous about a mandated rate decrease.

"You might see insurance companies decide not to offer coverage up here," Kelly said, noting that although the state can require rate cuts it cannot require companies to do business in Alaska.

The Anchorage Republican said employers could find it difficult to obtain coverage if an excessive mandatory rate reduction forces companies to stop writing policies in Alaska. That would defeat the bill's purpose to bring about affordable worker's compensation coverage.

"You've got to have some control over the insurance industry," Kelly said, because the state requires employers to carry the insurance. But too much state control of rates could lead to problems, he said.

"At first blush it would appear that mandated rate decreases are attractive," said Paul Roller, acting director of the Division of Insurance. But the state cannot force a company to write insurance at a loss, he said.

"We are opposed to mandatory rate decreases because they are unworkable," Roller said.

Alaska employers spent about $180 million on worker's compensation insurance in 1987. Recent rate increases and fears of another major increase prompted legislators, labor and management representatives to join forces in an attempt to rewrite state laws setting out benefits for injured worker's.

The bill would restrict claims for stress-related injuries, reduce benefits to people living out of state, limit rehabilitation services and change several other aspects of the program, with the intent of lowering costs to insurance companies and rates to employers.

A letter of intent accompanying the Senate bill said the measure is expected to result in at least a 2 percent drop in rates, but letters of intent do not carry the force of law.

Fewer cases going to litigation, lower rehabilitation costs and fewer stress-related claims are the major money-savers of the bill.

Roller said Maine tried manda-

(See WORKERS, Page 5)

Weather helps cut into Redington's lead

News-Miner and AP reports

TRIPPLE—Strong winds and unseasonably warm temperatures have whittled Joe Redington's lead in the 1,150-mile Iditarod Trail Sled

By the time he decided to move, Herbie Nayokpuk decided his team rested enough to push on. ...yokpuk, known as the Shishmaref Cannonball, had arrived in [illegible] than six hours behind

Shultz said, underscoring the seriousness with which the United States views the situation there.

He accused Noriega of trying to impose a military coup in Panama by deposing President Eric Arturo Delvalle, whom the United States regards as the legitimate constitutional authority.

Under the Caribbean Basin Initiative, Panama and about 20 other countries are eligible to sell most products duty-free to U.S. markets.

But this measure will have mostly symbolic impact because the bulk of Panama's exports to the Un-

WORKERS

(Continued from page 1)

tory rate cuts in 1985 and the state has suffered through tremendous problems since then, including massive rate increases to return insurance companies to financial stability.

Donley expects to move the bill out of his committee next week, sending it to House Judiciary for further review.

Labor and Commerce members are scheduled to vote Tuesday on the substitute version and other proposed amendments to the Senate bill. If the House changes the bill, it would have to return to the Senate for concurrence with the amendments.

Donley wants to amend the bill to provide a "direct cash incentive for businesses to develop and maintain workplace safety programs." His proposed amendments would require insurance companies to pay a 5 percent rebate of premiums to employers that have an approved safety program and have not been cited for serious safety violations in the past year.

"The total failure of the other body (the Senate) to act on work place safety legislation . . . requires that we try to incorporate some protection for worker's' health and safety in the measure before us," Donley said.

Safety incentives are the best way to save lives and save ...ney on insurance, he said.

Fairbanks Daily News-Miner, Fairbanks, Alaska, Friday, March 11, 1988—5

ACCOUNT NUMBER 36C411423 ACCOUNT ID 0007Q2435 CURRENT DATE 01/30/87
PANEL ID. 0509

A C C O U N T I N F O R M A T I O N R E P O R T

ACCOUNT SUMMARY

NAME S.O.K. LUMBER COMPANY, INC.
DOUBLE K ENTERPRISES

ADDRESS P.O. BOX 10449

CITY FAIRBANKS STATE AK ZIP 99701

CA195038P IF YOU WISH TO SEE A CLAIM LISTING LINE BY LINE - DEPRESS PFKEY3,
CLAIM TOTALS - DEPRESS PFKEY4, NO CLAIM LISTING - DEPRESS PFKEY5.

PF KEY F X F

ACCOUNT NUMBER 36C411423 ACCOUNT ID 0007Q2435 CURRENT DATE 01/30/87
PANEL ID. 0442

A C C O U N T I N F O R M A T I O N R E P O R T

POLICY-CLAIM LISTING

CS177719368501

ITEM NO.	CLAIM NUMBER	CLAIM DATE	DIR INDEM AMT	DIR EXP AMT	DIR O/S AMT	DIR INCURRED AMT	R/I INCURRED AMT	RG LINE
*01	914G05622700	06/13/85	125401	2470	329417	457288	0	COMP
*02	914G05626901	04/24/85	124	26	0	150	0	COMP
*03	914G05626902	04/24/85	197	52	0	249	0	COMP
*04	914G05626903	04/24/85	152	36	0	188	0	COMP
*05	914G05626904	04/24/85	0	90	0	90	0	COMP
*06	914G05628500	06/01/85	20520	565	0	21085	0	COMP
TOTALS			146394	3239	329417	479050	0	

08

CL*573.2
IOJ

ALASKA NATIONAL INSURANCE
LOSS EXPERIENCE
ALL POLICIES AND ASSOCIATED CLAIMS SINCE 1984

PAGE 1
REPORT DATE: 12/31/87
RUN DATE: 01/05/88

* * * * * * I N S U R E D * * * * * *
O.K. LUMBER CO., INC.

