ALASKA LEGISLATURE COMMITTEE FILES, 1989-1990 8672
5643 HOUSE HEALTH, EDUCATION & SOCIAL SERVICES

47

STATE OF ALASKA
THE LEGISLATURE

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

LEGISLATIVE AFFAIRS AGENCY

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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. HESS 2-2-89

Original sponsors: Navarre and Swackhammer

IN THE HOUSE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

CS FOR HOUSE BILL NO. 89 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to eligibility for retirement under the teachers' retirement system."

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

* Section 1. AS 14.25.110(a) is amended to read:

(a) Subject to AS 14.25.167, a member is eligible for a normal retirement benefit if the member

(1) was first hired before July 1, 1975, has attained the age of 55 years, and has at least 15 years of credited service, the last five of which have been membership service;

(2) has attained the age of 55 years and has at least eight years of membership service;

(3) has attained the age of 55 years, has at least five years of membership service, and has at least three years of Alaska BIA service;

(4) has at least 25 years of credited service, the last five of which have been membership service;

(5) has at least 20 years of membership service;

(6) has at least 20 years of combined membership service and Alaska BIA service, the last five of which have been membership service; or

(7) has, for each of 20 school years,

(A) at least one-half year of membership service as a part-time teacher;

(B) one full year of membership service as a full-time

teacher; or

(C) any combination of service qualified under this paragraph [FOR EACH OF 20 SCHOOL YEARS].

HB

92

The CS would change HB 92 such that:

an insurer providing coverage
to state employees would not be required to provide the mental
or nervous condition coverage to persons drawing benefits
under a state retirement system.

Fiscal note assumed full coverage of mental [illegible]
inpatient treatment rather than 45 days
b/c limit may go against later contracts
of 45, then ↓ fiscal note.

assumed $2500 biannual limit b/c that is current
annual max. No aggregate max. Total
policy limit of $250,000 (under opt. #1)

current chem dep. limits $7,000 [illegible], 2 yrs / $14,000 [illegible]

Fiscal Notes:

If change [illegible] inpt [illegible] [illegible] ↑
will [illegible] [illegible] [illegible] [illegible] [illegible]
of ↑ cap. Then probably will [illegible] 50 [illegible]

mild ↑

5 month, b/c contract [illegible] in 2/90
∴ remainder FY 90 = 5 months.

no CS

HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES

P.O. BOX V, JUNEAU 99811
(907) 465-3759

HB 92

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HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES

P.O. BOX V, JUNEAU 99811
(907) 465-3759

M E M O R A N D U M

TO: Members of the House Health, Education and Social Services Committee

FROM: Rep. Johnny Ellis

DATE: May 2, 1989

RE: HB 92

**********.

In response to the enormous need for insurance coverage for mental and nervous conditions in the state of Alaska, I have introduced HB 92. This legislation would require an insurer providing major medical coverage within the state of Alaska to also provide each insured individual with coverage for treatment of a mental or nervous condition for 45 days per year of inpatient treatment, and a total of 50 hours per year of outpatient treatment or office visits.

The only exception to requiring coverage for mental and nervous conditions would be that employers employing fewer than 20 permanent, full-time employees for each working day during each of at least 20 calendar work weeks in the current or preceding calendar year, would only be required to provide coverage for mental or nervous conditions on an optional basis.

For this coverage, the insurer may not require a deductible or copayment that is higher than the deductible or copayment for treating another condition or illness.

STATE OF ALASKA
1989 LEGISLATIVE SESSION

Bill Version: CS HB 92 (L&C)
Publish Date:

FISCAL NOTE

REQUEST:

Revision Date:
Title: An Act relating to insurance coverage for mental/nervous conditions
Sponsor: Ellis
Requestor:

Agency Affected: Administration
BRU: Retirement and Benefits
Components: Retirement and Benefits

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	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	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

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)

This bill will not result in additional operations cost for the Division of Retirement and Benefits.
THIS BILL IS ESTIMATED TO COST ALL STATE AGENCIES $775.3 IN INCREASED PERSONAL SERVICES COSTS.
THIS BILL IS ESTIMATED TO COST SCHOOL DISTRICTS AND OTHER PARTICIPATING POLITICAL SUBDIVISIONS $89.5 IN FY 91. See pages 2 and 3 for a detailed analysis.

Prepared By: Sally Smith, Director — Phone: 465-4470
Division: Retirement and Benefits — Date: 4-12-89

Approved by Commissioner: John M. Andrews — Date: 4/14/89
Agency: Department of Administration

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

8/6K2/040308-9/2

Rev: 12/16/88

This analysis assumes a continuation of the full coverage of unlimited inpatient treatment rather than imposing the 45 days per year minimum as outlined in the bill. It also assumes the imposition of a $2500 annual maximum on outpatient treatment as a "reasonable" contract limitation. There is currently no limitation on the number of hours of outpatient treatment or office visits. This is more liberal than the minimum of 50 hours outlined in the bill. We have also assumed no additional increase in the future since the plan's experiences will dictate any changes.

The analysis consists of two separate components. There is a summary of costs at the end of the analysis. The first component addresses the direct increase to health insurance premiums for active State employees for an increased level of coverage. The second component addresses the increased costs to school districts and political subdivisions participating in the State sponsored health plan.

1. Active State Employee Program. Health insurance premiums for active State employees are estimated to increase $4.97 per month per employee, effective February 1, 1990. For purposes of this analysis we have assumed no additional increase in the future. The total FY 90 increase in costs for active State employees is estimated to be $323,100. This is calculated by multiplying the estimated number of employees each month times $4.97 times 5 months. The full year equivalent (FY 91) of this increase is $775,300.

Total full year equivalent increase for active employee health insurance	$775.3

2. Political Subdivision Active Programs. There also would be an increase to the health insurance premiums for active employees of political subdivisions and school districts that participate in the State sponsored health plan. This increase would not take effect until FY 91. The estimated FY 91 costs for these employees will increase by $89,500. This is calculated by multiplying the estimated monthly increase per employee ($4.97) times the estimated number of employees (1500) times 12 months.

Total health insurance increase for political subdivisions and school districts in FY 91	$	89.5

Increased Costs Due to Expanded
Health Insurance (Thousands)

State	$775.3*
Political Subdivisions and School Districts	89.5**

* Shown as full year equivalent
** Shown as full year equivalent.
Costs would begin in FY 91.

STATE OF ALASKA
1989 LEGISLATIVE SESSION

BILL VERSION: CSHB 92(L&C)
PUBLISH DATE: _____

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: An Act relating to insurance coverage for the treatment of a mental or nervous condition
Sponsor: Ellis
Requester: House HESS Committee

Agency Affected: Commerce & Economic Dev.
BRU: Insurance
Components: Operations

EXPENDITURES / REVENUES: (Thousands of Dollars)

OPERATING	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
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	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary.)

No fiscal impact on the division.

Prepared by: Joan Brown, Administrative Officer
Division: Insurance
Phone: 465-2597
Date: 5-1-89

Approved by Commissioner: Larry Merculieff
Agency: Department of Commerce & Economic Development
Phone: 465-2500
Date: 5-1-89

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

4018D/050189a

STATE OF ALASKA
THE LEGISLATURE

POUCH Y STATE CAPITOL
JUNEAU, ALASKA 99811
907 465 3800

LEGISLATIVE AFFAIRS AGENCY

M E M O R A N D U M March 31, 1989

SUBJECT: Insurance for mental or nervous conditions - CSHB 92( )

TO: Representative Johnny Ellis

FROM: Michael F. Ford
Legislative Counsel

The following is a sectional analysis of CSHB 92( ):

Section 1 - Requires certain insurers who offer or renew major medical coverage to provide coverage for mental or nervous conditions of the insured. Specifies the coverage required and that other contract conditions may be imposed as long as a higher deductible amount is not required. Excludes coverage provided to persons drawing benefits under a state retirement system, and coverage provided to employers with fewer than 20 permanent, full-time employees. Adds certain definitions.

Section 2 - Provides an exception to the prohibition against discrimination against a person who provides a health care service under a group disability insurance policy.

Section 3 - Provides that required coverage of mental or nervous conditions applies to medical and hospital service corporations.

Section 4 - Applicability section.

MFF:gc
WKG8/100

Alaska Statutes

Title 21. Insurance.

Chapter

plications; delivery of policies or contracts; inspection of risks; fixing of rates; investigation or adjustment of claims or losses; collection or forwarding of premiums; or transaction of matters subsequent to effectuation of the contract of insurance and arising out of it;

(12) "wet marine and transportation insurance" means

(A) insurance upon, of interest in, or relating to vessels, crafts, hulls, except vessels of 50 displacement tons or less;

(B) insurance of marine builders risks, marine war risks and contracts of marine protection and indemnity insurance;

(C) insurance of freight and disbursements pertaining to a subject of insurance coming within this paragraph; and

(D) insurance of personal property and interests in personal property, in the course of exportation from or importation into a country, or in the course of coastal or inland water transportation, including transportation by land, water or air from point of origin to final destination, in connection with any and all risks or perils of navigation, transit, or transportation, and while being repaired for and while awaiting shipment, and during any delays, transshipment, or reshipment incident to them. (§ 21 ch 117 SLA 1984)

Editor's notes. — This section is set out to correct a typographical error in the main pamphlet.

Chapter 36. Trade Practices and Frauds.

Sec. 21.36.090. Unfair discrimination. (a) A person may not make or permit unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for a contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the contract.

(b) A person may not make or permit unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for a policy or contract of disability insurance or in the benefits payable, or in any of the terms or conditions of the contract, or in any other manner whatever.

