ALASKA LEGISLATURE COMMITTEE FILES 1997-1998 8672
9099 HOUSE HEALTH EDUCATION & SOCIAL SERVICES

ALASKA NATIVE HEALTH BOARD

Alaska Native Health Board

STATE LEGISLATIVE PRIORITIES

FISCAL YEAR 1998

Alaska Native Health Board

4201 Tudor Centre Dr., Suite 105
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Phone: (907) 562-6006
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February 18, 1997

Dear Legislator:

This publication provides information concerning the statewide legislative priorities identified by the Alaska Native Health Board for the 1997 session of the Alaska State Legislature.

The Alaska Native Health Board appreciates this opportunity to communicate these issues of great importance to the Alaska Native community. As an elected representative in the State legislature, you are in a position to accomplish a great deal for the residents of our state, including Alaska's over 100,000 indigenous people.

We have worked diligently to develop partnerships between the Alaska Native health agencies and the State's Departments of Health and Social Services and Environmental Conservation to improve coordination of services and realize financial efficiencies where possible. We would like to work with you to further investigate the issues presented here and develop plans for continued improvements in state health policy and services.

For further information on any material included in this publication please contact our Executive Director, Anne M. Walker.

Sincerely,

Lincoln A. Bean Sr

Lincoln Bean, Sr
Chairman

ALEUTIAN/PRIBILOF ISLANDS ASSOCIATION
BRISTOL BAY AREA HEALTH CORPORATION
CHUGACHMIUT
COPPER RIVER NATIVE ASSOCIATION
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OF ANNETTE ISLAND RESERVE
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NINILCHIK TRADITIONAL COUNCIL
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SOUTHCENTRAL FOUNDATION
SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM
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YAKUTAT TLINGIT TRIBE

Alaska Native Health Board
FY1998 State Legislative Priorities

ALASKA NATIVE HEALTH BOARD'S VISION FOR THE YEAR 2002

LISTING OF ANHB BOARD OF DIRECTORS

PRIORITY ISSUE STATEMENTS:

I. VILLAGE WATER AND SANITATION

A. Village Water and Sanitation Facilities Construction

B. Rural Water and Sanitation Facility Operations and Maintenance

C. Water and Sanitation Services for all Village Health Clinics

II. TAX TOBACCO FOR HEALTHIER ALASKANS

III. TITLE 47 REIMBURSEMENT FOR HEALTH CARE FACILITIES

IV. REPLACEMENT OF STATE PUBLIC HEALTH LABORATORY IN ANCHORAGE

Alaska Native Health Board
Vision for 2002

The Alaska Native Health Board is committed to the following vision as part of its 10-year Strategic Plan (1992-2002):

- *A Native health system of high quality is the preferred provider for Alaska Native people.*
- *Needed statewide (Area Office) services are provided by/through a Native organization.*
- *The new Alaska Native Medical Center, operated under a "638" contract, is the pride of Native people.*
- *Tribal consultation directs the operation of the Indian Health Service.*
- *The Alaska Native health system has sufficient Native health administrators and professionals to provide the highest level of care for our people.*
- *Continuous quality improvement characterizes the Alaska Native health care delivery system.*
- *Native health care is provided through an interagency and interdisciplinary approach.*
- *Patients actively participate in their care, including prevention efforts.*
- *Health promotion/disease prevention takes a leading role in health services, communities, and the education system.*
- *To be sober and drug free is a Native cultural value.*
- *Suicide and injury-related deaths are significantly reduced.*
- *Each region has Native-operated child protection services.*
- *Cities and villages have the ability to support elderly, disabled, mentally ill, and terminally ill patients.*
- *Full coverage for vision, dental, and hearing care and AIDS treatment is provided with government funding.*
- *Village residents are served by well-equipped health clinics.*
- *Every health clinic has piped water and sewer service.*
- *Every Native village has facilities for safe water and sewage disposal.*
- *Alaska Native tribes are fully recognized and provide their own health services.*
- *The federal trust responsibility to provide health care to all Alaska Natives is preserved.*
- *Alaska Native Health Board is a model of unity in the Native community.*

ALASKA NATIVE HEALTH BOARD
MEMBERS OF THE BOARD OF DIRECTORS
FEBRUARY, 1997

NAME	REPRESENTING
Lincoln Bean Sr.	Southeast Alaska Regional Health Consortium
Larry Ivanoff	Norton Sound Health Corporation
Andrew Jimmie	Tanana Chiefs Conference
Esther Ronne	Chugachmiut
Eileen Ewan	Copper River Native Association
Lee Stephan	Native Village of Eklutna
H. Sally Smith	Bristol Bay Area Health Corporation
Cheryl Edenshaw	Manilaq Association
Margaret Roberts	Kodiak Area Native Association
Mike Zacharof	Aleutian/Pribilof Islands Association
Glen Gardner	Eastern Aleutian Tribes
Rachel Askren	Metlakatla Indian Community
Lotha Wolf	Mt. Sanford Tribal Consortium
Sharon Culhane	Ninilchik Traditional Council
Jane Thompson	North Slope Borough
Crystal Collier	Seldovia Village Tribe
Sophia Chase	Southcentral Foundation
Lisa Bismarck	Native Village of Tyonek
Tweet Parker	Valdez Native Tribe
Paul Manumik	Yukon-Kuskokwim Health Corporation

I. VILLAGE WATER AND SANITATION

A. Rural village water and sanitation facilities construction

The Alaska Native Health Board has consistently considered safe drinking water and adequate sanitation to be one its highest working priorities. Sustained commitments from both federal and state sources are necessary to eliminate public health problems resulting from poor sanitation conditions in rural Alaska villages. The Indian Health Service estimates the total cost of constructing piped water and sewer services in all rural Alaska communities at nearly $1 billion.

The Alaska Native Health Board has worked aggressively with the federal government to increase appropriations for rural Alaska water and sanitation through the Indian Health Service, the Environmental Protection Agency, the Department of Agriculture, and the Department of Housing and Urban Development.

Previous legislatures have demonstrated their commitment to providing state contributions through appropriations for community water and sanitation facility construction: FY1993-$24 million, FY1994-$26.5 million, FY1995-$21.7 million, FY1996-$21.5 million, FY1997-$19.3 million. The Alaska Native Health Board acknowledges these contributions.

Over the past year, the Alaska Native Health Board and our Rural Alaska Sanitation Coalition have participated in the deliberations of the Governors Council on Rural Sanitation.

The Alaska Native Health Board urges the Alaska State Legislature to adopt the recommendation of the Governors Council on Rural Sanitation, and appropriate $25 million to the ADEC Village Safe Water program for rural water and sanitation project construction in the FY1998 capital budget

B. Rural water and sanitation facility operations and maintenance

Lack of operations and maintenance resources for proper management of sanitation facilities in rural Alaska is a critical issue that must be addressed. Enhancement of operations and maintenance capacity is essential to prevent public health risks due to improper operation and to protect the investment of millions of dollars in facilities construction and rehabilitation.

The Alaska Native Health Board strongly urges the Alaska State Legislature to appropriate sufficient funds in the FY1998 operating budget to:

-the Department of Environmental Conservation for the support of twelve Remote Maintenance Worker positions

-the Department of Community and Regional Affairs to increase the number of Rural Utility Business Advisors (RUBA) to seven

-DCRA for the development of utility management materials and for development of "plain English" water quality regulations

While these state-offered operation and maintenance support services listed above are important, these programs are primarily designed and delivered from outside the rural communities. This year the State of Alaska has a unique opportunity to develop a successful direct operation and maintenance support program based on needs identified by communities themselves. The solutions to meet these needs originate in and are unique to each community. Such a program will provide for operator and utility management financial support, preventive maintenance services, community planning capacity, and public education to meet these needs.

The Environmental Protection Agency awarded the Alaska Native Health Board $500,000 for a FY1996 project to provide operations and maintenance support to nine rural Alaska communities on a demonstration basis. Over 100 rural communities responded to our preliminary survey of interest in participating in this project, which requires a substantial matching contribution by the local community. The Environmental Protection Agency has committed $1,000,000 for continuation of this project in FY1997, which will allow support for approximately 17 additional communities beginning this summer.

The EPA and the Alaska Native Health Board have engaged the University of Alaska's Institute for Social and Economic Research (ISER) to conduct a comprehensive evaluation of this initiative over a multi-year basis to determine its cost-benefit.

B. Water and sanitation facility operations and maintenance (continued):

The Environmental Protection Agency has made the award of $500,000 for continuation of this program for FY1998 contingent upon approval of a State of Alaska matching contribution of $500,000.

The Alaska Native Health Board urges the legislature to approve the recommendation of the Governors Council on Rural Sanitation, and provide a $500,000 match in the FY1998 capital budget to support the ANHB Operation & Maintenance Support Demonstration Project.

C. Water and sanitation services for all village health clinics

The Alaska Native Health Board's vision is that by the year 2002 every village health clinic in rural Alaska will have piped water and sewage disposal. The State of Alaska has shared this commitment and, in FY1993 and FY1994, appropriated $500,000 each year for the hookup of village clinics to community sanitation systems. No funds were appropriated in the FY1995 and FY1996 capital budget.

$325,000 was appropriated in the FY1997 capital budget. These funds have been obligated through a project agreement with the Indian Health Service to fund clinic hookups in Manakotak, South Naknek, Koyukuk, Healy Lake, Rampart, Venetie, and Newtok. Some of these will be connected in the summer of 1997; others are in the planning/design stage.

However, at least twenty-five more village clinics remain without current or planned sanitation services, requiring community health providers to work in substandard sanitary conditions. The average cost of hookups is approximately $50,000 per community for a total unmet need of approximately $1.2 million.

Specific communities identified as requiring sanitation services for their community health clinics, for which no current funding is identified, are:

Akiachak	Akhiok
Arctic Village	Atmauluak
Beaver	Birch Creek
Brevig Mission	Chefornak
Circle	Eagle Village
Kipnuk	Kongiganek
Lime Village	Lower Kalskag
Manley Hot Springs	Napaskiak
Nulato	Pitkas Point
Platinum	Port Heiden
Portage Creek	Tuluksak
Tuntutuliak	Upper Kalskag

The Alaska Native Health Board urges the Alaska State Legislature to appropriate a minimum of $325,000 in the FY1998 capital budget to the Alaska Department of Environmental Conservation to ensure that additional village health clinics are connected to water and sanitation systems.

II. TAX TOBACCO FOR HEALTHIER ALASKANS

The Alaska Native Health Board was among the first advocates to present proposals for major tobacco tax increases in Alaska during the 1996 legislative session. We have been encouraged that this legislature is seriously considering a range of bills to accomplish this early in the session. There remain several important reasons for this legislature to approve a tobacco tax increase this year.

Tobacco is a major cause of death and illness in Alaska:

The recent publication of the Department of Health and Social Services "Saving Lives and Raising Revenue: The Case for Major Tobacco tax Increases in Alaska" states that *Alaska has one of the highest smoking prevalence rates in the United States*, and that tobacco kills more Alaskans than AIDS, aircraft crashes, alcohol, falls, fires, firearms, and motor vehicle crashes *combined.* Almost 20% of all deaths in Alaska between 1992 and 1994 were due to smoking. A disproportionately high percentage of these deaths are Alaska Native people.

Tobacco use by Alaskan youth is a serious concern:

A January 21, 1997 Bulletin of the Alaska Division of Public Health presents sobering statistics regarding "Tobacco Use by Alaska Youth." It reveals that 21% of all Alaska high school students are frequent smokers, and nearly 44% of Alaska Native high school students are frequent smokers. Of all the children who join the ranks of smokers each year, we can expect that one in three will eventually die from it. Half of those will die in middle age.

