M I N U T E S

SPECIAL COMMITTEE ON COMMERCIAL AND FINANCIAL INSTITUTIONS

June 28-29, 1977
Room 510, State House

Members Present

Senator Neil Arasmith, Chairman
Representative Jim Holderman, Vice-Chairman
Senator John Crofoot (June 29)
Senator Paul Feleciano, Jr.
Senator Larry Rogers
Representative Lloyd Buzzi
Representative Herman Dillon
Representative Charles Laird
Representative Mike Meacham
Representative John Reimer
Representative Marjorie Thomson

Staff Present

Bill Wolff, Kansas Legislative Research Department
Bill Edds, Revisor of Statutes Office
Emalene Correll, Kansas Legislative Research Department

Others Present

L.M. (Bud) Cornish, Kansas Life Association
Jack Roberts, Blue Cross/Blue Shield Insurance
Ron Todd, Kansas Insurance Department
Harriet Griffith, Mental Health Association of Kansas
Representative John Ivy
Dr. James B. Horne, Shawnee Community Mental Health Corporation
Dr. James W.D. Hartman, Kansas Committee on Drug Abuse
Dr. Robert Procter, Kansas Psychological Association
Clinton Willsie, Mental Health Center Directors Association
Ross Freeman, Security Benefit Life Insurance Company
J.W. Landes, Landes Oil Company, Salina, Kansas
Curtis Hartenberger, Director, Alcohol and Drug Abuse, SRS
Dr. R.A. Haines, Director Mental Health and Retardation Services
Glen Gilbert, Martin Tractor Company, Topeka, Kansas
Ben Farney, Citizens Advisory Committee on Alcoholism
Neta Pollom, Security Benefit Life Insurance Company
Rob Hodges, Kansas Association of Commerce and Industry
JoAnn Klesath, League of Women Voters of Topeka
David Riggins, National Association of Social Workers
Jim Holt, Kansas Credit Union League

June 28
Morning Session

The meeting was called to order by the Chairman, Senator Neil Arasmith, at 10:00 a.m. He reviewed the dates which tentatively had been set for the interim meetings. Since no major conflicts existed, those dates were approved. The Chairman announced that the first day of meetings will begin promptly at 10:00 a.m. (the second day begins at 9:00 a.m.). Afternoon sessions of the Committee will begin at 1:30 p.m.

Members were encouraged by the Chairman to attend as many interim meetings as possible. Those members who will miss meetings should obtain information from the Chairman, Vice-Chairman, or staff.

After completing the organization of the Committee, the Chairman called upon staff to brief the Committee on the four proposals assigned for study.

Proposal No. 10 - Privacy of Financial Records. A summary of the staff's explanation is attached. (Attachment A.) Chairman Arasmith requested that preliminary recommendations made by the federal Privacy Protection Study Commission be added to the members' notebooks, as well as a copy of the privacy legislation of Maryland and the Bank, Savings and Loan, and Credit Union sections of the California statutes. This subject will be studied in depth in September so the Chairman asked Committee members to keep their "ears to the ground" for individual complaints and experience reports from representatives of business firms and associations.

Proposal No. 11 - Usury Rate for Savings and Loan Associations. A brief summary was given by staff. Vice-Chairman Holderman told the Committee that the House Committee on Commercial and Financial Institutions was asked to introduce this issue (H.B. 2530) in the 1977 Legislature, but there was not sufficient time available for hearings. Hearings on this proposal are scheduled for August 16 and 17, 1977.

Proposal No. 12 - Equal Credit Opportunity. A summary of the proposal was presented by staff. (Attachment B.) The Chairman said that the ECOA is complicated and requested that staff prepare a comparison of the ECOA and 1977 H.B. 2499. The staff noted that a booklet, "Availability of Credit to Kansas Women," was on hand and could be checked out from the Kansas Legislative Research Department. Various sections of the Equal Credit Opportunity Act were reviewed by staff. The question was raised as to the number of complaints received since the statute has been in effect. Members expressed interest in both valid and invalid complaints received by various agencies, i.e., the Kansas and U.S. Civil Rights Commission, Consumer Credit Commission, the Kansas and U.S. Attorney's General Offices, etc. and staff was asked to gather this information. The Committee will look into this subject in greater detail at the July meeting.

Proposal No. 13 - Group Health Insurance Contracts. Staff presented an overview of the proposal and raised certain concerns for Committee consideration. (Attachment C.) Representative Laird reported that H.B. 2381 was introduced in his House Committee on Insurance only for assignment to interim Committee study and that no Committee hearings were held during the 1977 Session.

Committee recessed until 1:30 p.m.

Afternoon Session

Chairman Arasmith called the meeting to order at 1:30 p.m. and hearings began on Proposal No. 13.

Mr. Ron Todd, Kansas Department of Insurance, appeared to answer questions regarding Proposal No. 13. Mr. Todd told the Committee that he felt that those who wanted to buy coverage should have the opportunity to buy insurance covering treatment for drug abuse, alcoholism and mental illness. Many businesses, he said, do include in-patient hospitalization, but most do not provide out-patient coverage for these three illnesses in their group policies. Mr. Todd indicated that there was a considerable cost associated with such coverage. Mandatory Insurance covereage mandated in the past has resulted in numerous letters from consumers regarding higher costs.

Representative John Ivy, one of the authors of H.B. 2381, appeared as a proponent of Proposal No. 13. He told the Committee that he would like to see mental illness covered on the same basis as other illnesses. He informed the Committee of other states which utilize mental health coverage and supplied related data. (Attachment D.) Representative Ivy stated that there is a demand for this type of coverage and that the cost is not prohibitive. Senator Feleciano asked if Representative Ivy favored mandatory coverage or simply the availability of coverage. Representative Ivy said he opposed mandatory coverage. Staff asked about drug abuse and alcohol being included in the package. Representative Ivy said that he wants to offer the people of Kansas a mental illness insurance plan, but including drug abuse and alcoholism only if related to mental illness. Representative Holderman asked how many individuals would take advantage of this offer. Representative Ivy said that he did not have the figures available, but was sure they could be found.

Dr. James B. Horne, Medical Director of Shawnee Community Mental Health Center appeared before the Committee as a proponent of Proposal No. 13. His testimony is attached. (Attachment E.) He was asked for his definition of an alcoholic. Dr. Horne said that a person probably has an alcohol problem if use of alcohol has led to problems of physical health, interference with family, loss of job, or trouble with the law -- things that would make a sensible person stop drinking. Dr. Horne supported out-patient coverage as a part of any legislation

Harriet Griffith, Wichita, Kansas, testified for the Mental Health Association of Kansas in support of Proposal No. 13. A copy of her written testimony is attached. (Attachment F.)

Dr. Robert L. Procter, representing Kansas Psychological Association, presented written testimony in support of Proposal No. 13. (Attachment G.) Senator Feleciano asked Dr. Procter if out-patient clinics wouldn't be in competition with hospitals. Dr. Procter said that studies show that out-patient care reduces the need for in-patient hospitalization in the treatment of mental health. Representative Laird wondered if people would not abuse the offer of five free visits as suggested. Dr. Procter said that some may, but he didn't expect a great deal of abuse since therapy is not fun. Dr. Procter added that often people who become addicted to drugs and alcohol have other problems which they are trying to overcome.

Dr. James W.D. Hartman, Wichita, Kansas presented testimony on behalf of the Kansas Advisory Commission on Drug Abuse in support of Proposal No. 13. His written testimony is attached. (Attachment H.) Chairman Arasmith asked Dr. Hartman if he was referring to group policies or individual policies. Dr. Hartman said he included all policies. Senator Feleciano asked Dr. Hartman why the strong opposition on the part of insurance companies to mandatory coverage? Dr. Hartman said different reasons had been offered, including a lack of information and questions of higher costs. Dr. Hartman provided certain information that is now on file in the Legislative Research Department.

Meeting was adjourned at 3:45 p.m.

June 29
Morning Session

The meeting was called to order by Chairman Arasmith at 9:00 a.m.

Mr. Clint Willsie, Wichita, Kansas representing the Association of Directors of Community Mental Health Centers of Kansas appeared as a proponent of Proposal No. 13, and a copy of his brief statement is attached. (Attachment I.) Mr. Willsie supported testimony given by the representative of the Kansas Mental Health Association.

Mr. Jack Roberts, representing Blue Cross and Blue Shield of Kansas appeared in opposition to Proposal No. 13. (See Attachment J.) He told the Committee that these social problems are recognized by insurance companies and that the illnesses are not predictable to determine costs. Blue Cross/Blue Shield does provide a minimum coverage of 30 days for mental illness, alcohol and drug abuse problems in their in-patient group hospital contracts. For out-patient psychiatric treatment, however, a rider is necessary. Mr. Roberts told the Committee that Blue Cross and Blue Shield currently was offering every coverage included in the proposal. If coverage for these three illnesses were made mandatory, he said, it would make full coverage costs too high and, therefore, not readily accessible to subscribers.

Mr. Curtis Hartenberger, Department of Social and Rehabilitation Services, Division of Alcohol and Drug Abuse, appeared in support of Proposal No. 13. (Attachment K.) Mr. Hartenberger told the Committee that alcoholism is a most treatable disease and if recognized early, treatable at a relatively low cost. Data shows, he said, that the cost is not substantial in mandating coverage. He explained that alcholics and drug abusers are handicapped persons and should be treated as such. Senator Feleciano was told that $3.2 million of Title XIX was paid for the treatment of substance abusers. Senator Feleciano said that it appeared that early treatment paid for by the insurance companies would save the state money. Exact figures are not available, but Mr. Hartenberger said he would gather the data and pass them along to the staff.

Mr. Roberts of Blue Cross/Blue Shield reported that 850,000 Kansans would be covered for alcoholism as of July, 1977, because of S.B. 105's passage. Senator Feleciano pointed out that that still leaves nearly two million other Kansans uncovered.

Dr. R.A. Haines, Director of Mental Health and Retardation Services, Department of Social and Rehabilitation Services, appeared in support of Proposal No. 13 and supplied the attached data. (Attachment L.) Dr. Haines urged the Committee to propose mandatory coverage, including in such coverage out-patient care.

Mr. Ross Freeman, Security Benefit Life, Topeka, Kansas, appeared in opposition to Proposal No. 13. He took issue with the previous statement that 16 states have mandatory insurance coverage of this type. He argued that only eight states have enacted such coverage. He agreed to provide his information. (Attachment M.) The issue, said Mr. Freeman, is mandatory coverage that will cause escalating health care cost. Senator Feleciano asked if any figures were available to show costs before and after mandating in the eight states mentioned above. No figures are now available. Senator Crofoot asked if Mr. Freeman could accept "the option to buy theory." Mr. Freeman said he could support the "mandatory offer" concept.

Mr. L.M. (Bud) Cornish, Kansas Life Association, spoke in opposition to Proposal No. 13 and told the Committee that mental illness, drug and alcohol abuse were social problems. While he acknowledged that the need to arrive at preventative measures was great, he questioned whether insurance is the appropriate vehicle. The purpose of insurance, he explained, is to spread a risk among policy holders. Since someone has to pay for benefits, should 90 percent of the subscribers pay for the 10 percent using this type of coverage? Mr. Cornish opposed any type of mandatory benefit, but would support a provision for a mandatory offer.

Mr. Jack Landes, Landes Oil Company, Salina, Kansas, appeared in opposition to Proposal No. 13. He told the Committee he is a small businessman opposed to any form of mandating health care plans. According to Mr. Landes, 20 percent of his employees take home pay is spent on health insurance premiums. His employees are more concerned with mundane types of coverage rather than other more exotic plans. The average workingman may be unable to pay higher health costs if they continue to accelerate as in the last few years, he said. Mr. Landes explained that his employees select the package of insurance and never have requested this type of coverage. Senator Rogers asked if he thought this type of coverage should be available. Mr. Landis said yes, but on an elective basis.