(c) A person may not make or permit arbitrary or unfair discrimination between insureds or property having like insuring or risk characteristics, in the premium or rates charged for a policy or contract of property, casualty, surety, marine, wet marine or transportation insurance, or in the dividends or other benefits payable on the insurance, or in the selection of it, or in any other of the terms and conditions of the insurance.

(d) Except to the extent necessary to comply with AS 21.42.365, 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 non-profit 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, nurse midwife, advanced nurse practitioner, naturopath, physical therapist, or occupational therapist. (§ 1 ch 120 SLA 1966; am § 5 ch 163 SLA 1976; am § 1 ch 80 SLA 1983; am § 28 ch 2 FSSLA 1987; am § 1 ch 56 SLA 1988; am § 1 ch 150 SLA 1988)

Effect of amendments. — The 1987 amendment, effective January 1, 1988, deleted "or" preceding "nurse midwife" and added "naturopath, physical therapist, or occupational therapist" at the end of subsection (d).

The first 1988 amendment inserted "advanced nurse practitioner" in the second sentence in subsection (d).

The second 1988 amendment, effective January 1, 1989, added "Except to the extent necessary to comply with AS 21.42.365" at the beginning of the first sentence in subsection (d).

While neither amendment gave effect to the other, both have been given effect in this section as set out above.

Sec. 21.36.150. Procedures as to undefined practices. (a) If the director believes that a person engaged in the insurance business is engaging in this state in an unfair method of competition or in an unfair or deceptive act or practice in the conduct of the business that is not defined as being unfair or deceptive under this chapter, the director shall hold a hearing on the matter, if the director believes it would be in the public interest to do so after giving notice of the hearing and of the charges. Upon conclusion of the hearing the director shall make a written report of the findings of fact relative to the charges and serve a copy upon the person and any intervenor at the hearing.

(b) If the report charges a violation of this chapter and if the method of competition, act or practice has not been discontinued, the director may, through the attorney general of this state, at any time after the service of the report cause an action to be instituted to enjoin and restrain the person from engaging in the method, act, or practice. In the action the court may grant a restraining order or injunction upon just terms, but the state shall not be required to give security

the insurer of the occurrence of a failure resulting in impending expiration of its certificate of authority. (§ 1 ch 120 SLA 1966; am § 27 ch 26 SLA 1985)

Effect of amendments. — The 1985 amendment substituted "set under AS 21.06.250" for "provided in AS 21.87.320" at the end of paragraph (1) of subsection (a).

Sec. 21.87.240. Annual statement. (a) Each service corporation shall annually before March 2 file with the director a statement of its financial condition as at the preceding December 31. The statement shall be in the form, and provide for the information relative to the corporation's affairs, which the director prescribes, consistent with this chapter. The statement shall be verified under oath by at least two of the corporation's principal administrative officers.

(b) At the time of filing the statement, the corporation shall pay a fee set under AS 21.06.250. (§ 1 ch 120 SLA 1966; am § 28 ch 26 SLA 1985)

Effect of amendments. — The 1985 amendment in subsection (b) substituted "set under AS 21.06.250" for "specified in AS 21.87.320" and made other minor word changes.

Sec. 21.87.320. Fee and licenses. [Repealed, § 30 ch 26 SLA 1985.]

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

(16) AS 21.89.040

(17) AS 21.89.060. (§ 1 ch 120 SLA 1966; am § 1 ch 92 SLA 1974; am § 2 ch 95 SLA 1975; am § 2 ch 84 SLA 1976; am § 24 ch 40 SLA 1981; am § 3 ch 45 SLA 1981; am § 3 ch 150 SLA 1988)

Effect of amendments. — The 1988 amendment, effective January 1, 1989, substituted "and 21.42.355" for "—21.42.365" in paragraph (15).

Chapter 88. Health Care Providers Insurance.

Article
2. Medical Indemnity Corporation of Alaska (§ 21.88.050)
3. Loan Fund (§ 21.88.210)
4. General Provisions (§ 21.88.900)

Article 2. Medical Indemnity Corporation of Alaska.

Section
50. Powers and duties of the corporation

Sec. 21.88.050. Powers and duties of the corporation. (a) The corporation shall

(1) in the form approved by the director, issue to all physicians, nurses, and hospitals who are found to be acceptable risks under standards developed under (5) of this subsection, and who pay the premiums for it, a contract or contracts indemnifying physicians, nurses, and hospitals and their employees who are health care providers against loss by reason of liability for covered claims for an act or omission in the delivery of professional health care in this state, and agreeing to tender on behalf of the physicians, nurses, and hospitals and their employees who are health care providers a defense to a covered claim in a proceeding brought under AS 09.55.530 — 09.55.560; the limits of liability for policies issued by the corporation shall be approved by the director; the contract shall cover the defense against but need not indemnify liability for punitive damages arising from a covered claim; at the option of the corporation, if approved by the director, and for an additional premium the contract may cover claims against the physician, nurse, or hospital that arise out of professional services performed by the physician, nurse, or hospital for any period before the contract is issued, except that coverage will not be provided for a claim already filed or that the physician, nurse, or hospital had or reasonably should have had notice at the time the retroactive insurance was purchased;

(2) charge a premium for the protection provided by the contracts issued by the corporation which shall be determined by the board of governors in accordance with AS 21.88.080 and subject to the approval of the director;

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le charges, please
ee number:
800-426-3211

oup Health Care &
Benefits
ared by:
ment and Benefits
CR
99811-0203
/s, Director

GROUP HEALTH CARE AND LIFE INSURANCE PLAN

INFORMATION BOOKLET

FOR STATE OF ALASKA SUPERVISORY UNIT EMPLOYEES

July 1, 1986

IMPORTANT: Travel benefits apply only to the conditions covered in this medical section. They do not apply to the audio, dental or vision sections.

Travel benefits are not payable for diagnostic purposes or second opinion diagnosis except as provided under the section entitled Second Surgical Opinion on page 6. However, to ensure that the travel benefit will be paid should covered medical treatment be rendered, always have your travel conditionally preauthorized by the carrier.

Travel claims submitted under items (b) and (c) must be preauthorized.

A "Travel Preauthorization Application" (form 400-4868) is required in all instances that do not involve a genuine life endangering emergency. You may obtain a supply of these forms from your employer.

For travel which is not of a life endangering nature, but must be made before preauthorization can be obtained by using this form, you must call the Health Carrier's travel representative, (access code) and 800-426-3211 for information and instructions.

Alcoholism/Drug Abuse Treatment Services

Your Plan will pay for treatment as an inpatient in a Hospital or in an Approved Treatment Facility. If services are received in a treatment facility that is not approved, payment will be limited to $1,000 in any Benefit Year. Outpatient Physician's Services will be paid as part of the Mental and Nervous Disorders benefit under the following section at normal plan benefits (90-100%) of eligible expenses up to a maximum of $7,000 per covered member per any two consecutive benefit years.

Mental and Nervous Disorders – Current Coverage

Services for Mental or Nervous Disorders (see definition on page 36) will be covered as follows:

- Physician's expenses will be paid at 50% of eligible expenses up to a maximum of $2,500 per covered Member per Benefit Year.
- Hospital expenses will be paid the same as those stated on page 4 under COVERED MEDICAL EXPENSES.

Temporomandibular Joint (TMJ) Dysfunction

The Plan will pay normal Plan benefits for diagnostic services and necessary treatment of TMJ dysfunctions. Necessary TMJ treatment means services or supplies that are generally recognized by the medical or dental profession as effective and appropriate treatment for TMJ dysfunction and its symptoms, and are in the guidelines of medical necessity and UCR determinations. Routine dental services covered under the Dental Plan are not covered under medical services for TMJ conditions. Dental procedures listed as not covered under the Dental Plan are excluded from benefit payment under this provision.

Questions regarding payment for specific treatment should be directed by your dentist to the health carrier.

MEDICAL EXPENSES NOT COVERED

Limitations and Exclusions

The State's Medical Plan does not cover any condition, ailment or injury for which you receive:

- benefits from your employer's liability plan or federal or state Workers' Compensation or similar law;
- benefits available under any federal or state act, even though you or your dependents waive rights to such benefits.

Services provided in the following facilities are not covered:

- an institution which is primarily a rest home, home for the aged, nursing home, skilled nursing facility, convalescent home or any facility of like character;
- convalescent or custodial services regardless of where such services are provided, or any portion of a Hospital stay which is primarily convalescent or custodial; and
- charges incurred for education, training and room and board while confined in an institution which is primarily a school or other institution for training.

Charges for or in connection with cosmetic treatment or surgery will not be paid unless:

- treatment or surgery is for injuries sustained in an accident which occurs while you or your dependents are covered and such treatment or surgery is started within 90 days of the accident; or
- treatment or surgery is for a congenital abnormality in your natural child provided the child was born to you while you were covered by the State's Medical Plan.

Cosmetic surgery which is not covered includes:

- surgery for sagging skin of the eyelids (blepharochalasis), face (meloplasty or rhytidectomy), neck or abdomen;
- breast or hip enlargement or reduction procedures; or
- reshaping of the nose (rhinoplasty).