** P O L I C Y **
YR PRE NUMBER
86A WS 02247

PRODUCER 951

UNDERWRITER OFFICE 13

GROUP 930

EFFECTIVE DATE 11/01/86

EXPIRATION DATE 01/01/87

* C L A I M A N T *	ACCIDENT DATE	LINE	* CLAIM * NUMBER	CAT	LOC CD	INJ CD	* P A I D * IND. LOSSES	* P A I D * MED. LOSSES	PD ALLOCATED LOSS EXPENSE	NET OUTSTAND LOSS RESERVE	INCURRED LOSS AND LOSS EXPENSE	
LARRABEE, ALDEN D. LOW BACK INJURY/CAUSE UNKNOWN	04/29/86	150	86438	00	000	05	690.00	462.18	450.62	0.00	1,602.80	CLOS
HARDENBROOK, DEAN J. FELL OFF TRUCK/CONTUSION RIGHT THIGH	06/14/86	150	93301	00	000	06	0.00	61.00	0.00	0.00	61.00	CLOS
HATFIELD, PAUL H. MOVING TRUSS CART/INJURED LEFT WRIST	07/14/86	150	86573	00	000	05	110.07	0.00	0.00	0.00	110.07	CLOS
HATFIELD, PAUL H. MOVING TRUSS CART/INJURED LEFT WRIST	07/14/86	150	83418	00	000	06	0.00	311.41	0.00	0.00	311.41	CLOS
LANIER, ELWIN J. FELL INTO PILE OF LUMBER MULT. INJ.	07/22/86	150	86345	00	000	05	18,006.53	45,046.12	3,360.41	45,536.94	112,000.00	
CATES, DELANE SCOT BOARD FELL & HIT CLMT'S RIGHT HAND	09/26/86	150	83831	00	000	06	0.00	125.00	0.00	0.00	125.00	CLOS
LILLIE, JOHN V. MANUALLY ADJUSTING EQUIPMENT ON TRUCK/BACK	09/29/86	150	86765	00	000	06	0.00	60.00	0.00	0.00	60.00	CLOS
PARDY, JEFF CUT RIGHT HAND ON SKILL SAW	09/29/86	150	83832	00	000	06	0.00	332.00	0.00	0.00	332.00	CLOS
ADAMSON, ERIC W. CLMT'S LEFT HAND STRUCK BY PIECE OF WOOD	10/13/86	150	83992	00	000	06	0.00	131.00	0.00	0.00	131.00	CLOS
TOOMEY, BILL F. INJURED LEFT MIDDLE FINGER WITH HAMMER	11/12/86	150	83991	00	000	06	0.00	121.00	0.00	0.00	121.00	CLOS
SERRA, JOSEPH P. SLIVER FROM BOARD IN RT HAND/INFEC	12/26/86	150	84181	00	000	06	0.00	362.00	0.00	0.00	362.00	CLOS
* * * * * LOCATION TOTALS =							18,806.60	47,011.71	3,811.03	45,586.94	115,216.28	
* * * * * INSURED TOTALS =							18,806.60	47,011.71	3,811.03	45,586.94	115,216.28	

Out of Pool claim experience

If you are in a pool -
you get a different report.
Both are separate

Exhibit 2

MEDICAL EXAMINER'S CERTIFICATE

I certify that I have examined Jim Filippo
(DRIVER'S NAME (PRINT))

IN ACCORDANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS (49 CFR 391.41-391.49) AND WITH KNOWLEDGE OF HIS DUTIES, I FIND HIM QUALIFIED UNDER THE REGULATIONS.

☐ QUALIFIED ONLY WHEN WEARING CORRECTIVE LENSES.
☐ QUALIFIED ONLY WHEN WEARING A HEARING AID.
A COMPLETED EXAMINATION FORM FOR THIS PERSON IS ON FILE IN MY OFFICE AT 1765 Chadamer Way
(ADDRESS)

1-5-85
(DATE OF EXAMINATION)

A. Priest
(NAME OF EXAMINING DOCTOR (PRINT))

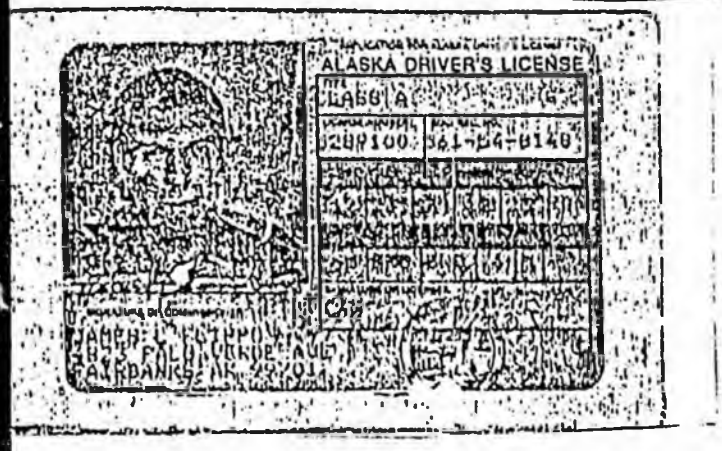
James Filippos
(SIGNATURE OF DRIVER)

1765 Chadamer Way
(ADDRESS OF DRIVER)

James Filippos
(SIGNATURE OF EXAMINING DOCTOR)

CTA Form 6488 Rev. 873

Doctor?
Where is the title?
Don't all doctors sign their name with title?
Is this also fraudulent?



Picture taken at 8:00 PM, 7/22/86.

See band-aid from doctors visit after his workmen's comp accident on 1:00PM 7/22/86.

The $100.00 office visit went over a $112,000.00 CLAIM!

How can we survive these costs

1987

PITCH WC 0760620 09 48 0001
SORT O K UNIT NUMBER LOSS DATE OCCURRENCE CLAIMANT
UNIT 001 RP-SEQ 032 05 CLAIMT ROBERT J. HOERLES

TN	LOS	DT	P	OC	CL	REPTD	CAUSE	A-I-A	RES	HST	CUR-RES	PAID	EXP
FP		020487	7	01	32	022487	WC	MED	THFB19			60.00	0.00
PP		020487	7	01	32	022487	WC	MED	THFB19			71.00	0.00
PP		020487	7	01	32	022487	WC	MED	THFB19			40.00	0.00
PP		020487	7	01	32	022487	WC	MED	THFB19			187.50	0.00
PP		020487	7	01	32	022487	WC	MED	THFB19			32.10	0.00
CL		020487	7	01	32	022487	WC	MED	THFB19		9-	0.00	0.00
RE		020487	7	01	32	022487	WC	MED	THFB19		400	0.00	0.00

