

ALASKA LEGISLATURE COMMITTEE FILES 1997-1998 8672

9543 SENATE HEALTH EDUCATION & SOCIAL SERVICES 180

GARY WILKEN

SENATOR
Districts 29 & 30
West Fairbanks



Senate

During Session:
State Capitol, Room 510
Juneau, Alaska 99801-1182
(907) 465-3709 (v)
(907) 465-4714 (f)
www.akrepublicans.org/wilken.btm
E-mail: Senator_Gary_Wilken@legis.state.ak.us

Senate Standing Committees

Chairman: Health, Education,
and Social Services (HESS)
Vice Chairman: Transportation
Vice Chairman: Community and
Regional Affairs

Interior:

119 N. Cushman St., Room 213
Fairbanks, Alaska 99701
(907) 452-3421
Fax (907) 452-3426

Special Committee

Member: Administrative Regulation Review

Senator Gary Wilken

Fax Cover Sheet

Date: 2/16/98

To: Legal Services

Attn: Mike Ford

Fax: 2029

From: Skilg

No. of Pages (including cover sheet): 2

Comments: Changes to SCR 14

Need final -

If you have any problems receiving this transmission, please contact sender at (907) 465-3709.

Mike

One more time for SCR 14 -

delete lines 7+8 on pg 2, version K

insert (1) "differential treatment in health insurance policies between insurance coverage for mental and physical disorders." (or words to that effect)

SCR 14 passed out of (S) HES this morning so I would like a final with the above change.

THANKS!

Shub

3762 - phone

4714 - fax

Marked Up

0-LS0926K
Ford
2/11/98

CS FOR SENATE CONCURRENT RESOLUTION NO. 14(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:

Referred:

Sponsor(s): **SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE**

A RESOLUTION

1 **Establishing the Alaska Task Force on Parity for Mental Health.**

2 **BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

3 **WHEREAS** persons in Alaska with mental health disorders and their families face
4 disparity in the adequacy, scope, and coverage of private health insurance that they need; and

5 **WHEREAS** it is estimated that mental health disorders cost the Alaska economy
6 \$187,272,000 in 1996 in lost productivity, absenteeism, disability, and early death; and

7 **WHEREAS** other states that have adopted insurance parity laws for mental disorders
8 have demonstrated that costs of parity have been far less than projected and that savings to
9 the public through decreased costs of Medicaid, Medicare, and other programs have far
10 outweighed the additional costs; and

11 **WHEREAS** the Alaska Mental Health Board estimates there are over 44,000 children,
12 youth, and adults in the state who experience serious mental illnesses and emotional disorders;
13 and

14 **WHEREAS** the Congress passed the Mental Health Parity Act of 1996 that does
15 address parity for lifetime benefits and annual reimbursement limits for mental health services,
16 but does not address differentiation between mental and physical illnesses with respect to co-
17 payments, deductibles, and benefit design; and

1 WHEREAS 15 other states have established laws addressing mental health parity in
2 insurance practices, and 25 other states introduced bills on the subject in 1997;

3 BE IT RESOLVED by the Alaska State Legislature that the Alaska Task Force on
4 Parity for Mental Health is established for the purpose of studying, after defining the terms
5 "mental disorders," "mental illness," "serious mental illness," and "mental health consumers"
6 for purpose of its work.

7 (1) ~~discrimination in health insurance policies against persons with mental disorders;~~ ^{differential treatment between coverage for} ~~mental-physical~~ ^{disorders.}
8 ~~disorders;~~ (deleted "including chemical dependency disorders")

9 (2) costs of mental health coverage in relation to other health care insurance,
10 with special emphasis on parity, and the extent of such coverage, including deductibles and
11 co-payments, disorders and conditions to be covered, and other pertinent issues;

12 (3) ways to define and quantify unmet mental health needs in the state and
13 recommending meaningful ways to measure the efficacy of treatment of mental health needs
14 by analyzing possible outcome data collection measures;

15 (4) the positive and negative effects on mental health consumers if parity for
16 mental health coverage is mandated in Alaska;

17 (5) the feasibility of implementing any recommendations of the task force
18 through legislation; and

19 (6) the effect of the September 30, 2001, sunset date for the Mental Health
20 Parity Act of 1996 on matters set out in (1) - (5) of this clause; and be it

21 FURTHER RESOLVED that the task force shall be composed of 11 members, as
22 follows:

23 (1) two members of the Senate appointed by the President of the Senate; one
24 member shall be a member of the majority, and one member shall be a member of the
25 minority;

26 (2) two members of the House of Representatives appointed by the Speaker
27 of the House of Representatives; one member shall be a member of the majority, and one
28 member shall be a member of the minority;

29 (3) the commissioner of health and social services, or a designee;

30 (4) one member representing the Alaska Mental Health Board appointed by the
31 Alaska Mental Health Board;

1 (5) two members representing the insurance industry appointed by the President
2 of the Senate and the Speaker of the House of Representatives; one member may be the
3 director of insurance;

4 (6) two members representing mental health consumers and community-based
5 mental health providers appointed by the President of the Senate and the Speaker of the House
6 of Representatives; one member shall be a consumer, and one member shall be a provider; and

7 (7) one member who is employed as staff to a member of the Congress
8 appointed jointly by the President of the Senate and the Speaker of the House of
9 Representatives; and be it

10 **FURTHER RESOLVED** that no general fund money shall be expended to support
11 the task force; and be it

12 **FURTHER RESOLVED** that a simple majority of the members of the task force shall
13 constitute a quorum for the transaction of business, and all actions of the task force shall
14 require the affirmative vote of a majority of the members present; and be it

15 **FURTHER RESOLVED** that the task force may conduct its work during the
16 legislative session and the interim between sessions, may use the teleconference network, and
17 may conduct public hearings to receive testimony about issues relative to parity for mental
18 health; and be it

19 **FURTHER RESOLVED** that the task force shall provide to the Speaker of the House
20 of Representatives, the President of the Senate, and the Governor a report of its findings and
21 recommendations on these matters not later than January 1, 1999; and be it

22 **FURTHER RESOLVED** that the task force is terminated at 11:59 p.m. on
23 February 28, 1999.

CS FOR SENATE CONCURRENT RESOLUTION NO. 14(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

**Offered:
Referred:**

Sponsor(s): SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

A RESOLUTION

1 Establishing the Alaska Task Force on Parity for Mental Health.

2 BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:

3 WHEREAS persons in Alaska with mental health disorders and their families face
4 disparity in the adequacy, scope, and coverage of private health insurance that they need; and

5 WHEREAS it is estimated that mental health disorders cost the Alaska economy
6 \$187,272,000 in 1996 in lost productivity, absenteeism, disability, and early death; and

7 WHEREAS other states that have adopted insurance parity laws for mental disorders
8 have demonstrated that costs of parity have been far less than projected and that savings to
9 the public through decreased costs of Medicaid, Medicare, and other programs have far
10 outweighed the additional costs; and

11 WHEREAS the Alaska Mental Health Board estimates there are over 44,000 children,
12 youth, and adults in the state who experience serious mental illnesses and emotional disorders;
13 and

14 WHEREAS the Congress passed the Mental Health Parity Act of 1996 that does
15 address parity for lifetime benefits and annual reimbursement limits for mental health services,
16 but does not address differentiation between mental and physical illnesses with respect to co-
17 payments, deductibles, and benefit design; and

1 **WHEREAS** 15 other states have established laws addressing mental health parity in
2 insurance practices, and 25 other states introduced bills on the subject in 1997;

3 **BE IT RESOLVED** by the Alaska State Legislature that the Alaska Task Force on
4 Parity for Mental Health is established for the purpose of studying, after defining the terms
5 "mental disorders," "mental illness," "serious mental illness," and "mental health consumers"
6 for purpose of its work,

7 (1) differential treatment in health insurance coverage between a person with
8 a mental disorder and a person with a physical disorder;

9 (2) costs of mental health coverage in relation to other health care insurance,
10 with special emphasis on parity, and the extent of such coverage, including deductibles and
11 co-payments, disorders and conditions to be covered, and other pertinent issues;

12 (3) ways to define and quantify unmet mental health needs in the state and
13 recommending meaningful ways to measure the efficacy of treatment of mental health needs
14 by analyzing possible outcome data collection measures;

15 (4) the positive and negative effects on mental health consumers if parity for
16 mental health coverage is mandated in Alaska;

17 (5) the feasibility of implementing any recommendations of the task force
18 through legislation; and

19 (6) the effect of the September 30, 2001, sunset date for the Mental Health
20 Parity Act of 1996 on matters set out in (1) - (5) of this clause; and be it

21 **FURTHER RESOLVED** that the task force shall be composed of 11 members, as
22 follows:

23 (1) two members of the Senate appointed by the President of the Senate; one
24 member shall be a member of the majority, and one member shall be a member of the
25 minority;

26 (2) two members of the House of Representatives appointed by the Speaker
27 of the House of Representatives; one member shall be a member of the majority, and one
28 member shall be a member of the minority;

29 (3) the commissioner of health and social services, or a designee;

30 (4) one member representing the Alaska Mental Health Board appointed by the
31 Alaska Mental Health Board;

1 (5) two members representing the insurance industry appointed by the President
2 of the Senate and the Speaker of the House of Representatives; one member may be the
3 director of insurance;

4 (6) two members representing mental health consumers and community-based
5 mental health providers appointed by the President of the Senate and the Speaker of the House
6 of Representatives; one member shall be a consumer, and one member shall be a provider; and

7 (7) one member who is employed as staff to a member of the Congress
8 appointed jointly by the President of the Senate and the Speaker of the House of
9 Representatives; and be it

10 **FURTHER RESOLVED** that no general fund money shall be expended to support
11 the task force; and be it

12 **FURTHER RESOLVED** that a simple majority of the members of the task force shall
13 constitute a quorum for the transaction of business, and all actions of the task force shall
14 require the affirmative vote of a majority of the members present; and be it

15 **FURTHER RESOLVED** that the task force may conduct its work during the
16 legislative session and the interim between sessions, may use the teleconference network, and
17 may conduct public hearings to receive testimony about issues relative to parity for mental
18 health; and be it

19 **FURTHER RESOLVED** that the task force shall provide to the Speaker of the House
20 of Representatives, the President of the Senate, and the Governor a report of its findings and
21 recommendations on these matters not later than January 1, 1999; and be it

22 **FURTHER RESOLVED** that the task force is terminated at 11:59 p.m. on
23 February 23, 1999.