The following services and supplies are not covered:

- hospitalization primarily for physiotherapy or diagnostic studies;
- routine physical and marital examinations;

- medical examinations or tests for diagnostic purposes unless related to a specific illness, disease or injury;
- X-ray, laboratory, pathological services and machine diagnostic tests unless related to a specific illness, injury or a definitive set of symptoms;
- treatment for obesity (excessive weight) including surgery and complications;
- services or supplies unless medically necessary for treatment of disease, illness or injury;
- marriage, sexual or family counseling; — currently not covered
- mental, neuropsychiatric and personality disorders, except as provided under "Mental and Nervous Disorders" (page 10);
- services, drugs or supplies for sex transformations, dysfunctions or inadequacies;
- charges for visual analysis, therapy or training relating to muscular imbalance of the eye; orthoptics;
- routine foot care procedures such as the trimming of nails, corns or calluses, fallen arches, other symptomatic complaints of the feet, impression casting for prosthetics and appliances including prescriptions therefor and routine hygienic care;
- charges for treatment designed primarily to provide a change in environment or a controlled environment (milieu therapy);
- charges you would not be required to pay if you did not have coverage except charges for services normally furnished, paid for or reimbursed under the Maternal/Child Health Unit and Handicapped Children's Program Section, Division of Public Health, Department of Health and Social Services of the State of Alaska;
- any services or supplies for which no charge is made or which would not have been made if this Plan were not in effect nor for services or supplies for which the Member would not be legally liable if this Plan were not in effect;
- services or procedures which are not customary and generally accepted by the medical profession and services or procedures which are experimental or for research;
- injury or other loss sustained as a result of war or an act of war, whether war is declared or not, or any international armed conflict or conflict involving armed forces of any international authority;

- eye refractions or hearing aids, or the fitting of eye glasses or hearing aids, except as provided under VISION AND OPTICAL BENEFITS on page 18 and under AUDIO BENEFITS on page 21;
- charges incurred for extraction of teeth or other dental procedures except as provided under DENTAL BENEFITS, on page 15. However, the Plan will provide Hospital care when there is an underlying medical condition that necessitates hospitalization;
- services or supplies not specifically listed as a covered benefit under this Plan;
- charges incurred with respect to a Member during or in connection with a period of Hospital confinement which commenced prior to the date the Member became covered under this Plan; or
- hospital admissions or other treatment primarily for rehabilitative care including, but not limited to, speech and occupational therapy or Hospital confinement which develops into primarily rehabilitative care.

NOTE: Charges for the services of an occupational or physical therapist may be recognized as covered expenses only if a signed Physician's statement accompanies the claim submitted to the Health Carrier which attests to the following:

- a specific treatment program relating to a specific degenerative condition or progressive disease has been prescribed by the attending Physician; the statement must outline the type of program to be administered, the frequency of treatment and the expected duration of the therapy;
- the services of the therapist will be rendered while the patient is still under the care of the attending Physician; and
- the Physician expects that the therapy will arrest the progress of the specific disease or degenerative condition.

Therapy will be reevaluated every 3 months to confirm that it is not primarily rehabilitative and that the treatment is not being provided solely at the discretion of the therapist or at the election of the patient.

INDIVIDUAL CASE MANAGEMENT

If you or your covered dependents have an illness or accident that may extend for a period of time, this plan provides for alternate means of care.

If you or your covered dependents face extended periods of care and treatment, this may be accomplished in an alternate setting, such as a skilled nursing facility, convalescent facility, or in your own home. These settings may offer cost savings to the plan along with advantages to you and your family.

Hospital Services and Supplies: Those services and supplies rendered by the Hospital which are required for treatment which do **not** include room and board, Physicians' fees or costs for special duty or private nursing care outside of an intensive care unit, services of a personal nature, such as charges for radio, television, guest trays, and the like.

Inpatient: A registered bedpatient in a Hospital for whom the Hospital makes a daily room charge.

Medical Emergency: Sudden illness or injury which requires immediate attention to prevent death or impairment of health.

Medically Necessary/Medical Necessity: Indispensable in the sense that in the reasonable opinion of this Plan, an illness, injury or condition harmful or threatening to the patient's life or health, or a direct effect of such, could not have been diagnosed or relieved without the medical service or supply in question. The mere fact that it was furnished, prescribed or approved by a Physician or other qualified provider does not in itself mean that it was medically necessary. A medical service or supply may be medically necessary in part only.

Medicare: The Health Insurance For the Aged under Title XVIII of the Social Security Act as amended by the Social Security Amendments of 1965 (Public Law 89-97), as such program is currently constituted and as it may be later amended.

Member: The Employee or eligible dependent covered under this Plan.

Mental or Nervous Disorder: A neurosis, psychoneurosis, psychopathy, psychosis, mental or emotional disease or disorder of any kind.

Benefits will not be provided for services rendered for adolescent behavioral problems, learning disabilities, marital, family, sexual, or other counseling or training services, custodial care, services rendered after a court-ordered admission or for services not medically necessary.

Other Group Plans: This includes the following sources of benefits which will be recognized for coordination of benefit purposes:

- group or blanket disability insurance or health care programs issued by insurers, health care services contractors and health maintenance organizations;
- labor-management trustee plans, labor organization plans, employer organization plans or employee benefit organization plans;
- governmental programs, including Medicare;
- coverage required or provided by any statute;
- group student coverage provided or sponsored by a school or policy which separately states whether it is or is not subject to this provision will also be determined to mean a separate "Program"; and

- will include the State of Alaska Group Health Care Plan.

Outpatient: One who receives treatment in a Hospital, but is not registered as a bed-patient of that Hospital.

Physician: A person who is licensed to practice medicine and surgery (M.D.), osteopathy and surgery (D.O.), dentistry (D.D.S. or D.M.D.), and other providers such as a licensed Psychologist or a psychiatric social worker supervised by a licensed Psychologist, Audiologist, Optometrist, Chiropractor, Podiatrist (D.P.M.), or a Christian Science Practitioner authorized by the Mother Church, First Church of Christ Scientist, in Boston, Massachusetts.

Plan: The agreement as described in this benefits contract between the State of Alaska and the Health Carrier, any endorsements not attached or later issued and the identification cards for eligible Employees indicating participation in the Plan.

Prescription Drug: Any medical substance, the label of which, under the Federal Food, Drug and Cosmetic Act, as amended, is required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription."

Professional Ambulance: A "professional ambulance" is a land or air vehicle specially equipped to transport injured or sick people to a destination capable of caring for them upon arrival. "Specially equipped" means that the vehicle has the appropriate stretcher, oxygen and other medical equipment needed for the patient's care enroute. This vehicle must have in attendance a medical technician who is trained in life saving services.

Totally Disabled: (1) the complete inability of an Employee to perform everyday duties pertaining to the Employee's occupation or employment, due to disease, illness, injury or pregnancy. (2) the complete inability of a dependent to perform the normal activities of a person of like age and sex due to disease, illness, injury or pregnancy. **The Plan reserves the right of determination of total disability based upon the report of a duly qualified Physician or Physicians chosen by the Plan.**

Usual, Customary and Reasonable: The amount normally charged for a covered medical expense. Since Physicians' charges vary due to geographic location, skill of the Physician and complexity of the service performed, the Health Carrier must determine which fees are "Usual, Customary and Reasonable." The Health Carrier takes into consideration the fee usually charged for a particular service by whomever provides the service. The fee should be similar to that charged for the same service by other Physicians in the area. If the particular service is not provided by enough Physicians in an area to determine an average cost range, the Health Carrier will decide the amount to be paid based on a

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. (BS 263)

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

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

That's 22 states in the 1970's.

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

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

---

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

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

**not counting mentally handicapped (32 states)*

AMHB Resolution 89-1

Whereas, the Alaska Mental Health Board is charged with reviewing statutes applicable to the mental health program of Alaska and with recommending appropriate changes, and,

Whereas, the Board has the duty to discourage duplication of services and promote efficient and coordinated use of federal, state, and private resources in the provision of mental health services, and,

Whereas payment for services through mental health insurance coverage is a major private resource for funding state wide comprehensive mental health services, and,

Whereas, present state law fails to provide for mental health insurance coverage in a manner treating mental illnesses and conditions equitably compared to other categories of illness or condition, and,

Whereas, persons with mental and emotional conditions can benefit from mental health services, whether or not paid for by the mental health trust, and,

Whereas, the provision of mental health services for persons with less severe conditions is in the public good, and,

Whereas, if these services are to be obtained from either the private or public sector they must be paid for, and,

Whereas, the reasonable source for funding these services is through the benefits of appropriate mental health insurance coverage, and,

Whereas, universally available mental health coverage comparable to health coverage for other conditions is in the best interest of the citizens of the state as well as essential to the provision of a comprehensive and integrated mental health program,

Now therefore be it resolved that,

The Alaska Mental Health Board supports development of legislation regarding mental health insurance coverage that:

1. mandates that all health insurance policies offered in the state include mental health coverage;

2. that the mandated coverage must be comparable to that coverage offered for other ailments in particular comparable with regard to deductibles and percentage of reasonable and allowable charges born by the policy as opposed to the beneficiary;

3. that ensures consideration of the nature, severity, typical course and prognosis of the mental illness or condition being covered and also considers the reasonable and allowable charges for the necessary and/or beneficial mental health services for such conditions;

4. that ensures mental health services can be directly compensated to service providers licensed and/or certified in the state when practicing within their area of competency;

5. that considers appropriate utilization of proceeds of the mental health lands trust for reinsurance provisions, and,

6. that recognizes the appropriate role of private health insurance in the funding of mental health services within a comprehensive and integrated mental health program for the state.

The Resolution passed unanimously.