UNIT 001 RP-SEQ 032 06 CLAIMT MICHAEL P. SMITH

TN	LOS	DT	P	OC	CL	REPTD	CAUSE	A-I-A	RES	HST	CUR-RES	PAID	EXP
		197	7	01	32	092287	WC	MED	GRS156		200		0.00
		787	7	01	32	062687	WC	MED	WRLA17			181.00	0.00
		787	7	01	32	062687	WC	MED	WRLA17		19-	0.00	0.00
		787	7	01	32	062687	WC	MED	WRLA17		200	0.00	0.00
	LOS					200	O/S	EXP		0	LOS	571.60	EXP 0.00
	LOS					0	O/S	EXP		0	LOS	0.00	EXP 0.00

NAME: ____________________

40   O/C
40

OFFICE CALLS: 40

97260-52 Spinal Manipulation	35
97260 INT Spinal Manipulation	*40.
97260-14 Spinal Manip.(Sun/Hol)	60
97260 Spinal Manipulation	N/C
A2000 (Medicare) Spinal Manip.	40
00590 (Medicaid) Spinal Manip.	40
97261 Manual Manip Extended 55 F/WC	

EXAMS-NEW PATIENTS:

90000 N.C. Hist/Exam	N/C
90000 Brief Hist/Exam	45
90010 Limited Hist/Exam	55
90020 Comprehensive Hist/Exam	*155

EXAMS-ESTABLISHED PATIENTS:

90040 Brief Re-Exam/Evaluation	35
90050 INT. Re-Exam/Evaluation	45
90080 Comprehensive Re-Exam	*120

SERVICES:

97741 Kinesitherapy Brief Nimmo	20
99740 Ext/Nimmo Kinesitherapy	35
99030 Thermo-Cryotherapy	20
97122 Traction	20
97014 Electric Stimulus	35
97110 Rehabilitation Exercises	12

SPECIAL SERVICES:

99070 NSF Charges	25
99033 NOF	*40
99000 Consultation	N/C
99080 Chart Notes/Records	25
99080 Narrative Report (page)	40

X-RAYS WITH ANALYSIS:

72010 Full Spine	*160
72010 Full Spine Re-Check	160
72040 Cerv Pre Pettibon	60
72040 Cerv Obliques (2)	80
72040 Cerv Flex/Ext. (2)	80
72100 Lumbar-AP/Lateral	80
72100 Lumbar-Obliques	80

MEDICAID X-RAYS:

00510 Radiologic exam, spine.cerv	65
00570 Lumbosacral: anteroposterior and lateral	65

SUPPLIES

97700 SPS/PS Checkout	20
99002 SPS/PS Exam/Casting	40
99070 Foot Levelers	**
99070 Cryogel Packs (2)	15
99070 Ortho Cervical-Collar	29
99070 Lumbar Support Belt	45
99070 Cervical SP/Support Block	25
99070 Ortho Lo-Back Spinal Support	28
99070 Exercise Fulcrums	45

Week ________ Month ________

Mon Tues Wed Thurs Fri Sat

( ) ROF ( ) RE ( ) REX

Comments: ____________________

CHARGE: ________ PAID: ________

** See Price Lists

all items marked — are workmans comp costs.

W/WC. (1st billing) $505.

If you are an individual & no insurance the cost is 35.00 visit + 160.00 x-ray

2nd Visit W/W.Comp.
W/ W.C. Insurance
40.00 visit cost
+ 120.00 Reexam cost
total w/ work/comp 160.00

personal visit 35.00 gets Exact Same Service
By me who has been hurt!

PROVIDENCE WASHINGTON INSURANCE GROUP

☐ PROVIDENCE WASHINGTON INSURANCE CO. ☒ PROVIDENCE WASHINGTON INSURANCE COMPANY OF ALASKA
☐ MOTOR VEHICLE CASUALTY CO. ☐ WESTERN ALLIANCE INSURANCE COMPANY
☐ YORK INSURANCE COMPANY

☐ EASTERN REGIONAL OFFICE — 20 Washington Place · Providence, RI 02901
☐ MIDWESTERN REGIONAL OFFICE — 209 North York Street · Elmhurst, IL 60126
☒ ALASKAN REGIONAL OFFICE — 301 W. Northern Lights, Suite 501, Anchorage, AK 99503
☐ SOUTHWESTERN REGIONAL OFFICE — 7715 Chevy Chase Drive · Austin, TX 78761

DATE 2/12/88
CANCELLED ☐ P/R ☐ S/R
POLICY NUMBER WC 760628

INSURED: O.K. LUMBER COMPANY, INC.
LOCATION:
POLICY PERIOD: 1/19/87 TO 1/19/88

AGENT # NAME: 469 FRED S. JAMES (ASSIG NED RISK)
LOCATION:
AUDIT PERIOD: SAME TO

CLASS	DESCRIPTION	BASIS OF PREMIUM	RATE	PREMIUM	RATE	PREMIUM	RATE	PREMIUM
AK								
8232	to 1/1/88	40,886	16.22	6,632.00				
8058		120,708	3.54	4,273.00				
2802		80,164	10.06	8,064.00				
8810		95,822	.82	786.00				
8742		20,439	1.04	213.00				
9898	Experience Mod 1.20			23,962.00				
0900	Expense Constant	358019		114.00				
8232	from 1/1/88	1,249	15.44	193.00				
8058		4,036	5.05	204.00				
2802		952	12.59	120.00				
8810		2,606	.82	21.00				
9898	Experience Mod 1.20	8843		646.00				
0900	Expense Constant			15.00				
		366.862						
	COLUMN TOTALS							

19968 $3994 - high risk out adder

538 prem. + Hi risk adder

NOTE: All premiums shown have been fully ear
Payment is therefore due immediately o
presentation of this bill.