SENATE CONCURRENT RESOLUTION NO.
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTIETH LEGISLATURE - FIRST SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Introduced:
Referred:

A RESOLUTION

1 Establishing the Parity for Mental Health Task Force.

2 BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:

3 WHEREAS mental health disorders cost the American economy \$147,800,000,000 in
4 1990 in lost productivity, absenteeism, disability, and early death; and

5 WHEREAS the Alaska Mental Health Board estimates there are over 31,000 children,
6 youth, and adults in the state who experience serious mental illnesses and emotional disorders;
7 many of these Alaskans require and seek mental health services through private insurance that
8 is inadequate in scope and coverage of services required; and

9 WHEREAS the Congress passed the Mental Health Parity Act of 1996 that does
10 address parity for lifetime benefits and annual reimbursement limits for mental health services,
11 but does not address differentiation between mental and physical illnesses with respect to co-
12 payments, deductibles, and benefit design; and

13 WHEREAS, currently, 11 other states have established laws addressing mental health
14 parity in insurance practices, and 35 other states are now considering legislation;

15 BE IT RESOLVED by the Alaska State Legislature that the Alaska Task Force on
16 Parity for Mental Health is established for the purpose of studying

17 (1) discrimination in health insurance policies against persons with mental

1 disorders;

2 (2) costs of mental health coverage in relation to other health care insurance,
3 with special emphasis on parity, and the extent of such coverage, including deductibles and
4 co-payments, maximum number of visits, and other pertinent issues; and

5 (3) unmet mental health needs in the state and the feasibility of implementing
6 any recommendations of the task force through legislation; and be it

7 **FURTHER RESOLVED** that the task force shall be composed of 11 members, as
8 follows:

9 (1) two members of the Senate appointed by the President of the Senate, one
10 member shall be a member of the majority and one member shall be a member of the
11 minority;

12 (2) two members of the House of Representatives appointed by the Speaker
13 of the House, one member shall be a member of the majority and one member shall be a
14 member of the minority;

15 (3) the commissioner of health and social services, or a designee;

16 (4) one member representing the Alaska Mental Health Board appointed by the
17 Alaska Mental Health Board;

18 (5) two members representing the insurance industry appointed by the
19 Governor;

20 (6) three members representing mental health consumers, community based
21 mental health programs or agencies, or health care providers, appointed by the Governor; and
22 be it

23 **FURTHER RESOLVED** that the members of the task force shall receive no
24 compensation for serving on the task force, but shall receive travel and per diem as provided
25 for members of boards and commissions under AS 39.20.180; and be it

26 **FURTHER RESOLVED** that a simple majority of the members of the task force shall
27 constitute a quorum for the transaction of business, and all actions of the task force shall
28 require the affirmative vote of a majority of the members; and be it

29 **FURTHER RESOLVED** that the task force may conduct its work during the
30 legislative session and the interim between sessions and may conduct public hearings to
31 receive testimony about issues relative to parity for mental health; and be it

1 **FURTHER RESOLVED** that the task force shall provide to the Governor, the
2 Speaker of the House of Representatives, and the President of the Senate a report of its
3 findings and recommendations on these matters not later than January 1, 1998; and be it

4 **FURTHER RESOLVED** that the task force is terminated at 11:59 p.m. on
5 February 28, 1998.

TELECOPY COVER SHEET

SHARON MACKLIN

**Government Relations
Phone 586-9518
FAX 586-9520
e-mail - macmor@alaska.net**

Shiela - Senator Wilken's office

TO: _____ 465-4714

ATTN: _____ FAX _____

INSTRUCTIONS: Think for you help
with this.

DATE SENT: 4/16/97 TIME: _____

NUMBER OF PAGES 2 (COUNTING COVER SHEET)

TRANSMITTED BY Sharon Macklin

The draft looks great other than we'd like one change on page 2, line 4, delete "maximum number of visits" and add "disorders and conditions to be covered" We feel this is more in line with looking at the bigger picture of mental health parity.

I've attached page 2 for you to see these changes.

Thanks for your help.

WORK DRAFT

WORK DRAFT

0-LS09261A

1 disorders;

2 (2) costs of mental health coverage in relation to other health care insurance,
3 with special emphasis on parity, and the extent of such coverage, including deductibles and
4 co-payments, ~~maximum number of visits~~ ^{disorders & conditions to be covered} and other pertinent issues; and

5 (3) unmet mental health needs in the state and the feasibility of implementing
6 any recommendations of the task force through legislation; and be it

7 **FURTHER RESOLVED** that the task force shall be composed of 11 members, as
8 follows:

9 (1) two members of the Senate appointed by the President of the Senate, one
10 member shall be a member of the majority and one member shall be a member of the
11 minority;

12 (2) two members of the House of Representatives appointed by the Speaker
13 of the House, one member shall be a member of the majority and one member shall be a
14 member of the minority;

15 (3) the commissioner of health and social services, or a designee;

16 (4) one member representing the Alaska Mental Health Board appointed by the
17 Alaska Mental Health Board;

18 (5) two members representing the insurance industry appointed by the
19 Governor;

20 (6) three members representing mental health consumers, community based
21 mental health programs or agencies, or health care providers, appointed by the Governor; and
22 be it

23 **FURTHER RESOLVED** that the members of the task force shall receive no
24 compensation for serving on the task force, but shall receive travel and per diem as provided
25 for members of boards and commissions under AS 39.20.180; and be it

26 **FURTHER RESOLVED** that a simple majority of the members of the task force shall
27 constitute a quorum for the transaction of business, and all actions of the task force shall
28 require the affirmative vote of a majority of the members; and be it

29 **FURTHER RESOLVED** that the task force may conduct its work during the
30 legislative session and the interim between sessions and may conduct public hearings to
31 receive testimony about issues relative to parity for mental health; and be it

1

AMENDMENT

OFFERED IN THE SENATE BY LEMAN
TO: CS SCR 14 (HES)
LS0926\H date 2/3/98

Page 2, Line 10: DELETE
[UNMET MENTAL HEALTH NEEDS IN THE STATE AND THE
FEASIBILITY OF IMPLEMENTING ANY RECOMMENDATIONS OF THE
TASK FORCE THROUGH LEGISLATION;]

Insert:
ways to define and quantify unmet mental health needs in the state and
recommending meaningful ways to measure the efficacy of treatment of mental health needs
by analyzing possible outcome data collection measures; and

Page 2, line 13: DELETE
[AND BE IT]

Page 2, line 14: insert:

(5) the feasibility of implementing recommendations of the task force through
legislation; and be it

Passed

A M E N D M E N T

#2

OFFERED IN THE SENATE

BY SENATOR GREEN

TO: CSSCR 14(HES), Draft "H" Version

- 1 Page 2, line 4, following "studying":
- 2 Insert ", after defining the terms "mental disorders," "mental illness," "serious mental
- 3 illness," and "mental health consumers" for the purposes of its work,"

Passed

A M E N D M E N T

#3

OFFERED IN THE SENATE

BY SENATOR GREEN

TO: CSSCR 14(HES), Draft "H" Version

- 1 Page 2, line 13, following "Alaska;":
- 2 Insert a new paragraph to read:
- 3 "(5) the effect of the September 30, 2001, sunset date for the Mental Health
- 4 Parity Act of 1996 on matters set out in (1) - (4) of this clause;"

Passed

A M E N D M E N T

#4

OFFERED IN THE SENATE

BY SENATOR GREEN

TO: CSSCR 14(HES), Draft "H" Version

- 1 Page 2, line 6:
- 2 Delete ", including chemical dependency disorders"

- 3 Page 2, line 14:
- 4 Delete "13"
- 5 Insert "11"

- 6 Page 2, lines 25 - 26:
- 7 Delete all material.

- 8 Renumber the following paragraphs accordingly.

- 9 Page 3, lines 2 - 5:
- 10 Delete all material and insert:
- 11 "(7) one member who is employed as staff to a member of Congress
- 12 appointed jointly by the President of the Senate and the Speaker of the House of
- 13 Representatives;"

Passed

4 yes 1 no

AMENDMENT TO CS SCR 14 (HES)
0/LS0926\H 2/3/98

5

by Gary Wilken by request

Page 1, Lines 5-6: DELETE

[WHEREAS it annually costs the state at least \$432,072,000 to treat mental illness and substance abuse; and]

Page 1, Line 5: INSERT

WHEREAS it is estimated that mental health disorders cost the Alaskan economy \$187,272,000 in 1996 in lost productivity, absenteeism, disability, and early death; and

Passed

AMENDMENT TO CS SCR 14 (HES)
0/LS0926\H 2/3/98

by Gary Wilken by request

Page 1, Lines 5-6: DELETE

[**WHEREAS** it annually costs the state at least \$432,072,000 to treat mental illness and substance abuse; and]

Page 1, Line 5: INSERT

WHEREAS it is estimated that mental health disorders cost the Alaskan economy \$187,272,000 in 1996 in lost productivity, absenteeism, disability, and early death; and

Statement Regarding SCR 14

SCR 14 establishes a Task Force to study the issue of mental health parity in health insurance policies, and to make recommendations to the Legislature on how to address mental health parity in Alaska. The Task Force is funded through Mental Health Trust income receipts and will not involve an expenditure of state general funds.

Currently, 9 out of 10 insurance policies nationwide treat mental illnesses differently than physical illnesses. This usually means limited coverage or no coverage at all for mental illnesses. This is despite the increased recognition that mental illnesses are brain disorders which are treatable like any other illness.

The federal Mental Health Parity Act of 1996 takes an important first step in addressing parity by equalizing annual limits and lifetime limits between physical and mental health for most health insurance policies. Many states have bolstered the federal legislation through state parity laws—15 states have already passed mental health parity laws and 25 more, including Alaska, are currently considering legislation.

The fiscal impact of parity looks very encouraging. For example, the Rand Corporation estimates that the average cost of equalizing annual limits between mental health and physical health will only cost one dollar/per person/per year. States that have implemented parity are finding little or no cost increases in private insurance. In addition, increased mental health coverage in the private sector will allow more people with mental illnesses the opportunity to work—and reduce their reliance on Medicaid and other public welfare programs.

There are many different ways to address mental health parity. SCR 14 established an 11-person Task Force to study the approaches that have been taken by other states and recommend options which address the unique needs of Alaska. I urge your support for SCR 14.

ALASKA MENTAL HEALTH BOARD

*Tony Knowles, Governor
State of Alaska*

*431 N. Franklin Street, #101
Juneau, Alaska 99801
Office: (907) 465-3071
FAX: (907) 465-3079
TTY: (907) 465-4764*

January 21, 1998

Dear Senator or Representative:

This information is being provided to you by a steering committee made up of several organizations working together to ensure that parity for mental health is evaluated. We are committed to passage of SCR 14 and HCR 21, which establishes a task force on parity for mental health.

We believe the attached information will provide the basis for your support on this important issue.

For additional information, please contact Walter Majoros, Executive Director of the Alaska Mental Health Board, at 465-3071 or Sharon Macklin, Bridges lobbyist, at 586-9518.

Mental Health Parity Steering Committee Participating Organizations

Alaska State Hospital and Nursing Home Association
Alaska Community Mental Health Services Assoc.
DH&SS, Advisory Board on Alcohol and Drug Abuse
American Psychological Association, Alaska Chapter
Building Bridges Campaign for Mental Health
American Psychiatric Association, Alaska Chapter
Mental Health Association in Alaska
Substance Abuse Directors Association
Disability Law Center of Alaska
Alaska Mental Health Trust Authority
NASW, Alaska Chapter
Rural Mental Health Directors Association
Alaska Alliance for the Mentally Ill

mhparltr.1/98

Mental Health Insurance Parity

Fact Sheet

General

- Nine out of 10 Insurance policies treat mental health differently from physical health problems.
- In 1996 the federal government passed the Mental Health Parity Act, otherwise known as the Dominici Wellstone Law, which goes into effect in January 1998. This law provides partial parity regarding lifetime and annual limits, but there are significant loopholes. It does not provide true parity.
- Fifteen states have passed parity legislation, these states include: Texas, Maine, New Hampshire, Maryland, Rhode Island, Minnesota, Maine, Arkansas, Arizona, Colorado, Connecticut, Indiana, Missouri, South Carolina, and Vermont.
- In 1997, 34 states considered parity legislation, nine states passed legislation while additional states passed legislation in one body and will seek passage in the other body in 1998.

Mental Illnesses are Treatable

- Treatment for bipolar disorder has an 80-90% success rate, treatment of major depression 70-80% successful, and treatment of acute schizophrenia is 60% successful. Treatment of heart disease has just a 45-50% success rate and often requires expensive, dangerous surgery. (1)
- Treatment of mental illness is more affordable now than in the past. With new generations of medications continually being developed, there is increased precision in relieving symptoms and eliminating side effects associated with past treatments.
- The annual cost of treating a person with severe diabetes has been found to be more expensive than treating a person with schizophrenia. (1) In Texas, the total cost of treating state employees and family members with brain disorders was one-fifth the cost of treating cardiovascular disease. (2)
- About 2.8% of all adult Americans, some 5 million people, suffer from a brain disorder. Approximately 40% of those people do not or can not seek treatment, in part, due to a lack of adequate insurance coverage. (3)
- It is estimated that 90% of insurance companies offer less benefits for treatment of mental illness than other physical conditions.