Dated the 26th of February, 1989

_____

Thelma Langdon, Chairperson
Alaska Mental Health Board

Attest: _____

Patricia Ryan-Clasby, Secretary/Treasurer
Alaska Mental Health Board

SPECIAL MEETING
OF
THE ALASKA MENTAL HEALTH PROGRAM DIRECTORS' ASSOCIATION
February 19, 1988

RESOLUTION 4-88

CS-SB 67

Whereas, there is pending before the legislature CS-SB 67, a bill which mandates inclusion of mental health coverage in policies of insurance providing coverage for physical health,

AND

Whereas it is apparent to this Association that there is a critical need for welfare of citizens of Alaska for said coverage,

NOW therefore be it RESOLVED

That this organization supports and urges passage of said CS-SB 67.

ADOPTED: February 19, 1988

Pamela J. Delys-Baglien, Ph.D.
Chair, Alaska Mental Health Program
Directors' Association

MEMORANDUM

State of Alaska

Alaska Mental Health Board

TO: Division of Insurance

DATE: August 25, 1988

FILE NO:

TELEPHONE NO:

THRU

SUBJECT: Information Request

FROM: Dennis Scholl, Ph.D.
Executive Director, AMHB
419 6th Street, Room 124
Juneau, Alaska 99801

As specified in statute (AS 47.30.661-669) the Alaska Mental Health Board (AMHB) is to assist the state in ensuring an integrated comprehensive mental health program. Additionally, the AMHB is to "have access to information in the possession of state agencies" [AS 47.30.666.(5)].

Adequate health insurance for mental and emotional conditions is an essential element of an integrated comprehensive mental health program. Recently, the Governor vetoed SB67, legislation that would have considerably improved mental health insurance coverage in Alaska. Much of the basis for the veto apparently came from positions taken by the Division of Insurance and the Department of Administration.

The Legislative Committee of the AMHB has taken up the insurance issue as a major initiative for the coming legislative session. To deal with the issue the AMHB requests the Division of Insurance and the D.O.A. to provide all the information they have compiled regarding mental health insurance, including but not limited to:

1. Position Paper
2. Fiscal projections/impact
3. Correspondence with the health insurance carriers
4. Correspondence with other governmental units including but not limited to the legislature and the governor's office

We also as that you provide comparable information on the Alcohol Treatment coverage legislation which was enacted this year.

The AMHB looks forward to working with the Division of Insurance in developing mental health insurance coverage legislation for the coming session. Your cooperation in this project will be appreciated.

DS/RAS/ras

LETTERS

Juneau Empire July 9, 1987

Mental illness bill should've been OK'd

Editor's Note: The following letter was written to Gov. Steve Cowper and submitted for publication.

Dear Governor:

It is a big disappointment that you have vetoed the bill sponsored by Sen. Jan Faiks which would have provided equitable coverage for the mentally ill.

I believe that the rationale as provided in the news was inaccurate and misleading. These arguments were raised three years ago and the provisions outlined in this present bill were targeted to overcome those objections. None of your administrative assistants made any comments opposed to this bill in any committee.

In specific: We question the concern that the legislation would raise premium costs for state employees. The provisions for hospitalization and outpatient visits is essentially the same as in the present state employee contract because it is a "minimum coverage" type of bill. Every basic health insurance will have 45 days of inpatient and 60 outpatient days.

Secondly, it is essential that this type of coverage be a mandated rather than optional because it spreads the "base" over a larger pool primarily because most people do not ever think they will need mental health coverage yet 20 percent of our population require some coverage at some point of their life.

Thirdly, other states who have similar bills, (17 so far) have not experienced a rate increase of more than $2 per month. Montana had no increase as a result.

Fourth, small companies with 20 or less employees were exempt which answered the concern about small businesses.

Fifth, mental illness is a no-fault illness and it concerns us that coverage for substance abuse was approved and the mentally ill still get to be the last victims on the list even though this bill has been actively sought for four years. A patient who is suffering from mental illness in a hospital pays the same dollars per bed as anyone who breaks a leg but average policies only cover 50 percent. Some policies even are so bad that they have a $5,000 cap or an exclusion for mental illness.

Governor, we urge you to ask your administration to actively work on legislation to overcome the inequities of health insurance for mentally ill persons.

Sharron Lobaugh
President
Alaska Alliance
for the Mentally Ill
Juneau

Low stream levels due to logging

Dear Editor:

This letter is for your readers who watched the KTOO "Currents" program on the Tongass National Forest on June 9.

We ran out of time before I could finish my comments regarding the recent years of "record salmon harvests" and concerns over timber harvest.

Basically what needed to be brought out is this: people have a real short memory – since they seem to have forgotten last year's very low level of salmon harvest. This extremely b[illegible] catch was due to winter freeze-ou[illegible] plus die-offs of unspawned pink salmon because of lowered stream flow levels in summer months. These problems were the worst in southern S.E. Alaska (Prince of Wales Island) where the most intensive and extensive logging has occurred.

Researchers are pointing at the loss of streamside cover as the cause of reductions in pink salmon. Old growth holds these streams together. Disruption of this habitat greatly reduces nature's way of moderating the extremes of weather.

Thank you,
Bart Koehler
Executive Director
Southeast Alaska
Conservation Council
Juneau

Friendship Flight work of many Alaskans

To the Editor:

It was a thrill to hear a headline story one recent morning on the radio about the reunion of Alaskan and

MY TURN

ALPA ALASKA PSYCHOLOGICAL ASSOCIATION

FEB 12

February 3, 1988

file

Co-Chairs HESS
Representative John Ellis
Representative Niilo Koponen
P. O. Box V
Juneau, Alaska 99811

Dear Sirs:

The Alaska Psychological Association strongly supports the mandatory wording in S.B. 67. We endorse S.B. 67 as a means of increasing availability of mental health services to the consumer and thereby reducing overall medical health care utilization. This ultimately reduces costs to the insured and insurer alike. The mandatory clause ensures cost containment for the consumer and encourages utilization of the mental health services shown to reduce overall health system costs.

Please call if you have any questions or concerns or would like testimony in support of this bill.

Sincerely,

Bruce Smith Ph.D.

Bruce N. Smith, Ph.D.
Past President
Chair Legislative Committee

BNS/cs

cc: Jan Falks
Clark Gruening

3211 Providence Drive, Anchorage, Alaska, 99508 907-786-1711

Sitka Mental Health Clinic

P.O. Box 1763
Sitka, Alaska 99835
(907) 747-8994

Michael Boyd, Ph.D.
Psychologist

12-9-87

Honorable Nilo Koponen
Co-Chairman House, Health Ed. and Soc. Svcs. Comm.
Rm. 106
Capital Building
P.O. Box V
Juneau, Alaska 99811

Dear Representative Koponen:

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

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

Respectfully,

Michael J. Boyd, Ph.D.
Psychologist

MB/imr

cc: Albert P. Adams
John Sund
Albert Adams

Rep Goldwater

4/5

Johnny -

I am concerned about the provision of HB92 that pays for hospitalization. An increasing number of youths are being "institutionalized" by their parents without due process, using these kinds of insurance benefits.

Perhaps there could be a limit on the types of diagnoses that could be used for hospitalization — or maybe by way of supporting the prevention which we could include non-institutional care, while limiting hospitalization to crisis periods (5 days?).

Love time I'd like to talk - otherwise, these are my comments.

Ann S.

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

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

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

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

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

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

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

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

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

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

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

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

Research design

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

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

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

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

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

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

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

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

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

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

Comparison of the groups

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

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

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

Mental health treatment costs and utilization

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

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

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

Pre-post patterns of medical care

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

The primary research question

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

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

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

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

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

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

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

Longitudinal analysis of total health care costs

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

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

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

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

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

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

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

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

Conclusions

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

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

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

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

It is not possible to estimate exactly how much of the decline in health care utilization after initiation of treatment is due to treatment per se versus other factor such as self-selection and motiva tion, regression toward the mean and so forth. The relatively lon periods before and after initiatio of treatment used in our analyse however, provide a valuable pe spective for evaluating this issu

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

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

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

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

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

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

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

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

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

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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.

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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 that

(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.
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I certify that statements made by me above are correct and complete.
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Dispelling Myths About Mental Health Benefits

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

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

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-

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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.

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

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

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

The Uncontrollable Costs Myth

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

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

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

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

The Cost-Effectiveness Debate

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

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?

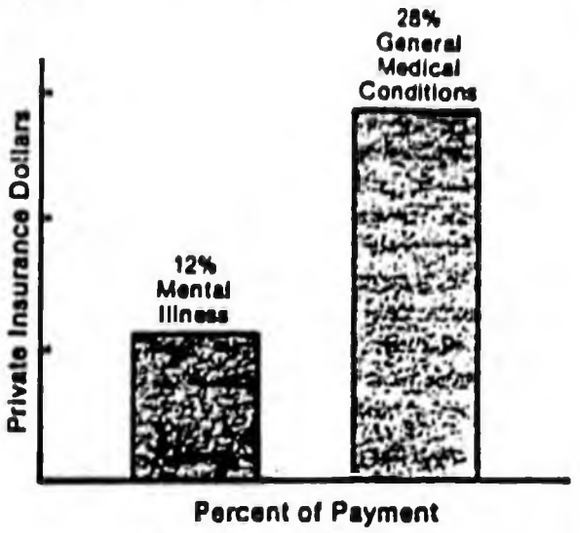
Yet some notable studies have been done which document the cost-effectiveness of psychiatric care in quantifiable terms. Among these was an extensive, three-part study reported in 1980 which found that the use of community based programs for the chronically disabled psychiatric patients greatly reduced 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 not accountable to insurance carriers. Utilization review in the form of peer review has become the cornerstone of organized psychiatry's accountability to payers and consumers. The goal of utilization review is to monitor the necessity and appropriateness of care, while peer review is intended to improve the quality of care. Psychiatric peer review is carried out by psychiatrists and it is concerned with utilization review, quality review, continuing education, advocacy with third party payers for improved care and cost control.