Tobacco use costs Alaska:

The Alaska Department of Health and Social Services estimates that tobacco use costs the Alaska economy over $96 million each year in direct medical care costs. Meanwhile the Alaska cigarette tax of 29 cents per pack is below the national average. The proposed tax increase on cigarettes and other tobacco products will generate over $40 million per year.

Increasing tobacco taxes reduces tobacco use:

Research shows that "few measures exhibit the speed and magnitude of impact achieved by increasing taxation on tobacco products" (National Cancer Institute). The cigarette tax increase recommended (to $1.29 per pack) is expected to reduce youth smoking by almost one-third. This amounts to thousands of lives saved over time, especially if the increase is indexed for inflation.

II. Tax Tobacco for Healthier Alaskans (continued):

The arguments raised by the tobacco industry that the tax increase will result in the smuggling of tobacco products should be dismissed as a "smoke-screen." There are numerous demographic, geographic, and political factors that would prevent any substantial rise in illegal sales.

The cost of smuggling tobacco products from Washington is prohibitive, given the transportation costs and the already-high tobacco tax imposed in that state. The Department of Defense has demonstrated its willingness to limit the amount of tobacco sales on military bases in other states that have raised taxes.

The Alaska Native Health Board rejects the argument being offered that tribal governments will undermine this legislation through the establishment of tax-free smoke-shops (tribal tax-exempt sales can only be made to their own tribal members anyway). The majority of Alaska Natives, along with the majority of Alaskans, support the proposed tax increases and are concerned about the increasing rates of cancer and other diseases caused by tobacco.

We are also concerned about efforts to 'water down' this initiative by reducing the amount of the tax increase below the amounts originally proposed. It is important to make a significant change in policy, one that will have a real effect on tobacco use especially among young people.

The Alaska Native Health Board joins with the American Cancer Society, the American Heart Association, and the American Lung Association in encouraging this Alaska State Legislature to approve the tobacco excise tax increases of at least $1.00 per pack on cigarettes and to 100% of the wholesale price on other tobacco products.

III. TITLE 47 REIMBURSEMENT FOR HEALTH CARE FACILITIES

Alaska Native health organizations that operate hospitals and health centers throughout rural Alaska have been inappropriately bearing a heavy financial burden for services provided to intoxicated persons.

Title 47 of Alaska State Statutes provides financial support to local governments for public safety services provided to intoxicated and incapacitated individuals. Under certain circumstances such individuals are referred to local health care facilities for medical screening prior to being released, returned to police custody, or transferred to treatment facilities.

Even though local protocols may be developed to limit the number of such referrals, as many as one-third of the individuals entering the public safety system in some areas are screened by medical professionals at a significant cost in terms of time and resources.

The problem faced by the Alaska Native Health Board's member organizations throughout rural Alaska is that their hospitals and health centers are not reimbursed for these services. Very few of these individuals have Medicaid coverage or other private insurance. Local city governments have disclaimed responsibility for payment for these services, and have made provisions in some locations to release those in custody at the hospital door and then re-arrest upon discharge to avoid liability.

Kanakanak Hospital in Dillingham estimates that the uncompensated care provided for such individuals is valued at least $100,000 per year. Other hospitals are reporting similar losses.

It is our understanding that this problem is significant for other hospitals outside of the Alaska Native health care system as well. The Alaska State Hospitals and Nursing Homes Association has raised this as a legislative concern as well, recommending that state law concerning municipal taxation of alcoholic beverages be revised to generate a revenue stream.

The Alaska Native Health Board urges the Alaska State Legislature to recognize the financial hardship being faced by small rural hospitals due to the demands of medical screening for intoxicated persons, to work with the Department of Health and Social Services and local governments to develop a strategy to address these concerns, and to ensure that sufficient financial support is provided to meet governmental obligations to provide these services.

IV. SUPPORT REPLACEMENT OF THE STATE PUBLIC HEALTH LABORATORY

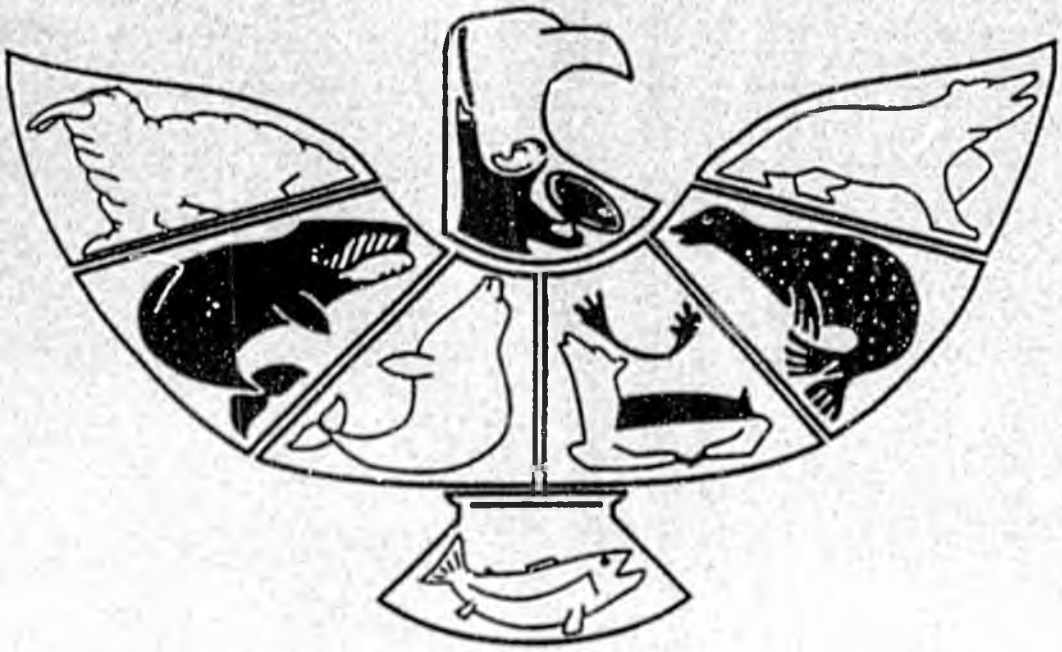
The Alaska Native Health Board recognizes the essential services provided to the health care facilities operated by our member health organizations throughout Alaska by the Alaska State Public Health Laboratories in Juneau, Fairbanks, and Anchorage. These laboratories provide a full range of disease control, environmental monitoring, preventive health care, and research services.

The facilities that are currently housing these laboratory facilities in all three locations are rapidly becoming inadequate to maintain these services. Without adequate facilities our public health laboratories cannot meet standards of economic and administrative efficiency, maintain the types and volumes of tests required, and maintain the confidence of our medical providers and health care consumers.

The Department of Health and Social Services has proposed the construction of a new $20 million public health laboratory in Anchorage, which will include the Medical Examiners Laboratory and consolidate the functions of the Juneau and Anchorage laboratories.

The Alaska Native Health Board urges the Alaska State Legislature to approve legislation this session to initiate the construction of a replacement facility for the Alaska Public Health Laboratory in Anchorage.

ALASKA NATIVE HEALTH NAKAMURA



STATE LEGISLATIVE PRIORITIES

FISCAL YEAR 1999

Alaska Native Health Board

4201 Tudor Centre Dr., Suite 105
Anchorage, Alaska 99508

Phone: (907) 562-6006
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February 1, 1998

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For further information on any material included in this publication please contact our President and Chief Executive Officer.

Sincerely,

Larry Ivanoff
Chairman

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TANANA CHIEFS CONFERENCE
YUKON-KUSKOKWIM HEALTH CORPORATION
VALDEZ NATIVE TRIBE

Alaska Native Health Board
FY1999 State Legislative Priorities

I. Implementation of the Rural Sanitation 2005 Action Plan

II. Enhancing Health and Social Services for Children and Youth

III. Substance abuse services and regulation

I. IMPLEMENTATION OF THE RURAL SANITATION 2005 ACTION PLAN

Remedying the significant problems of inadequate water supply and sanitation services in rural Alaskan villages has been the highest legislative priority of the Alaska Native Health Board since the early 1990's, and remains such in 1998.

We acknowledge that the overall federal and state resources allocated to address these problems have gradually increased over the past few years, and appreciate the commitment made by the Alaska State Legislature to maintain these resources in light of the deficit-reduction requirements it faces.

ANHB has also been actively involved with the development of the Rural Sanitation 2005 Action Plan initiated at the direction of Governor Tony Knowles. Our President/CEO has served as a member of the Governor's Council on Rural Sanitation. Our subsidiary organization, the Rural Alaska Sanitation Coalition, has also been represented on the Council. ANHB have been active participants in the committee and hearing processes.

We believe that the Rural Sanitation 2005 Action Plan presents the most current and most comprehensive strategies for addressing the water supply and sanitation crisis in rural Alaska; it has been developed with extensive community and agency participation and contributions over a two-year period.

Now that the planning process has been completed it is time for implementation of the key strategies that are recommended in the Action Plan. ANHB recommends full consideration and endorsement by the Alaska State Legislature of the Rural Sanitation 2005 Action Plan, and requests that the Legislature offer a serious and long-term commitment to its implementation.

There are several key recommendations made in the Action Plan that we would like to emphasize for priority consideration by the Alaska State Legislature:

A. *Remote Maintenance Worker program support:*

It is essential that this program, operated by the Alaska Department of Environmental Conservation, be sustained at its current level of funding, supporting thirteen RWW positions in Alaska.

B. *Rural Utility Business Advisor program support:*

Legislative support for incremental increases in this DCRA program will ensure that local communities are provided sufficient technical assistance to maintain the operation of systems constructed with state capital funding.

I. Rural Sanitation 2005 Action Plan Implementation (continued)

C. *Rural community utility financial subsidies:*

The operations and maintenance of rural community water and sanitation support are critically dependent on maintenance of current levels of support from the Power Cost Equalization program, the Revenue Sharing program, and Safe Communities (Municipal Assistance) programs.

D. *Village Safe Water project construction financing:*

ANHB concurs with the Action Plan's recommendation that State of Alaska capital budget contributions of a minimum of $25 million per year be sustained for FY1999; such appropriations will provide a matching contribution for an equivalent award of federal funds for project construction.

E. *State General Obligation bonds for construction financing:*

ANHB concurs with the Action Plan's recommendation that the Alaska State Legislature authorize a ballot proposition for the issuance of $150 million of State General Obligation bonds for the installation, replacement, and repair of rural sanitation facilities. This approach would stabilize long-term State financing for these projects and enhance the success of long-term federal financing commitments as well.

The Alaska Native Health Board is confident that a legislative commitment to work cooperatively with the Governor on implementation of this Action Plan will achieve significant improvements in addressing the serious deficiencies we currently are experiencing in water supply and sanitation services in our rural villages.

II. ENHANCING HEALTH AND SOCIAL SERVICES FOR ALASKA'S CHILDREN AND YOUTH

The Alaska Native Health Board has carefully reviewed Governor Knowles proposal "Smart Start for Alaska's Families", which would allocate over $30 million from the recently-approved increase in the federal match for Medicaid for the enhancement of children's medical services, preventive health care services, and child protection services in Alaska.

ANHB concurs with the Governor that these are the highest priority uses of these funds, and calls for the Legislature not only to adopt the Governor's plan but to enhance it through an additional $8 million investment in prevention and protective services.

The *Children's Health Services* component of the initiative ($7.2 million) would allow an additional 11,000 children and 800 pregnant women who are now uninsured to benefit annually from Medicaid eligibility. It should be noted that 41 other states exceed Alaska's current coverage for pregnant women and children.

This approach is particularly beneficial with respect to eligible Alaska Native pregnant women and children because, for those who use the Indian Health Service or tribal health providers for care, the State will be reimbursed at a 100% matching rate from the Health Care Financing Administration.