Costs of Mental Health Parity

- A study by the Rand Corporation, published in the *Journal of the American Medical Association*, showed that equalizing annual limits - a key to the provision of the federal Mental Health Parity Act - will only increase costs by only \$1 per employee per year. (4)
- The same study showed that more comprehensive change required by some state laws (i.e. removing limits on inpatient days and outpatient visits) will increase costs by less than \$7 per enrollee per year. (4)
- Since the 1994 passage of the Rhode Island parity bill, premium costs have only increased by 30 cents per person per month. (5)
- In North Carolina, where they passed a parity bill 1992, total mental health costs have actually *declined* 3.4%. (6)
- Persons who have inadequate mental health coverage and need extensive mental health treatment often end up using public resources such as Medicaid and Medicare.

A total of \$26.6 billion was spent on treating severe mental illness in the US in 1990. 57% of all treatment costs for severe mental illness was paid by federal and state entitlement programs at tax-payers expense, whereas, Tax-payers pay only 43% of the costs of all other illnesses. (3)

Alaska

- Prior to the enactment of the federal legislation, the state of Alaska limited the mental health benefits available for their own employees to a \$25,000 *lifetime* maximum cost cap, while other medical services were covered up to a \$1,000,000 lifetime benefit.
- Many private insurance plan in Alaska have low annual limits on mental health benefits or require larger co-payment for mental health services (such as paying 50% of the cost for mental health services, while paying 70% to 90% for other medical services).

References

- 1.) National Advisory Mental Health Council, Health care reform for Americans with severe mental illness; report of the National Advisory Mental Health Council, *American Journal of Psychiatry*, 1993; 150: 1447-1465
- 2.) FY 94-96, HealthSelect of Texas, administered by Blue Cross-Blue Shield of Texas.
- 3.) National Institute of Mental Health
- 4.) Sturm, R. (1997). How Expensive is Unlimited Mental Health Care Coverage Under Managed Care? . *Journal of the American Medical Association*. 278:18, p.1533-1537
- 5.) Emmet, W., Alliance for the Mentally Ill, Rhode Island, April 1996
- 6.) Cameron, S., Executive Director, North Carolina Psychological Association, "State Health Plan Data on the Mental Health Benefit," April 30, 1996.

Mental Health Insurance Parity

Why Consider it?

- ◆ Nine out of 10 insurance companies treat mental illnesses differently from other physical illnesses
- ◆ Mental illnesses are biological brain disorders & should be treated like other illnesses
- ◆ Mental Illness is treatable and treatment costs less than treatment of many other common physical illnesses
- ◆ The *cost* of mental health parity is *minimal* to non-existent! Based on *actual* data from states that have passed parity legislation

RECEIVED
December 3, 1997
DEC 08 1997

The TRUST

The Alaska Mental Health Trust Authority

Senator Gary Wilken
Chairman
Senate Health & Social Services Committee
State Capitol, Room 128
Juneau, AK 99801-1182

Dear Senator Wilken:

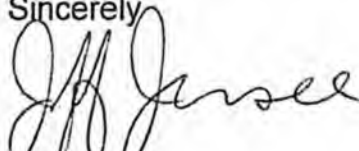
This is to inform you that the Alaska Mental Health Trust Authority has approved \$50,000 to fund the Mental Health Parity Task Force. The Trustees obligated these funds on July 22, 1997 contingent upon passage of SCR 14 or HCR 21 which establishes the Task Force.

The Trust supports addressing the issue of health insurance parity for mental health. It is our expectation that the Task Force would provide more clarity of state policy for mental health services and a report which will guide legislative activity addressing insurance parity.

We understand that this funding will be used for travel, conference calls, printing, staff to the Task Force and other costs related to compiling information regarding parity for mental health.

We appreciate your foresight in introducing this legislation and look forward to continuing to work with you on this important issue to ensure it moves forward.

Sincerely,



Jeff Jessee
Executive Director



States that have Passed Parity

State	Enactment	Type of Bill	Effective On
Texas	1990	Diagnosis-Based; covers all state employees, including local, county, municipal, public higher education and public school employees.	09/01/91
Maine	1993	Diagnosis-Based; covers all groups of 20 plus employees; raised minimum benefits to 100K lifetime; 60 days annual inpatient; 2K outpatient	01/01/94
New Hampshire	1994	Diagnosis-based; applies only to groups & HMOs regardless of size	01/01/95
Maryland	1994	All mental health and substance abuse; medical treatment only	08/01/94
Rhode Island	1994	Diagnosis-based; all health care and HMO policies; in and outpatient equal	01/01/95
Minnesota	1995	All mental Health and chemical Dependency Services equal to in-patient and outpatient medical services	08/01/95
Maine	1995	Diagnosis-based; groups of 20 plus employees; all co-pays and caps, both annual and lifetime equal to all other medical coverage	07/01/96
Arkansas	1997	Equal coverage for mental health and developmental disorders; limitations are cost increase may not exceed 1.5%; only groups of 50 plus employees	06/01/97
Arizona	1997	Mental Illness, mirrors Federal Domenici-Wellstone law, no substance abuse	
Colorado	1997	Diagnosis-based; all co-payment and caps both annual and lifetime are equal to all other medical coverage	
Connecticut	1997	Diagnosis-based; all insurance and HMOs; coverage equal to medical / surgical	10/01/97
Indiana	1997	Mental illness, mirrors Federal Domenici-Wellstone law, no substance abuse and full parity for state employees; including co-pays, caps and lifetime limits	
Missouri	1997	All DSM-VI in managed care plans only; part of larger managed-care regulatory bill	09/01/97
South Carolina	1997	Mental illness, mirrors Federal Domenici-Wellstone law. no substance abuse	
Texas	1997	Diagnosis-based; employee groups of 50 plus; limitations: 60 outpatient visits & 45 inpatient days annually.	01/01/98
Vermont	1997	All mental health and substance abuse	01/01/98

JUDGE DAVID L.
BAZELON
CENTER
FOR
MENTAL
HEALTH
LAW

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

1101 Fifteenth Street N.W.
Suite 1212
Washington D.C. 20005-5002
202/467-5730

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 PARTY 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.

For additional information, contact Chris Koyanagi or Lee Carty at the Bazelon Center. . .

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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

- The state runs a high-risk re-insurance pool for people who are uninsurable (the Minnesota Comprehensive Health Association), which also must adhere to the parity mandate. Recently, this plan was able to *raise* its lifetime cap and provide greater protection to all its enrollees. Again, while there is no evidence that the parity law caused this improvement, the mandate clearly did not impede it.
- The Minnesota Department of Employee Relations, Employee Insurance Division, reported in a fiscal note that the cost of this mandate on the health insurance plans for all state employees would be an added 1%-2% premium increase.
- In implementing this mandate for state employees, two companies that offer plans to state workers handled the mandate in distinct ways. One (Allina) absorbed the increase and made no increase in individual cost-sharing requirements. The other (Health Partners) redistributed the cost across all users of health services by requiring a new \$10 per doctor visit co-payment for all health services.

It is also noteworthy that in the recent legislative session no attempt was made either to repeal the Minnesota parity statute or to weaken it through amendment.

Accordingly, while data are preliminary, all evidence suggests that the Minnesota law requiring parity for all mental illnesses, including chemical dependency, has a minimal impact on the cost of health insurance. This is particularly true when health plans use managed care.

The Maryland Experience

On July 1, 1994, a new law prohibiting discrimination against persons with mental illness in health care contracts went into effect in Maryland. This law covers companies with 50 or more employees.

The Maryland law is also similar to the Domenici-Wellstone amendment. It provides that each contract in the state (including health maintenance organizations) that provides coverage

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

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 costs, 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)

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 than 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.

for health care may not discriminate against any person with a mental illness, emotional disorder or drug abuse or alcohol abuse disorder by failing to provide benefits for treatment and diagnosis of these illnesses under the same terms and conditions that apply for treatment of physical illness. The law applies to companies with 50 or more employees.

Like the Senate-approved amendment, the Maryland law prohibits arbitrary and lower day and visit limits for mental health care than for other health care services. For inpatient services, the law requires parity in terms of out-of-pocket costs; for outpatient services it permits varying co-payments (80% coverage for the first five visits; 65% for visits 6-30; 50% for more than 30 visits per year). Partial hospitalization (day-long treatment) is also a required service. As in Minnesota, substance abuse services are specifically included.

The most important difference between the Maryland law and the Senate-passed amendment is in the outpatient cost-sharing.

The Maryland law went into effect in July 1994, but for the first year, inpatient benefits could be capped at 60 days per year. In July 1995, full parity was implemented.

The Impact of the Maryland law:

The Maryland law built upon a substantial mental health benefit that was already in place, which required coverage of 30 days inpatient care and unlimited outpatient services (with variable co-payments). However, the parity bill greatly expanded inpatient services.

Data are now available on the first year's impact of the Maryland parity law on inpatient utilization. Data on outpatient services are not available because such information is not comprehensively collected in the state.

According to a recent study from the Maryland Health Resources Planning Commission, prior to passage of this law, inpatient stays in Maryland hospitals were declining each year. Blue Cross, other insurance, HMOs, Medicare and Medicaid and other payers all experienced a year-by-year decrease in the length of inpatient stays in psychiatric units of general hospi-

tals. For example, the number of people staying longer than 20 days in private psychiatric hospitals in 1993 was about 24%. In 1995, the year after the law's enactment, it was less than 18%. Over the same period, the number of people staying 10 days or less went from 50.4% to 61.44%.

With a requirement of parity for inpatient mental health treatment, hospital stays continued their decline for all but one payer (in the "other" category) of stays in private psychiatric hospitals. There has been no dramatic increase in utilization of the most expensive mental health service as a result of this law; in fact, cost savings have continued to accrue with respect to inpatient care.

The data from general hospital psychiatric care are even more positive. In general hospital acute care, HMO and private insurance inpatient stays longer than 30 days accounted for less than 0.4% of admissions in 1995, the first full year of the parity requirement. Only 11 people were hospitalized for more than 60 days in 1995, compared with 21 in 1993. The parity amendment was important in offering these few people a guarantee of appropriate continuing care.

As in Minnesota, the Maryland legislature has made no attempt to repeal or amend this law, suggesting that insurers and employers have not had much difficulty meeting the requirements.

In another similarity with Minnesota, Maryland has seen enormous growth in the use of managed care, first under its mental health mandate law and now under its parity amendment.

The overall data on utilization of hospital services reported here indicate that in Maryland, as in Minnesota, requiring an equitable mental health benefit that is essentially the same as the benefit for other health care does *not* result in overutilization of services and therefore would not drive up health care costs significantly.

Conclusion

The disparity between mental illness and other conditions in health insurance coverage is unfair, outdated and unreasonable. There is solid documentation of the high cost to the American economy of mental health disorders: over \$130 billion a year in lost productivity, absenteeism, disability and early death. Yet opponents continue to predict high utilization rates and soaring premium costs as outcomes of a parity mandate. The experience to date of the two states with legislation much like the Domenici-Wellstone parity amendment clearly indicates that their predictions grossly distort what actually occurs.

National mental health policy should be based not on hyperbole but on available evidence—and now evidence *is* available about the impact of mental health parity. Congress, insurers and businesses would do well to look more closely at Minnesota and Maryland to understand how mental health care can be covered for all Americans without the unjustified discrimination in most current health insurance plans.