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

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

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

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

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

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

Business Leadership Needed

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

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

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

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

The public sector has a responsiblity 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.

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U.S.News & WORLD REPORT

APRIL 24, 1989 $1.95

WHEN MENTAL ILLNESS HITS HOME

- What we know about depression and schizophrenia
- How families cope with their ordeal

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WHEN MENTAL ILLNESS HITS HOME

Sometimes after months of silence the telephone would ring in the darkness, startling Mary Alexander from sleep. "Do you have a daughter . . . ?" The voice blandly official, the caller in some other town or state, in Minneapolis this time, or Pittsburgh, "Mrs. Alexander, do you have a daughter . . . ?" She would close her eyes, waiting for the next words, bracing for them. "Mrs. Alexander, do you have a daughter who is living on the golf course and disturbing neighbors?" Who is walking down the street in mid-December with no clothes on. . . . Who tried to throw herself in front of a bus. . . . "Mrs. Alexander, we have your daughter here in the hospital. . . ."

In her mind are images of Janet years ago, building a fort with her three younger sisters, her blond hair in long straight locks. Janet on the chairlift with her father in Aspen, or reading, curled in the window seat of the big New England farmhouse, white chenille bedspreads, a framed picture of blue mountains and open fields. "I swear to God, I would rather my child had cancer than this agony of a disease. . . ."

"Deinstitutionalization has failed." It is the mental-health mantra of the '80s, a popular slogan, borrowed by politicians and pundits. On our streets, severely disturbed people are among the homeless, living without treatment or community resources, eating out of garbage cans, filing through revolving doors to hospitals and jail cells. Yet those who are homeless are only the most visible subplot of a larger story. In fact, 60 percent of the 2 million Americans with disabling mental illness live with their families at least part of the time, and hundreds of thousands more reside in nursing homes and privately run "board and cares." In quiet subur-

STUDIO PHOTOGRAPHY BY LINDA L. CREIGHTON
SNAPSHOTS COURTESY OF THE ALEXANDER FAMILY

ban neighborhoods and in Park Avenue apartments, parents take out second mortgages to pay for the care of mentally ill sons and daughters. Husbands, aunts, brothers offer prayers for a cure. Over the years, families shepherd those they love through a torturous labyrinth of mental-health services, often to no obvious benefit.

"More money" is the familiar cry of those who work within an overburdened system. But it is not just a problem of money. "There is a kind of Russian distribution system, where the food never reaches the shelves. It rots in the countryside," says Dr. John Talbott, chairman of psychiatry at the University of Maryland, who has long pondered these problems. There is a constant shortage of hospital beds, but no long-term plan for building the community services that could keep patients out of hospitals to begin with. There are outpatient clinics, but no one to make sure patients arrive there to be treated. There are model programs, but they reach only a fraction of those who are in need. There is a two-tiered network of care, public and private, rich and poor. But even wealth does not ensure good treatment.

In this fragmented and sublimely ineffective system, cities, states and the federal government play "chicken" to see which will shoulder the financial burden of the mentally ill. Mental-health workers squabble over priorities and semantics. Everyone is affected by the deeply cynical decision society seems to have made collectively, if unconsciously: We will do nothing.

In the face of this national tragedy, it is the families of the mentally disturbed who are finally forcing change. A coalition of families, the National Alliance for the Mentally Ill, almost singlehandedly persuaded the National Institute of Mental Health to shift its $345 million research program away from more sociological studies, toward research on the cause and treatment of schizophrenia and other serious disorders. In Chicago, St. Louis and New Orleans, when parents found rehabilitation centers or housing projects for the mentally ill nonexistent, they went out and created them. In Massachusetts, a state that has inspired its share of mental-hospital exposés, the Department of Mental Health two years ago decided to bring both families and former patients into the equation: In a unique collaborative arrangement, citizen monitors conduct unannounced inspections of all public psychiatric institutions. The involvement of families, says Dr. Herbert Pardes, president-elect of the American Psychiatric Association and a former NIMH director, "is one of the most important things to happen in the history of mental health."

Families, and patients themselves, want to change more than just programs and services; they are struggling to eliminate the entrenched stereotypes and age-old misconceptions still governing society's attitudes toward mental illness. It was not that long ago that insanity was a family secret, that a schizophrenic aunt or daughter was chained in the attic. And still, today, a qualified engineer is denied a job because three years ago he was treated for depression, a psychiatrist is disqualified as an expert witness because while in training she received psychotherapy, and a presidential candidate must act quickly to squelch rumors that he might have sought counseling after his brother's death.

The myths have to be debunked through constant repetition: Schizophrenia is not the same as "split personality"; mental illness is not the result of weak character or moral failure; most mental patients are not violent; serious mental disorders are not "hopeless," and patients can get better, with the right treatment.

"Progress is more often illusion than reality," says Dr. John Nemiah, editor of the *American Journal of Psychiatry*, writing about society's management of chronic mental illness. "We are perhaps no further along than we were 200 years ago—indeed, we may have been traveling in circles."

Everyone likes Janet. Graceful, smoothly drawn figures appear under the expert control of her pen. Of the sisters, she is the superior athlete, a proficient skier, dexterous with a hockey stick. She laughs easily, glides effortlessly through her seventh-grade classes at a private school in a Boston suburb.

Janet and her sister, Nancy, 2½ years her younger, are best friends. They have nicknames for each other, "Fink 1" and "Fink 2"; they choose adjacent bedrooms so they can tap secret signals across the wall. "She was so pretty. I wanted to look like her, to be like her," Nancy says. Yet, there were twinges of unhappiness, early warnings. Janet won't come down to dinner. Her weight drops until her 5-foot-7-inch frame registers on the scale at 95 pounds.

And then it is the late 1960s, a time of uncertainty between parents and their teenage children, and Janet, 15, lets the hair grow on her legs, sloughs through the day in khakis with fraying knee holes, refuses to wash her hair. "But then, so did other kids," says her mother. "We knew parents with kids into the drug scene, and Janet wasn't. We thought this all would pass."

An adolescent specialist is consulted, a prominent doctor known for his gifted touch with "troubled" adolescents. No need to worry, he tells them.

In 1972, Janet changes schools for the third time—boarding schools are not for her—and lives at home. She becomes a born-again Christian, and at night her parents hear her, lying on her bedroom floor, crying and screaming, "I'm damned to hell, and my family is damned to hell." Janet slams Nancy against the wall. "Sinner!" She tells them, "You're not my family." No, she does not want to go to the Rhode Island School of Design, ignoring the letter that offers her an interview for the freshman class. It is almost a relief when Janet leaves home, moving in with a cult leader in downtown Boston, collecting donations on the street and eating from open carts in the North End.

A chilly fall evening, and Mary and Jack Alexander sit in the car outside a counseling center where Janet, now 19, has asked to meet them. It is getting dark, and there is no sign of her. Looking in the rearview mirror, Mary Alexander sees her daughter running toward the car, expression wild, blond hair tangled. Now, Janet is shouting, hitting her father on the shoulder. It is 11:30 at night, and they are in the emergency room at Deaconess. She is punching the walls, running in circles. "Can't you do something?" her mother pleads. On the psychiatric ward, Janet prays with the other patients. It is her first hospitalization.

Mental illness has always baffled and disturbed. Anyone who has seen up close the disintegration of a mind by schizophrenia, the laceration of consciousness, the shredding of thought that is paired with deep apathy and withdrawal, must wonder how such a thing occurs. No less puzzling are the violently distorted moods of manic-depression, highs that send the sufferer into an unstoppable frenzy of words and wild ideas, lows that plunge him into such a state of despair that "one's only wish is for silence and solitude and the oblivion of sleep," as composer Hector Berlioz described it. "For anyone possessed by this," wrote Berlioz, who during his youth fell victim to crippling emotional swings, "nothing has mean-

ing, the destruction of a world would hardly move him."

The musician's eloquence conveys the texture of psychic torment but not its prevalence. At any moment, 25 percent of hospital beds in the U.S. are filled by mental patients, more than the total for cancer, heart disease and respiratory illness patients combined. Insanity appears to have been common in past centuries as well; it is only society's response to it that has changed.

The Puritans believed "distraction," as they called it, was possession by the Devil, or else punishment for sins. Yet the strange behavior of those afflicted was looked upon with tolerance. The Puritans were certain of the moral order and could view departure from the rational without themselves becoming unsettled by it.

Through much of the 1700s, family or friends were expected to take care of the mentally ill. Thus James Otis, Jr., a prominent politician in prerevolutionary Massachusetts, was remanded to his father's house or taken to the country by colleagues when he periodically went mad, once smashing all the windows in Boston's town hall. When no family was present, community leaders took over,

EXPLAINING THE INEXPLICABLE

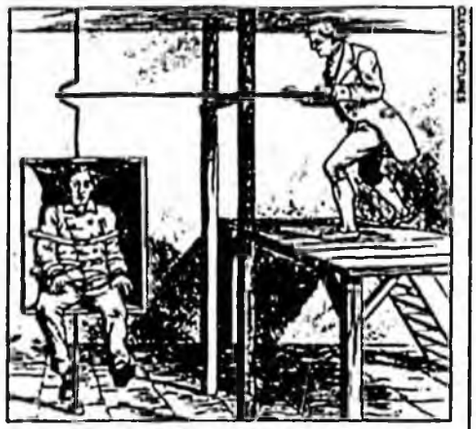
Scientists are finding that a genetic predisposition may be triggered by stress

Over the centuries, everything from "an excess of passions" to the malevolent influence of the moon has been proposed as a scientific explanation for mental illness. But modern psychiatry, trading on technological advances in neuroscience and molecular genetics, is beginning to confirm what many suspected. The extreme changes in perception, behavior and mood that occur in serious mental disorders are, at least in part, biological.