Mr. Glen Gilbert, Martin Tractor Company, Topeka, Kansas, told the Committee that in his insurance group there are 135 members choosing by their vote those items to be covered in the group policy. Chairman Arasmith asked if he would be opposed to mandatory coverage. Mr. Gilbert said yes, but not to an elective offer.

Mr. Ben Farney, Topeka, Citizen Advisory Committee on Alcoholism, appeared in support of Proposal No. 13 and told the Committee that S.B. 105 has not had tunity to work. If, however, the Legislature feels mandating coverage for other illnesses (mental illness and drug abuse) is necessary, he would like to see alcohol included. He did not feel that the cost to people or insurance companies should be a large factor in the legislative decision. Representative Meacham asked if treatment of alcoholics on an out-patient basis worked fairly effectively. Mr. Farney said yes. He reiterated that alcoholism, detected early, could be treated with greater success and at less cost than now charged.

Chairman Arasmith announced that discussion would begin after lunch on this proposal and that each Committee member would be called upon for his opinions.

The Committee adjourned for lunch at 12:00.

Afternoon Session

The meeting was reconvened by the Chairman at 1:30 p.m. for discussion on Proposal No. 13. Two issues were raised. Since S.B. 105 addressed alcoholism, the Committee must make a decision whether to include it in legislation regarding health care for mental health and drug abuse. Secondly, should health care for mental illness, drug and alcohol abuse be mandatory

The Committee members each were asked for their comments. From the discussion which followed, it became clear that the Committee was nearly unanimous in its rejection of mandating such coverage. However, there developed a nearly unanimous feeling that legislation should be presented to the 1978 Legislature which requires a "mandatory offer" in group insurance contracts to cover nervous and mental conditions, drug abuse and alcoholism.

Representative Laird moved, seconded by Representative Reimer, to recommend legislation requiring that the mandatory affirmative offer of insurance coverage for mental health, alcohol and drug abuse be required of insurance companies issuing group health insurance contracts in this state. Motion carried.

Representative Holderman wanted to know if members felt that this legislation was necessary, since all insurance companies now are capable of offering such coverage. If a particular employees' insurance company does not cover these illnesses, the group can go to another insurance company to obtain coverage. In response, it was suggested that this type of proposed legislation might make every group aware of coverages available.

After considerable discussion, two additional motions were adopted to further elaborate upon the originally approved motion. Representative Buzzi moved, Senator Feleciano seconded, that the draft bill provide a minimum of 30 days in-patient coverage in medical care facilities licensed for the treatment of mental illness, licensed drug abuse facilities, licensed alcohol treatment facilities, community mental health centers, and psychiatric hospitals. Motion carried. Senator Feleciano moved, seconded by Representative Buzzi, that the draft bill provide out-patient coverage for 100 percent of the first $500 spent for care with an additional $1,000 in care paid for on a co-insurance basis of 80 percent contributed by the insurer and 20 percent by the insured. As a substitute motion, Representative Holderman moved that the draft bill provide out-patient coverage for 100 percent of the first $250 spent for care with an additional $1,250 in care paid for on a co-insurance basis of 80 percent contributed by the insurer and 20 percent by the insured. The substitute motion carried.

Staff was directed to prepare a list of facilities suited to provide out-patient care. The Revisor's staff was further directed to draft a bill implementing the motions adopted by the Committee. That draft will be reviewed at the July 26-27 meeting as the first order of business. The remainder of that meeting will be dedicated to hearings on Proposal No. 12 - Equal Credit Opportunity.

The meeting adjourned at 3:00 p.m.

Prepared by William G. Wolff

Approved by the Committee on:

July 26, 1977
(date)

"A"

MEMORANDUM

June 27, 1977

TO: Special Committee on Commercial and Financial Institutions

FROM: Kansas Legislative Research Department

RE: Proposal No. 10 - Privacy of Financial Records

In 1970, the Congress found that "The banking system is dependent upon fair and accurate credit reporting. Inaccurate credit reports directly impair the efficiency of the banking system, and unfair credit reporting methods undermine the public confidence which is essential to the continued functioning of the banking system."

The drafting of legistion to insure fair and accurate credit reporting did not relate primarily to banks. Rather the Fair Credit Reporting Act concerns "Consumer Reporting Agencies." However, Section 607 of the Act states that every consumer reporting agency must develop procedures which, in part, "require that prospective users of the information identify themselves, certify the purpose for which the information is sought, and certify that the information will be used for no other purpose."

It would appear that banks as users of information gathered by consumer reporting agencies are subject to several sections of the Fair Credit Reporting Act, such as Section 607 noted above. Perhaps of greater consequence, for the consumer and for banks, is the applicability of the penalty sections of the Fair Credit Reporting Act to "users of information gathered by credit reporting agencies.

Section 616, "Civil liability for willful noncompliance" provides (1) any actual damages; (2) such amount of punative damages an the court may allow; and (3) in any successful action, the costs of the action together with reasonable attorneys' fees.

Section 617, "Civil liability for negligent noncompliance" provides (1) any actual damages; and (2) in any successful action, the costs of the action together with reasonable attorney's fees.

Any bank record pertaining to the credit status of a customer, obtained from a credit reporting agency, would be subject to the provisions of the Fair Credit Reporting Act. Any person who devulged such information to others not a party to the original purpose for obtaining the credit information would be in violation of the Act. Seemingly, nearly all credit information in the possession of a bank would be protected by the federal enactment.

Atch. A

Of course, banks retain other information containing personal information about their customers. Certain of this information is maintained as prescribed in Section 21 of the Federal Deposit Insurance Act. While several subsections of Section 21 apply, subsection (g) states that "Any type of record or evidence required under this section shall be retained for such period as the Secretary (of the Treasury) may prescribe for the type in question. Any period so prescribed shall not exceed six years unless the Secretary determines . . . that a longer period is necessary." Apparently, the Kansas Bank Commissioner has proposed certain rules and regulations applicable to recordkeeping, but no such regulations are currently in force. K.S.A. 9-1139, requiring the retention of records as authorized by the Bank Commissioner, also indicates that "Nothing in this section shall be construed to affect any duty of a bank or trust company to preserve the confidentiality of their records."

It would appear that, for the most part, the financial and credit records maintained by banks are already subject to private or confidential status. However, retail merchants inundated by insufficient funds checks or other pieces of worthless paper require several items of identification before accepting a personal check. Generally, such additional information is written on the reverse side of a check. As result, while the bank is primarily interested with the financial terms of the check and, later for its storage, the bank also has become the repository of considerable personal information about its customers. The confidentiality of such personal data is not directly safeguarded except as it is an inseparable part of financial data.

Finally, all privacy provisions contain limitations. That is, certain supervisory agencies, both state and federal, have access to the financial data and, therefore, to the personal data as well. Generally, state public records required by law to be kept and maintained, K.S.A. 1976 Supp. 45-201, are to be open for a personal inspection by any citizen. The Kansas Supreme Court in Atchison T. & S.F. Rly. Co. v. Commission on Civil Rights (215 K. 911) has ruled, however, that 45-201 is inapplicable to investigation files of administrative agencies. Certain bank records or records of the Bank Commission would be included in this exception and thereby protect the privacy of the individual and the institution.

In a similar circumstance, information gained by federal agencies is subject to the Freedom of Information Act (1970) and, therefore, subject to public disclosure. As in the state situation, the federal government allows for certain exceptions from disclosure (seven discretionary exemptions). One of those exemptions applies to the agency holding the information concerning "trade secrets and commercial or financial information obtained from a person and privileged or confidential." Again, while the disclosure is discretionary, a certain level of privacy protection is provided.

Concerning the Internal Revenue Service, new amendments to the IRS code governing examination and inspection activities of the agency have recently been enacted, P.L. 94-455. After February 28, 1977, IRS will be required to issue a summons ordering the appearance of an individual or the production of books, papers or other data relevant to an investigation.

Section 7609 of the law provides procedures for third-party recordkeepers defined as banks; savings and loan associations; credit unions; consumer reporting agencies; persons extending credit through the use of credit cards or similar devices; brokers under the Securities Exchange Act of 1934; attorneys; and accountants. Any summons issued to a third-party recordkeeper must identify the taxpayer to whom the summons relates and provides the right to stay compliance. Certain additional requirements are imposed in the case of a John Doe summons.

Section 7610 of P.L. 94-455 will allow recordkeepers a reimbursement for such costs that are "reasonably necessary" in searching for, reproducing or transporting books, records or other data required to be produced by summons.

Consequently, upon the effective date of this act both individuals and third-party recordkeepers will receive prior notification by IRS that they or their records are the subject of IRS interest. Moreover, the act provides a mechanism for staying compliance until the federal district court can hear the case and either modify the summons, approve the summons as issued and order compliance, or reject the summons.

Despite the present attempts to safeguard the privacy of financial records, no level of government feels secure in the notion that sufficient controls exist to protect an individual's right of confidentiality over his or her financial records. In an effort to determine what new controls are needed, President Gerald Ford appointed the Privacy Protection Study Commission, which is currently completing its study leading to the issuance of a report containing its findings and recommendations. Certain preliminary recommendations made by the Commission are available if the Committee chooses to review them.

While the federal government awaits the results of its study, at least two states have enacted extensive privacy legislation -- Maryland and California. Again, copies of those laws are on file and can be made available for Committee consideration.

In Kansas the issue of confidentiality for financial records first arose in the 1975 and 1976 Session of the Legislature in the form of H.B. 2424. That bill was introduced by Representatives Lawing and Hoagland as an individual bill (no interim committee study has been made on the subject of confidentiality). House Bill No. 2424 related only to banks and required that specific information about a customer's balance, deposits and withdrawals was to be

accorded confidentiality. Bank officials, however, could express their views to others concerning the depositor's credit standing and financial strength and stability. That measure died in the House Committee on Commercial and Financial Institutions.

In the 1977 Session, Representatives Lowther, Glover, Hoagland and Luzzati introduced H.B. 2480. Briefly summarized, the bill prohibits any financial institution from disclosing to any person, including any governmental agency, other than the customer or his or her duly authorized agent, any financial records relating to the customer unless that customer has authorized disclosure or the financial records have been subpoenaed or seized under a search warrant. The bill also contains several provisions which outline situations wherein the act does not apply. House Bill No. 2480 remains in the House Committee on Commercial and Financial Institutions which recommended this study.

Attachment "B"

MEMORANDUM

June 27, 1977

TO: The Special Committee on Commercial and Financial Institutions

FROM: Kansas Legislative Research Department

RE: Proposal No. 12 - Equal Credit Opportunity

The Special Committee on Commercial and Financial Institutions is to make "A study of the recommendations made by the Kansas Advisory Committee to the U.S. Commission on Civil Rights regarding the availability of credit to Kansas Women; review existing federal legislation."

Perhaps the most important portion of the study question is the review of existing federal legislation -- Equal Credit Opportunity Act (ECOA) and Regulation B of the Board of Governors of the Federal Reserve System. In 1975, when the Kansas Advisory Committee was completing its study of credit discrimination in Kansas, the ECOA was a new enactment of which several significant sections were not yet in effect. Additionally, no regulations had been promulgated by the agency charged with prescribing those regulations, the Federal Reserve Board. It was with some justification that the Kansas Advisory Committee found "that married, divorced, and widowed women who are creditworthy have more difficulty obtaining consumer credit than their male counterparts."