My cost to insurance Company → 24,747.00

My Claims including 20% Reserve for 1987 761.60

EARNED PREMIUMS (DETAIL ABOVE)	24,737.00
LESS PREMIUMS PREVIOUSLY CHARGED	16,189.00
ADDITIONAL ~~XXXXXX~~ PREMIUMS	8,548.00

STATEMENT

INSURED'S COPY

Alaska Association for Marriage and Family Therapy

A DIVISION OF THE AMERICAN ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY

April 5, 1988

Senate Labor & Commerce
Testimony - DRAB

To: Representative Sund

From: Mercy Dennis

RE: SENATE BILL NO. 67

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

I wish to bring to your attention that this bill does not allow for consumer freedom of choice for mental health care providers. By requiring that the mental health care provider have "a masters or doctoral degree in psychology, nursing, or social work" the bill excludes several areas of nationally recognized and accredited training and educational programs that produce competent professionals in the mental health field. I have two suggestions that would allow for this bill to better serve the people in Alaska seeking mental health services.

1. Sec. 21.42.365 (c) (9) (D) to read "a person who works in a consulting relationship with a mental health care provider licensed by a state and has a masters or doctoral degree in psychology, nursing, social work, or **equivelent related field:** or "

Another solution to this problem would be:

2. **ADD** under Sec. 21.42.365 (c) (9) **(F)**

(F) a Marriage and Family Therapist who is

(i) licensed or certified as a marriage and family therapist by a state: or

(ii) a clinical member of The American Association for Marriage and Family Therapists;

Thank you for your consideration on this important matter.

cc Members of House Judiciary Committee

2550 Denali Street • Suite 905 • Anchorage, Alaska 99503 • Telephone (907) 276-2833

ALASKA STATE SENATE

JOE P. JOSEPHSON
DISTRICT H ANCHORAGE
3111 C STREET, SUITE 550
ANCHORAGE, ALASKA 99503
(907)561-7611

WHILE IN JUNEAU
P.O. BOX V
JUNEAU, ALASKA 99811
(907)465-4525

March 8, 1988

Raymond Norman Fedje, Ph.D.
Executive Director
Samaritan Counseling
Center of Alaska
4502 Cassin Drive
Anchorage, Alaska 99507

Dear Ray:

Thanks for your note of February 26. I supported SB 67, which has passed the Senate.

I am forwarding a copy of your note to my House colleague, Representative John Sund, who chairs the House Judiciary Committee, so that he can be aware of your recommendation for a possible amendment.

I will await House action with interest. Truth to tell, I strongly support the objectives of SB 67, but I think we need to be assured, especially in these difficult times for employers, that the passage of the bill will not accelerate a flight from group insurance for health in general.

I have also enclosed copy of the latest version of this measure, as it passed out of the House Health, Education and Social Services Committee.

With best personal regards, I am

Sincerely,

Joe P. Josephson
State Senator

JPJ:rak
Enclosure

cc: Representative John Sund

Alaska State Legislature

MAR 28 1988

SENATOR
ARLISS STURGULEWSKI
Chairman, Senate Community and Regional Affairs Committee
Vice-Chairman, Senate Judiciary Committee
Member, Senate Resources Committee

2957 SHELDON JACKSON STREET
ANCHORAGE, ALASKA 99508

While in Juneau
P. O. BOX V
JUNEAU, ALASKA 99811
(907) 465-3818

Senate

March 25, 1988

Pamela Kirk
SR 9817 Hiland Drive
Eagle River, AK 99577

Dear Pamela:

Thank you for your recent letter regarding SB 67 "An Act relating to insurance coverage for the treatment of a mental or nervous condition." This bill passed the Senate with my support on May 8, 1987.

Senate Bill 67 is currently in the House Judiciary Committee. I will send a copy of your letter to Representative John Sund who is chairman of that committee so he is aware of your concerns with the bill.

Kindest regards,

Arliss

Arliss Sturgulewski
Alaska State Senator

cc: Representative Sund

FREDERICK J. HILLMAN, M.D.

DENALI NORTH THERAPY ASSOCIATES
2550 DENALI STREET - SUITE 905
ANCHORAGE, ALASKA 99503

(907) 258-1121

15 March 1988

Mr. John Sund
Chairman, House Judiciary Committee
Alaska State Legislature
Pouch V
Juneau, AK 99811

Dear Mr. Sund,

Recently I sent a Public Opinion Message to Senator Ellis and Senator Koponen regarding SB 67 (health insurance for mental conditions) and received a response which then led me to write to them to enlarge my previous brief remarks. Since SB 67 is now in your committee, I am enclosing a copy of my letter to them and hope that you will find it of interest.

Sincerely yours,

Frederick J. Hillman

Frederick J. Hillman, M.D.

STATE OF ALASKA
THE LEGISLATURE

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

LEGISLATIVE AFFAIRS AGENCY

LEGISLATIVE REFERENCE LIBRARY

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

Mary Van Nimwegen

H. Jud MAY 5, 1988 1:30pm

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3991

April 29, 1985

TO:

FROM: Jonathan Sherwood
Legislative Analyst

RE: Mental Health Insurance
Research Request 85-314

You requested that we respond to the following questions:

- What types of health insurance coverage does the State now mandate?
- Does the State require an employer to pay a portion of the premium for health insurance or can entire premiums be passed through to the employee?
- What would be the cost of optional mental health insurance benefits providing the same copayments, deductibles, and length of coverage as physical health insurance?
- Could the State require that optional mental health insurance be offered to individuals on group policies?
- What is the Hill-Burton Act and how does it relate to the funding of mental health services?

State Requirements for Health Insurance

Under current Alaska law, employers are not required to provide health insurance coverage for employees. Alaska Statute 21.51 and AS 21.54, the chapters addressing disability and group disability policies respectively, contain requirements that health insurance policies must meet; however, there is no provision which requires an employer to offer, provide, or pay for any employee health insurance. This circumstance has been used to argue against mandating specific kinds of health coverage; critics argue that if the cost of procuring insurance for employees becomes too high, employers may exercise their option not to provide any health coverage.

Cost of Optional Mental Health Coverage

The potential cost of optional mental health insurance depends on a number of factors. The types of services covered, the dollar limits on coverage, and provisions for copayments and deductibles affect the cost of an insurance policy. Furthermore, it makes a significant difference whether the State permits the choice of purchasing mental health insurance to be made for a group as a whole or requires that each individual within the group be given the option of purchasing mental health insurance.