Resources in Maryland:

Paul Gentile, Maryland Health Resources Planning Commission
410/764-3255

Linda Raines, Mental Health Association of Maryland
410/235-1178

Resources in Minnesota:

Ron Brand, Minnesota Association of Community Mental Health Programs
612/642-1903

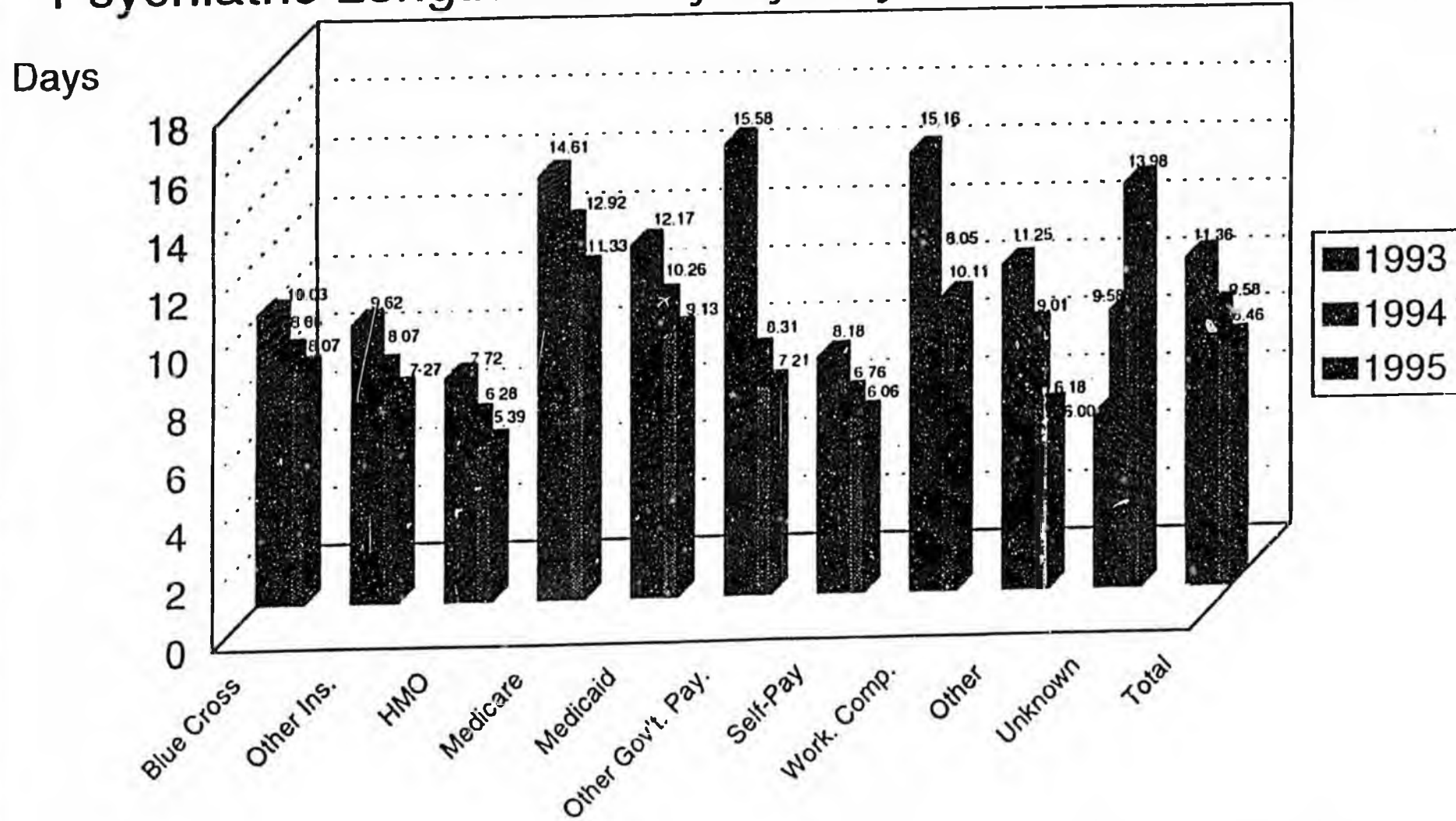
Kathy Kelso, Mental Health Association of Minnesota
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Maryland Acute General Hospital Psychiatric Units

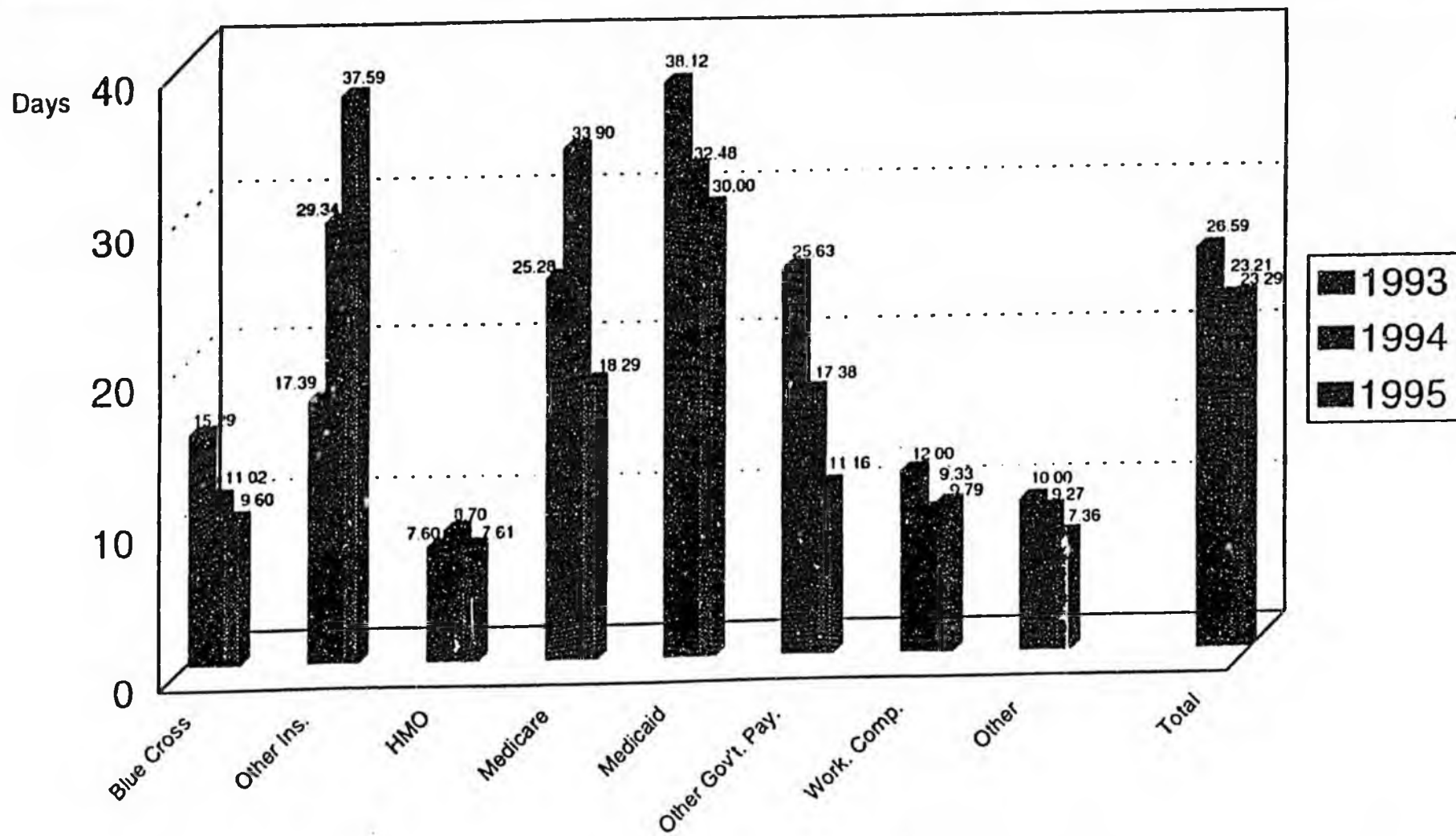
Psychiatric Lengths of Stay By Payor Source CY 1993-1995



Source: Paul Gentile, Maryland Health Resources Planning Commission, May, 1996

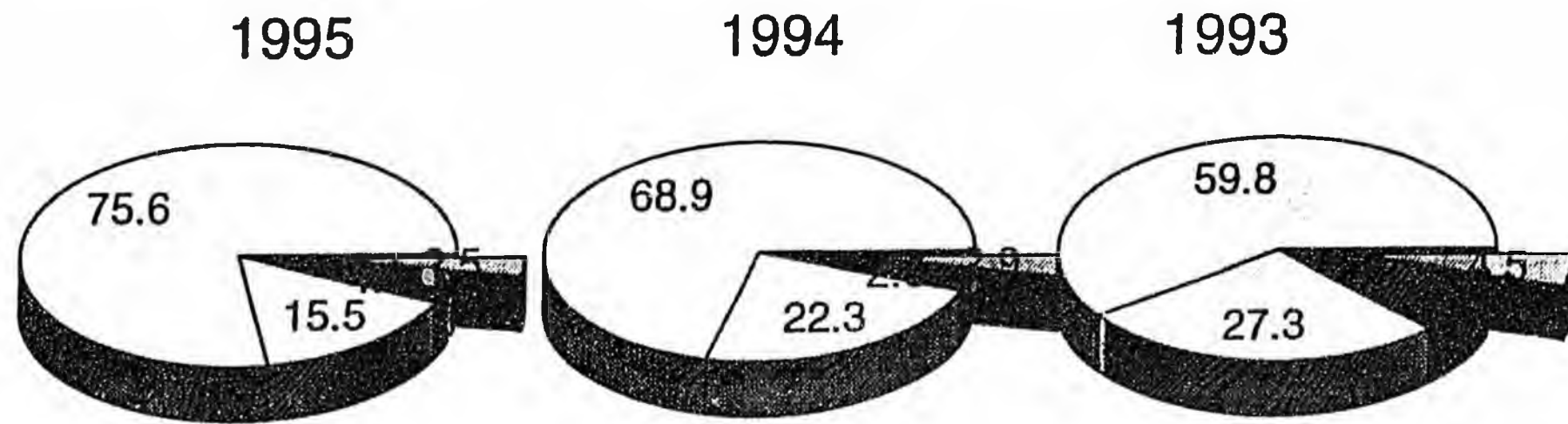
Maryland Private Psychiatric Hospitals

Average Length of Stay By Payor Source CY 1993-CY 1995



Source: Paul Gentile, Maryland Health Resources Planning Commission, May 1996

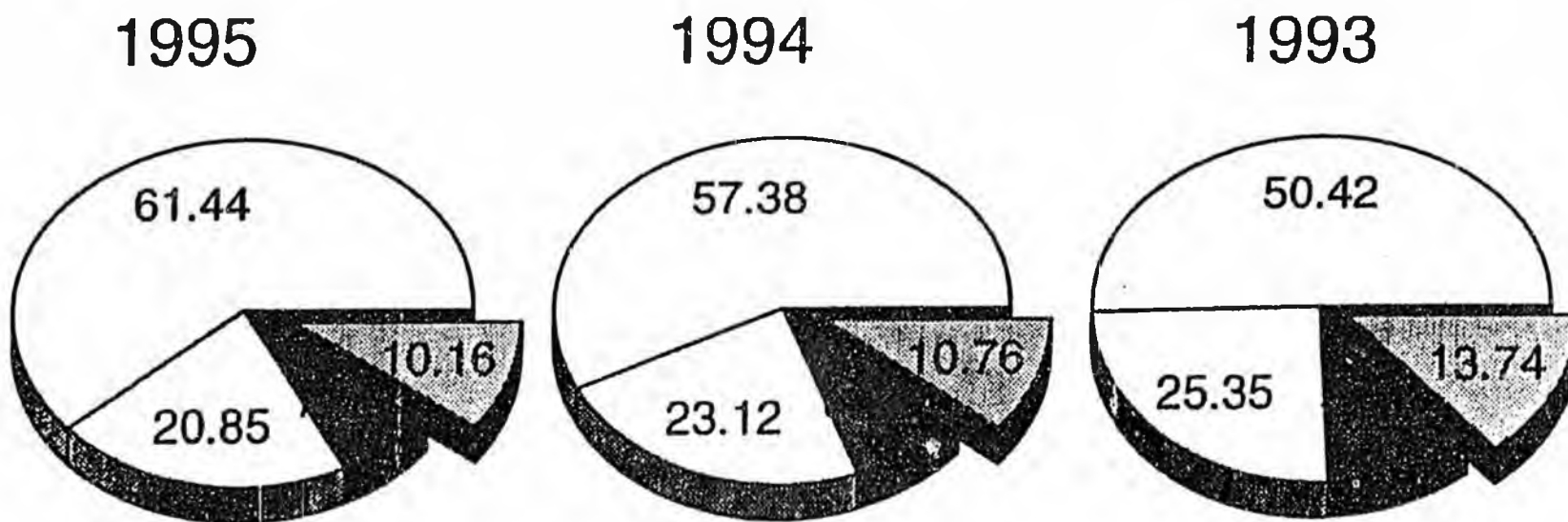
Maryland Acute General Hospitals Psychiatric Discharges Frequency Distribution Percentage By Length of Stay, 1993-1995