Since that time, all sections of the ECOA have taken effect and, in fact, the original enactment has been amended. The last amendments became effective on March 23, 1977. Certain rules and regulations adopted by the Federal Reserve Board took effect as late as June 1, 1977. It would appear, as a consequence of congressional activity, that the solution to credit discrimination in Kansas is to be found in the ECOA and its companion regulations.

There remains, however, an area for state legislative activity. Subsection (g) of section 705 of the ECOA directs that "The Board shall by regulation exempt from the requirements of sections 701 and 702 of this title any class of credit transactions within any State if it determines that under the law of that State that class of transactions is subject to requirements substantially similar to those imposed under this title or that such law gives greater protection to the applicant, and that there is adequate provision for enforcement." Clearly, the Kansas Legislature could enact its own equal credit legislation subject to state enforcement. To date, no state has applied to the Board for an exemption, but there appears to be some effort underway in Massachusetts and California to develop a plan for legislation.

Atch. B

In Kansas, three bills have been introduced on the subject of credit discrimination, H.B. 2918 and H.B. 3161 in 1976, and H.B. 2499 in 1977. As noted in section one of House Bills 3161 and 2499, identical measures, the act was to be cited as the Kansas Equal Credit Opportunity Act. Section four of the bills authorized the Consumer Credit Commissioner to prescribe rules and regulations to carry out the purposes of the Act. The Committee may wish to compare the provisions of the Kansas bills to those of the federal statute with the intention of qualifying Kansas for the exemption from the federal law.

"C"

MEMORANDUM

June 3, 1977

TO: The Special Committee on Commercial and Financial Institutions

FROM: Kansas Legislative Research Department

RE: Proposal 13 - Group Health Insurance Contracts

The Special Committee on Commercial and Financial Institutions is to undertake "A study to determine the desirability of mandating that group health insurance contracts provide coverage for mental or nervous conditions, drug abuse, and alcoholism." This subject of study is not new to the Legislature.

Since the topic contains three different subject areas, it is appropriate to separate the items for purposes of providing background information.

A. Coverage for Mental Illness --

In the 1973 interim, the Special Committee on Delivery and Financing of Mental Health Services heard testimony concerning insurance coverage for mental illness. In general, the testimony showed that there is less insurance coverage for mental illness than for physical illness, both for inpatient and outpatient care.

As a result of its study, the Committee concluded that clear discrimination exists in health insurance between the coverage offered for physical illness and that which is offered for mental health care. As a remedy for the imbalance, the Committee recommended that all group health insurance contracts in Kansas be required to provide minimum coverage for inpatient and outpatient psychiatric care. House Bill 1642 was introduced during the 1974 Session to implement the recommendation. Upon later deliberations, the Senate Committee on Commercial and Financial Institutions reported H.B. 1642 unfavorably. The Committee indicated, however, that the bill warranted additional study.

The Special Committee on Commercial and Financial Institutions in the 1974 interim again took testimony on the subject. After hearing the proponents and opponents, the Committee made no recommendations to the 1975 Legislature. While other bills on this topic have been introduced since 1975, none have passed nor has additional study been made of the question until this time.

Att. C

House Bill 2381, introduced in the 1977 Session by Representatives Ehrlich and Ivy, is nearly identical to 1975-76 S.B. 338, authored by Senator Jan Meyer. That bill died in the Senate Committee on Commercial and Financial Institutions. The present study was requested of the Legislative Coordinating Council by the Kansas Mental Health Association.

B. Coverage for Drug Abuse --

Apparently, the idea of requiring insurance coverage for the treatment of drug abuse has never been studied by a legislative interim committee. The issue was a part of Senator Meyer's bill in 1975-76 and, of course, is a part of the House Bill under interim study.

C. Coverage for Alcoholism --

In addition to Senator Meyer's bill, S.B. 338, the House Committee on Insurance introduced H.B. 2553 in the 1975 Session. That measure dealt primarily with "indemnity for services rendered in the treatment of alcoholism." House Bill 2553 passed the House by a vote of 108 yeas to 10 nays. In the Senate, the bill was referred to the Senate Committee on Commercial and Financial Institutions where, upon hearings, it was recommended for interim study. No study was authorized for the next interim, 1976.

In the 1977 Session, Senator Meyers introduced S.B. 105, which requires group insurers to make available by affirmative offer, the same reimbursement or indemnification for the treatment of alcoholism as is provided for services rendered to a person in a medical care facility. Treatment for alcoholism and payment for such treatment may be in a medical care facility or in a licensed alcohol treatment facility. The group policy offered must provide a minimum of 30 days coverage per year in either type of licensed facility. Senate Bill 105 was enacted by the 1977 Legislature.

The major policy question involved in every part of the study is governmental mandate of certain types of insurance upon private businesses and private citizens.

"D" per pr conversation from Jerry Cole to John L 6-28-77

Leg. Library Services Presentation 6-28-77

DATA

In the Federal Employees High option plan covering 5.6 million persons the per person cost in 1973 for virtually all outpatients was $6.60 annually for an individual and 45.52 dollars annually for a family. The Plan includes a $100 deductible and 20% co-insurance for outpatient care.

In the Canadian Federal Provintual Health Insurance programs they provide care to the same extent for physical illness as for outpatient services range (1971-73) from .43 cents annually to 3.15 dollars annually per covered person.

The Health Insurance Plant of Greater New York provides Mental Illness coverage for three people or more at $2.70 per month in 1972.

Utilization of Mental Health Coverage

The United Automobile Workers Blue Cross/Blue Shield Plan of Michigan in 1973 was 2.4 % of the 2.4 million participating.

The utilization of psychiatric services (no copayment for the first 5 outpatient visits)

The Federal Health Employees Benefits High Option program requires $20 deductible and 20% coinsurance. .63 percent of the total enrollees received an outpatient benefit and .13 percent received an inpatient benefit in 1973. Those receiving benefits for mental illness were 1.1 percent of the total

Att. D

population covered by the Federal Employees Health Program in the years 1971-1973 or about 2.5 percent of the number receiving any benefit in each year.

A comparasion of benefits paid by Blue Cross/Blue Shield for all conditions and for the treatment of mental and nervous disorders in 1975. Shows that Mental Health benefits paid were 7.5% of the total, or just over 90 million dollars.

The Kaiser Health Foundation plan in Northern California in a study of service utilization determined that patients after a brief psychotherapy (2 date visits) reduced their utilization of medical services in the five years following their therapy by 75%.

INFORMATION THAT HARRIET GRIFFITH HAS:

That in the California Health Insurance x plan which provides for psychiatric services a recent study for the year 1975-76 has shown that over all medical utilization has dropped by 20% as a result of the addition of the psychiatric care coverage.

"E"

Testimony To: Interim Committee on Group Health Insurance contracts

From: James B. Horne, M.D.
Medical Director of Shawnee
Community Mental Health Center

Mandatory insurance coverage is a sticky issue, because each mandate increases the cost to the public like a tax. What legislator wants to increase taxes? What taxpayer wants to pay them?

On the other hand we pay taxes to educate our children, to protect us from crime and fire. We have found that voluntary contribution or fees alone will not do the job. We join large group insurance programs to provide services when we need them. Shared prorated costs make it possible for all of us to have the service, when we need it.

Now, a service that costs relatively little and is required often, like a haircut, is paid for out of current funds or we do without. Sure, but infrequent expenses, like property taxes, we save for. Unpredictable expensive things, like fire and disease, send us to the insurance salesman.

Why mandate coverage for mental illness, drug and alcohol abuse treatment? Average man, ignoring all statistics, does not consider the need for this kind of treatment, for himself, until the need is upon him. That is not the time to apply for optional coverage. The most popular delusions have always involved denial of unpleasant facts. The pain and bankruptcy that go with mental illness, alcoholism, and drug abuse are most painful indeed. The agony of mental illness, alcoholism, and drug abuse in one's spouse, parents, or, especially, children are even more painful. The majority of insurance buyers prefer to ignore these painful facts and save a few dollars in premiums.

The costs are much lower than assumed. The most severe cases of mental illness, alcoholism and drug abuse may be extremely costly to treat, but the common cases are not. We don't tend to think of the milder cases because they are so obviously people just like us that we can't preserve our delusion that mental illness, alcoholism, and drug abuse affect other people but never ourselves.

Please cast aside all these popular delusions yourselves and support House Bill 2381.

Atch. E

"F"

Testimony on behalf of the Mental Health Association in Kansas regarding the mandating of minimum mental health coverage in group insurance contracts in Kansas.

My name is Jerry W. Cole. I'm a resident of Wichita, Kansas. I'm a partner in the firm of Armfield-Cole Consultants, Inc. I'm also an active volunteer for mental health.

I have been a full-time insurance agent in the State of Kansas since 1963 and am a CLU. My firm, Armfield-Cole Consultants, Inc. works primarily in the group insurance market. ~~We design insurance benefit packages for employers and unions and then obtain competitive bids from insurance companies. We also do Administration and pay claims from our office.~~

I ~~have~~ been active ~~in the Mental Health Association since 1969. I am past president of the Mental Health Association~~ in Kansas and ~~currently serve as a director and Vice President of the Mental Health Association at the National level.~~

I am here today to tell you some of the reasons why minimum mental health coverages should be provided, by law, in any group insurance programs written in Kansas. I am here to try to persuade you as to the significant ~~part of this~~ social impact such legislation could provide.

Att. F

Such legislation could ultimately make the availability of mental health services accessible to many more Kansas citizens. It could provide more emphasis in the area of prevention of mental illness with major resulting economic benefits to the community. It could help emphasize the utilization of out-patient treatment for nervous and emotional conditions. (Treatment that is both more effective and less expensive.) It could do all of this and at the same time But less lessen demand on tax-supported institutions ~~and facilities~~ by providing for payment of treatment through the private sector.

We know much more about the treatment ~~of mental illness and the~~ prevention of mental illness than we ever did before. More advances have been made in this field in the last ten years than in all the previous history of mankind. We know that institutionalization as ~~a viable~~ treatment ~~modality has~~ in the ~~vast majority~~ has in most of cases been superceded by more effective out-patient treatment. we know that we are able to treat people in the community without ~~necessarily~~ removing them from their families, and, in many instances, treat them while they continue on their jobs. We are beginning to know how to utilize preventative measures and how to intervene in early stages of mental problems before long-term care is necessary.

Unfortunately, while major ~~advances and revolutionary~~ advances are taking place in the methods of treatment of mental illness, the insurance industry is still, in most instances, providing woefully inadequate coverage for nervous or emotional conditions. ~~When mental health care is mentioned in most insurance contracts it is in either the section that talks about limitations or exclusions.~~

At a time when out-patient care, day care, and partial hospitalization are the preferred modalities of treatment, group insurance contracts, if they don't exclude mental health treatment entirely, tend to emphasize in-patient care. In the vast majority of cases, there is either no provision for out-patient coverage or it is so limited as to be of no consequence.

Unfortunately, the kind of insurance coverage available does much to dictate the treatment ~~modality~~ that is chosen by the mental health practitioner. If, for example, the insurance contract provides coverage for mental health services while the patient is hospitalized but no coverage for out-of-hospital care, the practitioner may elect to hospitalize the patient. Many times, this is the case because the mental health professional knows that unless the insurance company pays for the treatment, the individual will receive no treatment until ~~possibly~~ the condition is so advanced that the only alternative is commitment to a state hospital.

You may hear from representatives of the insurance industry that to provide mental health coverage would be "too expensive". I don't believe that would be the case. In the first place, by providing ~~for utilization of~~ out-patient and preventative care, which the Mental Health Association in Kansas advocates, people could utilize much less expensive kinds of treatment than hospitalization. Secondly, I believe that the insurance industry has been so remiss in providing for this kind of coverage, that they don't have any hard data to support the assumption of major increased costs.