Psychiatrists have always recognized that schizophrenia and manic-depression differ markedly from less severe complaints. Unlike "the blues," or mild anxiety, these illnesses can make it impossible for those afflicted to hold jobs or negotiate daily routines. While the emotional swings of manic-depression begin in adulthood, schizophrenia most often develops in adolescence or early adulthood. Many experts believe it will prove to be a family of illnesses rather than a single disorder, but there are common characteristics: Thought patterns become peculiar and convoluted. Hallucinations and delusions often mix with withdrawal and apathy.

Early evidence that changes in brain chemistry might be involved in schizophrenia and manic-depression came from the development of drugs to treat them. Researchers discovered that antipsychotic drugs, which help about 60 percent of schizophrenics, change the levels of a substance called dopamine, one of many chemicals that transmit nerve impulses in the brain. Antidepressants and drugs like lithium carbonate, used to treat mania, alter the balance of other neurotransmitters and bring relief to the vast majority of sufferers. But though scientists reason that these chemicals are involved in mental illnesses, their role is still unproved.

Window to the brain. The case for brain irregularities has been strengthened with the development of imaging devices that can take readings of brain structure and function. In schizophrenic patients, brain



Early science. *"No well-regulated institution should be unprovided with the circulating swing," says an 1818 text*

scans indicate that the frontal lobe—intimately tied up with high-order abilities such as future planning—shows lower-than-normal levels of blood flow during the performance of a simple cognitive task. Other studies have found that some schizophrenics have enlarged brain ventricles—the fluid-filled spaces within the brain—indicating that brain tissue has shrunk or developed abnormally.

At the same time, psychiatrists are building evidence for heredity's contribution to mental illness. Researchers have known for years that schizophrenia and manic-depressive illness tend to run in families. But only recently have they been able to start tracking down the specific gene or genes that may predispose someone to fall ill. Last fall, an international team of scientists reported finding an abnormality on chromosome 5 in 39 schizophrenic members of five families. An earlier, 11-year study of a Pennsylvania Amish family with a history of manic-depression found that afflicted individuals shared an abnormal gene on another chromosome, No. 11.

Yet this work is only the barest blush of a beginning. No one so far has succeeded in replicating the studies. And because all mental illnesses involve complex human behaviors, most experts believe genetic predisposition will not turn out to be as simple as a single abnormal gene.

The nature of nurture. Even without the specifics of inheritance, however, scientists have been able to estimate an individual's risk of developing severe mental illness. In schizophrenia, for example, a child with one schizophrenic parent runs an 8-to-18-percent likelihood of being afflicted. If both parents are schizophrenic, that figure jumps to between 15 and 50 percent. But unlike diseases such as Down syndrome, mental disorders are only in part genetic, as studies of identical twins have shown. Even when one twin is schizophrenic, the other has only a 50-to-60-percent chance of developing the disease.

However strong the influence of heredity, researchers believe that severe mental illness has a substantial nurture component as well. "The question is not nature vs. nurture, but the nature of nurture," says Dr. Jack Grebb, of New York University Medical Center. One theory suggests schizophrenia may result from prenatal events—infection by a virus, perhaps—that affect a fetus genetically susceptible to the illness. Another theory proposes stress as the triggering factor. There is some evidence that a high degree of emotional tumult in a family, good or bad, may make schizophrenic patients more prone to relapse. "But this doesn't suggest that the families of schizophrenics are any different from other families," says Dr. William Carpenter, director of the Maryland Psychiatric Institute. "It suggests that within family life there are things that patients may have a hard time dealing with." In a field filled with many more questions than answers, the fact that bad parenting is not likely to cause schizophrenia may be the one thing scientists are increasingly sure of. ■

sometimes "auctioning out" the person to a foster family.

By the 19th century, this early version of a community mental-health system was breaking down. "What worked in small villages didn't work with urbanization," says Gerald Grob, professor of history at Rutgers University. Immigrants poured into American cities, and persons suffering from schizophrenia or other mental disorders wandered the streets or were sent to almshouses or jail cells. Dorothea Dix, the crusading schoolteacher who took up the cause of the mentally ill in the mid-1800s, found disturbed individuals living in sordid conditions, "confined in cages, closets, cellars, stalls, pens: Chained, naked, beaten with rods and lashed into obedience."

Humane treatment in mental hospitals, Dix felt, was the solution, and by the time of her death in 1887 every state had at least one public mental hospital. There, doctors practiced a treatment called "moral therapy," because insanity was, they believed, caused by a childhood spent in an improper environment. The hospitals were proud of their "cures" for mental illness, often discharging patients within a year. They kept meticulous—if peculiar—statistics. From the 1843 annual report of Utica State Asylum:

"Total weight on admission of 276 patients	34,856 lb.
Total weight of those discharged and remaining, December 1st	35,825 lb.
Increase in weight of all received	1,029 lb."

Towns and cities initially paid for the care of their residents at the state hospital. But by the 1890s, in an effort to discourage communities from cutting costs by keeping the afflicted in local almshouses, mental patients were declared wards of the state. So began the warehousing that in this century was the function of state hospitals. Seizing the opportunity to shift the economic burden onto the state, local officials began to redefine senility as "psychiatric illness," sending thousands of elderly men and women, demented and physically fragile, to state institutions. Between 1900 and World War II, more than half of patients admitted to state hospitals were over 65 years of age.

From there, the story is all too familiar. There were exposés, *The Snake Pit*, *The Shame of the States*. New studies showed that patients could be treated effectively, humanely and less expensively, in the community, and the serendipitous development of antipsychotic drugs in the 1950s made this a viable alternative. Then, in the 1960s, the Great Society initiated a wholesale policy of deinstitutionalization. State hospitals emptied their wards, from 558,000 patients in 1955 to fewer than 130,000, mostly short-term patients, today. At the same time, the Community Mental Health Centers Act of 1963 called for the opening of 2,000 community treatment centers around the nation, and the federal government poured millions of mental-health dollars into counties and cities. But the dream was never realized. Fewer than half the projected centers actually came into being. The bulk of federal funds was spent on mental-health "prevention," on therapy for divorced mothers and low-income families, not on care for the chronically ill.

For Janet, there are more hospitals, the best private hospitals, with gardens and thick-pile carpeting and tasteful paintings on the wall. When the insurance runs out, there are others: City hospitals, where she is pinned on a gurney in leather four-point restraints; state hospitals, where patients stare in smoke-filled dayrooms, and disheveled men, lost in their own version of hallucinatory hell, grab onto her arm. In her chart, they give names to her suffering, calling it "schizophrenia," "atypical psychosis" or a catch-all, "schizoaffective disorder."

"Janet must be home to get well," a doctor tells her parents. "Above all, don't take her home," cautions another.

She cannot remember the names of all the drugs. Haldol and Mellaril, Stelazine and lithium. They are prescribed alone and in combination. They make her muscles stiff, her hands tremble. For 60, maybe 70 percent, they can calm, alter, palliate. But they don't help Janet.

Sometimes, she escapes from the hospital and disappears for months. Sometimes, she is discharged, the doctors telling her parents, "There's nothing more we can do." One night, Janet is picked up hitchhiking on the Massachusetts Turnpike, snow whirling around her feet. Once, she is arrested for shoplifting. In between, there are months in halfway houses or at home, periods when suddenly there is a glimpse of the old Janet, and then it fades. "I didn't feel comfortable bringing friends home unless they knew Janet before she was ill," says Nancy. "I didn't bring a guy around without thoroughly prepping him. To me, it was a death. The person whom I knew and who was so much like me in so many ways had died, and I didn't know this person who was living in the house any more."

Toward the end of his life, the painter Vincent van Gogh wrote to his brother, Theodore, "What consoles me is that I am beginning to consider madness as an illness like any other, and I accept it as such." Were there a credo for the family movement, it might well be van Gogh's words. "The evidence that serious mental illnesses are diseases is now overwhelming," says Dr. E. Fuller Torrey, a psychiatrist whose sister is schizophrenic and who recently published *Nowhere to Go: The Tragic Odyssey of the Homeless Mentally Ill.* "Why should we treat them any differently than Parkinson's or Alzheimer's or multiple sclerosis?"

But old attitudes die hard. With the rise of psychoanalysis in the United States in the mid-20th century came a view of mental illness that held mothers and fathers responsible. Freud himself doubted that schizophrenia and other psychotic disorders could be ameliorated through his "talking cure." But he talked of conflicts and drives and the role of early-childhood experiences, and others picked up the theme, adding the term "schizophrenogenic mother."

The family movement prefers to call mental illnesses "brain diseases" and speaks of Freud with disdain. It is more than a quibble over words. The notion that the patient or his family is somehow to blame has persisted in the public mind, affecting in a very real way the fate of those afflicted. Most private insurers require larger co-payments and set lower reimbursement ceilings for psychiatric disorders. To many families, this seems just another bitter legacy of an emphasis on mental "health" instead of mental illness, a focus that blurred distinctions between the "worried well" and the "walking wounded." And some argue that the former—those suffering from life dissatisfaction or other mild ills—should pay more for counseling out of pocket. The latter, those with more-serious disorders that require extended hospitalization or drug therapy, ought to be fully covered.