The allocation for *Preventive Health Services* component of the initiative ($10.6 million) is a more long-term investment in public health services that have been significantly under-funded over the past decade. The Alaska Native Health Board and our member organizations have been actively participating in the State's Public Health Improvement Process, and recognize that many of the public health system's deficiencies are addressed through these proposals.

Over 50% of this allocation will be invested in day care assistance, welfare-to-work child care, and Head Start services. ANHB firmly believes that these investments will increase the number of Alaska Native families that will be able to transition from public assistance to employment. The increasing emphasis being placed on health curriculum in the Head Start programs will benefit the health status of both young children and their parents.

We strongly endorse the $200,000 proposed investment in village-based mental health and substance abuse programs, and the proposed $650,000 increment for tobacco use reduction activities. It is appropriate to reinvest smokeless tobacco tax revenues in tobacco education and prevention.

ANHB's member organizations are committed to be active partners in the Governor's childhood immunization initiative, and will provide substantial in-kind matching contributions, especially in the rural communities, to raise our childhood immunization levels up from our current ranking of 48th among the United States.

It is essential to expand the home visiting/healthy families program to more Alaskan communities, especially the rural cities and villages where the child abuse and neglect situations have been clearly and sadly documented. We believe that the proposed $2 million investment will have long-term payoffs in reducing other state costs for child protection services and remedial treatment.

The final component of this initiative is *Child Protection* ($14.5 million) is key to addressing the problems that have been well-documented by the administration over the past several months. The Alaska Native community is particularly concerned about this issue given the disproportionate rates of child abuse, foster care, juvenile corrections, and related public safety problems experienced both in our larger cities and our villages.

Specific programs with this component that we are requesting Legislative support for include the $600,000 allocation for residential services for women and children, the $1.8 million allocation for foster care-related services, the $2 million allocation for youth corrections and treatment facilities, and the $428,000 allocation for child abuse response specifically for village communities.

ANHB encourages the State to take significant new steps to develop partnerships with our regional Native non-profit organizations, as well as with individual tribal governments, to extend these services further into the Native community, and to redesign these services in new and more effective ways. It is essential that the State continue to recognize and be responsive to compliance with the Indian Child Welfare Act, and to support tribal governments in our efforts to make this federal legislation work in our communities.

All of these initiatives require no new State general fund obligations. It is imperative that the Legislature use the opportunity offered by the increased federal support for Medicaid to make these long-term investments in the health and welfare of our children.

III. SUBSTANCE ABUSE SERVICES AND REGULATION

This section addresses ANHB's concerns and recommendations with respect to several pending bills relating to substance abuse in Alaska as well as to the financing of substance abuse treatment services.

A. *Substance Abuse Counselor licensing:*

HB 192 was introduced in the last session to address the licensure of substance abuse counselors in Alaska. The Alaska Native Health Board, and its associated Association of Rural and Alaska Native Drug and Alcohol Programs (ARANDAP) have carefully reviewed the proposed legislation.

It is our collective recommendation that this bill should not be enacted into law in 1998 because of concerns about the potential inadvertant impacts on many Alaska Native health care programs and their affiliated providers.

Alaska Native health care service agencies are deeply committed to providing professional substance abuse counseling services and ensuring that our staff meet standards of training and quality. However we feel that additional time is required for review of this legislation and the consideration of alternative approaches, including revision of this legislation from a practice bill to a title bill. We request that the Alaska State Legislature defer action on this bill during this session, and plan for consideration of the issue again during the 1999 session.

ANHB and ARANDAP members are committed to undertaking a careful and deliberate review of the issues relating to this legislation over the next 10 months and bringing a recommendation to the Legislature next session.

B. *Supporting HB58: Alcohol Safety Action Program for minor offenders*

The Alaska Native Health Board has reviewed HB58, which would extend the availability of the Alcohol Safety Action Program beyond its current services for adult offenders to include minors. We believe that this would have beneficial impact, and encourage the Alaska State Legislature to approve this legislation this session.

C. *Supporting SCR14: Requiring non-discrimination by insurance companies regarding mental health and substance abuse services*

The Alaska Native Health Board has reviewed SCR14, which would require health insurance companies to treat mental health and substance abuse services in the same manner as all other medical conditions. We believe that this legislation will rectify a discriminatory practice that has limited the access of such services to many Alaskans, and urge the Alaska State Legislature to enact this legislation this session.

III. Substance Abuse Services and Regulation (continued)

D. *Financial support for inhalant abuse prevention and treatment services*

Inhalant abuse is not a new phenomenon in Alaska, but the accelerating rate of inhalant abuse is causing serious concern among Alaska Native leaders and health providers throughout the state.

The 1995 Alaska Youth Risk Behavior Survey reported that nearly 20% of all middle-school students surveyed had used inhalants. Because this survey was not conducted in schools with less than 25 high school students, over ½ of the (mostly small rural) schools in Alaska did not participate. In Alaska inhalants are used most frequently by children and early adolescents.

A 1995 survey at an adult Alaska Native alcohol treatment program revealed that 50% of the clients had used an inhalant of some type in the previous year.

The sale or use of vaporous (inhalant) products for the purpose of having 'mind-altering experiences' is not controlled by State or Federal law, and there are over 1400 such products currently available.

Since product regulation is not feasible, prevention efforts are critical. In FY1998 the State is spending approximately $100,000 for prevention messages through contracts with media outlets and a health promotion organization. It is essential that this effort be maintained if not increased in FY1999.

Prevention investments are prudent given that a 19-year old Alaskan who has chronically abused inhalants, and caused significant brain, nerve, and other organ damage, will have lifetime medical care and rehabilitation requirements at a cost estimate of $1,400,000.

In Alaska there are no treatment services which have been designed specifically for persons who have chosen an inhalant as the primary substance of abuse. Existing substance abuse treatment centers are not equipped to provide the medical (neuro-physiological) assessments required nor offer the types of programs required for young persons who are organically impaired. Alaskans requiring treatment have been referred to the "Our Home" facility in North Dakota.

Last year the Alaska Mental Health Trust Authority committed to provide financial support to develop one Alaskan residential facility to provide specialized inhalant abuse treatment. The Alaska Native Health Board urges the Alaska State Legislature to work cooperatively with the Authority to develop a plan for establishing this new health service program at the earliest possible time.

ALASKA NATIVE HEALTH BOARD
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ALASKA PUBLIC HEALTH IMPRVMNT

Traveling the Road to a New Century in Public Health

From Alaska's Letter of Intent to Apply for a Turning Point Grant from the Robert Wood Johnson and W.K. Kellogg Foundations; March 27, 1997

Executive Summary

Alaska's public health system has been successful during this past century in protecting and promoting the health of our citizens. Public health activities such as population-based screening for infectious disease, providing immunizations, and assuring safe restaurant foods and clean drinking water, are primarily responsible for improved health status and increased longevity. The need for improvement in the public health system has been recognized for some time though. Discussions regarding system reform began during the last decade. These discussions took on more urgency during the health care reform debates of the early '90s, and have culminated in the implementation of a strategic process to improve Alaska's public health system.

Public health leaders in Alaska recognize the opportunities present in the many changes taking place today throughout our society. Examples of some of the issues that now compel Alaskans to examine and reform our public health system include: movement in the clinical care sector towards managed care; movement in the Native health care system towards increased self-determination; changes in the way businesses and governments are conducting business in the new information age; the movement towards smaller, more efficient government; and shifts in values that are reemphasizing personal responsibility and community involvement and control.

The Alaska Public Health Improvement Process began in December, 1996, and is focusing on developing partnerships to evaluate and revitalize the mission of public health in the state. The nexus of these partnerships will be a common vision of healthy Alaskans in healthy communities. This vision will be realized through the re-invention of the public health system. The role of public health in the lives of Alaskans, and in Alaska's communities, will be defined; a strategic process for assessing and addressing critical issues affecting the system will be implemented; the capacity required in the system to protect and promote the health of Alaskans will be identified; strategies for achieving needed capacity will be developed; the responsibilities of the different levels of government and other important partners will be determined; new relationships will be formed; and old relationships will be strengthened.

Partners in the statewide process include traditional public health sector organizations, as well as clinical health care providers and payers, business, consumers, academia, and the faith community. Participating local community partnerships will strengthen the statewide process by focusing the statewide partnership on the needs of communities and the value of local participation, responsibility, and control.

Alaska welcomes the opportunity to receive support from the foundations under the *Turning Point* initiative. There are unique opportunities and challenges present here that the foundations and other states will find engaging. For example, the Indian Health Service has played a strong role in Alaska's public health system during this past decade. There is currently a significant shift in responsibilities from federal to tribal control, as the 226 federally recognized tribes in Alaska continue to assert their self-determination rights to administer their own health care services. Another example is that, unlike most other states, Alaska has no HMO penetration. This situation presents a valuable opportunity to work with the clinical health care sector from the beginning of managed care system development to identify public health's role in managed care, and to redefine the clinical health care system's role in public health. Because of issues such as these, the public health community is committed to continuing this most important project.

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Peter Wallis, President [Fairbanks]

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Laraine Derr, Executive Director, Alaska State Hospital and Nursing Home Assn. [Juneau]
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Alaska Public Health Improvement Process

Challenges & Opportunities

- Lack of Clear Public Health Policy
- Tribal Compacting
- Government Downsizing
- Federal Block Grant and Performance Partnership Proposals
- Health Care Reform
- Welfare Reform
- Medicaid Reform
- Changing Demographics
- New Technologies & Public Health Threats

Alaska Public Health Improvement Process

Expected Outcomes

- Assessment of Alaska's Public Health System
- Identification of the Appropriate Alaska Public Health System Capacities and Infrastructure for the 21st Century
- Strategic Plan for Strengthening Alaska's Public Health System
- Development of Benchmarking and Performance Measurement System for the Alaska Public Health System
- Improved Public Health Performance
  - Increased coordination and collaboration of public health planning, decision-making, and service delivery
  - Strengthened relationships with public health system partners
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  - Improved accountability in the public health system
  - Clarification of the role of public health for the public

Turning Point:

Collaborating for a New Century in Public Health

An Initiative of the Robert Wood Johnson and W.K. Kellogg Foundations

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- Identify technical, organizational, legal, and revenue changes needed to strengthen public health's capacity to address challenges to community health
- Develop a public health improvement plan describing the infrastructure needed to improve population-based health
- Establish priorities for implementation and a timetable for achieving needed changes
- Identify a strategy for financing and maintaining proposed changes

Alaska Public Health Improvement Process

PROCESS FLOW CHART

By 12/31/97

1 What Are We Building?

Steering Committee, Action Team, & PHSA Workgroup
- *Define Public Health and the parameters of the public health system*

10/28/97 - 7/31/98

2 Assess What We Have Now

Public Health System Assessment Workgroup
- *designs process to create a picture of what the current public health system in Alaska looks like today*
  - *Inventory of Current Services, Resources & Mandates*
  - *Customer Surveys*
  - *Provider Surveys*
  - *Health Status*
- *conducts a Best Practices Analysis to compare current system to standards and models*
  - *lit search*
  - *Consult with National/ International Experts*

8/1/98 - 9/30/98

3 Develop a Vision of What's Possible

Steering Committee
- *Develop the specifications for the appropriate public health system for Alaska (i.e., required functions and capacities)*

10/1/98 - 5/31/99

4 Design Alaska's New Public Health System

Public Health System Design Workgroup
- *recommend roles and responsibilities of different levels of government, private health care sector tribal health orgs., and other public health partners*
- *recommend appropriate organizational structure for Alaska's public health system*
- *identify technical, legal, and revenue changes needed to implement public health system reform*

Pilot
Turning Point Communities
- *test new public health system design at the local level*

6/1/99 - 1/1/00

5 Implement Public Health System Redesign

Steering Committee
- *Approve public health system design*
- *implement/advocate system reform strategies*