I would like to give you one example of a plan that has recently been placed in force with a small health and welfare trust in California with 1,000 employees. The trust is well established and had been insured by the Crown Life Insurance Company of Canada for the five years prior to adding the "California Psycological Health Plan". CPHP emphasizes early intervention and utilization of coverage for nervous and emotional conditions. It offers incentives for utilization through a system consisting of total confidentiality, no deductible, no co-payment for the first five visits, quality control and other incentives.

The following statistics represent the "experience" of the trust prior to the installation of CPHP and following one year of operation with CPHP. (This is the ratio of total paid premium to the total amount paid by the insurance company for medical claims.):

November of 1974 to August of 1975	95%
December of 1975 to September of 1976	73.5%

These figures represent an approximate decrease of 20% in medical care utilization. The only component of the trust which changed was the mental health benefit.

We have some supportive descriptive material regarding the "California Psycological Health Plan" that I will leave with you.

I'm sure all of you are aware that the community mental health centers in Kansas have done yoeman's work in providing community-based treatment facilities. Unfortunately, many people, perhaps the majority, resist using these facilities - either from the lack of understanding or because they simply prefer to go through a private practitioner. However, inclusion of mental health coverage in insurance

contracts would also provide these mental health centers with sources of revenue for the services they provide to patients who are covered under the group insurance contracts. This would, as a consequence, lessen the demands for funds to support these centers from tax money.

Unfortunately, mental illness still carries with it a stigma that causes many people to be hesitant to discuss it. The first time people are aware of the serious lack of mental health coverage in their group insurance is at the time they or someone in their family needs therapy. It has been my experience that most insurance agents are not significantly aware of the needs for mental health coverage so as to recommend it to their clients.

Eventually, we will be able to educate people from attaching adverse stigma to mental illness. Eventually, employers will come to realize the necessity to demand their insurance contracts include provisions for mental health care. Eventually, the insurance companies will understand that it may, in fact, be less expensive to provide for preventative care and out-patient care for nervous and emotional conditions. But when this eventuality will become a reality is anybody's guess. That is why the Mental Health Association is petitioning legislators who should be better informed than the average citizen, to provide that <u>any group insurance contract issued in the State of Kansas shall not discriminate in out-patient care against nervous and emotional conditions</u>. By that I mean that if coverage is provided for out-patient care for physical illness that it must be provided for mental illness.

The insurance industry has long neglected their responsibility to provide quality health coverage in this most important area. The have too long relied on the government to provide this kind of care from tax monies. The Kansas legislature has the opportunity to act most responsibly by requiring that the insurance industry close this appalling loophole in present coverage.

Thank you for the opportunity to appear before you on behalf of the Mental Health Association in Kansas and on behalf of the consumers of mental health services in Kansas. I would be glad to answer any questions you may have.

California Psychological Health Plan

CPHP

To All Eligible Employees:

Stationers Corporation presents this Evidence of Coverage brochure summarizing benefits under a new health care concept within your group insurance program.

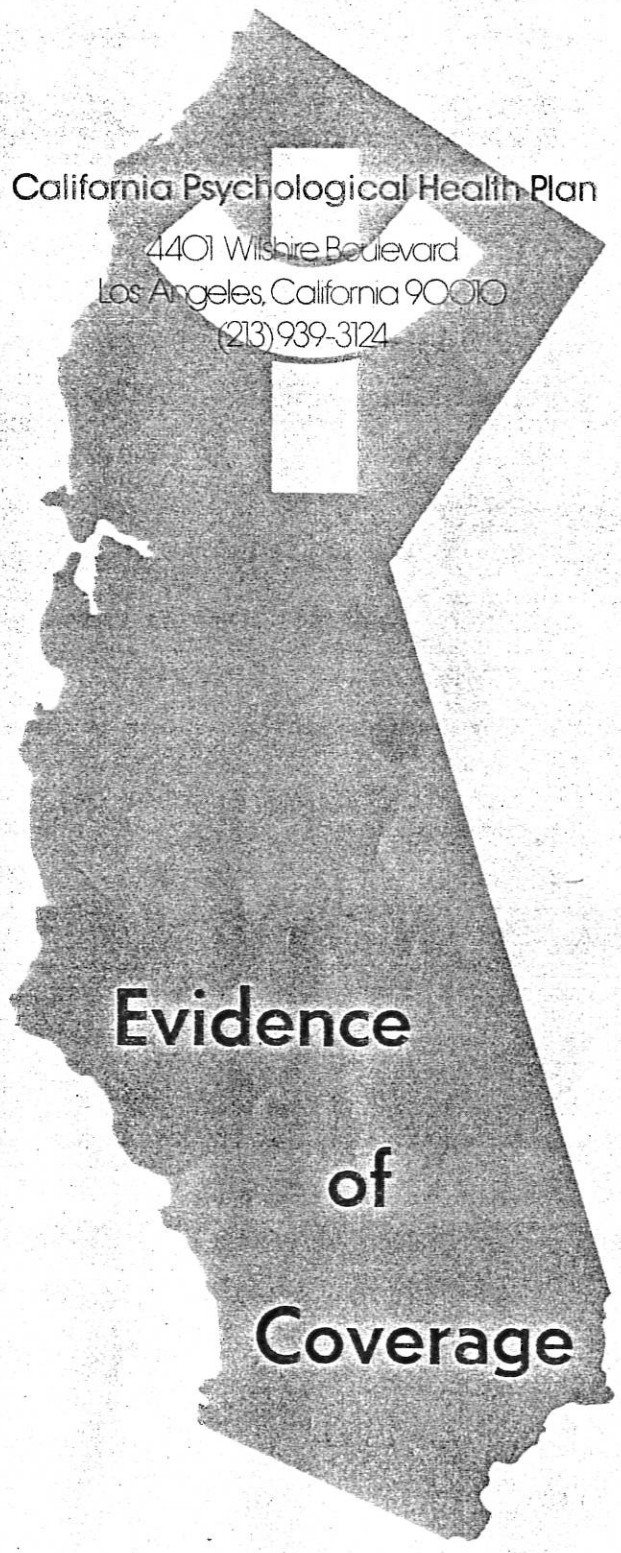
California Psychological Health Plan (CPHP) is a statewide prepaid mental health plan. CPHP's Panel Providers (psychologists and psychiatrists) provide outpatient mental health services to eligible employees and their dependents.

The Plan is paid for by Stationers Corporation and is designed to provide care in the most neglected area of good health. California Psychological Health Plan deals directly with good mental health and is concerned with assisting employees and their families to deal more effectively with day to day problems of living in today's stressful world. Confidentiality is a keynote to this program.

Selection of this plan was based on Stationers Corporation's continued efforts to provide employees and their families with the newest and most effective means of preventive health care.

Sincerely,
STATIONERS CORPORATION

Lillian W. Boyd,
President



STATIONERS CORPORATION

DEFINITIONS

Provider: Any licensed psychologist or psychiatrist working individually, or within a corporation, clinic, or group practice who delivers mental health care benefits to eligible subscribers under CPHP. A **Panel Provider** is any Provider who has contracted with CPHP to deliver mental health care benefits to CPHP subscribers. CPHP publishes a geographical listing of all Panel Providers, their addresses and telephone numbers. A **Non-Panel Provider** is any Provider who has *not* contracted with CPHP.

Subscriber: An eligible employee and/or that employee's eligible dependents.

Family-Unit: An eligible employee, *together with* that employee's eligible dependents.

Number Of Sessions: Number of sessions refers to the aggregate number of private or group sessions used by members of the family-unit (subscriber and/or subscriber's eligible dependents).

Private Session Is Defined As: A 50 minute session with a Provider by a subscriber or combination of subscribers from the same family-unit, as treatment needs prescribe.

Group Session Is Defined As: A 90 minute session combining several family-units or individual members of different family-units.

Professional Standards And Management Committee: This committee is composed of CPHP Panel Providers and functions to assure quality control of treatment. Prior to the subscriber's sixth private or eleventh group session the provider must submit a treatment plan to the Professional Standards and Management Committee which is promptly reviewed. The treatment plan, as approved by the Professional Standards and Management Committee, provides authorization for continued treatment and for CPHP payment to the provider for services rendered.

Mental Retardation: Refers to subnormal, general, intellectual functioning (border line mental retardation indicates an IQ between 68 and 83) which originates during the development period and is associated with impairment of either learning and social adjustments or maturation or both.

ELIGIBILITY

Who Is An Eligible Employee? Each permanent, regular part-time or temporary employee for whom a full monthly contribution has been paid by one or more participating employers.

When Does an Employee become Eligible as a Subscriber? Each employee who is eligible as outlined above, shall be covered on the first day of the month following the month for which a full contribution is paid by a participating employer.

Who is an Eligible Dependent? The eligible employee's lawful spouse and unmarried dependent children to age 19, or to age 23 if full-time students. Children include step-children, adopted children, and foster children provided such children are dependent upon the employee for support and maintenance. Those in military service are not eligible.

Reinstatement: If an employee is terminated and he returns to active employment, he will become eligible as provided under Eligibilty (above).

HOW TO USE YOUR CPHP PROGRAM

SESSIONS WITH PANEL PROVIDERS

Eligible subscribers and their dependents are entitled to obtain benefits from any participating Panel Provider of CPHP. *A list of Panel Providers including the names, addresses and telephone numbers is made available to eligible subscribers and this list is updated periodically as necessary.*

How To Make An Appointment: Refer to the CPHP Panel Provider list. Call the provider of your choice; advise the provider that you are an eligible employee, or eligible dependent covered under CPHP. At this time give the provider your social security number and the name of your employer. No claim forms are necessary for sessions with Panel Providers.

Subscriber Is Responsible For Co-Payment: The first five private sessions or first ten group sessions used by the family-unit are paid by CPHP at 100% of the CPHP authorized rate. Beginning with the sixth private session, or eleventh group session, the subscriber is responsible for the co-payment as listed under Summary of Benefits.

SESSIONS WITH NON-PANEL PROVIDERS

If you use the services of a Non-Panel Provider, you must obtain a claim form from your employer, or from the CPHP Administration Offices, 4401 Wilshire Boulevard, Los Angeles, CA 90010, Phone (213) 939-3124.

BENEFITS

SESSIONS WITH CPHP PANEL PROVIDERS

CPHP benefits in the form of private and group sessions are available to CPHP subscribers and their families from Panel Providers or their qualified professional employees with NO DEDUCTIBLE.

The first five private sessions, or the first ten group sessions, used by the family-unit are available at *no cost* to the subscriber.

After the fifth private session, or tenth group session, and upon authorization for continuation of treatment from the CPHP Professional Standards and Management Committee, the family-unit is entitled to further sessions for which the subscriber pays a *co-payment*, specified in Summary of Benefits below.

SUMMARY OF BENEFITS

SESSIONS WITH CPHP PANEL PROVIDERS

The *Number of sessions* refers to the *aggregate* number of private or group sessions used by the family-unit.

Co-payment is based on the number of sessions used by the family-unit.

NO DEDUCTIBLE

NUMBER OF PRIVATE SESSIONS	NUMBER OF GROUP SESSIONS	*PAID BY CPHP	*CO-PAYMENT PAID BY SUBSCRIBER
1-5	1-10	100%	—0—
6-10	11-20	85%	15%
11-15	21-30	70%	30%
Balance	Balance	50%	50%

MAXIMUM NUMBER OF SESSIONS ALLOWED WITH PANEL PROVIDERS:

PRIVATE 500
GROUP 1000

*These percentages are paid in accordance with the CPHP authorized uniform hourly rate: $50./private session; $25./group session.