If the choice is made at the group level, then costs should be comparable to the costs of mandated group mental health coverage. Martin Tirador, with Blue Cross of Washington and Alaska, noted that the costs for group coverage under a mandated offering would be somewhat higher than under mandated coverage because not every group would elect coverage, thus, there would be fewer people across which to spread the risks and administrative costs of the mental health coverage. According to Mr. Tirador, Blue Cross estimates that under SB 295, which mandates a mental health coverage offering, the rate for employee-only coverage under a group basic and major medical plan with a $100 deductible would increase an average of 6.8 percent for all group sizes. For a group of 5-10 persons, the increase comes to about $7.45 per month per employee.

This estimate is considerably higher than the estimate of $3.54 per month for each family covered that Blue Cross made for coverage mandated under HB 313; however, Mr. Tirador stated that Blue Cross is in the process of revising its estimate for HB 313, and the company anticipates that it will be much closer to the estimates for SB 295.[1]

If mental health insurance were offered at the individual level, with the person choosing between coverage and some other alternative, then the cost of the insurance will probably be higher. When individuals are given the option of buying insurance or not, adverse selection usually occurs--the people who choose insurance are those most likely to make claims against the policy. Individuals who perceive little likelihood of using the covered services will not elect to buy coverage, preferring to use their money for some other purpose. This concentration of high risk individuals in the pool of insured individuals leads to higher per person costs of insurance than when the risk is spread across a group that includes lower risk individuals as well.

In the extreme case, adverse selection can price all but a few out of a market for insurance. As the price increases, individuals who do not

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[1]I will provide you with the revised estimates for Blue Cross insurance costs under HB 313 as soon as I receive them.

anticipate heavy usage of the covered service will be even less likely to purchase insurance. In turn, prices must rise to reflect the increasing concentration of high risks in the pool of insured individuals and even more people will opt out of insurance coverage.

Of course, not everyone has an accurate perception of the probability of their needing mental health services. Some individuals may overestimate the risk. In addition, some individuals may place a high value on security even if they perceive only a small chance that they will need services. These people might purchase mental health insurance even at a higher price than the probability of their needing the coverage would otherwise justify. To the extent that people with below average utilization of mental health services elect to purchase insurance, the effects of adverse selection will be moderated.

State Requirement for Individual Choice of Mental Health Option

A requirement for each individual covered under a group health plan to be offered mental health coverage could work in many different ways. The cost of the coverage could be borne by whoever pays for the group health plan or the premiums could be separate, paid for by the individual selecting mental health coverage. Rates could be the same for all members or could differ according to the risk associated with various classes of individuals.

J.P. Tangen, who represents the American Council of Life Insurance, stated that he did not see any legal problem with simply requiring insurers to make a mental health insurance plan available to individuals, assuming they bore the cost of the coverage themselves. John George, Director of Insurance for the Department of Commerce and Economic Development, mentioned that there are questions as to the extent to which the federal Employee Retirement Income Security Act (ERISA) preempts state regulation of employer-provided health insurance, the major form of group health insurance in Alaska.

John Ambrose, with the National Mental Health Association, was not aware of any state with a mandated offering of mental health coverage which required that the individual be offered the choice of whether to purchase mental health coverage. The decision is usually made for the group.

There may be some practical problems with offering the mental health coverage on an individual basis. As noted earlier, there is the question of who is to pay for the coverage. If an employer pays for the coverage, employees presumably would be offered some alternative benefit. For individuals to have a meaningful choice, they must be given an alternative; if there is no cost to the insurance or no alternative

benefit is foregone, then virtually everyone would choose mental health insurance.

Some employers, such as the State of Alaska, offer their employees supplemental benefit packages from which employees are permitted to choose options. Mental health insurance could be offered as an option in such a package.

If employees were required to purchase insurance out of their own pocket, they would be using money for which they may have incurred some tax liability. By shifting the cost of the insurance from pretax to posttax dollars, the cost of mental health coverage may be increased, as deductions for health care do not cover all health care expenses.

Another potential problem is the rate structure for mental health coverage. Some of the individuals whom we contacted noted that because of the problems of adverse selection, a single rate for all members of a group selecting mental health coverage could be very expensive. However, individual rates based on risk could prove cost prohibitive to the individuals most in need of coverage.

The Hill-Burton Act

The Hill-Burton Act generally refers to the Hospital Survey and Construction Act of 1946 and its subsequent amendments. One of the features of the act was that state, municipal, and nonprofit health care facilities were eligible to receive capital project grants. In return, the facilities were required to provide a level of uncompensated care to needy patients.

Under the formula established by the Hill-Burton Act, the facilities were required to provide each year for twenty years the lesser of:

1) uncompensated care equal to 10 percent of the Hill-Burton grant, indexed to the Consumer Price Index for inflation; or

2) uncompensated care equal to 3 percent of the facility's operating costs.[2]

Every facility with a Hill-Burton obligation must offer uncompensated care to individuals with incomes that fall below the federal poverty

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[2]Facilities receiving grants under Title XVI of the Public Health Act must also meet the annual uncompensated care requirements shown; however, there is no limit to the duration of that obligation. It continues indefinitely.

standards set for the program. There are no limitations on assets other than income. The current annual income limits under the Poverty Income Guidelines for Alaska are shown below:

Size of Family Unit	Poverty Guideline
1	$6,560
2	8,810
3	11,060
4	13,310
5	15,560
6	17,810
7	20,060
8	22,310
Each Additional Member	2,250

* * * *

Facilities are also given the option of providing care to patients with up to twice the income of the federal poverty guidelines. Within this range, facilities can set their own income limits and institute a reduced rate schedule for covered services. For example, a facility might charge a patient with an income one and one-half times the federal poverty standard 25 percent of the normal charge for services. The difference would then be charged against the facility's Hill-Burton obligation.

The health care facility must bill other sources of coverage before applying the cost of a patient's treatment to its Hill-Burton obligation. Anything above and beyond what is met by that third-party coverage may be charged to Hill-Burton. Eligibility for Hill-Burton coverage is not considered a source of coverage for other government health programs; Medicaid, Medicare, and catastrophic illness programs do not require individuals to seek coverage from Hill-Burton before paying for the cost of care.