□ <10 Days □ 11-20 Days ■ 21-30 Days ▨ >31 Days

Source: Paul Gentile, Maryland Health Resources Planning Commission

Maryland Private Psychaitric Hospitals Discharge Frequency Distribution Percentage By Length of Stay, 1993-1995



<10 Days
 11-20 Days
 21-30 Days
 >31 Days

Source: Paul Gentile, Maryland Health Resources Planning Commission

Bazon Center for Mental Health Law - Mental Health Parity—The First Step

For the first time ever, after decades of appeals from advocates for people with mental illness, Congress has approved legislation regulating discriminatory insurance practices that limit mental health coverage. The legislative language is based on the Mental Health Parity Act of 1996, introduced by Senators Domenici, Paul Wellstone (D-MN) and 12 other Senators. It was enacted as an amendment to an appropriations bill for housing programs (HR 3666, P.L. 104- 191).

Although the amendment does not eliminate all aspects of discrimination, it is a monumental achievement because it establishes the precedent that Congress can override blatant discrimination in health-plan benefits for mental illness.

The amendment's status remained in doubt until the very end due to extremely strong lobbying by the business community, which continues vehemently to oppose any provisions to regulate mental health coverage in insurance plans. Opponents are misinformed about mental illness and the treatments now available—vastly improved in the last two decades. The efficacy of treatment for mental illness is now as well established as treatments for many physical disorders, and the costs are as easily controlled.

What the Amendment Does

The parity amendment was first developed as a compromise fallback position during the debate earlier this year about adding full parity to the Kennedy-Kassebaum health insurance reform bill. It addresses only the all-too-common discrimination in lifetime caps and annual reimbursement limits. Insurance plans would still be free to limit the number of days or visits of coverage per year and to charge higher co-payments for treatment of mental illness than for other health conditions. Currently, insurance policies generally have lifetime caps of \$50,000 for mental health, compared with a cap of \$1 million or more for other health care. Specifically, the amendment:

- + prohibits health plans from having separate and different lifetime caps on mental illness benefits than for medical/surgical benefits (a separate cap is allowable if equal to the medical/surgical lifetime cap), and
- + prohibits separate and different annual reimbursement limits for mental illness benefits, except that separate limits are allowable if the same limits apply to medical/surgical reimbursement.

Restrictions

To win passage, supporters were forced to accept several provisions that restrict applicability of the amendment. It does not apply to plans of employers with 50 or fewer employees (these plans are also exempted from the Kennedy- Kassebaum health insurance reform law).

- + It does not take effect until January 1, 1998, and sunsets on September 30, 2001.
- + It only affects plans that include mental health benefits; nothing prevents a plan from having no mental health coverage at all.
- + It will not apply to any plan if its implementation increases the health plan's costs, resulting in premium increases of one percent or more.
- + Health plans are still permitted to limit mental health services to those deemed "medically necessary" and to use managed care to control costs.

Despite these limitations, this amendment lays the groundwork for further advocacy to establish the rights of people with mental illness to equal coverage under their health care plans.

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To the Bazelon Center's home page.

Bazelon Center for Mental Health Law - chrisk@bazelon.org

Provided by Sharon Macklin

Bazelon Center for Mental Health Law

Advocacy Facts

[Image] One in five families in the United States is directly affected by mental illness. [Bourbon, K. H., Rae, S., et al., Estimating the Prevalence of Mental Disorders in the U.S. Adults from the Epidemiologic Catchment Area Survey, Public Health Reports, Vol. 107, No. 6, Nov-Dec. 1992] Estimates of individuals with serious mental illness count approximately 4 million adults and 2 to 3 million children.

[Image] Although mental illness affects people at all income and education levels, people with serious mental illness are disproportionately represented among our country's poor. This is because, while mental illnesses do not discriminate, people with serious mental illness not only have disabilities stemming from their disorders but also face discrimination in employment, housing, health insurance coverage and health care delivery.

[Image] Although mental illness can be effectively treated and managed, allowing people to lead normal and productive lives, limitations on access to basic services force millions to live in poverty. Publicly funded mental health care (under Medicaid or with state-funded services) is the only means of treatment available to millions of adults and children with serious mental disorders. Though Congress recently took a first step toward ending discriminatory coverage of mental health care, few of these consumers have access to private health insurance; 85% of people with serious mental illness are unemployed. And even when private insurance is available, its limits on mental health coverage often deny treatment just when it is most needed.

Report Documents Affordability of Equal Mental Health Coverage in Maryland and Minnesota

A May 29, 1996, report by two leading national mental health advocacy groups documents the minimal cost impact of state insurance laws mandating equal coverage of physical and mental health services. These findings contradict arguments by opponents of a similar "parity" mandate in the Health Insurance Reform Act approved by the United States Senate on April 23, which, had Congress accepted it, would have prohibited different restrictions on mental health care in insurance plans.

Preliminary outcomes in Minnesota and Maryland, the only two states with the same requirement of equal coverage for all mental illnesses as the Senate bill, show "that ending discriminatory treatment of mental illness by private health insurers is not only fair it's cost effective," the report states.

- * In Minnesota, in the year after the state parity law took effect, one large managed care plan increased its fee by only 26 cents per member per month, while a major insurer announced a 5%-6% premium reduction in the plans it writes for small businesses.
- * In Maryland, data on the first year showed a continuing decline in the length of inpatient stays, the most costly mental health service, in both psychiatric hospitals and psychiatric units of general hospitals.

The report, *Paying for Parity*, was written by Chris Koyanagi, legislative policy director of the Bazelon Center for Mental Health Law and released jointly by the Bazelon Center and the National Mental Health Association. The two groups co-chair the Mental Health Liaison Group, a coalition of 37 national consumer, provider and advocacy organizations that has endorsed the Senate amendment.

"Recognizing that new treatment approaches and managed care techniques make mental health care much more cost-effective than it was even a decade ago, Maryland and Minnesota have led the way," Koyanagi explained. "The Senate endorsed the same approach in its health insurance reform bill and Senator Domenici is committed to parity legislation. By joining him in enacting parity, Congress can move mental health policy out of the dark ages once and for all."

Mike Faenza, president and CEO of the National Mental Health Association, added: "The real-world experiences of these two states directly challenge the hysterical cost estimates produced by our opponents, who represent entrenched special-interest business groups. Rather than breaking the bank, Maryland and Minnesota prove that mental health parity makes both common sense and economic sense."

[Image] For more information about parity, the Mental Health Parity Page includes the Senate debate and a list of Senators with links to their home pages and email addresses.

[Image] For more information about the Bazelon Center's advocacy for parity, send an email message to Chris Koyanagi.

PLEASE DELIVER TO: FRANCES CUTER (AK)



NAMI News

FOR IMMEDIATE RELEASE
December 15, 1997

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PIVOTAL VICTORY FOR AMERICANS WITH SEVERE MENTAL ILLNESSES Mental Health Parity Law to Be Fully Enforced, Administration Sources Reveal

Arlington, VA -- The National Alliance for the Mentally Ill (NAMI) today lauded the Clinton Administration for standing behind a landmark law that ends at least some health insurance discrimination against millions of Americans with severe mental illnesses. The White House is expected to release a formal decision sometime next week.

Despite intense pressure from special interests to allow a legal loophole, the Administration has decided that employers must first comply with the Mental Health Parity Act of 1996 before seeking an exemption because of higher health insurance costs.

"This is a tremendous victory, an important first step in getting equal treatment for mental illness," said NAMI Executive Director Laurie Flynn. "The Administration's move in favor of American families sends a loud and clear message -- discrimination is wrong. We applaud the President for his courage in putting people first."

The parity law, which requires annual and lifetime benefits for mental illnesses to be equal to that offered for other disorders, allows employers to be exempted if their costs rise more than one percent as a result of complying with the law.

According to sources today, the Administration has ruled that employers must first comply with the law in 1998 and develop a cost history (retrospective data) before seeking an exemption. By contrast, some business groups had argued that firms be allowed to use the exemption based on estimates of higher costs (prospective data), thereby relieving them of the responsibility to ever comply.

- more -

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<http://www.nami.org> • NAMIhelpline 1-800-950-NAMI [6264]

December 15, 1997

NAMI: Parity Act to Be Fully Enforced

"The days of being cast as second-class citizens from a health care system historically indifferent to their needs are over," said Flynn. "This modest anti-discrimination law eliminated the double standard held against millions of Americans suffering from brain disorders and instead gives them renewed hope for reestablishing full and productive lives."

The Administration is also expected to require disclosure of the names of firms seeking exemption, a hotly debated issue opposed by many business groups.

While special interests were pressuring the White House to draft regulations that would weaken the law, researchers at the Rand Corporation and the University of California at Los Angeles found that mental health benefits would not add significantly to insurers' costs. The Rand study concluded that parity will increase costs by only about \$1 per employee each year.

Additionally, a survey conducted for NAMI by William M. Mercer, Inc., indicated little resistance by employers to comply with the new law, with 85 percent of businesses familiar with the law either in compliance or planning to make changes to comply with the law by the end of the year.

With more than 168,000 members, NAMI is the nation's leading grassroots organization solely dedicated to improving the lives of persons with severe mental illnesses, including schizophrenia, bipolar disorder (manic-depressive illness), major depression, obsessive-compulsive disorder and anxiety disorders. NAMI has more than 1,140 state and local affiliates in all 50 states, the District of Columbia, Puerto Rico, and Canada.

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NATIONAL ASSOCIATION OF SOCIAL WORKERS
ALASKA CHAPTER

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Testimony Regarding

SCR 14 - PARITY FOR MENTAL HEALTH TASK FORCE

Before the
HEALTH EDUCATION AND SOCIAL SERVICES COMMITTEE
ALASKA SENATE
January 30, 1998

Presented by
Angela M. Salerno, ACSW
Executive Director,
National Association of Social Workers Alaska Chapter



NATIONAL ASSOCIATION OF SOCIAL WORKERS
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The National Association of Social Workers (NASW) is the world's largest organization of professional social workers. NASW's 155,000 members nationwide and 500 in Alaska work in a wide range of settings at all levels in the public and private sectors. Professional social workers focus on vulnerable populations and promote state and federal policies which enhance the lives of the people we serve.

NASW supports SCR 14 and strongly recommends its passage.