BENEFITS

Renewal of Benefits: In the event all members of a subscriber family-unit have an uninterrupted break in treatment for a minimum of six months duration, that family-unit will be considered eligible to re-establish the 100% benefit payable by CPHP for sessions with Panel Providers.

Charge For Broken Appointments: The subscriber family-unit will be charged with a session for any appointment made with a Panel Provider and not kept.

SESSIONS WITH NON-PANEL PROVIDERS

Subscribers who secure benefits from licensed Non-Panel Providers may submit a claim form and bill for partial reimbursement to CPHP. Reimbursement to subscribers for benefits secured from Non-Panel Providers is fixed at 50% of the allowances for Panel Providers listed in the Summary of Benefits.

MAXIMUM PAYMENT FOR SESSIONS WITH NON-PANEL PROVIDERS IS LIMITED TO $500. TO A SUBSCRIBER FAMILY-UNIT IN ANY CALENDAR YEAR.

CPHP reserves the right to reject any and all claims for sessions with Non-Panel Providers which are filed more than 90 days after benefits are secured.

SERVICES NOT COVERED

No payment will be made by CPHP for any of the following services or treatment:

Mental retardation, other than primary diagnosis.

Educational training in therapy sessions.

Sessions while confined in a hospital as an in-patient.

Services or treatment paid for by other group insurance.

Sessions in excess of those listed in the Benefits Schedule.

Sessions in excess of those authorized by the CPHP Professional Standards and Management Committee.

Services or treatment provided as a result of any Workmen's Compensation law, or similar legislation, or obtained through or required by any government agency or program whether Federal, State or any subdivision thereof, (exclusive of Medi-Cal).

CPHP MAY AT ITS DISCRETION WAIVE ANY OF THE PLAN LIMITATIONS IF, IN THE OPINION OF THE PROFESSIONAL STANDARDS AND MANAGEMENT COMMITTEE, THIS IS NECESSARY FOR THE SUBSCRIBER'S WELFARE.

TERMINATION OF BENEFITS

All benefits of the subscriber shall terminate: (1) on the date the contract is terminated; (2) on the first day of the second month following the participating employer's failure to remit the required contribution to CPHP.

Service After Termination: If service for a subscriber is being rendered as of the termination date of the contract, such service may be continued to completion of treatment only if authorized by the Professional Standards and Management Committee, but in no event beyond 30 days after the termination date of the contract.

COORDINATION OF BENEFITS

If subscribers receive mental health benefits under another "plan" as defined below, benefits provided by CPHP will be coordinated with the benefits from the other plan.

A "plan" is considered to be any group insurance coverage or other arrangement of coverage for individuals in a group which provides benefits or services on an insured or uninsured basis, and any government program providing benefits or services of a similar nature.

LIABILITY OF SUBSCRIBERS

By law, every contract between CPHP and each CPHP Panel Provider provides that in the event CPHP fails to pay the Panel Provider, the subscriber **shall not be liable** to the Panel Provider for any sums owed by CPHP.

In the event that CPHP fails to pay for the services of a Non-Panel Provider, the subscriber may be **liable** to the Non-Panel Provider for the cost of services.

DISPUTES OR ARBITRATION

In the event of dispute or controversy arising from services under this contract which cannot be resolved to the mutual satisfaction of both the subscriber and CPHP, the parties (CPHP and subscriber) shall each select an arbitrator to settle the matter by arbitration. Should there still be no resolution, the arbitrators shall select a third arbitrator whose judgment and determination shall be final.

This Evidence of Coverage constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage.

The information in the "Evidence of Coverage" booklet is provided to help you understand your covered benefits under California Psychological Health Plan and how to use them.

If you have any questions or complaints, please contact:

California Psychological Health Plan
4401 Wilshire Boulevard
Los Angeles, California 90010
Phone: (213) 939-3124

1-30-77 2500-500

California Psychological Health Plan 4401 Wilshire Boulevard, Los Angeles, 90010, (213) 939-3124

CALIFORNIA PSYCHOLOGICAL HEALTH PLAN

California Psychological Health Plan (CPHP) was formerly registered and qualified in compliance with the Knox-Mills Health Care Service Plan Act of 1975 with the California Attorney General. This year, with a change in government organization, CPHP is being registered and re-qualified with the California Commissioner of Corporations.

CPHP is a non-profit corporation which was designed following years of research by insurance consultants and members of the California State Psychological Association (CSPA). The intent of this research was to develop a quality out-patient mental health program which could be implemented in any health care delivery system (Insured, Pre-paid, HMO, Trust Fund). It is the feeling of a majority of psychiatrists and psychologists, as well as most consumers, that the out-patient mental health benefits currently available in most traditional insured health plans are too limited. This belief was the initial basis for the study and subsequent development of CPHP.

However, during the developmental stages of this psychological health plan, researchers discovered that there existed a greater need to which CPHP should be directed. This need was demonstrated in studies conducted by various organizations (Kaiser-Permanente, Kennecott Copper, Group Health Association in Washington, D.C., Bechtel Corporation) that showed a majority of persons attending physicians' offices had an emotional rather that a physical basis for their complaints (articles attached).

Unfortunately, as noted, the traditional system of health care delivery is primarily concerned with remedy, repair and restoration of physical ailments. Emotional, or psychogenic complaints are either ignored or given ancillary attention. Even if the facilities and treatment on the physical care side of the system are improved through additional funding, the system's orientation toward health care delivery experiences no change other than an improved funding mechanism.

Skyrocketing health costs can be attributed to many factors. Inflation and high utilization of an expensive health care system account for the major portion of the current 18% per year increase in health delivery costs. CPHP is one direct answer to the solution of this problem. If, as studies indicate, a large percentage of people attending physicians have an emotional base for their complaints, then an intervening out-patient mental health program should reduce physical care utilization. When this utilization is lowered, costs can be affected by way of the insurer passing on a savings to the Major Medical portion of the insured health plan.

One might ask: Can CPHP prove these claims? A one year pilot program of CPHP implemented in a Trust insured by the Crown Life Insurance Company of Toronto, Canada showed major medical experience dropped 20%. As Jack Roberts, FSA and Sr. Vice President of Crown, stated in a letter explaining his testimony before the Health Insurance Association of America:

"In particular, I was able to tell the meeting that rates for the policy year just ending for this case were substantially below those which we would have charged for a policy providing similar benefits issued today." (Attached)

There is often a stigma attached to utilization of mental health benefits. John E. Armer, the marketing director for CPHP, has developed an employee communications firm that meets with employee groups to discuss the need and importance of good mental health. It is Mr. Armer's objective to promote utilization of these benefits and to relieve, through an open discussion, much of the stigma attached.

In addition, to further promote utilization, the California Psychological Health Plan offers an incentive. There is no deductible, and the first five visits are paid 100%. Probably even more important, there are no claim forms and complete confidentiality is assured. Use of the plan is arranged directly between the employee and one of our panel providers. The providers' private offices are located throughout the state (see list of panel providers). Quality assurance is built into the CPHP benefit plan. Panel providers under CPHP contracts have consented to a confidential review process prior to a subscriber's sixth visit. We believe this idea of collaborative, cooperative, professional assistance being provided employees while still maintaining complete confidentiality, is a first.

CPHP is attempting to provide answers not only to major economic problems, but to the confidential and quality control aspects of health care delivery. It is our objective to integrate this important benefit within all health care delivery systems. We believe that every individual should be guaranteed the right to have "total" health care. The California Psychological Health Plan provides an important component to health care delivery by dealing directly with good mental health. CPHP is concerned that employees and their families are able to deal more effectively with day to day problems of living in today's stressful world.

Rx for the 'Worried Well': Psychotherapy —or Simply the Right Doctor

By Patrick Young
From San Francisco

Mrs. W repeatedly visited the Kaiser-Permanente medical facilities here, complaining of severe headaches. Her physician could find no physical cause for her pain—no tumor, no eye problems, nothing organically amiss. Yet the headaches grew more intense, while drugs eased her pain less and less. Finally her doctor suggested she talk with a psychologist employed by the prepaid medical plan.

Dr. Cummings

The woman was 39 at the time, married and the mother of three children. Her anger quickly surfaced in psychotherapy. She had discovered her husband was having an affair with his secretary, but she was reluctant to confront him. She and her psychologist explored her fears, and between her second and third session, Mrs. W berated her spouse for his infidelity. She was surprised and gratified to find her husband remorseful and eager to mend their torn marriage. Her headaches disappeared, and she dropped therapy.

Mrs. W's treatment is regarded as a dual success by Dr. Nicholas A. Cummings, chief psychologist of Kaiser-Permanente's northern region. The patient's pain was eliminated, and she no longer required a physician's time and expensive diagnostic tests for a problem that neither drugs nor surgery could ever cure.

Doctors see a lot of patients like Mrs. W. Although precise figures are impossible to obtain nationwide, anywhere from 50 per cent to 80 per cent of all doctor visits are by people with [illegible]

psychiatrist here, and Dr. Cummings compared the medical utilization of 152 patients for five years after they underwent some form of psychotherapy with their use in the year before therapy.

The 80 patients who attended a single session reduced their utilization 60 per cent over the next five years; the 41 patients who underwent two to eight sessions dropped their use 75 per cent. The 31 patients who went through nine or more sessions, however, seemed to substitute psychotherapy for their previous doctor visits.

Other studies have confirmed the value of treating the mind as well as the body. In 256 patients studied at the Group Health Association, a prepaid medical plan in the Washington, D.C., area, psychotherapy reduced the number of doctor visits and the number of laboratory and X-ray procedures by about 30 per cent.

'Something Must Be the Matter'

Kennecott Copper Corp. found that employes who received mental-health counseling reduced their medical utilization 55 per cent and their unexplained absenteeism 33 per cent, in comparison with a group of employes who refused such help.

Though the problems of the worried well may lie in the mind, their bodies hurt nonetheless, sometimes excruciatingly so. Fevers, breathing difficulties, headaches, and digestive problems are a few of their complaints. But unlike a psychosomatic illness — one where organic damage such as an ulcer develops because of emotional stress—the worried well have no physical causes of their problem.

Yet, says Dr. Kerr L. White of Johns Hopkins University School of Hygiene and Public Health, "Something must be the matter with a person who consults a physician when in fact nothing is the matter with him."

Graduates Unprepared

Medical students are largely chosen for their interest in physical and biological sciences rather than the humanities and social sciences. Much of their training is focused on medical research and the unusual disease. This emphasis has produced many great researchers and exciting cures, surgical procedures, and biological advances. But it also leaves many medical-school graduates unprepared for the realities of private practice.

"Our medical education process, our postgraduate work, and our continuing-education courses are all oriented toward organic disease," says Dr. William Barclay, the American Medical Association's assistant executive vice president for scientific affairs. "Most medical students have nothing to do with the worried well. They come out with a distorted view of what the public's medical needs really are."

"Too many doctors see themselves as technicians," says Dr. Daniel Patterson, chief psychiatrist at Group Health Association. "They're there to treat the patient, not listen to his problem." White tells of a woman who told one medical specialist, "Doctor, I hope you treat what I've got." The specialist replied, "Lady, I hope you've got what I treat."

The Customer Is Right

"Psychiatrists and primary-care physicians have known for a long time that patients do not present you with diagnoses; they present you with symptoms, conditions, and, above all, with problems," says White. "They want help and understanding in resolving their problems. I would say that we had better proceed on the assumption that the customer is always right."

White and others detect more willingness among physicians today to make the effort to work with patients' [illegible]

The plan recommends establishment of regional transit service policies by April, 1975. By July, we expect mode selection to be made for the different corridors. And, by October, we recommend that priorities be assigned to various corridors and communities for new services. Under this schedule, the transit districts should be able to begin preliminary engineering for an initial usable segment of guideway transit by December of this year.