6 Evaluate/Reframe

Steering Committee

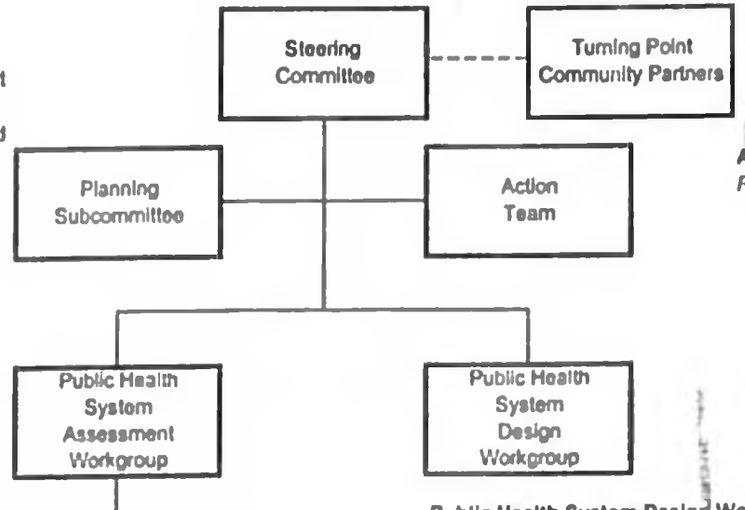
7 On-Going Planning and Management

Steering Committee

1-21-98

Alaska Public Health Improvement Process

MANAGEMENT STRUCTURE



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1) Assuring that the project has resources and support to get the work done;
2) Creating a vision of the outcome that is realistic and supportable;
3) Reviewing products from workgroups to:
   a) assure supportability;
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Planning Subcommittee of the Steering Committee

Role: Works with Action Team to plan Steering Committee meetings and address issues that require Steering Committee guidance during interims between quarterly meetings.

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Role: To provide the Steering Committee with information on the condition of Alaska's current public health system.

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Note: Full workgroup provides oversight and guidance to smaller teams responsible for data collection.

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Role: Provide staff support to the Steering Committee; manage process support functions such as communications and marketing; and coordinate the work of the various workgroups.

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Role: To develop for the Steering Committee the design for a new public health system for Alaska that meets the system specifications envisioned by the Steering Committee.

A) Recommend roles and responsibilities of different levels of government
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1-21-98

SUBSTITUTION

THE FOLLOWING DOCUMENT(S)
HAVE BEEN REFILMED TO
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Central Microfilm Services
Department of Education
State of Alaska

Rev. 6/98

Alaska Public Health Improvement Process
Steering Committee

CONFIRMED MEMBERS[1]
as of December 15, 1997

Tribal Health Organizations

Anne Walker, Executive Director, Alaska Native Health Board [Anchorage]
Carolyn Crowder, President, Norton Sound Health Corporation (and current Chair of the Tribal Health Directors) [Nome]

Tribal Government

Deborah Vo, Executive Director, Alaska Inter-Tribal Council [Anchorage]

Local Government

Kevin Ritchie, Executive Director, Alaska Municipal League [Juneau]

Local Health Departments

Elaine Christian, Director, MOA Department of Health & Human Services [Anchorage]
Doreen Knodel, Director, North Slope Borough Department of Health & Social Services [Barrow]

State Government

Karen Perdue, Commissioner, DHSS [Juneau]
Peter Nakamura, MD, MPH, Director, Division of Public Health [Juneau]
Michele Brown, Commissioner, DEC [Juneau]
Janice Adair, Director, Division of Environmental Health [Anchorage]

State Legislators

Senator Jim Duncan
Senator Johnny Ellis
Representative Con Bunde

Federal Government

David Schraer, MD, Acting Director, Alaska Area Native Health Service/IHS [Anchorage]
Rick Albright, Director, Alaska Operations, Environmental Protection Agency [Anchorage]
Major Danny Glover, Elmendorf AFB Chief of Public Health [Anchorage]

Alaska Public Health Association

Delisa Culpepper, President [Anchorage]

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[1] In addition, there is a seat on the statewide steering committee for a representative from each community that organizes a local public health improvement partnership and implements a local public health improvement process.

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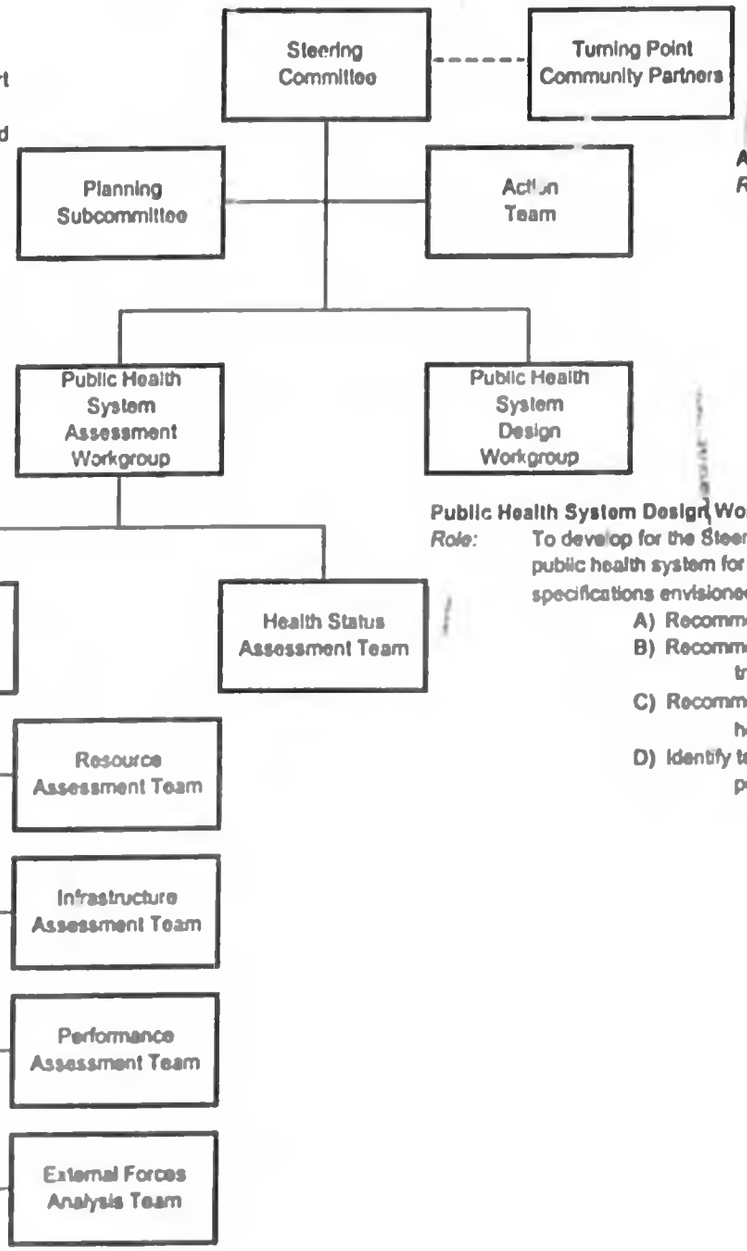

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1-21-98

BUILDING BRIDGES

3/19/97

Field Notes

Tricia Edwards, Editor

A Publication of the Mental Health Association in Alaska Special Edition, 1997

Community Services

This issue

Special Edition on Stigma

Working for Alaska's Mental Health

Stigma is Everywhere

A mental illness is, more accurately, a brain disorder; and brain disorders -- like epilepsy -- are biologically based medical problems. The newest medical technology can take "pictures" that show differences between brains with disorders and normal brains.

In any given year, about 5 million American adults suffer from acute episodes of one of five serious brain disorders: schizophrenia, bipolar disorder, major depression, obsessive-compulsive disorder, and panic disorder. Even many of America's children -- more than 3 million -- suffer from these disorders.

Untreated, disorders of the brain profoundly disrupt a person's ability to think, feel, and relate to others and to his or her environment.

Brain disorders are shrouded in stigma and discrimination. For centuries they have been misunderstood, feared, hidden, and often ignored by science. Only in the last few decades has the first real hope for people with brain disorders surfaced, and that hope has grown from pioneering research that found both a biological basis for brain disorders and treatments that work.

Brain disorders are treatable. The current success rate for treating schizophrenia is 60 percent. The success rate for treating bipolar disorder, also known as manic depression, is 65 percent, and for major depression it is 80 percent. Mental illnesses can now be diagnosed and treated as precisely and effectively as other medical disorders. But the stigma -- and the discrimination caused by that stigma -- remains.

Stigma is an ancient evil. It still limits all aspects of life for people with brain disorders: housing, education, insurance, science, research, services, jobs, religion, and personal relationships.

By the NAMI Campaign to end discrimination against people with severe mental illness. Contact Sylvia Matthews at the Alaska Alliance for the Mentally Ill at 1-800-478-4462 or 1-907-277-1300 for more information.

Former Mental Patients Talk About Stigma

Example A

Ten years ago I was a professional actress in Los Angeles, and one day I came offstage and had a breakdown. The doctor told my parents that I was chronic and would be hospitalized all my life. Eventually, I found respite, became a resident, and I have been without hospitalization for 8 years. Since leaving respite, I have used it as a crisis center whenever I have had a problem. I worked my way back to the point where I could finish my college education and hold a job as a teacher.

At this point, I am unemployed and looking for work. But I have come to realize that I must rely on the technique of "the cover-up." I will do everything I can to conceal the fact that I was once diagnosed as chronic, that I was hospitalized, and that I once lived in a halfway house. If I am asked by an employer if I have ever had a nervous breakdown, I will answer, "No." If I am asked why there was a gap in my employment, I will say, "I traveled." If they notice my hands are trembling because of my medication, I will say, "It's due to my thyroid." I must do all of this because there is a stigma attached to anyone who has had mental illness.

I hope that, in my lifetime, the ignorance of emotional illness turns to understanding; that fear turns to security; and that the cover-up will no longer be necessary.

Example B

The great stigma that is attached to people who have been or who are mentally ill often results in open discrimination. I have had some difficulty with both my resident manager and with the Federal agency where I was seeking employment. The fact that I was being prejudged was upsetting and annoying.

Only recently questions about an individual's history of nervous breakdowns were eliminated from the official form required for all applications for Federal jobs. The equal employment opportunity law, as amended, now includes prohibitions on discriminating against the physically and mentally handicapped. Because of the existence of these rights, I have more self-confidence. By supporting myself, I am proving that I am a responsible individual.

We need these kinds of changes in the law to protect our rights as individuals. Specifically, we truly need anonymity in order to cope with a difficult life, without carrying forever the label of "mentally ill." I like to use the expression: "Everyone is different; therefore, we should be treated the same."

Let's Talk About Mental Illness

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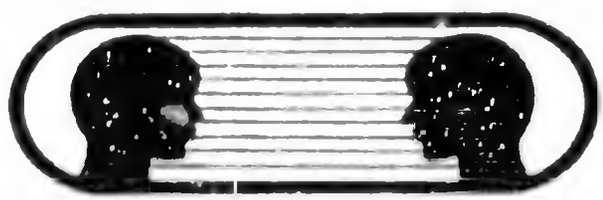


Let's Talk About Mental Illness

Attitudes of Stigmatized Persons

How do stigmatized persons feel about being stigmatized? What do they do about it? Erving Goffman has written about these feelings and actions.

Stigmatized individuals hold the same beliefs about their identity as we do. Their deepest feelings are that they are normal human beings like anyone else, persons who deserve a fair chance and a fair break. Yet they perceive, quite correctly, that, whatever others may profess, they are not really accepted.

Shame becomes a central possibility, arising from stigmatized persons' perceptions that one of their attributes is a defiling thing and one that they can see themselves as not possessing.