The National Institute of Mental Health has reported that one in five adults in the United States will have a mental disorder in the course of the year - using that statistic, over 100,000 Alaskans suffer from a mental illness. Currently in Alaska, many private insurance plans have low annual limits on mental health benefits or require larger co-payments for mental health services. Research shows such discrimination is unfair to sufferers of mental illness, and costly to the state.

This bill will authorize a task force designed to study the problem of discrimination in insurance coverage for brain disorders, mental illness and chemical dependency.

- Mental illness is a biological brain disorder, much like diabetes is a disorder of the pancreas. The assumption that mental health coverage is too costly has no basis in fact, and treats sufferers unfairly. Treatments for brain disorders available today are effective, and often less expensive than treating other serious disorders such as heart disease.
- People who suffer from serious mental illness and have inadequate insurance coverage often must rely on publicly-funded coverage such as Medicaid. The National Institute of Mental Health has reported that 57% of all treatment costs for serious mental illness are paid by federal and state entitlement programs.
- Data from states already providing equivalent coverage for mental illness reveal minimal increases in costs - Rhode Island saw premium costs increase by 30 cents per person per month; in North Carolina total mental health costs have **declined** by 3.4%.
- Chemical dependency disorders are known to be a factor in many social problems including family violence and child abuse. Adequate insurance coverage will help prevent these problems, lowering the cost of publicly funded social services.

Thank you for the opportunity to present this testimony to the committee.

ALASKA MENTAL HEALTH BOARD

TONY KNOWLES, GOVERNOR
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January 15, 1996

Senator Gary Wilken
State Capitol
Room
Juneau, Alaska 99811

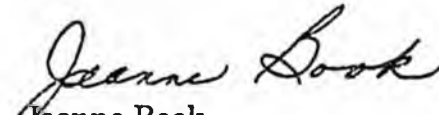
Dear Senator Wilken:

Congress and the President have recently taken small but important first steps toward recognizing that coverage for mental illnesses is a critical and legitimate part of basic medical insurance. Because some distance remains to be covered, Alaska has the opportunity to step to the front of an historic movement that is gathering momentum. The Alaska Mental Health Board emphatically supports the requirement that mental illnesses have full parity with physical illnesses for medical insurance benefit limits and scope of coverage. As the science of mental illness advances, two things become increasingly clear: 1) treatment, by and large, is effective and cost-effective and 2) the health of the mind and of the body are not separate, but different facets of a whole. Mental health services should be part of basic insurance coverage for a several reasons, including:

- Good mental health and good physical health go hand in hand.
- Physically and mentally healthy people contribute more to our economy.
- Crime, poverty, homelessness, and other social ills are closely linked with mental illness.

Finally, parity would be a powerful statement that mental illness is "just another" illness. If we are ever to debunk the stigma and stereotypes attached to mental illness, parity is fundamental. The Board urges you to work for parity. Thank you.

Sincerely,


Jeanne Book
Chair

RECEIVED

JAN 15 1997

STATE OF ALASKA

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE

TONY KNOWLES, GOVERNOR

P.O. BOX 110608
JUNEAU, ALASKA 99811-0608
PHONE: (907) 465-8920
FAX: (907) 465-4410
TOLL FREE: 1-800-420-8920

April 30, 1997

The Honorable Gary Wilken, Chair
Health Education & Social Services Committee
Alaska State Senate, Capitol Building, Room 510
Juneau, AK 99801-1182

Dear Senator Wilken:

The Advisory Board on Alcoholism and Drug Abuse is very interested in Senate Concurrent Resolution No. 14. Parity for alcohol and other drug treatment is a continuing area of concern for Alaska. Treatment programs in Alaska, both public and for profit, depend upon third party payers to provide good quality services. This is most important especially as we enter the new welfare reform era. The establishment of laws requiring parity between mental health, chemical dependency and other physical and psychophysiological illnesses is extremely important. A current national study of people who experience alcoholism or drug addiction problems reports that approximately 35% have insurance. Parity will ensure that employees have access to a full range of alcoholism and drug addiction treatment.

Ideal alcoholism and drug addiction parity law will require health plans to set the same aggregate limits on lifetime and annual dollar caps on coverage for alcohol and drug addiction as are set for medical and surgical services. Parity should also be required for deductibles, co-payments and treatment limits on visits. A current study reported by the National Association of Alcoholism and Drug Abuse Counselors reports that the cost of this issue is four tenths of one percent (.4%) on existing insurance programs.

We recommend that alcohol and other drug rehabilitation services be an additional focus of the recommended task force. To insure that our concerns are considered, we recommend that on line 17, "one member appointed by the Advisory Board on Alcoholism and Drug Abuse" be added. In order to keep the same size to the Task Force, we recommend that line 20 be changed to "two members representing mental health and chemical dependency consumers community mental health and chemical dependency programs or agencies, appointed by the Governor; and be it".

Your consideration on this matter would be appreciated.

Sincerely,



Don Dapevich
Executive Director

cc:Mail for: Sheila Peterson

Subject: SCR 14
From: Sheila Peterson 4/27/98 1:18 PM
To: dmarenah@customcpu.com at CC2MHS1

Denise,

Senator Wilken has requested that I respond to your recent e-mail, Denise. Today the Senate concurred with the changes made recently in the House so SCR 14 has passed the legislature. I would recommend that you closely monitor the task force activities over the summer. Walter Majorous, executive director, Alaska Mental Health Board, will be actively involved with the task force and will be able to keep you posted on the task force's progress. He can be reached at 465-3071.

Senator Wilken supports the activities of the task force and hopes that they will have a productive next few months.

Thanks for keeping in touch.

Sheila Peterson, staff
Senator Wilken

P.S. Probably the reason that your e-mail did not "go through" was that you misspelled Senator Wilken's name. There is no "s" on the end.

Senator_Gary_Wilken@legis.state.ak.us

Marenah, Denise

Sent: Friday, April 24, 1998 1:33 PM
To: 'Senator_Gary_Wilkens@legis.state.ak.us'
Subject: FW: Parity for Mental Health

> -----
> From: Marenah, Denise
> Sent: Thursday, April 23, 1998 4:14 PM
> To: 'Senato_Gary_Wilkens@legis.state.ak.us'
> Subject: Parity for Mental Health
>
> Sir:
>
> I'm a graduate student working on my Social Work degree at the University
> of Anchorage Alaska.
>
> Thank you for your time:
>
> One of my class assignments is to follow a piece of current legislation.
> I am interested in the Parity for Mental Health, Task Force legislation.
>
> Senator Wilkens, I agree with the efforts of the Mental Health board and
> the need to begin addressing issues regarding insurance agency
> differentiation between mental and physical health when determining
> benefit design.
>
> I believe that it is necessary in insuring that adequate services are
> provided for persons in need of mental health care, and physical health
> care on equal grounding.
>
> Senator Wilkens, my recommend the implementation of a Task Force to begin
> addressing this issue more seriously, we have waited long enough in
> holding insurance agencies accountable for implementing fair and equal
> health care practices.
>
> Senator Wilkens, I would appreciate hearing your stance on this issues.
>
> Note: Please reply at e-mail # dmarenah@customcpu.com
> Thank you for your time
>
> Denise Marenah
>

STATE OF ALASKA

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE

TONY KNOWLES, GOVERNOR

P.O. BOX 110608
JUNEAU, ALASKA 99811-0608
PHONE: (907) 465-8920
FAX: (907) 465-4410
TOLL FREE: 1-800-420-8920

February 3, 1998

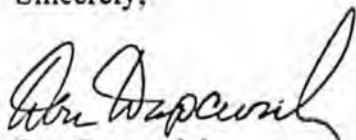
Senator Loren Leman
Alaska State Senate
State Capitol, Room 113
Juneau, Alaska 99801-1182

Dear Senator Leman;

During the Senate Health And Social Service Committee meeting on January 30, 1998, you asked if information could be provided on the cost of mental health and substance abuse to Alaskans. The information that was presented, gave only a national cost. We do not have the information normed for the Alaska population but we can look at the national data and transcribe the national data to Alaska. If we limit the costs to only Axis One diagnosis, the most severe mental illness, and to substance abuse the cost to Alaska is roughly \$187,272,000 for mental illness and \$244,800,000 for substance abuse. The total cost for both is conservatively \$432,072,000.

This estimate is based on the assumption that mental health and substance abuse are no greater or less a problem in Alaska than in the rest of the United States. We have enough empirical evidence to suggest that these problems are significantly greater in Alaska.

Sincerely,



Don Dapceвич
Executive Director
Advisory Board on Alcoholism & Drug Abuse

To: Senate HESS Committee
Senator Wilken, Chair
Senator Leeman
Senator Green
Senator Ward
Senator Ellis

28 January 1998

Public Testimony concerning SCR 14

My name is Kevin Brennan, and my family and I are mental health care consumers. I also have the pleasure of sitting on two statewide committees which are dealing with insurance parity, but it is as a consumer that I am addressing you today.

My family and I have felt the serious and detrimental affects of insurance discrimination. My wife has a severe brain disorder. Once the manager of a large commercial bank, she is currently unable to work. Our insurance had strict limits on the amount of money they would spend on "mental health services"... our lifetime insurance limit for mental health care was 40 times lower than the limit for "medical" care, and there was an annual limit to mental health benefits we could use. Plus they require precertification prior to care, patient care management, and have a limited preferred provider network of doctors and therapists that you must choose from.

What amazes me is that if my wife had a brain tumor or a cancer, if she had Parkinson's or Alzheimer's disease, any of which could produce similar symptoms to what she is now suffering with, then our insurance would allow her to fly to see specialists, would pay for dangerous surgery which might or might not work, and we could pick and choose the best doctors to use. But she doesn't have a tumor; she has a diagnosable, treatable, severe brain disorder called Bipolar Affective Disorder (also known as Manic Depression). She was able somehow to cope with this disorder most of her life, but after a stressful period in her life she broke down. After a short hospitalization, after they did thorough medical tests and could not find a "physical medical disorder" to account for her condition, she was turned out, given a handful of prescriptions, and told to go back home. That was when we discovered that our insurance limited her benefits simply because of the type of medical disorder she had.

We live in a small rural community, and unfortunately the quality and availability of mental health care has been very limited. We tried to work within the guidelines of our insurance, but it was obviously more important to find good treatment for my wife. We have spent tens of thousands of dollars on flights to Anchorage, on hospitalization, and on six different doctors and 4 different therapists. Most of that wasn't covered and has come out of our pockets, even though we spend over \$500 per month on insurance. Our savings are gone, including our children's college money, we have had to take a second mortgage on our home, and even taken out loans to help us make ends meet. It is impossible for us to not keep trying, and I am sure all of you would pay whatever you had to care for a sick spouse or child.

Comment on SCR 14

My wife has had to suffer the side affects of over a dozen changes in her medication. But worse is the stigma attached to mental illness. The uncertainty of having a continuity of care has been a constant worry. She is treated as though she has a character flaw and may be making this all up. She is questioned about her justifiable medical needs at every turn, and monetarily penalized because her disorder is related to brain chemistry. She feels that her medical problems are damaging her family's financial health and the future of her children. She is discriminated against by her own insurance company.

There is a rampant fear that allowing full insurance coverage for severe brain disorders will be too expensive for companies to bear. That is NOT true. Many States now have some form of mental health care insurance parity laws, and their experiences show that it is affordable. Plus we can keep people in the workforce as productive citizens if we treat their illnesses equally with other medical disorders. Many people are arguing that recent Federal Legislation (the Domenici-Wellstone Mental Health Parity Act) ends insurance discrimination, so further State action is not necessary in Alaska. There are serious loopholes to the Federal Legislation. For instance, insurers can not put unequal dollar limits on medical care and mental health care, but they can limit the annual NUMBER of visits to doctors and therapists, or drop their mental health coverage altogether.