Recommendations dealing with air quality and energy are very closely related. Generally, they can be divided into long-term and short-term strategies. In the long term, in addition to the reduction of the need for travel previously discussed, emission controls and more efficient engines should reduce pollution from automobiles to the point where it is a relatively small part of total air pollution — about one-third. At that point, it will become extremely costly to try to reduce auto air pollution any further and additional improvements would be minimal. Even then, however, we will not achieve the air quality standard in this basin for the long term. *That would require a 100% reduction in vehicle miles traveled!*

Most of these strategies require time to develop satisfactory technology and permit a turnover of the vehicle fleet. Accordingly, we need additional short-term strategies to provide satisfactory progress in the next few years.

Therefore, SCAG has proposed a 20% reduction in vehicle miles traveled (VMT) by 1977. To achieve this, we are proposing immediate and substantial improvements in public transit and heavy reliance upon carpooling, especially for commute trips. Preferential treatment on freeways, ramps, and streets will encourage this change. Most of these recommendations were contained in the previously adopted short-range plan.

Those using automobiles have excellent mobility in this region. For those without, there is a great need to improve their mobility through improvements in the public transit system. Both the current level and area of service must be expanded. This includes not only conventional bus transit but the implementation of less conventional services, such as jitney, group taxi, and demand-responsive service where appropriate. These latter types promise to be particularly effective in providing service rapidly to areas that do not now have service. We recommend the addition of about 1,900 additional buses over the next 5 years. We also suggest that existing transit operators are in a position to identify areas where jitney and group taxi projects could complement existing service.

We also believe that some guideway transit is necessary and that we should develop a starter leg as soon as possible.

We are not forgetting the role of highways either. The missing links in the existing freeway network should be completed as soon as possible. We have recommended a highway commitment to a $7.9 billion level of investment spread over the next 20 years.

REDUCING AUTO USE

The "state of the art" in estimating the effects of the strategies proposed in reducing VMT is at a low level of development. A great deal of improvement is required in our analysis tools and techniques. However, we have tried to estimate the results and it appears that a VMT reduction between 6% and 16% can be expected from the previous recommendations. Something else will be needed to encourage a reduction in automobile use.

We have looked at what we believe are the most feasible ways to provide this additional "encouragement." These include gasoline rationing, auto-free zones, gasoline tax, and traffic tolls. Of those alternatives, the gasoline tax is probably the simplest to impose. The additional financial cost has a direct effect on the miles driven.

We realize the regressiveness of the tax on gasoline. Accordingly, accompanying imposition of an additional tax on gasoline should be consideration of:

(a) More transit service to low- and moderate-income areas with a high degree of transit dependency.

(b) Some sort of tax credit against income taxes for low-income users of gasoline.

Therefore, perhaps the most controversial recommendation is to request that the State Legislature enact an additional gasoline tax of up to 10c per gallon. Money raised by such a measure (±$379 million) must be returned to this region for improving transportation facilities, improving air quality, and conserving energy. It must also be returned to maintain the regional economy. In these inflationary times, this recommendation is not offered without considerable thought. We realize that certain individuals in the region must drive a considerable distance and could be severely restricted by such a tax. Others in the region could afford it and even a much higher tax wouldn't make any difference to them. They still would take their automobiles.

I stress that any money raised from these taxes or fees, should be returned to the area where raised. We do not propose to subsidize the transportation systems (or anything else) of other regions.

We also suggest that additional auto disincentives be considered. These include higher vehicle registration fees for less efficient vehicles and the use of auto-free zones where practical.

Lawrence King, Secretary
Regional Planning & Development Section

"Is There an Answer to the Runaway Cost of Health Care?"

Speakers: DR. KARL E. POTTHARST
Clinical Psychologist
JOHN E. ARMER
President, John E. Armer and Associates

Stress is the acknowledged cause of great numbers of illnesses and disabilities. Research has indicated that emotional and mental problems often transfer into somatic complaints. As a result, overutilization of medical technology directs professional attention to physical problems without commensurate relief to the patient. In these cases, costs spiral because of what is, in fact, ineffective care. Is there an answer to this important and complex dilemma? Our speakers believe one answer is the psychological health plan.

John Armer holds degrees in both Psychology and Public Administration and is a Consultant to the Task

. American Psychological Association. A ~~Certified~~ CHARTERED Underwriter, his firm deals in financial consulting and benefit planning for both individuals and groups. Karl Pottharst received his doctorate in Clinical Psychology from the University of Michigan. He is a founder of the first free-standing, state-chartered accredited training program in professional psychology and currently is Director, internship Training, California School of Professional Psychology.

Presented to Town Hall Special Section
John E. Armer, Acting Chairman

DR. KARL E. POTTHARST

I should like to speak briefly on the evolution and development of the health systems over the last 50-60 years. Out of this evolution have come new concepts and new methods. One of these is preventive psychology. I would also like to discuss the availability of mental health manpower.

In Los Angeles about 75% of the available mental health manpower is available to only about 25% of the population. The other 25% is thinly distributed to the rest of the population. Where do you find the psychiatrists, the psychologists, and the licensed clinical social workers? Mostly, if not exclusively, you will find them in the more affluent middle-class communities.

Who seeks psychotherapy? There are 2 or 3 large groups: middle-class white housewives, college-educated young professionals, and people in the entertainment field and allied areas. Not because these social groups are particularly vulnerable to mental stress, but because they are more receptive and accept the option of doing something about their stress.

The people who receive the small remaining fraction of the mental health manpower available are more diverse than you might expect. These people have lower economic characteristics. They are white, black, brown, and other minorities. They are older people and families with problems. Often they are adolescents, blue collar workers, municipal employees, and rank-and-file employees of all businesses. They are a widely scattered group, living in inner cities, small towns, rural areas, and in the less expensive suburbs.

Mental health services at the turn of the century required hospitalization. Psychoanalysis was just emerging. At that time it was expensive, in time as well as money. Subsequently it became even more time consuming and costly. As of now, graduating students charge somewhere around $50 an hour. Yet, the profession has changed drastically in the form of development, indentifications, and implementations with use of numerous different kinds of approaches in treatment, in service, and in assessment.

Analysis started out for adults, for adolescents, and for families. Today analysis has different methods and different approaches to specific recipients; such as, problems of married couples, crisis intervention and crisis assessment, specialized residential adolescent settings, group therapy, and behavior modification. Prevention is stressed. Day care facilities may be utilized. A person may continue in his or her occupation, receiving treatment at night. Such approaches are a lot less expensive than full hospitalization.

There is now a system evolving that will bring about certain objectives and aims. The idea is to make mental health services more widely available to client groups and to provide less-expensive, short-term services to more people who are in need of them. The plan directs its interest into helping the family and strengthening the family group. Another aim is to spread the cost of treatment. And, finally, it will aim to avoid the stresses that lead to mental breakdown, thus permitting a more productive and satisfying life.

JOHN E. ARMER

About 3 years ago, it became very clear to me that the cost of delivering health care was escalating at such a rate that either the government would have to intercede or something dramatic would have to be done in the private sector.

This led me to develop 4 rather simple hypotheses. First, most people want to stay in shape (I'm talking both physically and mentally). Second, costs of health care are skyrocketing and everyone has felt it or is about to feel it. Third, from 50% to 90% of the people who are in physicians' offices need emotional help more than physical repair. Fourth, most of us who have at one time or another dealt with either insurance companies or bureaucracies would rather keep the health care delivery system out of the governmental bureaucracy.

REAL BENEFITS

There are all types of employee benefits, but the most important of all benefits today is a decent working environment. I'm not talking about the layout of the plant, or the number of windows or drinking fountains, or the appointments in the women's lounge. I'm talking about the feelings an employee has about his employer, his fellow employees, and himself or herself.

As far as medical or health benefits are concerned, we are now at a point where any well-informed and knowing employer or union head can purchase for employees and members the best kinds of medical attention.

These programs are quite capable of relieving the financial burdens of health care. Yet, there is a major problem faced by the employer or trustee today. On almost every insurance renewal date over the past several years, the cost of health care, through whatever the delivery system, has increased from 20% to 100%.

Is this enough of a problem to be really concerned? Is there a real social problem? I think so. When I first entered this business — about 20 years ago — 4.5% of the GNP was directed to health care. Today, with a greatly increased GNP, we are spending just under 8% — about $94.1 billion goes to the health industry.

In 1958, we wrote a health insurance program for the employees of the City of Santa Monica with a premium cost of $4/month per employee. A similar program for another municipality that we insure was lucky at the end of 1973 to get "only" an 80% increase in premium to $18/month per employee. A jump of over 400% in cost for similar benefits in 15 years!

Statistically, at least 9 out of 10 people today in the United States (about 203 million) have some form of coverage. Some 81 million are covered with major medical insurance. Despite this, a great number of employers or unions either can't afford or don't have the kinds of programs they should have. Authorities are now telling us that medical care costs are the leading cause of personal bank-

-y in the United States.

It seems to me that there has to be a way to achieve a better delivery system. The present programs do not seem to be working. I hold now, more than ever, the strong conviction, based upon my own observations and experience, that we cannot effectively turn the concern for health care over to a governmental bureaucracy. Medicare, with its $2 billion plus overrun, and the continuing problems of Medi-Cal here in California certainly aren't the kinds of solutions any of us are seeking. Let me say, however, that as a concerned citizen, and one who happens to be a part of the health industry, I was one of the few who welcomed both Medicare and Medi-Cal as urgently needed and long overdue.

PSYCHOLOGICAL HEALTH PLAN

What is the answer, if any, to the runaway cost of health care? I think it is this. I believe that 50% to 90% of the people who are in physicians' offices are there because they really have some kind of emotional or behavioral problem. If this is true, then we must target on that objective and put mental health benefits at the forefront of our delivery system, instead of using it in some ancillary way at the bottom of the system with limited benefits and limited effect.

I think the answer lies within a psychological health plan. A system that gives preventive care by reducing or removing stress.

While doing research, I was fortunate to have a meeting with Dr. Hans Selye — the internationally reknowned expert on stress. In an exchange of follow-up correspondence with him on the thesis of mental health treatment as a replacement for expensive physical care, he stated: "Adequate mental and emotional care would necessarily diminish an enormous group of so-called psychosomatic diseases which are ever more prevalent in today's society, especially among people working under great stress."

And who isn't today? Under a psychological health plan we can simply state that by paying attention to and making available adequate mental health benefits we can effectively reduce the cost of other, physical care utilization in a health delivery system. Admittedly there is little substantiating statistical data. Several studies have been done . . . all, in my opinion, lacking in one respect or another.

The Kaiser research, for its population, showed a significant diminution in the utilization of general care facilities by the use of psychotherapeutic intervention and treatment. Using control and experimental groupings, they discovered that just *one* visit to the mental health center produced a 60% reduction in utilization of the general care facilities at Kaiser! This was reported as a totally unexpected discovery. Further, during the 6-year study period, those in "short-term" treatment (2-8 sessions) showed an almost unbelievable 75% reduction in their use of the physical care facilities during the 5 years after discontinuing treatment! These statistics have remarkable implications.

In summer of 1973, at a symposium on health care in London, England, it was announced by a prominent and responsible executive in the British National Health Service that 65% of the expenditures of the British National Health Program were incurred in hospital charges. Of these charges 50% were for patients with mental or emotional problems! The evidence seems to be piling and it would seem ridiculous to ignore it.

I believe a psychological health plan that is well researched would fit prominently into every health care delivery system. It should stress prevention and there should be providers who are available in their offices all over California, who can be seen privately without getting involved with company or union personnel offices. There should be no stigma and there should be complete confidentiality.