Deinstitutionalization has created other agonizing dilemmas, among them those of people who are desperately ill but don't want treatment. Family advocates are attempting to reshape policy here as well. The problem was dramatized last year in the courtroom battle of Joyce Brown, a k a Billie Boggs. Living on the streets of Manhattan, Brown was hospitalized against her will as part of an attempt by New York Mayor Ed Koch to widen the scope of his state's commitment law. When a trial judge concluded that Brown—who shouted at passers-by, ripped dollar bills into shreds and used the sidewalk as a commode—was sane, it triggered a storm of editorials. "We

have condemned the homeless mentally ill to die with their rights on," protested columnist Charles Krauthammer.

Many families now are pressing for lawmakers to make it easier to force very ill patients into treatment, even if they do not pose a danger to themselves or others. As it now stands, lawyers, not doctors, decide when someone should be hospitalized, families say. In some urban areas, a patient must literally be slashing his wrists or brandishing a weapon before he can be held in a hospital. At least 15 states have rewritten their commitment laws to reflect this view. Yet civil libertarians and most former patients deeply oppose such legal reforms. A person who has committed no crime and who is not dangerous should not be incarcerated against his will, they say. At least one study suggests that changing laws only makes things worse, that it leads to even greater overcrowding in crisis clinics and amplifies the already dire shortage of hospital beds.

These are signs of a deeply ailing system, one that no simple wave of a legislator's pen will heal. "No matter where you look, something is broken and needs to be fixed," says Laurie Flynn, NAMI's executive director. Of the $17 billion plus

PATIENTS FOR SALE: SUPPLY IS UP, DEMAND DOWN

In overcrowded psychiatric emergency rooms, healers become auctioneers

In a strained mental-health system, beds are scarce and indigent patients unpopular, a reality captured by the title of a recent journal article: "The Hospitalizable Patient as Commodity: Selling in a Bear Market." Inner-city psychiatric emergency rooms from New York to San Francisco are battlegrounds in a war between the private and public sectors as workers struggle to secure beds for their patients. These crisis clinics are a microcosm of the larger system, a showcase for forces that crush idealism and make good care all but impossible.

Police bring in a flood of patients, the psychic casualties of downtown streets and welfare hotels. Overwhelmed emergency rooms try to stem the tide. Public hospitals must treat anyone who comes in, so their emergency rooms devise subtle ways to discourage customers. In one Manhattan crisis clinic, administrators require police to stay until a disposition is reached for any patient they bring in. The process can take hours.

Psychiatric emergency rooms are supposed to provide brief treatment and, if necessary, find patients beds in hospitals or halfway houses. But this task is more difficult to do for some patients than for others, forcing even the most dedicated care provider into the role of salesman. Emergency-room workers must coax and cajole, cutting through the skepticism of an admissions nurse at the other end of a telephone line. Private hospitals and nursing homes are picky about whom they will take. State hospitals often have quotas for how many patients they accept from a given city or county.

Creative excuses. For hospitals on the receiving end, the cardinal rule is to find an excuse for keeping out undesirable patients. "We only admit medicaid patients one day a week" was one creative explanation given doctors at a Bronx emergency room by a hospital that would not take a 16-year-old suicidal patient. It took 13 days and negotiations with 10 hospitals before the girl was finally placed in a locked psychiatric ward.

Nowhere to go. *Patients at San Francisco General's crisis clinic sleep in the "day room," while the staff tries to find a psychiatric ward that will admit them.*

The sellers have their techniques, too. "If you make a patient sound too bad, hospitals won't take him," says Joe Larson, a psychiatric nurse at San Francisco General Hospital's psychiatric emergency room. "If he doesn't sound bad enough, they're afraid his medicaid will be cut off and they'll be stuck with the bill."

The hardest patients to sell are the repeaters with bad reputations, the fire setters and those who are potentially violent. Drug abuse is a negative selling point. So is no health insurance, AIDS, incontinence or a need for long-term care or constant observation.

More often than not, the emergency-room workers fail, and their unfortunate charges spend as long as a week sleeping on foldout armchairs, watching television and pacing in cramped quarters beneath blue-white fluorescent lights. In Northern California, four psychiatric emergency rooms were recently issued citations by state officials for keeping patients longer than the mandated 24-hour limit. But they have no choice. If a patient is dangerous to himself or others, the hospital cannot let him go.

Ultimately, difficult patients often end their emergency-room stay by being sent to the overcrowded wards of the same city hospitals—dumping grounds for the poor and the uninsured, for patients no one else will take. "We enter the field with the best of intentions, to comfort, aid and assist," writes Stephen Goldfinger, M.D., of Harvard University Medical School. "And yet how easy it becomes to lose these lofty motivations when confronted with the daily realities.... We are all—patients, planners and practitioners—diminished by this process." ■

spent annually in the U.S. on mental-health care, more must be funneled toward those who most need it, in the form of coordinated community services, networks of halfway and three-quarterway houses, crisis centers, outreach teams, housing, job training programs.

Innovative programs, programs that *work*, already exist in small pockets across the country, in Madison, Wis., in Tucson, Ariz., in Toledo, Ohio. The Robert Wood Johnson Foundation has awarded a total of $29 million to nine cities to redesign their mental-health systems. Even in New York City, where thousands are homeless or on the brink of homelessness and the bleak interior of the Bellevue Hospital crisis clinic is almost always crowded, there are islands of sanity. The solution is not, as Koch recently concluded, to take patients out of hospitals and place them in homeless shelters, even if the shelters offer mental-health services. Rather, there are places where mental patients live with dignity: The St. Francis residences, a program run by three Franciscan friars; Fountain House, where 4,000 mentally disabled club members learn skills and function as capable members of a community, many living on their own in subsidized apartments.

The reign of the state hospitals ended in a flurry of exposés, accounts of patients chained to beds, lying in their own feces. A return to warehousing mental patients in large state institutions is not the answer. "It's not economically, legally, morally, ethically or clinically feasible," says Steven Schnee, superintendent of San Antonio State Hospital. "It's not necessary. It's not appropriate. Mentally ill people deserve the opportunity to make a contribution."

Until there is a cure for schizophrenia, there will be a need for long-term care for the small group of patients who cannot function even with medication, or who are continuously violent or suicidal. "Some patients require intensive treatment," says Leona Bachrach, of the University of Maryland. "It can be done in the community. We know that because in a few places it has been done. But there is a lag between knowing and doing it, and into this gap many disabled people fall." In the meantime, state hospitals, most of which are themselves overcrowded, try to fill this role.

Yet the most basic obstacle to treating mental illness is neither lack of knowledge nor lack of money. It is a question of values. The values of a psychiatric profession that rewards private practice and economically penalizes those who choose to work with the severely ill in the public sector; a society that takes cancer and heart disease seriously but largely ignores mental illness; the values of citizens who don't want halfway houses in *their* neighborhoods and often forget that the homeless man they see on the television screen is also someone's son, someone's brother.

The last year. *"Janet had so much power over our family," says her sister, Darsie. "Even now, I still feel that power"*

Janet Alexander's diary, Nov. 26, 1977: "Janet just simmer down. Stop thinking nonsense. Your imagination does not run the world. It does not run the planet. Especially the Hemisphere. Your radio is not a man. Your coat is not gold.... Please please, I know dear, it's hard to contain, but keep as best to yourself. I hope the snow doesn't stop, that it continues snowing forever so we'll all die.... Remember, long walks are still the best way. Long walks are still the best way."

There was, in the last years, a period of peace. Janet lived in a halfway house in Pittsfield, 2½ hours from the Alexander home. Occasionally, she broke the rules, smoking cigarettes or causing scenes, but the staff cared about her, and perhaps she felt that. She was lonely. She sat in the upstairs window and waved at people who walked by. Once, a young woman wheeling a baby carriage asked her over for a cup of tea. "You would have thought she was invited to Buckingham Palace," says her mother.

It is an early spring weekend in 1985, and Janet is visiting her parents. Nancy takes the old gray Honda Accord, and the two of them drive on back roads, past the farm where a black lamb is toddling toward its mother and the white geese settle noisily by the pond. "I don't have a future," Janet says. "You are going on with your life. I am going nowhere."

Aug. 25, 1986: Mary Alexander and her youngest daughter, Darsie, are in New York, staying with Jack's parents, when the call comes. They have spent the day at the Museum of Modern Art, a mother-daughter trip planned for ages. Late in the afternoon, they return to the apartment. Mary's father-in-law is in the doorway between living room and vestibule. "I have something painful to tell you," he says. "Janet has died." The letters are in the mailbox when they get home. To her parents: "Dear Mom and Dad, I love you very much. Janet." To her mother: "Mom, I'm sorry. Janet." The autopsy reveals that Janet Alexander drank several bottles of nail-polish remover and that her injuries are consistent with a jump or fall from a second-story window.

A few days later, Nancy has a dream. Her sister is coming toward her, her face altered by her illness, the way it was in the last months. "I'm O.K. now," Janet says. "You don't have to worry any more." ■

by Erica E. Goode

STATE OF ALASKA
THE LEGISLATURE

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

LEGISLATIVE AFFAIRS AGENCY

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Mary Van Nimwegen

H. Labor & Commerce 4-6-89

H. Labor & Commerce 4-11-89

H. FIN 5-2-89

HB

95

STATE OF ALASKA
THE LEGISLATURE

POUCH V · STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

LEGISLATIVE AFFAIRS AGENCY

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Mary Van Nimwegen

H. HESS 1-31-89

STATE OF ALASKA
1989 LEGISLATIVE SESSION

BILL VERSION: HB 95
PUBLISH DATE: HOUSE 1/20/89

FISCAL NOTE

REQUEST:

Revision Date:
Title: An Act extending the termination of the Board of Pharmacy;...
Sponsor: Rules Committee
Requestor: Governor

Agency Affected: Commerce & Economic Dev.
BRU: Occupational Licensing
Components: Licensing Boards

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL						
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	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)

Funding for the Board of Pharmacy is included in the department's FY 90 operating budget request.