The Hill-Burton Act does not distinguish between mental and other types of health services. Any health care service provided by the facility may be paid for with Hill-Burton funds. However, the facility determines which services will be covered under its Hill-Burton obligation. At the beginning of each fiscal year, the facility must publish an allocation plan stating how much uncompensated care it intends to provide during that year and what kinds of services are included. It should be noted that even if a hospital received federal funds to construct an outpatient facility, it would not have to cover the services of that facility under Hill-Burton. It could limit Hill-Burton coverage to inpatient services.

Each year, a facility that has received Hill-Burton funds must publish a public notice of its allocation plan in its community; notices must also be posted in the facility and provided to each patient entering the facility. Patients can apply for Hill-Burton eligibility at any time during their stay; the facility has two working days to make an eligibility determination. A tentative approval may be made pending verification of income information.

We have provided only a brief synopsis of the Hill-Burton program; if you would like additional information on the mechanics of the program, or if you have any other questions concerning this memorandum, please do not hesitate to contact us.

JS

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3991

May 2, 1985

MEMORANDUM

TO:

FROM: Jonathan Sherwood
Legislative Analyst

RE: Cost of Mental Health Insurance under HB 313 and SB 295
Research Request 85-314 (Additional Information)

Martin Tirador, with Blue Cross of Washington and Alaska, has provided me with the most current estimates of the cost of mental health coverage under HB 313 and SB 295. This information is presented on the following page. Mr. Tirador emphasized that although these estimates are more accurate than earlier numbers, they still represent Blue Cross's best guess.

Blue Cross gives coverage groups one of several possible risk ratings, depending on its characteristics. According to Mr. Tirador, Risk Level 3 is a moderately low risk group.

If you have any questions, please do not hesitate to call me.

JS

Attachment

ESTIMATED INCREASED MONTHLY COSTS FOR MENTAL HEALTH COVERAGE

Group Plans

Basic Hospitalization and Major Medical
$100 Deductible
Risk Level 3
(for rate effective April 1, 1985)

Group Size	HB 313	SB 295
5-10	$8.20	$7.45
11-24	7.50	7.20
25-99	7.25	6.60

Comprehensive Health
$100 Deductible
Risk Level 3
(for rate effective April 1, 1985)

Group Size	HB 313	SB 295
5-10	$9.70	$8.80
11-24	9.45	8.60
25-99	8.60	7.80

Nongroup Plans

Individual Only
Age 40-44

Deductible	HB 313[a]	SB 295
$200	$8.30	$7.55
$500	6.40	5.80
$1,000	5.20	4.70

[a]HB 313 does not mandate coverage for individual plans; this column represents the cost of including coverage mandated under HB 313 in nongroup plans.

Source: Martin Tirador, Blue Cross of Washington and Alaska.

Table Prepared by the House Research Agency, May 1985.

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

P.O. Box Y, State Capitol
Juneau, Alaska 99811-3100
Mail Stop 3100
(907) 465-3991

February 15, 1988

MEMORANDUM

TO: Representative Niilo Koponen

ATTN: Lisa McLaren

FROM: Karen Oakley KO
Legislative Analyst

RE: Mental Health Insurance: Cost of Mandatory Availability
Research Request 88.167 (Preliminary Information)

Senate Bill 67 mandates that insurers offering major medical insurance include mental health coverage as an option, and you asked how much the addition of such coverage would add to the cost of a major medical premium. In this memorandum, we provide preliminary information on this topic.

Background

Twenty-six states have statutes addressing the provision of mental health benefits under private health insurance policies. These statutes are of two general types: 1) mandated coverage statutes which require that mental health coverage be provided under major medical policies and which specify the benefits that must be provided; and 2) mandated availability statutes which require only that mental health coverage be offered at the policy holder's option and which may or may not specify the benefits that must be offered. Mandated coverage is found in 13 states.[1] Mandated availability is found in 13 other states (see Table 1).

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[1]States with mandated coverage statutes are Colorado, Connecticut, Maine, Maryland, Massachusetts, Minnesota, Montana, New Hampshire, North Dakota, Ohio, Oregon, Virginia, and Wisconsin.

Alaska is one of 24 states that does not currently have a statute addressing the provision of mental health benefits. Senate Bill 67 would require that insurers in Alaska offer mental health benefits as an option under major medical insurance policies; Alaska would then become a mandated availability state. During the 1985 session, the legislature considered two bills which mandated availability, House Bill 313 and Senate Bill 295. House Research Memoranda 85.263 and 85.314 discuss these bills, including cost estimates, and are attached.

In Table 1 (attached), the laws of states mandating availability of mental health insurance are compared. The laws differ with respect to the following criteria:

- the type of providers eligible to be reimbursed;
- whether group or individual policies must be covered; and
- whether minimum inpatient, outpatient and partial hospitalization benefits are specified;

Summarizing the features of the current mandatory availability laws:

- Most of the laws were enacted 10 to 15 years ago. Ten of the 13 states enacted mandatory availability of mental health coverage during the 1970s; three states enacted their legislation during the 1980s.
- Six states mandate that coverage by offered to groups only; the remaining seven states mandate that coverage be offered to groups and individuals.
- All states consider psychiatrists and psychologists to be eligible providers; otherwise, states vary considerably in their definition of eligible providers.
- Only two states specify a minimum benefit for partial hospitalization.
- States differ in specification of the inpatient and outpatient benefits which must be offered. Washington and California have not specified required benefits. The other states typically require the offering to include coverage for 30 to 45 days per year for inpatient benefits or require the coverage to be the same as that provided for other illnesses. For outpatient benefits, the other states typically specify an upper dollar limit, ranging from $500 to $1,500 per year, or specify the maximum number of visits, ranging from 20 to 50 visits per year.

Cost of Optional Mental Health Coverage: General Considerations

Adding mental health coverage to a major medical insurance policy increases the cost of the premium because additional benefits are provided. How much the added coverage will cost depends on a number of factors, including several factors within the control of the legislature. The provisions of a mandatory availability statute that will most affect the cost of the insurance include:

- the types of services covered;
- the dollar limits to the coverage;
- any provisions for copayments or deductibles; or
- whether the choice of purchasing mental health insurance must be made for groups as a whole or whether each individual within a group has the option to select the mental health benefit.