The primary feature of a stigmatized individual's situation in life is a question of acceptance. Those who have dealings with them fail to accord them respect and regard.

How do stigmatized persons respond to this situation?

In some cases they make a direct attempt to correct the failing, as when a physically deformed person undergoes plastic surgery or an illiterate person undertakes remedial education. Ironically, when such repair is possible, what often results is not the acquisition of a fully normal status but merely the transformation into someone who has had a blemish corrected.

Another approach that stigmatized persons use is to devote great effort to the mastery of areas that are usually closed to people with their shortcomings. The lame person learns to swim, ride, play tennis; the blind person becomes expert at skiing and mountain climbing.

Finally, persons with differences which causes them shame can break with what is called reality and obstinately attempt to employ an unconventional interpretation of the character of their social identities.

Stigmatized individuals may use their stigma for "secondary gains," as an excuse for failures that have really come about for other reasons. Or stigmatized individuals may see the trials they have suffered as a blessing in disguise, especially because they feel that suffering can teach them about life and other people. Or they may reassess the limitations of normal people and believe that they can be of special help to normals.

Stigma and the Violation of Rights

The stigma of mental illness has been reflected in many laws that restrict the freedom of mentally ill persons to make their own choices. Robert Plotkin, a lawyer formerly with the Mental Health Law Project, has summarized some of these restrictions.

Certain groups of Americans are "protected" by law from enjoying the freedom to make their own choices. The chief "beneficiaries" of the State-sponsored paternalism are the mentally different, those who are thought to be incompetent to make rational choices. The result is a double-track system: one law for "normal" people and another for the mentally different.

Voting: Virtually half the States have statutory language flatly forbidding mentally handicapped persons to vote. The range of exclusions runs from "idiots" to "insane persons" to "persons under guardianship." These laws bar mentally handicapped persons from participation in the political process, without regard for individual ability to exercise this right rationally.

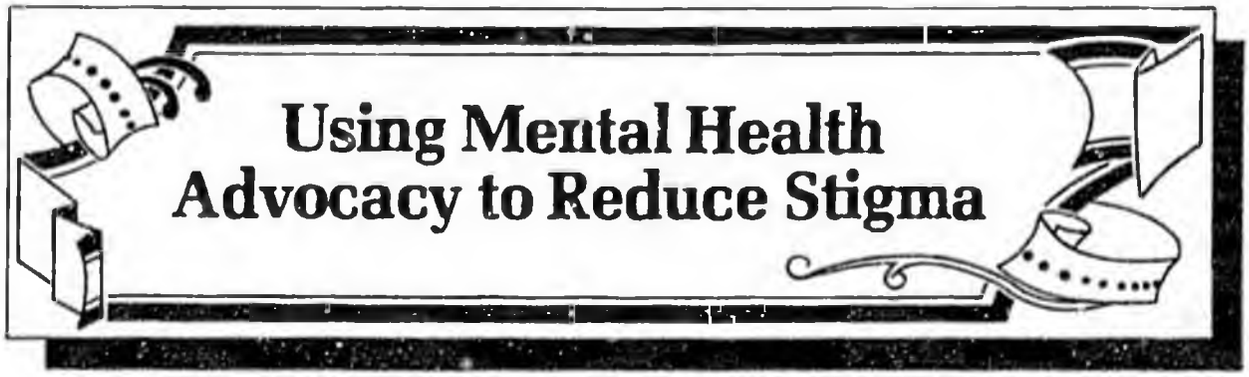
Marriage: Many States have statutory bans which prevent the "feeble-minded," incompetent, or those under guardianship from marrying. If such marriages occur, they can be annulled or speedily ended by no-fault divorce. Given the problems of some so-called normal people--rising divorce rate, high incidence of child abuse, and sexual maladjustment--it is puzzling that the mentally disabled are singled out.

Adoption: In more than half the States children can be adopted without the consent of mentally disabled parents. There may be situations where parents cannot care for children and adoption is in everyone's best interest, but requirements that protect the rights of "normal" parents are forgotten when a child's parents are mentally different.

Sterilization: Some States have statutes allowing involuntary sterilization of the incompetent. Other statutes allow sterilization in "voluntary" situations, without addressing the question of how an "incompetent" decides to consent "voluntarily" to sterilization. In some States there is no judicial inquiry into the sterilization if the person's parent or guardian gives "consent."

Guardianship: Guardians have the authority to admit persons "voluntarily" into institutions, to have them sterilized or experimented upon, to invest their money and manage their affairs. Generally, a guardian sincerely believes that he or she is honestly protecting the interests of an incompetent person, and usually this is so. But there have been instances of overzealous or unscrupulous persons acting as guardians, and the law should provide greater protection to the person being "guarded."

If the law has any obligation to the mentally handicapped, it is to increase their options and to expand their opportunities, not to limit their choices and physically and legally segregate them.



Using Mental Health Advocacy to Reduce Stigma

Mental health advocacy is a recent and fruitful attempt to provide better care for the mentally ill and to decrease their stigma. Louis E. Kopolow, Chief of the Patients Rights and Advocacy Program at the National Institute of Mental Health, outlines the elements of a comprehensive advocacy program.

Mental health advocacy provides a unique mechanism by which psychiatry can respond constructively and effectively to the dilemma of delivery of mental health care in a system increasingly influenced by legal requirements and consumer demands. Advocacy is a method by which psychiatrists, lawyers, and patients' representatives can work cooperatively in meeting the patients' wishes, needs, and rights.

A comprehensive advocacy program consists of a tripartite system:

The primary element is the patient's representative, who is concerned with screening patients for such matters as the appropriateness of commitment or guardianship, of forced medication and other forms of treatment, and of transfer or release to large institutions. The patient's representative also devotes his or her efforts to preserving "the right to noninstitutionalization" and to arranging transfer of patients to other mental health programs in the community.

The second element of the program involves the legal advocates. They are necessary in handling the multitudinous legal problems, especially those of an indigent and deprived population. In carrying out the role, the legal advocate uses all the skills of the legal profession, bringing court action on behalf of the patient against the institution, filing class action suits, and lodging complaints regarding specific violation of patients' rights in order to secure redress. The active involvement of mental health staff in assisting attorneys to represent their clients' wishes goes a long way toward assuring that alternative clinical regimens have been explored. The attorney's main task, however, is to be available as a last resort for serious problems which the patients' representative has failed to solve through less formal adjustment mechanisms.

The ombudsman is the third element in a comprehensive advocacy program and is especially relevant for a mental health system undergoing rapid change. The ombudsman addresses problems throughout the entire mental health system.

This model for patient advocacy is helpful in preventing the unfortunate situation of patients being caught in a tug of war between two opposing forces--the psychiatric and the legal professions--battling for their custody. Such a comprehensive advocacy program can become an important and lasting alternative to litigation and can help to create a mediated flexible system of care for the mentally ill.

When "Normal" and Stigmatized Persons Meet

A crucial question, especially for the mentally ill, is what happens when normals and the stigmatized are in the same social situation. Goffman has analyzed these "mixed contacts."

The very anticipation of contacts with each other can lead normals and the stigmatized to arrange life so as to avoid them. This will have greater consequences for the stigmatized, since more arranging will usually be necessary on their part.

All too often the stigmatized person withdraws from social contacts and becomes a social isolate. Lacking the salutary feedback of social intercourse, a self-isolate can become suspicious, depressed, hostile, anxious, and bewildered.

When normals and stigmatized do in fact enter one another's immediate presence, especially when they attempt to sustain a conversation, the causes and effects of stigma must be directly confronted on both sides.

The stigmatized individuals may feel unsure of how normals will identify and receive them. They feel that they do not know what others are really thinking about them. Further, stigmatized persons are likely to feel that they are "on," having to be self-conscious and calculating about the impressions they are making--to a degree not required of others.

Also they are likely to feel that the usual interpretations of everyday events have been changed. Minor accomplishments may be assessed as signs of remarkable and noteworthy capabilities. For example, a criminal or a mentally ill person who reads the "classics" may be complimented profusely.

At the same time, minor failings or incidental impropriety may, they feel, be interpreted as a direct expression of their stigmatized differentness. Former mental patients are sometimes afraid to engage in a sharp interchange with spouse, employer, or friends, for fear of what a show of emotion might be taken as a sign of.

Given what stigmatized individuals face when entering a mixed social situation, they may respond with defensive cowering. Or they may attempt to approach such contacts with hostile bravado which can induce its own troublesome reciprocations. Stigmatized persons sometimes vacillate between cowering and bravado, racing from one to the other, thus demonstrating how ordinary face-to-face interaction can run wild. Here again, the mentally ill person's understandable reaction to a social situation can result in behavior that reinforces an opinion that the person is indeed mentally ill.

With what both the stigmatized and "normals" introduce into mixed social situations, it is understandable that not all will go smoothly. We "normals" often try to carry on as if the stigmatized persons fit naturally into the situation, thus treating them as people who are better or people who are worse than we really believe them to be. If that doesn't work, we often act as if they're not even present, giving them only ritual notice. Stigmatized persons are likely to go along with these strategies, at least initially.

Even when no explicit reference is made to the handicap, the interaction often is articulated too exclusively in terms of it--the unspoken evidence felt in under-lying awkwardness, self-consciousness, and heightened awareness. The familiar signs of discomfort and stickiness emerge--guarded references, common words suddenly made taboo, a fixed stare elsewhere, artificial levity, compulsive talking, awkward solemnity.

Stigmatized individuals, because they frequently are exposed to such sticky uneasiness, become more adept at managing awkward situations than we "normals" do.

The Mentally Ill – and the Stereotype of Dangerousness

A person who is found to be mentally ill and dangerous can be involuntarily committed to a mental institution. Saleem Shah, a psychologist specializing in studies of crime and delinquency at the National Institute of Mental Health, has pointed out serious issues in preventive detention and the prediction of dangerousness

Typically, an individual cannot be involuntarily confined to a mental institution simply because of anticipated--or even demonstrated--dangerousness. First, there has to be a finding of mental illness and then of an associated propensity of predicted likelihood for engaging in dangerous behavior.

Since involuntary civil commitment represents an exercise of State power that may deprive individuals of their liberty and also compel them to undergo psychiatric treatment, it raises a fundamental question: What potential harms to society or to the individual are sufficiently serious to justify resorting to coercive confinement?

The question involves public policy, sociopolitical and legal issues, not medical, psychiatric, psychological, or mental health issues. In the existing situation, however, public policy and legal issues are confounded with psychiatric and mental health concerns.

It is difficult to discern how the link between mental illness and dangerous behavior came about and why it continues to be maintained with such enduring zeal.

Several studies have examined the arrest records of patients discharged from mental hospitals. These studies do not support the stereotype of the mentally ill as highly dangerous and unpredictable. Although persons diagnosed as seriously mentally ill (those likely to be hospitalized) are not any less dangerous than persons not so diagnosed, the evidence also points to the conclusion that the mentally ill do not constitute one of the most dangerous groups in our society.

It should be noted that some of the most predictably and demonstrably dangerous persons are not preventively detained or handled with greater concern for public safety. For example, numerous studies have shown that about 50 percent of all fatal auto accidents involve drunken drivers. Our society demonstrates a truly astonishing tolerance for this group of dangerous persons.

Given the numerous court proceedings in which the dangerousness of a mentally ill person is at issue and grave decisions affecting life and liberty must be made, one might assume that some reasonable accurate means of predicting dangerous behavior are available. This assumption is false. No instrument has been developed that can predict violent and other dangerous behavior accurately or satisfactorily. In fact, no test has been developed that can adequately identify such behavior retrospectively--let alone predict it.

A Bill of Rights for Mentally Ill Patients

Title V, Section 501 of the Mental Health Systems Act, 42 U.S.C. 9501, for the first time defines in United States law a Bill of Rights for mentally ill patients.