Prepared by: Jennifer Strickler, Admin. Officer
Division: Occupational Licensing
Phone: 465-2144
Date: 11-2-88

Approved by Commissioner: Larry Merculieff
Agency: Commerce and Economic Development
Date: 11/3/88

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

STEVE COWPER
GOVERNOR

HB95
.76
.17

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

January 19, 1989

The Honorable Sam Cotten
Speaker of the House
Alaska State Legislature
P.O. Box V
Juneau, AK 99811

Dear Representative Cotten:

Under the authority of art. III, sec. 18, of the Alaska Constitution, I am transmitting three bills, to extend the Board of Pharmacy, the Board of Veterinary Examiners, and the State Physical Therapy and Occupational Therapy Board, respectively, for the standard four years. These boards are currently scheduled to "sunset" on June 30, 1989.

The boards provide valuable services and should be continued. I urge your prompt and favorable action on all three bills.

Sincerely,

Steve Cowper
Governor

Department of Commerce & Economic Development / POSITION PAPER

HB 95: An Act extending the termination of the Board of Pharmacy and providing for an effective date.

The bill proposes to extend the termination date of the Board of Pharmacy to June 30, 1993. To date, the board has issued licenses to 418 practitioners. The board continues to operate in the best interest of the public by granting licensure only to competent, qualified individuals.

The department supports continuation of the Board of Pharmacy and feels that the board is necessary to protect the health, safety and welfare of the public.

S. Merculieff

Larry Merculieff, Commissioner

Date: 2-6-89

LW/dgl3198D-3
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A FOLLOW-UP REVIEW ON THE DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT BOARD OF PHARMACY

July 1, 1985 - June 30, 1988

Audit Control Number

08-1341-89-R

Commissioner, Department of Commerce and Economic Development	Larry Merculieff
Deputy Commissioner, Department of Commerce and Economic Development	Vacant

Members of the Board of Pharmacy

Chair	William P. Larson
Secretary	Margaret D. Soden
Member	Emil L. Cekada
Member	Christy C. Nielsen
Member	Gerald W. Race
Member	Claire Strand

STATE OF ALASKA

THE LEGISLATURE

BUDGET AND AUDIT COMMITTEE

AUDIT DIVISION
P.O. BOX W
JUNEAU, ALASKA 99811-3300

November 30, 1988

Members of the Legislative Budget
and Audit Committee:

According to the provisions of Titles 24 and 44 of the Alaska Statutes, the Division of Legislative Audit is required to conduct a "sunset" review of the Board of Pharmacy.

At the request of the Chairman, during Fiscal Year 1988 budget deliberations, the Audit Division's budget was revised to reflect certain changes in the organization of the Committee's two Divisions. The revised budget of the Audit Division reflected efficiencies that might be obtained by utilizing the staff of the Legislative Finance Division on selected audit assignments during the interim.

As a result, the audit of the Board of Pharmacy was conducted and this report has been prepared by the Legislative Finance Division. We feel this report discharges our responsibility under Titles 24 and 44. The report is submitted for your review.

Randy S. Welker, CPA
Legislative Auditor
Division of Legislative Audit

STATE OF ALASKA

THE LEGISLATURE

BUDGET AND AUDIT COMMITTEE

FINANCE DIVISION
P.O. BOX WF
JUNEAU, ALASKA 99811
PHONE: (907) 465-3795

November 30, 1988

Members of the
Legislative Budget and Audit Committee:

In accordance with the provisions of Title 24 and 44 of the Alaska Statutes (sunset legislation), the attached report is submitted for your review.

A PERFORMANCE REPORT
ON THE BOARD OF
BOARD OF PHARMACY

July 1, 1985 - June 30, 1988

Audit Control Number

08-1341-89-R

Mike Greany, Director
Legislative Finance Division

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PURPOSE AND SCOPE OF THE REPORT

PURPOSE

In accordance with the intent of Titles 24 and 44 of the Alaska Statutes (sunset legislation), we have examined the activities of the Board of Pharmacy for the past three fiscal years to determine if the Board has been operating in an efficient and effective manner.

Legislative intent requires consideration of this report during legislative oversight hearings to determine whether the Board of Pharmacy should be reestablished. The law now specifies that the Board will terminate June 30, 1989, and has one year from that date to conclude its affairs.

SCOPE

The major areas of our examination were the licensing, examination, administration, complaint, and affirmative action functions of the Board. We reviewed and evaluated the following:

1. Applicable statutes and regulations.
2. Tests of files and documents of licensee.
3. Interviews with the license examiner.
4. Complaints filed with the Division of Occupational Licensing, Human Rights Commission, Equal Employment Opportunity Offices, Attorney General's Office, and the Ombudsman's Office.
5. Discussions with Board members.
6. Minutes of Board meetings and Division correspondence files.
7. Attorney General's opinions applicable to the professional Board.

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ORGANIZATION AND FUNCTION

The Board of Pharmacy is a regulatory Board with seven members; two public members having no direct financial interest in the health care industry and five professional members with three years practical experience and licensed in Alaska. Whenever possible, each judicial district should be represented by a Board member.

The Board regulates five types of licenses: pharmacists, retail pharmacies, wholesale pharmacies, hospital pharmacies, and drug rooms. The Board sets the minimum standards to practice in Alaska by:

1. Examining and issuing licenses to qualified applicants.

2. Establishing, amending, or eliminating regulations controlling pharmacy practices.

3. Revoking, annulling, or suspending licenses in accordance with the Administrative Procedures Act when a person has violated pharmacy statutes or regulations.

Applicants for registration as a pharmacist are required to pass the National Association of the Boards of Pharmacy Licensing Examination and a jurisprudence exam covering Alaska pharmacy law and the Federal Controlled Substance Act.

Pharmacists licensed to practice in another state who apply for licensure in Alaska can be licensed by credentials, except for those applicants from California or Louisiana. These two states require applicants to pass a state exam, not the national exam. Consequently, these applicants must take the national exam when applying in Alaska.

The Board may also issue temporary or emergency permits. Temporary permits allow qualified applicants to practice until the Board can formally license them; emergency permits allow pharmacists licensed in another state to practice in Alaska in an emergency. Both permits are limited in their duration and application.

(Intentionally left blank)

REPORT CONCLUSION

POLICY ISSUES

This review contains policy and/or procedural issues raised as a result of our evaluation of various Board practices. The final decisions affecting the practices are not within the scope of this report, but required legislative consideration. In debating these issues, the oversight committees should take into consideration the findings and recommendations presented in this report so that the potential impact on changes can be evaluated.

REPORT CONCLUSION

In our opinion, the Board of Pharmacy should be reestablished. The regulation and licensing of qualified professionals is necessary to protect the public's health, safety, and welfare. The Board provides this service by establishing minimum educational and experience requirements that provide reasonable assurance that persons licensed are qualified. Assurance that licensed professionals act in a competent manner is provided by active investigation of complaints and revocation of suspension of licenses where appropriate.

The Findings and Recommendations Section (see page 7), describe areas where weaknesses or conflicts exist. Therefore, we have made recommendations which, if implemented, will improve the efficiency and effectiveness of the Board.

(Intentionally left blank)

FINDINGS AND RECOMMENDATION

Recommendation No. 1

The Board of Pharmacy should comply with AS 08.80.460(b) which requires the Board to establish a schedule of fines for violation of AS 08.80.295, the generic drug substitution law.

During our review of Board's statutes and regulations we found the Board has not established regulations mandated by AS 08.80.460. AS 08.80.460(b) requires the Board to establish a schedule of fines for violation of AS 08.80.295, the generic drug substitution law.

The Attorney General has taken a similar position in a memorandum dated February 20, 1985. The Attorney General stated AS 08.80.460(b) imposes civil penalties through a schedule of fines for violation of AS 08.80.295. Further, the Board is mandated to adopt these regulations.

We recommend that the Board adopt these regulations as soon as possible.

(Intentionally left blank)

ANALYSIS OF PUBLIC NEED

Limited Analysis

The following analyses indicate both positive and negative factors as they relate to the public need defined in the "sunset" law. These analyses are not intended to be comprehensive, but address those areas we were able to cover within the scope of our review.

I. The extent to which the board, commission, or program has operated the public interest.

A. The Board has held meetings and administered examinations in accordance with statutory requirements.

B. The Board has promulgated regulations governing its duties and licensure requirements. Specifically, the Board has updated and revised regulations pertaining to lapsed licenses, continuing education and hospital pharmacies.

II. The extent to which the operation of the board, commission, or agency program has been impeded or enhanced by existing statutes, procedures, and practices which it has adopted, and any other matter, including budgetary, resource, and personnel matters.

The Board has not adopted regulations required to enforce the generic drug substitution law (see Recommendation No. 1).

III. The extent to which the board, commission, or agency has recommended statutory changes which are generally of benefit to the public interest.

The Board has proposed various statutory changes regarding the number of Board meetings per year, temporary license requirements, grading and content of examinations and miscellaneous housekeeping changes.

IV. The extent to which the board, commission, or agency has encouraged interested persons to report to it concerning the effect of its regulations and decisions on the effectiveness of service, economy of service, and availability of service which it has provided.

The Board has published public notices of all examination, meetings, and regulation changes.

V. The extent to which the board, commission, or agency has encouraged public participation in the making of its regulations and decisions.