In general, the more services that are required to be covered, the higher the dollar limits to the coverage, and the lower any copayments or deductibles, the higher the premium will be. Because treatment of mental conditions most often occurs on an outpatient basis, the cost of mental health insurance is largely dependent on the required outpatient benefit offering and on the amounts of any copayments or deductibles for the outpatient benefit.

The costs of mental health insurance under a mandatory availability statute are also dependent in large part on whether the decision to elect mental health coverage is required to be made at the group level. Under a mandatory coverage statute, the insured population is large; this reduces the per capita cost. Under a mandatory availability statute, the insured population will undoubtedly be smaller, and premiums will be higher. If the statute requires that the decision to elect mental health coverage be made at the group level, the costs should be comparable to but slightly higher than costs of mandated mental health coverage.

If the decision to elect mental health coverage resides with the individual, the costs will be even higher. When individuals have the option to select coverage, the people who are most likely to make claims are the ones most likely to select the coverage. Thus, high risk individuals predominate in the pool of insured individuals; this increases the cost.

Estimates of the Cost of Mandated Availability in Alaska

Estimates of the additional cost to a major medical or comprehensive health insurance policy from selection of a mental health benefit under proposed mandatory availability statutes considered during the 1985 session, SB 295

and HB 313 were made by Blue Cross. These estimates are presented in Table 2. Estimates for mandated availability were in the range of $7 to $9 per month for group policies.

I contacted Blue Cross for an estimate of the costs under SB 67, but they were still in the process of analyzing the cost. Presumably Blue Cross will provide this information during their testimony on the bill.

Costs of Mental Health Coverage in Other States

In the time available, I was able to obtain information on mental health insurance costs in only three states: Florida, California and Washington.

In Florida, the mandatory availability statute was passed originally in 1976 and then amended in 1983. The statute applies only to group policies; inpatient coverage is limited to 30 days per year, and outpatient coverage is limited to $1,000 per year. According to Charlie Gray, of the Florida Insurance Commissioner's Office, major medical premiums for groups that include the mental health coverage are about 5 percent higher than for policies without the coverage.

In California, the mandatory availability statute was passed in 1973. Milo Pearson, of the Department of Insurance, said that at the time of passage, the increased cost was minimal and not a major issue.

Washington has had a mandatory availability statute for five years. Their statute is somewhat unique in that the benefits that must be offered are not specified. Beth Stecher, a rate analyst with the Office of Insurance, provided a sampling of rates charged by various insurers for mental health coverage. The typical benefit provided is $2,000 for inpatient and $500 for outpatient services.[2] Typical rates for low risk groups ranged from $1 to $2 per employee with the cost doubling if the coverage applied to the employee's spouse as well.

I hope you find this information useful. Additional information on costs of mental health coverage in other states will be provided. Please let me know if you need any additional information.

Attachments

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[2]Ms. Stecher noted that the $2,000 benefit for inpatient services is illusory since few people required inpatient treatment. She also said that the outpatient limit of $500 is almost too low to have any value and that the Washington legislature is considering specifying the benefits that must be offered.

TABLE 1

COMPARISON OF THE PROVISIONS OF SENATE BILL 67 TO EXISTING STATE LAWS MANDATING AVAILABILITY OF MENTAL HEALTH INSURANCE

STATE	DATE	POLICIES COVERED	OTHER ELIGIBLE PROVIDERS (SEE NOTE 1)	REQUIRED BENEFIT OFFERINGS		
				INPATIENT	OUTPATIENT	PARTIAL HOSPITALIZATION
Alaska Senate Bill 67	not applicable	Group	licensed general or psychiatric hospitals; community mental health centers; person with a master's or doctoral degree in psychology, nursing or social work and works in conjunction with a licensed mental health care provider	45 days per year	50 outpatient treatments or office visits per year	Not specified
Arkansas	1979	Group, Individual	licensed outpatient psychiatric centers	Pyschological evaluation, counseling psychotherapy or related mental health services are entitled to payment or reimbursed on an equal basis	Reimbursed provided service is provided by facilities licensed as outpatient psychiatric center	Not specified
California	1973	Group	licensed marriage or family counselor; registered nurse with masters in pschiatric mental nursing and 2 years experience; licensed clinical social worker	Terms of all coverage agreed upon between the group policy-holder and the insurer	Terms of all coverage agreed upon between the group policy-holder and the insurer	Not specified

TABLE 1 (Continued)

COMPARISON OF THE PROVISIONS OF SENATE BILL 67 TO EXISTING STATE LAWS MANDATING AVAILABILITY OF MENTAL HEALTH INSURANCE

STATE	DATE	POLICIES COVERED	OTHER ELIGIBLE PROVIDERS (SEE NOTE 1)	REQUIRED BENEFIT OFFERINGS		
				INPATIENT	OUTPATIENT	PARTIAL HOSPITALIZATION
Florida	1976 Amended 1983	Group	licensed mental health professional	30 days per year	$1,000 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
Georgia	1984	Group, Individual	not specified	30 days per year under an individual policy and 60 days per year under a group policy	48 visits per year under an individual policy and 50 visits per year under a group policy	Not specified
Illinois	1975	Group, Individual		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	Coverage 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	Not specified
Kansas	1978	Group	community mental health center or clinic; pyschiatric hospital	30 days per year	Coverage for the first $100 and 80% of the next $500 per year	Not specified
Louisiana	1975	Group	board certified social worker in consultation with a physician	Benefits on par with those offered for other illnesses	Benefits on par with those offered for other illnesses	Not specified

TABLE 1 (Continued)