A person admitted to a program of facility for the purpose of receiving mental health services should be accorded the following:

The right to treatment and services under conditions that support the person's personal liberty and restrict such liberty only as necessary to comply with treatment needs, law, and judicial orders.

The right to an individualized, written, treatment or service plan (to be developed promptly after admission), treatment based on the plan, periodic review and reassessment of needs, and appropriate revisions of the plan, including a description of services that may be needed after discharge.

The right to ongoing participation in the planning of services to be provided and in the development and periodic revision of the treatment plan, and the right to be provided with a reasonable explanation of all aspects of one's own condition and treatment.

The right to refuse treatment, except during an emergency situation, or as permitted under law in the case of a person committed by a court for treatment.

The right not to participate in experimentation in the absence of the patient's informed, voluntary, written consent; the right to appropriate protections associated with such participation; the right and opportunity to revoke such consent.

The right to freedom from restraint or seclusion, other than during an emergency situation.

The right to a humane treatment environment that affords reasonable protection from harm and appropriate privacy.

The right to confidentiality of records.

The right to access, upon request, to one's own mental health care records.

The right (in residential or inpatient care) to converse with others privately and to have access to the telephone and mails, unless denial of access is documented as necessary for treatment.

The right to be informed promptly, in appropriate language and terms, of the rights described in this section.

The right to assert grievances with respect to infringement of this Bill of Rights, including the right to have such grievances considered in a fair, timely, and impartial procedure.

The right of access to a protection service and a qualified advocate in order to understand, exercise, and protect one's rights.

The right to exercise the rights described in this section without reprisal--including reprisal in the form of denial of any appropriate, available treatment.

The right to referral, as appropriate, to other providers of mental health services upon discharge.

Mental Health Association in Alaska

Membership Application

Please count me among the
"People Helping People"

Date: _____

Name _____ Phone _____

Street _____ City/State _____ Zip Code _____

Memberships:

Student/Senior	Sustaining	Contributing	Patron	Corporate
❑$10.00	❑$25.00	❑$50 - 100	❑$100 - 500	❑$1,000 and UP

❑I would like more information about the Association

❑I would be willing to devote time to the efforts of the Association

(Your membership contribution is tax deductible and includes a subscription to COPING Magazine.)

Method of Payment

❑Charge to ❑MasterCard ❑VISA ❑American Express

Credit Card No. ❑❑❑❑❑❑❑❑❑❑❑❑❑❑❑❑

Signature _____ Exp. Date _____ Amount _____

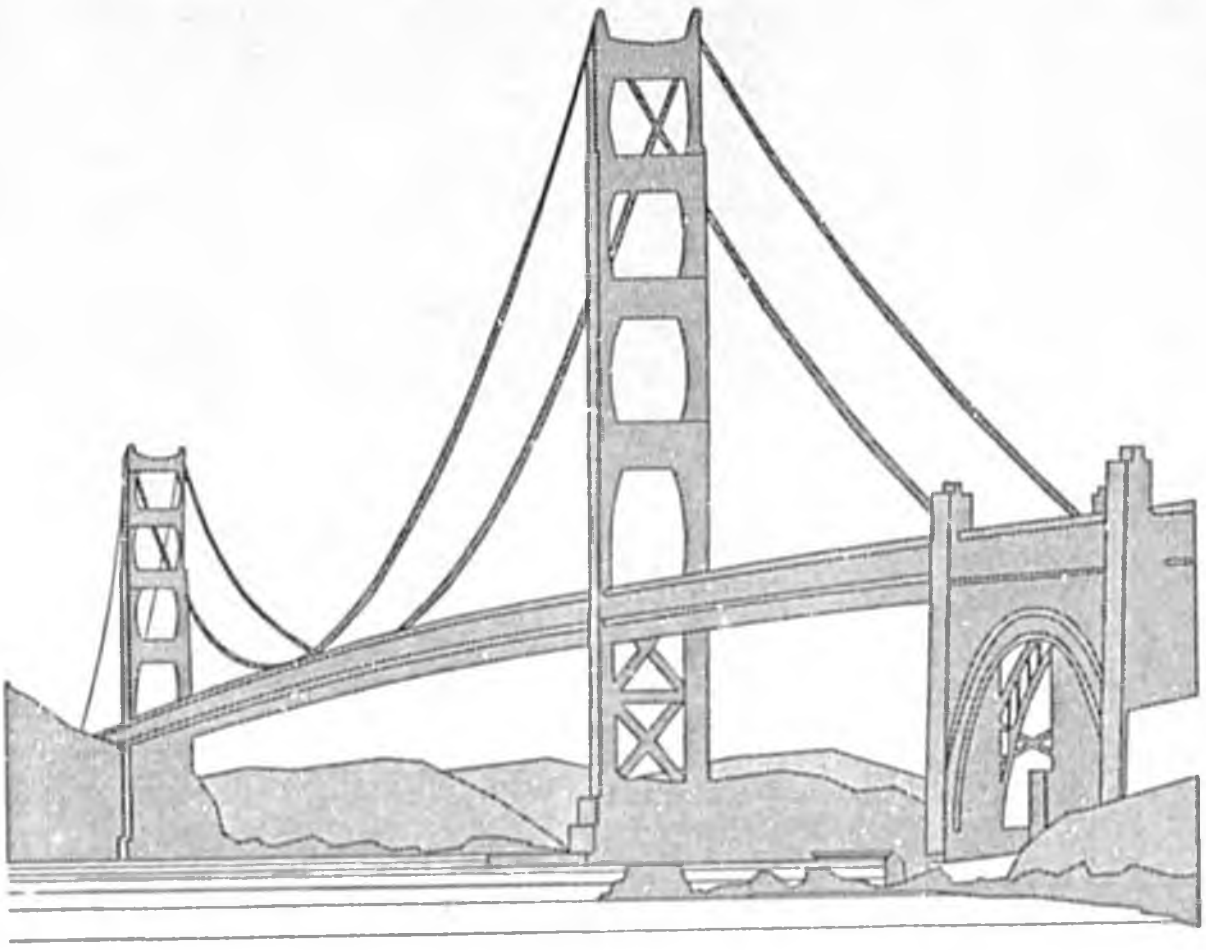
❑Check Enclosed

Please Join & Support the Mental Health Association

Mental Health Association in Alaska
4050 Lake Otis Parkway, Suite 202
Anchorage, Alaska 99508

Advocating to Reduce Stigma

Building Bridges Campaign for Mental Health



FY98 Legislative Priorities

MISSION STATEMENT OF THE BUILDING BRIDGES CAMPAIGN FOR MENTAL HEALTH

* Empower mental health consumers, their families, providers and advocates.

* Turn awareness into action for Alaska's mentally ill and emotionally disturbed citizens.

* Increase state funding for community based services and programs serving persons experiencing mental and emotional illnesses.

* Facilitate a grass roots effort to positively affect the legislative and other public policy decision making processes.

* Increase cohesiveness within Alaska's mental health community.

* Advance principles of Life Domains and coordinate with other advocacy efforts in Alaska.

BRIDGES c/o MHA in Alaska ● 4050 Lake Otis Parkway, Suite 202
Anchorage, Alaska 99508-5221
Tel 907-563-0880 ● Fax 907-563-0881 ● Toll Free 1-800-478-0880
Email mhaa@alaska.net

Dear

The Building Bridges Campaign is pleased to present to you a copy of our FY98 legislative priorities.

Building Bridges signifies the need of people with mental and emotional illnesses to have bridges to their families and communities. Lack of treatment and support results in isolation and dysfunction. With bridges of treatment and support, full community participation, contribution, and responsibility are possible.

On March 18th, 19th and 20th, the Building Bridges group (family members, consumers, service providers, and friends) will come together in Juneau. The purpose is raising public, legislative, and administrative awareness regarding mental health and the needs of those who experience mental and emotional illnesses.

We appreciate the support the Alaska legislature has provided for development of a mental health service system over the past several years. Through your support we have made significant progress in establishing services for some of the groups who suffer mental illness. Unfortunately, our system is still lacking critical elements.

We ask for your support. We must stabilize the service system that is already in place in our communities. Also, ways must be found to continue the development of necessary services. The Building Bridges Campaign endorses the Alaska Mental Health Board's Shared Vision Plan and FY98 Funding Recommendations for Alaska's Comprehensive Mental Health program. The portions of the Board's recommendations which were prioritized by Building Bridges are presented to you in this booklet.

We thank you for your time and for the opportunity to meet with you and your staff.

Respectfully,

Building Bridges

Building Bridges Campaign

Who are we?

The Building Bridges Campaign is a rural and urban group of consumers, family members, and providers. We suffer from and/or provide services for people who experience mental and emotional illnesses. The people we are advocating for have inadequate resources to obtain adequate mental health care.

What do we want?

The Building Bridges Campaign wants mental health care which is:

 Affordable

 Accessible

 Within our Community

 High Quality

What is my stake in this?
The pain and loss for our children, family, friends, and neighbors is real and unrelenting. We have come forward to share our experiences with you.

What am I asking from you?

I need ***your help and your leadership to ensure adequate mental health care*** for Alaskans.

Specifically, we ask your support for:

 **A fully developed system of mental health care**

 **Community mental health program grants**

 **Medicaid program funding**

When people are unable to receive adequate community mental health care, the results are felt in other areas of the community.

When Community Care is not available to:	*Care is Provided by:*
People who are in crisis	*Emergency Rooms* *Hospitals*
People with mental illness	*Alaska Psychiatric Hospital* *Correctional Facilities* *Private Hospitals*
Children with Emotional Disturbance	*Private Hospitals* *Public Institutions*
People with Alzheimer's and Related Disorders, or Seniors with Mental Illness	*Public Institutions* *Private Hospitals* *Nursing Homes*
Adults with Emotional Problems	*Physicians* *Correctional Facilities*

The results of inadequate community mental health services are inappropriate ar l more expensive treatment.

Legislative Concerns

Education Regarding Mental Illness

- People are not mentally ill or emotionally troubled by choice.
- Treatment for mental illness and emotional disturbance works.
- Community treatment works better and costs less and is preferred by the people receiving service.

FY98 Budget

The primary support for mental health services to people without enough money to pay their own way comes from state grants and Medicaid. Both sources are necessary to continue successful community treatment.

FY98 Budget Priorities

Building Bridges endorses the following budget recommendtions for protection of base budget and for budget increments.

The increments proposed are taken from the Alaska Mental Health Board's FY98 Budget Recommendations, dated July 31, 1996.

The Building Bridges group supports the following levels of priority:

The *first* level is for no cuts to the mental health system in either grants or Medicaid budgets.

The *second* level is for increases of service capacity.

Building Bridges Campaign

FY98 Priorities
Summary by Budget Request Unit

DMHDD Mental Health Services Grants

First Level = No Cuts

Funding at Base Budget Levels	**$26,689.1**
General Community Mental Health	$ 888.4
Psychiatric Emergency Services	$6,777.4
Chronically Mentally Ill	$10,918.7
Seriously Emotionally Disturbed Youth	$ 5,789.8
Native Assoc. BRU's	$ 2,267.0

Second Level

FY98 Alaska Mental Health Board's Recommended Proposed Increments	**$8,736.3**

Supporters of the BUILDING BRIDGES Campaign for Mental Health

Northern Region

Copper River Mental Health Center
Fairbanks Community Mental Health Center
Family Centered Services of Alaska
Four Rivers Counseling Center
Maniilaq Counseling Services
North Slope Borough Community Counseling Center
Norton Sound Community Mental Health Center
Railbelt Mental Health & Addictions Program
Tanana Chiefs Conference Mental Health & Alcohol Program
Tok Area Mental Health Center
Yukon Flats Care Center
Yukon-Koyukuk Mental Health & Alcohol Program
Yukon-Tanana Community Mental Health & Substance Abuse Program

Southeast Region

COHO Mental Health Services, Inc.
Community Connections
Gateway Center for Human Services
Islands Counseling Services
Juneau Alliance for the Mentally Ill
Juneau Community Mental Health Center
Juneau Youth Services, Inc.
Lyn Canal Counseling Center
Petersburg Mental Health Services, Inc.
SEARCH-Behavioral Health Services Division
Sound Alternatives
Wrangell Mental Health Services, Inc.