Treatment of brain disorders is progressing. New medications which act specifically toward certain disorders, with a minimum of side effects, are being developed. Our knowledge of brain function and chemistry is growing daily. Many previously "incurable" mental health disorders are now successfully treatable. To limit our opportunity to find those cures is unconscionable. To discriminate against a group of people less fortunate than you or I is un-American, and just plain wrong. I urge you to do all in your power to allow for equal treatment for Alaskans who suffer from brain disorders. Insurance parity is only the first step we should be taking against this discrimination.

Sincerely,



Kevin Brennan
P.O. Box 2230
Kodiak, AK 99615
(907) 486-6475



Alaska State Legislature

Please enter into the record my testimony to the Senate HESS Committee
committee name
committee on SCR 14 - Mental Health, dated 1-28-98
bill/subject

(PLEASE SEE 2 PAGE ATTACHMENT)

Signed: Kevin Brennan
Testifier

Representing (Optional)
PO Box 2230 Kodiak, AK 99615
Address
907-486-6475
Phone No.



Alaska Commission on Aging

RESOLUTION 98-2

In support of establishing the Alaska Task Force on Parity for Mental Health

WHEREAS, mental health is essential to the well-being of Alaskans of *all* ages; and

WHEREAS, the number of older Alaskans is growing rapidly; and

WHEREAS, mental illness is often not recognized and treated among older generations, thus leading to unnecessary disability and suffering and loss of productivity; and

WHEREAS, the Alaska Commission on Aging is mandated to make recommendations to the Governor and the Legislature with respect to public policy that sustains us as we age; and

WHEREAS, CSSCR 14, *Establishing the Alaska Task Force on Parity for Mental Health*, will assess and analyze issues and make recommendations concerning health insurance coverage discrimination against those experiencing mental health disorders, costs of mental health coverage in relation to other health care insurance, to identify Alaskans' unmet mental health needs, and assess the feasibility of legislative action to respond to Task Force recommendations;

THEREFORE, BE IT RESOLVED that the Alaska Commission on Aging supports HCR 21 and SCR 14 to establish the Alaska Task Force on Parity for Mental Health.

Adopted this 10th day of February, 1998.

Donald M. Hoover

Donald Hoover, Chair

Sheela

[Image] The report lists the names and telephone numbers of sources in each state. Copies can be ordered through our publications page.

You are welcome to reproduce all or part of the text on this web page electronically or in print, crediting as your source the Bazelon Center for Mental Health Law. We would greatly appreciate receiving a copy of your use of our material. Please send to:

Lee Carty, Communications Director
Bazelon Center for Mental Health Law
1101 15th Street NW, Suite 1212
Washington, DC 20005-5002
Fax: 202-223-0409
e-mail: leec@bazelon.org

To the Bazelon Center's home page.

Bazelon Center for Mental Health Law - chrisk@bazelon.org

Provided by Sharon Macklin

SCR

19

SENATE COMMITTEE REFERRAL
First Committee of Referral

DATE: 1/12/98

FURTHER: Finance

Date of 5-Day Notice: 1/22/98
 (in accordance with Uniform Rule 23)

DATE TURNED
 IN TO OFFICE: 2/6/98

HESS Committee considered SENATE CONCURRENT RESOLUTION NO. 19

Relating to the use of prototype designs in public school construction projects.

and recommends:

- be replaced with _____ CS SCR 19 (HES)
- adopt previous _____ CS _____
- attached amendment(s)
- adopt Letter of Intent by _____ Committee
- further referral to the _____ Committee

- Senate Bill:**
- same title
 - new title
- House Bill:**
- same title
 - technical title
 - new: SCR# _____

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	NR	DNP	AM
<i>[Signature]</i>	<input checked="" type="checkbox"/>	<i>[Signature]</i>	<input checked="" type="checkbox"/>		
		<i>[Signature]</i>	<input checked="" type="checkbox"/>		
		<i>[Signature]</i>			<input checked="" type="checkbox"/>
CHAIR: <i>[Signature]</i>	<input checked="" type="checkbox"/>	CHAIR:			

NEW FISCAL NOTE(S):

Department Date Zero Fiscal

Department	Date	Zero	Fiscal
Education	1/27/98	indisc.	

PREVIOUS FISCAL NOTE(S):*

Department Date Zero Fiscal

Department	Date	Zero	Fiscal

APPROPRIATION -- no fiscal note

*include fiscal notes accompanying Governor's bill

0-LS1345B
Ford
2/4/98

CS FOR HOUSE CONCURRENT RESOLUTION NO. 24(STA)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY THE HOUSE STATE AFFAIRS COMMITTEE

**Offered:
Referred:**

Sponsor(s): HOUSE RULES COMMITTEE BY REQUEST OF THE DEFERRED MAINTENANCE TASK FORCE

A RESOLUTION

1 Relating to the use of prototype designs in public school construction projects.

2 BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:

3 WHEREAS art. VII, sec. 1, Constitution of the State of Alaska, requires the state to
4 establish and maintain a system of public schools to meet the educational needs of children
5 throughout the state; and

6 WHEREAS the Alaska State Legislature recognizes the crucial role that local school
7 districts serve in the state in meeting this most important constitutional responsibility; and

8 WHEREAS the Alaska State Legislature understands the challenges school districts
9 face to ensure Alaska's children have skilled teachers, quality curriculum, and safe schools;
10 and

11 WHEREAS continued growth is projected in the state's school age population that will
12 increase the need for new schools and place further pressure on school district budgets; and

13 WHEREAS prudent stewardship of state resources requires that every effort be made
14 to get the best value for each state dollar spent; and

15 WHEREAS use of prototype school designs has enabled the Municipality of
16 Anchorage, Fairbanks North Star Borough, Kenai Peninsula Borough, and Matanuska-Susitna
17 Borough school districts to more quickly and economically respond to their district's need for

1 new schools and realize cost savings; and

2 **WHEREAS** the use of prototype school designs reduces future routine and major
3 maintenance cost and improves a school district's maintenance program through the use of
4 standardized building components, systems, and products; and

5 **WHEREAS** school districts experience substantially fewer problems during the first
6 school year in a prototype school, thereby reducing the school district's costs and improving
7 the teaching environment for teachers and learning environment for students; and

8 **WHEREAS** public facilities should be designed to accurately reflect the unique needs
9 of our subarctic and arctic environments, and northern design principles can help minimize
10 annual operating and maintenance costs;

11 **BE IT RESOLVED** that the Alaska State Legislature encourages school districts to
12 use prototype school designs wherever feasible so future school classrooms can be constructed
13 quicker and funds maximized; and be it

14 **FURTHER RESOLVED** that the Governor is requested to direct the Department of
15 Education to develop prototype school designs for grades K - 6 in consultation with
16 engineering and architecture design professionals, including their statewide and regional
17 organizations, who are familiar with the unique climatic conditions in this state as well as
18 other conditions that affect application of appropriate school designs; and be it

19 **FURTHER RESOLVED** that the Governor is requested to direct the Department of
20 Education to consult with the bond reimbursement and grant review committee in developing
21 incentives for school districts to use prototype school designs in school construction funded
22 through the educational facilities maintenance and construction fund (AS 37.05.560); and be
23 it

24 **FURTHER RESOLVED** that the Governor is requested to direct the Department of
25 Education, in those instances where a prototype design may not be appropriate, to identify
26 components within prototype building designs that can be standardized and can be
27 incorporated into the school design; and be it

28 **FURTHER RESOLVED** that, if statutory changes are necessary to implement these
29 incentives, the Department of Education is requested to report suggested statutory changes to
30 the legislature by March 1, 1998, so the changes can be considered by the Second Regular
31 Session of the Twentieth Alaska State Legislature.

1 **COPIES** of this resolution shall be sent to Shirley J. Holloway, commissioner of
2 education, to the Alaska State Board of Education, and to the school board of each school
3 district.

0-LS1357F ✓
Ford
2/5/98

CS FOR SENATE CONCURRENT RESOLUTION NO. 19(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

**Offered:
Referred:**

Sponsor(s): SENATE RULES COMMITTEE BY REQUEST OF THE DEFERRED MAINTENANCE TASK FORCE

A RESOLUTION

1 **Relating to the use of prototype designs in public school construction projects.**

2 **BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

3 **WHEREAS** art. VII, sec. 1, Constitution of the State of Alaska, requires the state to
4 establish and maintain a system of public schools to meet the educational needs of children
5 throughout the state; and

6 **WHEREAS** the Alaska State Legislature recognizes the crucial role that local school
7 districts serve in the state in meeting this most important constitutional responsibility; and

8 **WHEREAS** the Alaska State Legislature understands the challenges school districts
9 face to ensure Alaska's children have skilled teachers, quality curriculum, and safe schools;
10 and

11 **WHEREAS** continued growth is projected in the state's school age population that will
12 increase the need for new schools and place further pressure on school district budgets; and

13 **WHEREAS** prudent stewardship of state resources requires that every effort be made
14 to get the best value for each state dollar spent; and

15 **WHEREAS** use of prototype school designs has enabled the Municipality of
16 Anchorage, Fairbanks North Star Borough, Kenai Peninsula Borough, and Matanuska-Susitna
17 Borough school districts to more quickly and economically respond to their district's need for

1 new schools and realize cost savings; and

2 **WHEREAS** the use of prototype school designs reduces future routine and major
3 maintenance cost and improves a school district's maintenance program through the use of
4 standardized building components, systems, and products; and

5 **WHEREAS** school districts experience substantially fewer problems during the first
6 school year in a prototype school, thereby reducing the school district's costs and improving
7 the teaching environment for teachers and learning environment for students; and

8 **WHEREAS** public facilities should be designed to accurately reflect the unique needs
9 of our subarctic and arctic environments, and northern design principles can help minimize
10 annual operating and maintenance costs;

11 **BE IT RESOLVED** that the Alaska State Legislature encourages school districts to
12 use prototype school designs wherever feasible so future school classrooms can be constructed
13 quicker and funds maximized; and be it

14 **FURTHER RESOLVED** that the Governor is requested to direct the Department of
15 Education bond reimbursement and grant review committee to develop prototype school
16 designs for elementary schools in consultation with engineering and architecture design
17 professionals, including their statewide and regional organizations, who are familiar with the
18 unique climatic conditions in this state as well as other conditions that affect application of
19 appropriate school designs; and be it

20 **FURTHER RESOLVED** that the Governor is requested to direct the Department of
21 Education to consult with the bond reimbursement and grant review committee in developing
22 designs and incentives for school districts to use prototype school designs in school
23 construction funded through the educational facilities maintenance and construction fund
24 (AS 37.05.560); and be it

25 **FURTHER RESOLVED** that the Governor is requested to direct the Department of
26 Education, in those instances where a prototype design may not be appropriate, to identify
27 components within prototype building designs that can be standardized and can be
28 incorporated into the school design; and be it

29 **FURTHER RESOLVED** that, if statutory changes are necessary to implement these
30 incentives, the Department of Education is requested to report suggested statutory changes to
31 the legislature by March 1, 1998, so the changes can be considered by the Second Regular

1 Session of the Twentieth Alaska State Legislature.

2 **COPIES** of this resolution shall be sent to Shirley J. Holloway, commissioner of
3 education, to the Alaska State Board of Education, and to the school board of each school
4 district.

CS FOR SENATE CONCURRENT RESOLUTION NO. 19()

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY

Offered:

Referred:

Sponsor(s): SENATE RULES COMMITTEE BY REQUEST OF THE DEFERRED MAINTENANCE TASK FORCE

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14 Education to develop prototype school designs for schools in consultation with engineering
15 and architecture design professionals, including their statewide and regional organizations, who
16 are familiar with the unique climatic conditions in this state as well as other conditions that
17 affect application of appropriate school designs; and be it

18 **FURTHER RESOLVED** that the Governor is requested to direct the Department of
19 Education to consult with the bond reimbursement and grant review committee in developing
20 designs and incentives for school districts to use prototype school designs in school
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22 **FURTHER RESOLVED** that the Governor is requested to direct the Department of
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TWENTIETH LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

**Offered:
Referred:**

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3 district.