COMPARISON OF THE PROVISIONS OF SENATE BILL 67 TO EXISTING STATE LAWS MANDATING AVAILABILITY OF MENTAL HEALTH INSURANCE

STATE	DATE	POLICIES COVERED	OTHER ELIGIBLE PROVIDERS (SEE NOTE 1)	REQUIRED BENEFIT OFFERINGS		
				INPATIENT	OUTPATIENT	PARTIAL HOSPITALIZATION
Missouri	1980	Group, Individual		30 days per year; on par with other illnesses	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	Not specified
New York	1977	Group	social worker	30 days per year in a general or mental hospital	$700 per year deductibles and coinsurance on par with other benefits	Not specified
Tennessee	1974	Group, Individual	community mental health center with an approved plan for quality assurance; accredited hospitals	Not specified	30 visits per year copays and deductibles on par with physical illnesses	Not specified
Vermont	1975	Group	licensed mental health professional;	45 days per year in a general or mental	100% of the first 5 visits and 80% thereafter up to	45 day equivalents of active care per year

TABLE 1 (Continued)

COMPARISON OF THE PROVISIONS OF SENATE BILL 67 TO EXISTING STATE LAWS MANDATING AVAILABILITY OF MENTAL HEALTH INSURANCE

STATE	DATE	POLICIES COVERED	OTHER ELIGIBLE PROVIDERS (SEE NOTE 1)	REQUIRED BENEFIT OFFERINGS		
				INPATIENT	OUTPATIENT	PARTIAL HOSPITALIZATION
Washington	1983					
West Virginia	1977	Group, Individual	licensed or accredited general mental hospital; comprehensive health service organization; community center or clinic	45 days per year in a mental or general hospital; on par with illnesses in a general hospital	30% copayment up to $500 per year, sessions cannot exceed 50 per year	Not specified

SOURCE: Intergovernmental Health Policy Project

NOTES: 1. All of the states specify pyschiatrists and psychologists as eligible providers. "Other eligible providers" are those other types of mental providers eligible to be reimbursed for provision of mental health services to covered individuals.

Prepared by the House Research Agency, February 1988 (88.167).

Table 2

ESTIMATED INCREASED MONTHLY COSTS FOR MENTAL HEALTH COVERAGE

Group Plans

Basic Hospitalization and Major Medical
$100 Deductible
Risk Level 3
(for rate effective April 1, 1985)

Group Size	HB 313	SB 295
5-10	$8.20	$7.45
11-24	7.50	7.20
25-99	7.25	6.60

Comprehensive Health
$100 Deductible
Risk Level 3
(for rate effective April 1, 1985)

Group Size	HB 313	SB 295
5-10	$9.70	$8.80
11-24	9.45	8.60
25-99	8.60	7.80

Nongroup Plans

Individual Only
Age 40-44

Deductible	HB 313[a]	SB 295
$200	$8.30	$7.55
$500	6.40	5.80
$1,000	5.20	4.70

[a] HB 313 does not mandate coverage for individual plans; this column represents the cost of including coverage mandated under HB 313 in nongroup plans.

Source: Martin Tirador, Blue Cross of Washington and Alaska.

Table Prepared by the House Research Agency, May 1985. (85-263)

STATE OF ALASKA

DEPARTMENT OF ADMINISTRATION

DIVISION OF RETIREMENT & BENEFITS

PLEASE REPLY TO:

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

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

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

STEVE COWPER, GOVERNOR

February 24, 1988

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

Dear Representatives Koponen and Ellis:

Re: House CS CSSB 67 (HESS)

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

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

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

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

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

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

The increase in the PERS contribution rate (.20%) times the estimated FY 90 state PERS payroll ($479,549,872) equals:	$ 959.1
The increase in the TRS contribution rate (.15%) times the estimated FY 90 University of Alaska TRS payroll ($44,753,863) equals:	67.1
The increase in the TRS contribution rate (.15%) times the estimated FY 90 Department of Education TRS payroll ($5,613,930) equals:	8.4
	$1,034.6

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

The increase in the PERS contribution rate (.20%) times the estimated FY 90 political subdivision payroll ($329,744,333) equals:	$ 659.5
The increase in the TRS contribution rate (.15%) times the estimated FY 90 school districts' payroll ($319,882,344) equals:	$ 479.8
	$1,139.3

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

Sincerely,

Robert F. Stalnaker

Robert F. Stalnaker
Acting Director

RFS/MBC/cam/6

STATE OF ALASKA 1987 LEGISLATIVE SESSION
FISCAL NOTE

Bill Version: CS SB 67 (HESS)
Publish Date: 3-3-

REQUEST:

Revision Date:
Title: "An Act Relating to Insurance Coverage of a Mental Health or Nervous Condi.
Sponsor: Faiks and Kertulla
Requestor:

Agency Affected:
BRU: Institutions and Administration
Components: Alaska Psychiatric Institute

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
REVENUE	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of Dollars)

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

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

See attached

Prepared by: Deborah K. Smith
Division:
Phone: 465-3370
Date: 1/27/87

Approved by Commissioner: Nancy M. Munson
Agency: Dept. of Health & Social Services
Date: 3/18/87

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

CSSB 67 HESS

FISCAL NOTE

Payments to the Alaska Psychiatric Institute from 3rd party insurance are estimated to increase as a result of this bill. Community Mental Health Centers could expect additional revenue frc.. 3rd party payors also. Data is not available from this Division to calculate the potential increase in revenue. Currently, 40% of our clients have some form of insurance.

HOUSE COMMITTEE REPORT

Date referred: 5/9/87

FURTHER REFERRALS: Judiciary
Finance

DATE: 2-24-88

The Health, Education and Social Services Committee has considered CSSB 67(HESS)

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

RECOMMENDS:

[x] replace with HCS SB 67 (HESS) [✓] the same title
[ ] a new title

[ ] attached amendment(s)
- [ ] do pass
- [ ] do not pass
- [✓] no recommendation
- [ ] individual recommendations
- [ ] additional referral to the _____ Committee

ADOPTS: [ ] _____ letter of intent

ATTACHES NEW FISCAL NOTE(s):

[ ] fiscal impact
[ ] zero fiscal note
[ ] zero with analysis
[ ] same as previous fiscal note published _____
[ ] same as previous zero fiscal note published _____

SIGNING DO PASS:

H. Ellis
Vito Kozama
Mark Greenberg

SIGNING OTHER RECOMMENDATIONS:

Bill Hudson - No Rec.
Jim Dunlap No Rec
Robert Hall - No Rec.
Joyce Hawley - No Rec

Vito Kozama
co-Chairman's signature
H. Ellis