Southcentral Region

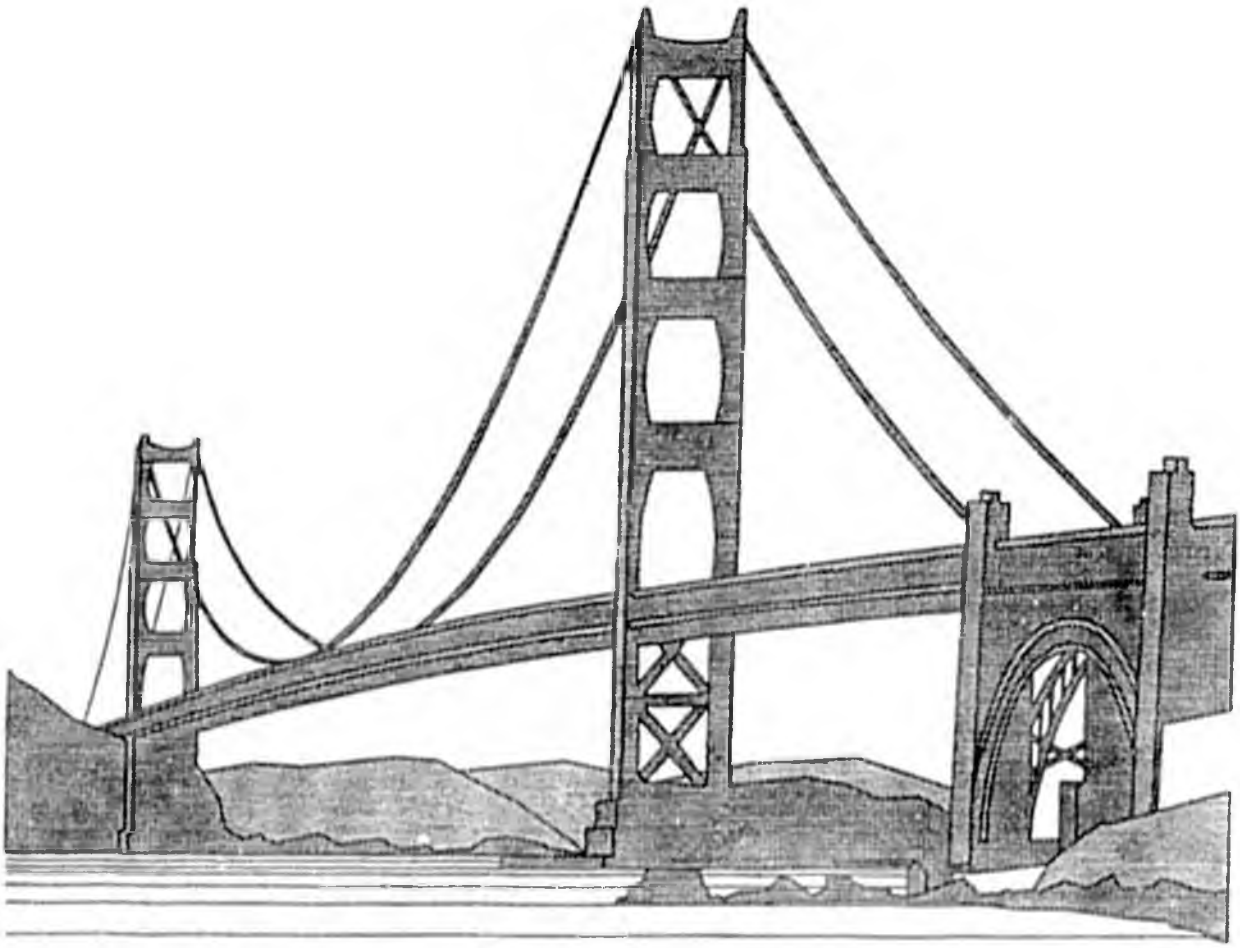
Aleutians East Health Department
Alaska Specialized Education & Training Services
Anchorage Center for Families
Bethel Community Services
Bristol Bay Area Health Corporation
Central Peninsula Counseling Services
Kodiak Island Borough Mental Health Center
Life Quest
Seward Life Action Council
South Peninsula Community Mental Health Center
Southcentral Foundation
Southcentral Counseling Center
The ARC of Anchorage
Yukon Kuskokwim Health Corporation Community Mental Health Center
Valdez Counseling Center

Statewide Advocacy Organizations

Alaska Alliance for the Mentally Ill
Mental Health Association in Alaska
Mental Health Consumers of Alaska
Disability Law Center of Alaska

Mental Health Parity

Resource Kit



Update on Mental Health Parity Laws

Seven States Pass Laws, Four Others Vote To Study Proposals

In October 1996, the American Managed Behavioral Healthcare Association (AMBHA) updated the status of behavioral health parity laws that have been passed or are proposed in 11 states. Five states passed laws requiring health plans to offer mental illness treatment equal to the treatment offered for physical illness. The states are: Maine, Maryland (parity for coverage of mental illness and substance abuse), Minnesota, New Hampshire, and Rhode Island. Maryland and Minnesota require parity coverage for all mental disorders. Maine, New Hampshire and Rhode Island require parity coverage for certain enumerated serious mental illnesses.

In other states, North Carolina and Texas have passed parity laws that require health plans to offer state and local government employees mental illness treatment equal to the treatment offered for physical illness. North Carolina also offers chemical dependency treatment. Louisiana, North Dakota, Oklahoma, and Virginia adopted resolutions to study parity and make recommendations to their legislatures on whether a parity law should be introduced and enacted in those states.

Following is a summary of the states' parity laws and resolutions.

Maine

Definition of mental illness covered by the law
The law requires that health care policies provide coverage for treatment of the following mental illnesses:

- schizophrenia;
- bipolar disorder;
- pervasive development disorder, or autism;
- paranoia
- panic disorder
- obsessive-compulsive disorder; and
- major depressive disorder.

The act defines "a person suffering from a mental or nervous condition" as "a person whose psychobiological processes are impaired severely enough to manifest problems in...social, psychological or biological functioning."

Scope of parity provision
The law requires that all contracts provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than benefits provided for medical treatment. The act's provisions exclude coverage for the treatment of alcoholism or drug dependencies through the diagnosis of a mental illness.
Effective date: July 1, 1996

Maryland

Definition of mental illness covered by the law
The law does not define "mental illness" or "mental health" and therefore, requires parity coverage for all mental illnesses. Note: the law also prohibits discrimination in health care coverage against any person with a drug or alcohol abuse disorder.

Scope of parity provision
The act provides that each contract providing coverage for health care may not discriminate against any person with a mental illness, emotional disorder, or a drug abuse or alcohol abuse disorder by failing to provide befits for treatment and diagnosis of these illnesses under the same terms and conditions that apply under the contract for treatment of physical illness. The law requires companies with 50 or more employees to provide inpatient coverage for mental health and substance abuse treatment on par with physical illnesses.
Effective date: July 1, 1994

Minnesota

Definition of mental illness covered by the law
The law does not define "mental illness" or "mental health" and therefore, requires parity coverage for all mental illnesses.

Scope of parity provision
The law requires that cost-sharing requirements and benefit or service limitations for inpatient and outpatient mental health and chemical dependency services must not place a greater financial burden on the insured or enrollees, or be more restrictive than those requirements and limitations for outpatient and inpatient medical services.
Effective date: August 1, 1995

New Hampshire

Definition of mental illness covered by the law
The law defines "mental illness" as "a clinically significant or psychological syndrome or pattern that occurs in a person and that is associated with present distress, a painful symptom or disability, impairment in one or more important areas of functioning, or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom." The following mental illnesses are covered by the law:

- schizophrenia;
- schizoaffective disorder;
- major depressive disorder;
- bipolar disorder;
- paranoia & other psychotic disorders;
- obsessive-compulsive disorder;
- panic disorder;
- pervasive developmental disorder, or autism.

Scope of parity provision
The law requires that health plans must "provide benefits for treatment and diagnosis of certain biologically-based mental illnesses under the same terms and conditions and which are no less extensive than coverage provided for any other type of health care for physical illness.
Effective date: January 1, 1995

Rhode Island

Definition of mental illness covered by the law
The law defines "serious mental illness" as "any mental disorder

that current medical science affirms is caused by a biological disorder of the brain and that substantially limits the life activities of the person with the illness." The term includes, but is not limited to:

- schizophrenia;
- schizoaffective disorder;
- delusional disorder;
- bipolar affective disorder;
- major depression: and
- obsessive-compulsive disorder.

Scope of parity provision
The law applies to inpatient hospitalization and outpatient medication visits. The law also requires that insurance coverage include the same durational limits, amount limits, deductibles, and co-insurance factors for serious mental illness as for other illnesses.
Effective date: January 1, 1995

Texas

Definition of mental illness and/or chemical dependency covered by the law
The law applies to "biologically based mental illness" which is defined as "a serious mental illness that current medical science affirms is caused by a physiological disorder of the brain and that substantially limits the life activities of the person afflicted with the illness." The term includes:

- schizophrenia;
- paranoid and other psychotic disorders;
- bipolar disorders (manic-depressive disorders);
- major depressive disorders; and
- schizo-affective disorders.

Scope of parity provision
The law applies to state and local government employees.
Effective date: September 1, 1991

North Carolina

Definition of mental illness and/or chemical dependency covered by the law
The law applies to health care coverage for mental illness and chemical dependency. The law defines "mental illness" as:

1. For adults, "an illness which so lessens the capacity of an individual to use self-control, judgment and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance, or control"; and
2. For minors, "a mental condition, other than mental retardation alone that so impairs the youth's capacity to exercise age adequate self-control, or judgment in the conduct of his activities and social relationships so that he is in need of treatment."

Scope of parity provision
The law applies to state government employees.
Effective date: January 1, 1996

Louisiana

Purpose of the study
The Louisiana legislature created the Louisiana Study Commission on Parity and Nondiscrimination in Health Care For Serious Mental Illnesses to study the feasibility of enacting legislation to prohibit discrimination in health insurance policies against persons with severe mental disorders.

Action to be taken by those studying parity
The commission is charged with providing the governor, the speaker of the House of Representatives, and the president of the Senate with a report of its findings and recommendations on enacting parity legislation no later than February 25, 1997.
Date adopted: June 10, 1996

North Dakota

Purpose of the study
The resolution directs the Legislative Council to study the feasibility and desirability of implementing recommendations made by the North Dakota Health Task Force. The task force recommended that a standard health care benefit plan provide coverage for mental illness and chemical addiction equal to the coverage provided for physical illness.

Action to be taken by those studying parity
The legislative council is to study the feasibility and desirability of implementing the recommendations and also monitor the rate of health care cost increases, review the impact of newly enacted programs to improve the health status of state residents and address unmet medical needs in rural areas.
Date adopted: March 20, 1995

Oklahoma

Purpose of the study
The resolution creates a Legislative Task Force on Parity for Mental Illness Insurance Coverage to study the issue of health insurance coverage for mental illness resulting from biologically based chemical disorders, including the cost of such coverage with special emphasis on parity of cost with that of other health care insurance, the extent of such coverage, the savings to society as a result of such coverage, and other pertinent issues.