The plan should have a professional standards review system in order to assure quality of treatment and, most importantly, be able to assure subscribers of a concert of professional opinion as to treatment prescription. This could provide the necessary mental health arm for prepaid health plans and eventually health maintenance organizations. Also, the insurance industry could replace their very limited "mental illness provision" with a psychological health plan.

Eventually, the plan could have specialized programs for detoxification for certain appropriate groups. Also the plan could put preventive ideas to work by helping employer and union heads with employee and management relations.

I think by encouraging utilization, my research indicates that a price could be set in the Los Angeles metropolitan area (depending, of course, upon demographic characteristics) at about $4 per month per family unit. I believe this to be a viable concept and an ambitious undertaking.

Frank L. Benedict, Rapporteur

"It Takes More Than Money"

Speaker: BERT A. JOHNSON
Regional Staff Supervisor, Pacific Telephone Company

At the turn of the century minority groups were seeking, and gaining, admittance to the wider community in this country. Irish, Italian, Jewish, Polish, Slavic, and other races lived in what we would now call ghettos. History's wheel has turned full circle and new groups now seek admittance: blacks; Spanish-speaking people from Puerto Rico, Mexico, and Central and South America; Asians and Pacific Islanders; and our original Americans, the "nations" that Columbus called Indians. Much is being done to absorb these groups into the mainstream of American economic life — some of it foolish, some wise. Mr. Johnson describes some of these efforts. For over 30 years Bert Johnson has

STATISTICS: FOR USE WITH CPHP

I. National Health Care Expenditures: Health care expenditures have increased dramatically during the past decade. The following statistics emphasize that fact and point to the need for cost containment programs.

A. From the Wage and Price Control Board (April 1976) - "The Problem of Rising Costs of Health Care".

1. 1965 - $39 Billion spent for health services: 5.9% GNP
   1975 - $118.5 Billion spent for health services: 8.3% GNP

2. 1965 - Average Hospital Stay = $311.00
   1975 - Average Hospital Stay = $1,110.00

3. 1965 - $14.44 Tax Expenditure per Capita for Health Care
   1975 - $132.00 Tax Expenditure per Capita for Health Care

4. 1965-1973 - Annual employer contribution to employee health plans increased 164%

5. 1975 - $555.00 per Capita spent on Health costs: 10% of an individual's income

6. Since 1965, there has been a 12% Increase per year in health care costs.

B. From the Consumer Price Index (CPI).

1. 39% of Health Care Costs were for hospital care - In Los Angeles a semi-private room costs about $110.00 and Intensive Care is $325.00 - $75.00 per day.

2. 19% of Health Care Costs were for Physicians' Services

C. From Business Insurance magazine: "Employee Benefits", December 15, 1975.

"In 1976, it will cost 20%-30% more to provide the same health insurance benefits as in 1975."

D. From the National Institute of Alcohol Abuse.

"In 1971, treatment for alcoholism accounted for 12% of the $68.3 billion health costs for Adult Americans."

E. From statistics released by General Motors - An example of costs in the private sector affecting the retail prices paid by consumers.

In 1975, the expenditure for health premiums was greater than the expenditure for steel. This cost component was the second highest of the price of an automobile - second only to wages.

II. Two questions raised by the Council on Wage and Price Control regarding health costs:

A. What are the opportunity costs? What are we giving up in order to spend this increased amount for health care?

B. What return is the nation receiving from this drastically increased spending? Has the overall health improved? Has the overall quality and delivery of health care improved?

III. Mental Health Studies: CPHP is a plan that provides an answer for reducing health care costs through quality mental health intervention. The following statistics illustrate the need for a prominent mental health program and the beneficial effects of having such a program.

A. Kaiser-Permanente (Follette / Cummings)

1. A study of its 1,250,000 members showed 68% make doctor visits for complaints for which no organic cause could be found.

2. A special study involved 152 individual patients over five years:

a. 80 attended a single psychotherapy session -- there was reduction of medical utilization by 60%.
b. 41 attended 2-8 sessions: Their medical utilization was reduced by 75%.
c. 31 attended 9 or more sessions and substituted psychotherapy for doctor visits.

B. Group Health Association Study (Prepaid health plan in Washington, D.C.)

1. 256 patients studied

2. Psychotherapy reduced medical utilization and lab X-Ray procedures by 30%

C. Florida Alcoholic Rehabilitation Program Study (Illinois Bell Telephone)

- Cited a decrease in sickness disability of approximately 46% after a one year involvement with the rehabilitation program.

D. Statement from HEW Conference on High Blood Pressure - November, 1976.

1. "High blood pressure has cost the nation an estimated:

a. "...$8.6 billion in lost wages...
b. "...additional (losses) for medical bills...
c. "...52 million man-days of lost production."

2. "Today, there are 75 million employed Americans. 15% or 11.25 million are known to suffer from high blood pressure or some form of cardiovascular disease..."

IV. SURVEY: Presented to the National Council on Wage and Price Stability by the Washington Business Group on Health (formed at the suggestion of the Business Roundtable's Health Legislation Task Force and representing almost every major United States based corporation on the New York Stock Exchange). The survey emphasizes the private industry's concern over health care costs and various methods adopted to contain these costs. CPHP, being a pre-paid, out-patient plan, that focuses on prevention, addresses itself to the majority of approaches mentioned.

A. Of 169 major employers surveyed, 48% indicated they were conducting or establishing a cost containment program.

B. Three significant impacts of programs:

1. The cost savings techniques represent an endorsement for the preventative-care approach!

2. Health education is increasingly viewed as a critical component of both quality care and cost savings.

3. Expanded coverage of home health, ambulatory care/out-patient care is viewed as cost-effective and quality improving.

C. Measurement of Savings included:

1. Lower company contributions to health fund or insurance premiums

2. Reduced lost time for employees

3. Lower hospital utilization

4. Fewer incidences of illness

D. Most Common Mechanisms Used to Affect Costs:

1. Health Education

2. Altered coverage to encourage preventive and outpatient care

3. Peer and Utilization Claims Review

4. Multiphasic health testing (health screening and testing procedures)

E. A Special study on multiphasic health testing (MHT) revealed:

1. MHT can be a major stimulus to increasing patient awareness about health habits and life-style alternatives.

2. MHT appears to be the best and least expensive way to meet OSHA requirements.

3. Most effective applications are for health hazard groups and pre-employment.

4. Most important factors for establishing the MHT program:

a. Reduce employee disability - 57% employers surveyed
b. Boost employee morale - 36% employers surveyed
c. Comply with regulatory requirements - 34% employers surveyed

5. The survey stressed the fact that only with a follow-up program can substantial benefits be derived from MHT.

* This is another important facet of CPHP. If results indicate hypertension, stress, alcohol problems, etc. CPHP can be utilized as an extremely cost-effective follow-up program.

F. Individual Case Studies

1. Kennecott Copper - Employees who received mental health counseling reduced medical utilization 55% and unexplained absenteeism by 33%.

2. Bechtel - Program for alcocol, drugs, emotional problems - Program costs of $150,000 have been more than off-set by reduced lost time, lower hospital utilization, fewer incidences of illness, increased work efficiency and "overall morale improvement".

3. IBM - 72,821 employees examined - 4,075 were found to have heart abnormalities - hypertension was eliminated in 81% of the cases after identification.

V. Conclusion: As a regular component in any established health care system, CPHP can be used as an effective cost containment program. Survey results also indicate a mental health program has substantial effects on employee morale and productivity. In addition, if used in conjunction with a multiphasic health testing program, CPHP offers a low cost means of effective follow-up.

TESTIMONY

and

SUPPORTING DOCUMENTS

by

THE KANSAS PSYCHOLOGICAL ASSOCIATION

to the

INTERIM STUDY COMMITTEE
of the
KANSAS STATE SENATE
and
HOUSE OF REPRESENTATIVES

SPECIAL COMMITTEE ON
COMMERCE & FINANCIAL INSTITUTIONS

on

Proposal 13

Regarding the desirability of mandating group health insurance contracts to provide coverage for nervous and mental conditions, drug abuse and alcoholism.

June 28, 1977

Atch. G

June 28, 1977
Procter

Mr Chairman, Members of the Committee, Staff, and Visitors:

My name is Dr. Robert L. Procter and I am a practicing clinical psychologist certified in Kansas. I have been asked by Dr. Henry Remple, President of the Kansas Psychological Association, to convey to you the strong interest and concern of the Kansas Psychological Association in support of mandatory group health insurance to cover nervous and mental conditions, drug abuse, and alcoholism.

The KPA is the state professional organization of psychologists dedicated to the use of psychological principles as a means of promoting human welfare and to promoting the highest standards of conduct and qualifications of psychologists. The KPA was originally a branch of The Kansas Academy of Sciences and became autonomous in the early 1940's. There are approximately 500 psychologists in Kansas and 400 psychologists who have been certified under Kansas law.

I have worked in Kansas as a psychologist for fourteen years: in Kansas State Mental Health Institutions, Mental Health Centers, as the Chief Psychologist in the State SRS System, and for the last three year as the chief psychologist of a non-profit group of mental health practitioners in Topeka.

The main points the Kansas Psychological Association would like to make today are:

1. Mental health, alcoholism, and drug abuse are major health problems and should be covered on a parity with physical illness.
2. Results of the last decade in mental health indicate that early outpatient intervention decreases the use or duration of hospitalization thus lowering costs

and increasing productivity in the long run. Expanding the availability of these services will bring these benefits to more Kansas citizens.

3. Many recent studies have shown that the utilization of mental health, alcoholism, and drug abuse outpatient services lowers the rate of utilization of other physical care facilities thus lowering costs.
4. Mandatory coverage of nervous and mental conditions, alcoholism, and drug abuse could provide financial support for community health centers, state hospitals and other elements of the mental health system which include non-profit treatment agencies and private practicing psychiatrists and psychologists.
5. Mandatory coverage would provide relief from the spiraling medical costs of the Kansas Social and Rehabilitation Services Department in that: many people upward-bound from Medicaid coverage, would have greater flexibility in finding gainful employment and being able to continue the treatment they need.

The Kansas Psychological Association would like to call the attention of the Sub-Committee to certain conditions which are undesirable and subvert attempts to provide adequate coverage:

1. Unfortunately, many insurance policies currently exclude alcohol and addictive disorders from their hospital benefits to which the person would otherwise be entitled.
2. Despite the intent of the Kansas Legislature in enacting a freedom of choice law so that in Kansas a citizen with

mental health coverage can utilize the benefits to see either a psychiatrist or a psychologist, there are many policies which are placed with carriers chartered outside the State of Kansas which deprive Kansas citizens of the mental health benefits which the policy seems to provide. In - surance companies with home offices in states other than Kansas may have different and restrictive laws with undesirable exclusions. The Kansas Psychological Association hopes this sub-committee can make recommendations for legislation which can eliminate these inequities which currently exist and prevent them from happening in ~~the~~ any future legislation.

3. The Kansas Psychological Association would favor no deductible or co-insurance for the first several visits so that people with emotional problems may be encouraged to seek help rather than discouraged from seeking it.

Finally, mental illness, alcoholism, and drug abuse are expensive to society in loss of productivity and taxes. They fragment families and produce social and physical impairments which are expensive to ameliorate and, when allowed to continue, magnify their tragedies throughout every aspect of the social and economic system. Mandatory insurance covering these disorders adequately is a sound investment which will return financial and social benefits to the citizens of Kansas in the long run.

Thank you for allowing The Kansas Psychological Association the privilege of hearing these remarks.