Prototype School Design – CS SCR 19

This bill deals with prototypical designs for schools. Currently, school designs are the responsibility of each local school district. There are some districts in Alaska who have made good use of prototypical designs and this use may have resulted in some cost savings in the construction costs of the schools using these designs. In looking at the use of prototypical designs and their possible use as a means of controlling costs of school construction attention has been focused on the use of prototypical designs in Anchorage and Fairbanks. It is useful to note that implementation of prototypical design in these areas has been limited to elementary schools. The use of prototypical designs has been successful in these areas for several reasons. These include:

- Similar site conditions (i.e., topography, soils, climate)
- Facilities are being used under the same educational program
- The same contractor group bid the jobs, utilizing an experienced labor pool
- Staff and community input was limited due to previous acceptance of the design

If the primary motivation for developing and using a prototype (or, series of prototypes) in the state, part of the investigation should consider all aspects of the costs which would accrue to prototype use. This should include a review of the problems associated with state use of a stock plan implemented in the 1970's in rural Alaska.

This bill considers two requirements:

1. "that the Department of Education is requested to develop a prototype school designs for core school functions that could be used by school districts; and
2. "that the Department of Education is requested to develop incentives for school districts to use prototype school designs in school construction funded through the educational facilities maintenance and construction fund (AS 37.05.560).

These two requirements offer several challenges. The challenges involve issues the breadth of the scope desired by the legislature and what is meant by "core school functions".

The request to develop "...a prototype designs for core school functions..." appears to focus on a concept presented in a department briefing paper on prototypes presented to the Bond Reimbursement and Grant Review Committee. The paper discusses the conditions where prototypes have been successful and suggests that use of prototypical components might be appropriate for Alaska. If a prototype design is to be developed, there are several factors which might effect the successful use of the design. Two of these are:

- There are at least three major climatic regions of the state, southeast, central and arctic, which require unique design considerations.
- There are also varying size requirements required by schools districts around the state. These vary from the 600 student elementaries being built in Anchorage and Fairbanks to the 25



student K-12 school needed in Healy Lake. The size requirements could be considered in terms of a series of ranges (e.g., 0-50, 51-250, 250-500, and 500 and over). However, this still leaves a large number of design options to be considered when coupled with the three climatic regions.

- Is the project a new totally new project, or is it an addition to an existing school?

Just these three factors begin to frame the challenges of designing a single prototype to be used across the state. The concept becomes more feasible when considering that the Deferred Maintenance Task Force may have been suggesting use of prototypical components. If the concept is applied to the "core school functions" specified in this Resolution, components could be identified, e.g., mechanical room, office/teacher preparation areas, multipurpose rooms, library/multi-media center/computer lab areas. These could then be configured and sized for population ranges similar to those noted earlier in this discussion.

The second requirement of the Resolution is a request to develop incentives for districts to use prototype school designs. The types of incentives to be developed are not specified and could range from point awards, which might effect the priority of projects ranked by the department to financial incentives. Certainly any incentives developed would need to be applied equally to all districts. The challenge in developing these incentives is in first assuring that the concept of prototype use is applicable to all districts. If, as has been suggested in several nationally published papers, prototypes only work well in a homogeneous environment of moderate to high growth, then they may only work in the three large districts in Alaska: Anchorage, Fairbanks, and Mat-Su.

As the concept of using prototypical components is explored, the design of each component will need to include the flexibility to support a variety of configurations. This will allow designs to adapt to meet the demands presented by the site, wind driven rain or drifting snow, and unique programmatic demands.

The requirement to develop incentives is dependent upon how the issue of prototypes is developed. Design development costs for total prototypical schools could vary depending on the number of factors considered.

Further development of the range options and application for an Alaskan prototype will allow definition of the potential costs.

ALASKA STATE LEGISLATURE

Rep. Eldon Mulder, Co-Chair
Rep. Kim Elton
Rep. Richard Foster
Rep. Jeannette James
Rep. Beverly Masek
Rep. Gail Phillips



Sen. Tim Kelly, Co-Chair
Sen. Loren Leman
Sen. Georgianna Lincoln
Sen. Robin Taylor
Sen. Gary Wilken
Sen. Mike Miller

DEFERRED MAINTENANCE TASK FORCE

Capitol Building, Room 501 • Juneau, Alaska 99801 • Phone (907) 465-2647 • FAX (907) 465-3518

Sponsor Statement

Senate Concurrent Resolution 19 *HES Committee Substitute*

Use of Prototypical Designed Schools

The Deferred Maintenance Task Force received testimony on the cost savings and operational advantages of prototypical schools. Several communities use them today. The Task Force found that the savings in design cost and the ease of maintaining several identical physical plants offered the opportunity to fund more schools as the savings are achieved.

One rural school district has expressed great interest in using a prototype for schools in its district. They are currently in discussions with the Fairbanks School District to learn from the Fairbanks experience.

This resolution requests the Department of Education to develop prototype schools and incentives for districts to use them. The Department of Education is requested to report to the legislature by March 1, 1998 any statutory changes that may be needed to accomplish this goal.

The proposed Committee Substitute speaks to several concerns that have been expressed and several technical corrections.

*Page 1 line 6
replaces "critical" with "crucial"*

*Page 1 lines 15 through Page 2 Line 1
corrects the names of the municipalities*

*Page 2 Lines 2 through 7
These lines were added at the suggestion of representatives of the Fairbanks North Star Borough School District. They refer to the success of*

SCR 19
Sponsor Statement

prototype designs in reducing maintenance costs and reducing first year operational problems with new schools.

Page 2 lines 8 through 10

notes that designs need to reflect the unique environments found in Alaska

Page 2 line 15

specifies that the development of prototype designs is for elementary grades

Page 2 lines 15 through 18

adds consultation with architects, engineers, and professional organizations familiar with Alaskan climactic conditions and its effect on school design

Page 2 line 20

directs the Department of Education consult with the bond reimbursement and grant review committee

Page 2 lines 24 through 27

adds a resolve to request that the Dept. of Education identify prototype components when a prototype design might not be appropriate.

Page 2 Line 30

Charges report date to March 15


MEMORANDUM

State of Alaska
Department of Education

To: Senate HESS

Date: January 27, 1998

Phone: 465-1858

From: Michael Morgan 
Facilities Manager
ESS/Facilities Support

Subject: Prototypes
SCR 19

The Bond Reimbursement and Grant Review Committee is convened by statute (AS 14.11.014) and is given as one of its duties a charge to: "...analyze existing prototypical designs for school construction projects..." (AS 14.11.014 (b)(4)). The attached briefing paper was prepared by the department and was presented to the Committee for consideration at their December 3, 1997 meeting.

Submitted for background information, this paper frames issues surrounding the use of prototypical designs and results of research on the subject.

By: Facilities Staff

Date: December 3, 1997

Phone: 465-6906

File: g:\br_grcom\papers\prototyp

For: BR&GR Committee

Subject: Prototype Schools

BRIEFING PAPER

Background

As part of the legislation enabling this committee, one of the specific charges specified was for the committee to "analyze existing prototypical designs for school construction projects"(AS 14.11.014(4)). This paper looks at the issue of use of prototypical designs from a generic perspective, addresses their possible use from a state perspective and provides a recommended policy statement for the department to implement.

Department staff is currently analyzing two existing prototypical designs in current use.

Discussion

One of the items for review and study established by statute for the Committee is the use of prototype school designs in Alaska.

A dictionary definition of prototype is, "the first thing...of it's kind; a model." This of course differs from the common application of the term to mean stock plans or "off the shelf" design.

Considerable literature exists on the subject of prototypes in relation to schools, including seminars at the 1995 CEFPI conference in Scottsdale. Various experiments using prototypes in school districts in Alaska have been tried with varying degrees of success.

Some surveys have been made of school districts and state Departments of Education regarding "stock plans." The Georgia legislature, after a survey of other states, (a copy of the Georgia study is available), recently rejected their use. Of the states contacted, 41 responded. Three states used stock plans, three rejected them, nine did feasibility studies regarding use and rejected them, nine built a total of 39 schools from stock plans and would not do so again. Maine built 49 very small schools from stock plans but would not do so again, based on programmatic limits

and liability problems. California rejected the use of prototypes based upon staff costs to modify and update plans, comply with codes, adapt to site conditions and, because of the lack of local involvement in the design process.

Prototypes have been used more successfully in the following four ways:

1. As simple planning tools, examples of successful solutions to similar programmatic, space, construction type, and site orientation.
2. As basic component designs and details, specifications and planning options that could be put together like "Lincoln Logs."
3. Full contract documents which could be modified for special conditions.
4. And of course, the "off the shelf" set of contract documents or cookie cutter plans.

One speaker at the CEFPI conference listed 'types' of prototypes as:

A. Typical 'Type':

A single district having a school designed for a specific location but developed for reuse in other locations. The district does a post occupancy evaluation and has the plans modified to correct items in the evaluation and adjusted to a new site. Suggestion was that a new prototype might be revised every 3-4 years. This might be applicable to a larger and growing district and could save a small amount of fee; considerable repetition of administrative staff time and some construction cost savings, if enough projects were built in a short period of time.

B. By default 'Type':

One school built, or building, and "hurry up we need another" therefore, adjust the design we have for site and utilities and bid again.

C. Henry Ford production line 'Type':

For a variety of very fast growing districts, as in Florida where a district might need several high schools and 6-8 elementary schools a year, there could be fee savings, time saving, and no time to incorporate large amounts of local input.

D. Copy cat 'Type':

A smaller district sees a school on another district and buys the plans from the architect with only site modifications.

Another speaker emphasized the concern of teachers, and administrators that prototypes usually did not allow for input by the real users and typically do not allow for the sense of ownership by the community. He emphasized the concern for response to varying educational program needs, code deficiencies, liability and any real reduction of cost.

A type of prototype only alluded to at the conference, but increasingly available through the computerization of the drafting process is the development of prototype components. These can vary from cabinet details, to classrooms, toilet room and kitchen components, to total core units with multiple classroom possibilities, as well as varying construction details.

Generally cited advantages for the use of prototypes are fee cost savings, decrease in the amount of time to be bid ready, and possibly reduced construction costs. Of these most of the educators

played down the actual cost savings as usually being small in comparison to total project cost. Time saving to be bid ready was usually realized although in slower growing districts and where older schools were being replaced this was not an advantage.

Almost uniformly speakers agreed that the disadvantage of prototypes was the missing response to differing educational programming, to local community input and to the sense of being "our school." Also the need to make revisions for code changes and site conditions sometimes made the prototype an inappropriate solution.

The use of prototype school design in Alaska has not been surveyed in detail. A few districts responded to an initial request for information. Anchorage, Fairbanks, Mat-Su and Kenai have all used prototypes with varying success to deal with the requirements mandated by a rapidly growing student population. The districts with smaller schools have not had such rapid growth although it is in those districts that the BIA used stock plans and after the Molly Hootch case DOTPF promoted prototype concept designs, though in many cases these weren't implemented. Recently, one rural district, replacing BIA stock plan schools has used prototype components with considerable success.

After considering the positive and negative factors associated with the use of prototypical school designs, one conclusion which can be drawn is that creation, selection and successful use of a single, complete set of stock school plans for the entire state of Alaska is not feasible.

Recommendation

1. It is recommended that the attached policy be reviewed by the committee.
2. Staff will complete a the review of existing Alaskan prototype designs, as mandated in the committee defining statute, for consideration before advancing a final policy.