Action to be taken by those studying parity
The task force is directed to file a written report of its findings and recommendations with the president of the Senate and the speaker of the House by January 7, 1997.
Date adopted: May 31, 1996

Virginia

Purpose of the study
The resolution directs the Parity Task Force, established by the Special Advisory Commission on Mandated Health Insurance Benefits, to attempt to reach consensus on what constitutes adequate mental health and substance health insurance benefits.

Action to be taken by those studying parity
The resolution directs that the task force is to complete its work and submit its findings to the special Advisory Commission on Mandated Health Insurance Benefits. The commission is directed to report the task force findings to the governor and the 1996 session of the General Assembly.

For more information, call E. Clarke Ross, Executive Director, American Managed Behavioral Healthcare Association, 700 Thirteenth Street, Washington, D.C. 20005, 202-434-4565, fax: 202-434-4564.

from Open Minds, January 1997, pages 8 and 9
44 South Franklin Street, Gettysburg, Pennsylvania 17325;
phone (717) 334-1329; fax (717) 334-0538;
E-mail: openmind88@aol.com, Web Site: http://www.openminds.com

BUILDING BRIDGES
4050 Lake Otis Parkway, Suite 202 Anchorage, Alaska 99503
(907) 563-0880● Fax (907) 563-0881●Toll Free 800-478-0880
EMail mhaa@alaska.net

MENTAL HEALTH STATISTICS

PREVALENCE

More than 51 million Americans have a mental disorder in a single year. (NIMH & CHMS, 1994)

During the course of any given year, while more than 40 million adult Americans are affected by one or more mental disorders, 5.5 million Americans are disabled by severe mental illnesses. (NIMH, 1990)

Preliminary studies indicate that 1 in 5 children/adolescents (20 percent) may have a diagnosable disorder. Estimates of the number of children who have mental disorders range from 7.7 million to 12.8 million. (CMHS, 1993). These youth are estimated to have severe emotional or behavioral problems that significantly interfere with their daily functioning.

Less than one-third of the children under age 18 with a serious emotional disturbance receive mental health services. Often, the services are inappropriate. (Children's Defense Fund) (CMHS-Mental Health, U.S., 1994)

An estimated 19.9 million Americans--8.8 percent of the population--experience phobias. About 9.1 million--5.1 percent--live with major depression. Some 3.9 million have obsessive compulsive disorder; 2.0 million have schizophrenia; 2.4 million have panic disorder; and 2.0 million experience bipolar disorders. (NMHA, 1993), (Mental Health, U.S., 1994)

At least two thirds of elderly nursing home residents have a diagnosis of a mental disorder such as major depression. (NIM, 1990)

Up to 25 percent of the population with AIDS will develop AIDS-related cognitive dysfunction. Two-thirds of all people with AIDS will develop neuropsychiatric problems. (Mental Health Liaison Group, 1993)

A majority of the 29,000 Americans who commit suicide each year are believed to have a mental disorder. Suicide is the eighth leading cause of death in the U.S. and the third leading cause of death among people aged 15 to 24. (NIMH, 1994)

Source: For further information on these statistics, contact: Office of External Liaison, Center for Mental Health Services, 5600 Fishers Lane, Room 13-103, Rockville, MD 20857

Nearly one-third of the nation's estimated 600,000 homeless individuals are believed to be severely mentally ill adults. (CMHS, 1992)

More than 1 in 14 jail inmates has a mental illness. Twenty-nine percent of the nation's jails routinely hold people with mental illnesses without any criminal charges. (National Alliance for the Mentally Ill and Public Citizens Health Research Group, 1992)

ECONOMIC COSTS

Mental illnesses impose a multibillion dollar burden on the economy each year. Total economic costs amounted to $147.8 billion in 1990. More than 31 percent of those costs--$46.6 billion--are for anxiety disorders. (The Economic Burden of Affective Disorders. Dorothy P. Rice, Sc.D., and Leonard S. Miller, Ph.D., 1993)

Direct costs--expenditures for professional health care for persons suffering from mental disorders, including care in mental specialty institutions, hospitals and nursing homes, physician and other professional services and prescription drugs--accounted for $67 billion, or 11.4 percent of all personal health care expenditures in 1990. (Rice and Miller, 1993)

Three independent studies between 1971 and 1985 found that mental health costs remained relatively constant during the past 20 years, ranging from 9 to 11 percent of direct treatment costs for health care (Bazelon Center for Mental Health Law, 1993)

Direct treatment and support costs comprise 45.3 percent of the total economic costs of mental disorders. The value of reduced or lost productivity comprise 42.7 percent of the total economic costs of mental disorders. Mortality costs comprise 8 percent and other related cots, including expenditure for criminal justice, the value of lost time due to incarceration and an imputed value for caregiver services, comprise 4 percent. (Rice and Miller, 1993)

Morbidity costs-the value of goods and services not produced because of mental disorders--amounted to $63.1 billion for all mental disorders in 1990. Morbidity costs for anxiety disorders account for $34.2 billion; for schizophrenia, $10.7 billion. The morbidity costs for anxiety disorders reflect their prevalence in the population and the high rate of lost productivity. (Rice and Miller, 1993)

Mortality costs--the current value of lifetime earnings lost by all who died in 1990 because of mental disorders-amounted to 11.8 billion in 1990. (Rice and Miller, 1993)

Other related costs--the costs indirectly related to the treatment and lost productivity of people with mental disorders--amounted to $6 billion in 1990. (Rice and Miller, 1993)

FUNDING

The mental health system relies on a high proportion of funds from public sources rather than private insurance and out-of-pocket payments. In 1990, 28 percent of funds for mental health care came from state and local governments. In general health care, the comparable figure was 14 percent. Medicare, Medicaid, VA and other Federal programs accounted for an additional 26 percent. (National Advisory Mental Health Council)

Parity in Benefit Design: Existing Law

Below are the parity requirements used in 7 states (ME, MD, MN, NC, NH, RI, TX) and the recent national government mandate (DW: Domenici/Wellstone amendment).

1. Requirements apply only to designated diagnoses:
   4: ME, NH, RI, TX

2. Requirements apply to all contracts which provide mental health benefits:
   2: ME, DW (private sector only)

3. Requirements apply to all contracts which provide healthcare benefits:
   3: MD, NC, TX

4. MH coverage must not be more restrictive than requirements and limitations imposed on physical illness:
   5: MN, NH, NC, RI, TX

5. MH coverage must use the same durational limits, amount limits, deductibles, and coinsurance as physical illness coverage:
   2: NC, RI

6. Requirements apply only to the application of lifetime and annual financial caps:
   1: DW

7. Policies must not place a greater financial burden on the uninsured person or enrollee:
   1: MN

8. Medical necessity criteria must be the same for mental illness and physical illness:
   1: ME

9. Medical necessity criteria may be collected to determine whether they are consistent with other illnesses:
   1: RI

10. Requirements apply to addictions disorders:
   2: MD, NC

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Civil Rights and Human Dignity

PAYING FOR PARITY

A Review of Costs in Two States with Health Insurance Laws Mandating Equal Coverage of Mental Health Care

May 1996

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THE BAZELON CENTER

The Bazelon Center is a national nonprofit organization formed in 1972. As the leading national legal advocate for people with mental illness or mental retardation, the Bazelon Center has successfully challenged many of the barriers to dignity and choice that confront adults and children with disabilities. Our precedent-setting litigation has outlawed abuse, won protections against arbitrary confinement and opened up public schools, workplaces, housing and other opportunities for community life. Now, as all low-income people face loss of federal assistance, we work for access by children, adults and elders with mental disabilities to health and mental health care and other needed services and supports.

PAYING FOR PARITY was written by Chris Koyanagi with assistance by Lee Carty as part of the Bazelon Center's campaign for equity and fairness in health coverage for people with mental illness. Permission is hereby granted to quote from or reproduce this document with attribution to the Bazelon Center for Mental Health Law.

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PAYING FOR PARITY

A Review of Costs in Two States with Health Insurance Laws Mandating Equal Coverage of Mental Health Care

A review of two states' experience with laws requiring coverage for mental health services on a par with coverage for physical health care contradicts arguments by opponents of a similar mandate in the Health Insurance Reform Act approved 100-0 by the Senate on April 23, 1996.

The Bazelon Center for Mental Health Law has examined preliminary outcomes in Minnesota and Maryland, the only two states with such a requirement of equal coverage for all mental illnesses, to learn if the "parity" mandate would, as its opponents assert, escalate insurers' and employers' costs and thus make all health coverage unaffordable for hundreds of thousands of employees and their families. The Bazelon Center's review found just the opposite—that ending discriminatory treatment of mental illness by private health insurers is not only fair, it's cost-effective.

This report compares the Minnesota and Maryland statutes with the statutory language of the national parity amendment as approved by the Senate and summarizes data from the two states highlighting the minimal cost-impact of such a requirement.

The Domenici-Wellstone Amendment

The Senate's parity amendment to the House-passed insurance-reform act (HR 3103) was sponsored by Senators Pete Domenici (R-NM) and Paul Wellstone (D-MN) and passed the Senate by a roll-call vote of 68-30. It states:

> — an employee health benefit plan, or a health plan issuer offering a group health plan or an individual health plan, shall not impose treatment limitations or financial requirements on the coverage of mental health

services if similar limitations or requirements are not imposed on coverage for services for other conditions. —Nothing in (this section) shall be construed as prohibiting an employee health benefit plan, or a health plan issuer offering a group health plan or an individual health plan, from requiring preadmission screening prior to the authorization of services covered under the plan or from applying other limitations that restrict coverage for mental health services to those services that are medically necessary.

The impact of the Senate amendment would be:

- to eliminate arbitrary day and visit limits for mental health services when similar arbitrary limits are not imposed on other health care;
- to eliminate the common practice of requiring individuals with mental illness to pay higher out-of-pocket costs, in the form of co-payments and deductibles, than people who have other health conditions;
- to eliminate separate (usually very much lower) lifetime limits on payments for mental health treatment than the lifetime limit for all other health care;
- to continue health plans' use of managed care techniques that, over the past five years, have proven very effective in controlling the utilization and cost of mental health services.

The amendment does not specify that substance abuse or chemical dependency services would be included under the term "mental health services," though it could be interpreted that such services are included.

The Minnesota Statute

In August 1995, a Minnesota law took effect prohibiting greater financial burden or more restrictive coverage for individuals needing mental health or chemical dependency services.

The Minnesota statute is similar to the Senate-approved amendment. It prohibits cost-sharing and service limitations

for inpatient and outpatient mental health and chemical dependency services from being more restrictive or placing a greater financial burden on the enrollee than is the case for inpatient and outpatient medical services.

The Minnesota statute would therefore have a very similar impact to the Domenici-Wellstone amendment. Both eliminate the common practice of having lower visit and day limits on mental health services than on other forms of care and the equally common practice of charging individuals more in out-of-pocket costs when they need mental health care. Both also prohibit lower lifetime caps on mental health care.

The differences between the Minnesota law and the Senate amendment are:

- the Minnesota law specifically includes chemical dependency, while the Senate-approved provision is not explicit on this issue;
- the Minnesota law does not specifically allow for the use of managed care, though it also does not in any way inhibit it.

Accordingly, the Minnesota law is, if anything, more generous that the Senate-approved amendment.

The impact of the Minnesota law:

Because the Minnesota statute only took effect in August 1995, specific studies of its impact have not yet been conducted. However, health plans' response to the mandate yield consistent and very interesting information:

- Allina Health System, a large managed care organization in Minnesota, reported that the mandate on mental health and chemical dependency would add 26 cents per member per month for the 460,000 persons enrolled in Allina plans.
- After nearly a year's experience under the Minnesota parity law, Blue Cross/Blue Shield announced a premium *reduction* of 5%-6% in the plans it writes for small businesses in the state. Blue Cross/Blue Shield uses managed care techniques to control inappropriate utilization. While there is no indication that this reduction is related to the parity provisions, it makes clear that parity did not drive up costs.