November 14, 1975

SUMMARY OF THE STATEMENT
to the
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON HEALTH

on behalf of

AMERICAN PSYCHOLOGICAL ASSOCIATION
1200 Seventeenth Street, N.W.
Washington, D.C. 20036

COUNCIL FOR THE ADVANCEMENT OF THE
PSYCHOLOGICAL PROFESSIONS AND SCIENCES

and the

ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOLOGY
1200 Seventeenth Street, N.W.
Washington, D.C. 20036

Mr. Chairman, our testimony today may be summarized by these statements.

1. Those disorders and dysfunctions generally referred to as mental illness constitute a major health problem and should be covered on a parity with physical illness under National Health Insurance.

2. Costs of mental health services are not unreasonable.

3. Utilization of mental health services is controllable.

4. Utilization of mental health services tend to lower medical, surgical and laboratory diagnostic costs of users.

5. A state level Professional Standards Review Committee fashioned along lines of the federal PSRO is one of several mechanisms available to control quality and cost of psychological services in 50 states and D.C.

6. Providers of mental health services are in short supply.

7. Psychologists, especially trained, duly licensed, geographically well distributed and accepted as qualified health providers by both public and private insurance carriers should be recognized under National Health Insurance Plans.

COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH
U.S. HOUSE OF REPRESENTATIVES

November 14, 1975

Mr. Chairman, members of the Health Subcommittee of the Committee on Ways and Means, I am Charles Kiesler, Ph.D., a psychologist and Executive Officer of the American Psychological Association. I am accompanied here today by Herbert Dorken, Ph.D., a psychologist with the Langley Porter Neuropsychiatric Institute at the University of California system in San Francisco and currently chair of the APA's Committee on Health Insurance; and Clarence Martin, Executive Director and General Counsel of our sister organization, the Association for the Advancement of Psychology.

Mr. Chairman, the Board of Directors of the American Psychological Association adopted in July 1971 a position statement on National Health Care. These principles remain valid and I would like to take this opportunity to restate them..

"1. All persons should have equal access to all health services, regardless of the ability to pay or of other circumstances such as geographical location.

2. The health care system should protect the individual's rights in regard to human dignity, privacy, and confidentiality.

3. Funding of the system should provide for each of the following:

(a) direct services for both prevention and treatment of physical and

mental illness; (b) a full range of health manpower, including necessary training and upgrading of health care personnel at all levels; (c) research into the causes of illness and its treatment; (d) public education and other population-oriented programs of prevention.

4. The health care system should permit the individual freedom of choice among the full range of health services and providers of these services.

5. Consumers, as well as providers of health services, should have an opportunity to participate in the development of the health care system.

6. Redress for grievances resulting from the providing of personal health services should be available from review bodies which include both consumers and health professionals.

7. The quality and availability of health services should be evaluated continuously by both consumers and health professionals. Research into the efficiency and effectiveness of the system should be conducted both internally and under independent auspices.

8. The system of health care should be responsive to the findings of review bodies, to the results of research, and to emergence of new concepts of service."[1]

Since the adoption of those principles, much has happened in the field of health which reinforces the need for a national health system.

---

[1] Adopted as a position statement of the American Psychological Association by its Board of Directors on July 8, 1971. Based on a report of the Task Force on National Health Care (Victor Raimy, Chairman; Andie L. Knutson; William Schofield; S. Don Schultz; and Milton Theaman); John J. McMillan (Staff Liaison) and Jack G. Wiggins (Liaison from the Committee on Health Insurance); and the Board of Professional Affairs.

Total federal expenditures for personal health services have increased 86 percent to an estimated $28.6 billion for fiscal 1975.

The nation is now spending 8.3 percent of the total value of the goods and services it produces for health care.

Our national health statistics, however, remain poor in comparison with other industrial nations.

The members of this Committee and its predecessor committees in past Congresses have heard testimony on scores of health care bills.

The problems raised by these bills are many and the solutions offered by the hundreds of witnesses are often conflicting, seemingly irreconcilable or just down right too expensive.

No one at this moment knows what an ideal health system will look like. We can probably reach a consensus, however, on what that ideal system should achieve. It should achieve a long productive life, minimal illness and disability, effective treatment of unavoidable trauma and disease, rapid restoration of optimal functioning following disability, humane treatment, equitable access to quality care; and at a cost that permits the realization individually and governmentally of other desirable social and personal goals.

I would like, Mr. Chairman, to address myself to several items which I hope go to specific concerns of this Committee, the interest of the public and the potential contribution of American psychology.

The Committee must be concerned not only with the need for a service but with the cost. Health benefits must be paid for and we must all

be concerned with cost both as taxpayers and as responsible citizens.

There is ample reason to urge that mental health problems be a major concern of national health programming. Mental health problems are debilitating and often seriously impair or prevent employment. They can and do lead to physical illness. They place inordinate demands on the time of medical practitioners not equipped by training to cope with them. Data indicates that psychological disorders are frequently the factors precipitating a visit to a physician.

Reasonable mental health benefits, provided by qualified, experienced mental health practitioners including psychiatrists and psychologists will reduce the per capita cost of health care.

The availability and provision of mental health services have been shown through research to reduce dramatically the extent of subsequent use of surgical, in-hospital and diagnostic laboratory services.

From the available data it appears that there are in the United States somewhere between 8 million and 10 million persons presently utilizing mental health services.

It is further estimated that an additional unmet need exists for 11 to 16 million individuals.

Even if the incidences of need remain constant and increases only proportionate to population increases are projected, an additional number will come in need each year. Kramer's data does show that patient care episodes increased from .63% of the population in 1946 to 1.03% in 1955, 1.2% in 1963 and 1.99% in 1971. Utilization of mental hospitals during this

period declined from 61% in 1955 to 25% of the reported episodes in 1971. Outpatient clinics and community health centers accounted for 61% of the episodes.[2]

An increase in total episodes as well as greater utilization of outpatient treatment argue the necessity of a health policy which not only covers mental treatment in hospitals and other institutional settings, but in outpatient facilities and private office settings as well.

We strongly support the concept that defined mental health impairment, clearly delineated, should be included under National Health Insurance. We recognize also that it would be inappropriate and clearly impractical to try to include all human ills, mental or physical, under National Health Insurance. Limitations of treatment methods and utilization review of accepted treatments are necessary and proper in a NHI scheme.

Recent developments in the treatment of mental health problems have focused on the concept of individualized treatment plans for every patient. The individualized treatment plans include the nature of the problem, the goals for treatment, and the steps or procedures to be taken to meet those goals. It is no longer acceptable to simply state that a patient is under treatment. Every patient should have an individualized written treatment plan based on an assessment plan derived from diagnostic procedures developed along proven psychological principles.One of the great advantages of such a treatment plan is that it provides careful monitoring of the effectiveness of the treatment provided to each patient. It also provides for very careful control of the

---

[2] Kramer, M., Division of Biometry, NIMH "Issues in the Development of Statistical and Epidemological Data for Mental Health Services Research" 1974

kind and amount of treatment provided. Individualized treatment plans are now required for meeting accreditation standards and have been required by court action.

Psychologists have pioneered in the development of specific treatment plans. The psychologist's basic orientation in the behavioral sciences with a special focus on mental health has encouraged psychologists to carefully monitor their treatment approaches. Psychologists were involved in setting up behavioral or measurable objectives to treatment plans for some time. This very special orientation of the psychologist in the treatment of mental health problems permits not only careful monitoring of the treatment approaches but also effective evaluation of the outcomes of those approaches. With individualized written treatment plans which include objectives it is possible to determine to what extent the treatment plans are succeeding. Rather than maintaining a treatment approach which would not lead to changes, this system of individualized treatment plans permits the changing of treatment strategies to meet individualized patient needs. It also tends to maximize the treatment given by any therapist for any patient. This procedure has now been incorporated in the Standards for Providers of Psychological Services adopted by the American Psychological Association.

LIMITATIONS OF TREATMENT

One of the significant concerns raised in any discussion of National Health Insurance coverage for mental health services involves the possibility of coverages for a range of treatment approaches some of which may not be standard or acceptable treatment methods. There have been in the mental health

field innovative treatment approaches, some of which are clearly in the experimental stage and many of which may never achieve acceptance by the majority of the profession and would therefore never become acceptable standard procedures of the profession. It is critical that any National Health Insurance plan provide adequate coverage for the treatment procedures which have become acceptable, reasonable treatment methods meeting the standards of practice and ethics of the profession.

There are several controls and restrictions in this regard which should be pointed out. The training programs for clinical and counseling psychologists which exist in the major universities and hospitals throughout the country receive approval or accreditation by the American Psychological Association after careful review of all components of those programs. The accreditation process by the American Psychological Association assures a very significant degree of control over the nature and quality of training programs for the future health service providers in psychology. The accreditation system provides reasonable and acceptable standards for insuring that the training of health service providers in psychology includes the standard and well-founded psychological principles and techniques which have proven useful in the mental health field.

Another aspect of the profession's concern with reasonable acceptable treatment procedures are the established Standards for Providers of Psychological Services, the Code of Ethics and Professional Conduct, and other professionally designated control systems.

Psychology's peer review programs now in effect in all 50 states,

provide perhaps the most significant control in this area. Peer review organizations have already proven extremely useful in providing the appropriate checks and balances to treatment approaches by mental health professionals. Given the current organization in all the states and the early successes of the peer review system, it is anticipated that the peer review experiences will provide an efficient and reasonable method of monitoring treatment approaches as well as insuring the best service available to every individual patient.

FOCUS OF TREATMENT

The focus of the mental health coverage should be on the impairment of the individual rather than on any specific treatment approach. That is, coverages should be identified by the nature of impairment with the specific treatment plan to be determined by the individualized problem and treatment plan. One of the great problems in the mental health field is that some individuals will identify almost anything as being a reasonable psychological or mental health problem and therefore the cost projections become astronomical. This is clearly a distortion. The most accepted epidemiological estimates of the incidence of mental health problems in this country range around 10 to 20%. This is the percentage of individuals identified as being impaired in some fashion in their coping and requiring some kind of treatment. The population at risk then, for mental health insurance reaches a maximum of approximately 20%. Moreover, many of the problems which may be identified as mental health problems have in the past and continue to be seen by the general medical practice field. That is, there are existing mental health services which are being provided by health programs not necessarily identified

as mental health. A large portion of a pediatrician's work for example, consists of dealing with a range of developmental, behavioral, and other mental health problems of the infant.

The recent experience of insurance firms in the coverage of mental health problems provides good data for delineating those services which should be reimbursable. It has become very obvious that it is possible to identify those services which should be reimbursable and to eliminate those which should not be reimbursable. The great concern of unlimited coverage for a range of human condition problems has been solved and control methods exist. We will cite specific examples under the cost and utilization material later in this testimony.

Who treats mental illness

The number of psychologists and psychiatrists providing health services are about evenly divided. Most providers in both professions function in multiple delivery systems as well as in teaching, hospital and outpatient services. Psychologists are better distributed geographically than psychiatrists and there is a consistent trend towards recognition of psychologists as primary health providers in private insurance contracts and state and federal programs.

Estimates of total professional manpower in health delivery services by psychologists and psychiatrists have been estimated by DHEW as 28,332 physicians specializing in Psychiatry or Neurology (1972) and 26,927 psychologists (1970) in health providing services of some kind on a part or full time basis.

An American Psychological Association study in 1972 reported the following findings for psychologists in health delivery settings: 36% identified themselves as clinical psychologists; 19% were employed in hospital settings; 6% in medical schools, and 15% in clinics; 8% of the clinical psychologists were engaged in research and 13% were engaged in management or administration. Only 2% were foreign trained.

Psychologists practice in nearly all health care settings, with frequency of practice being approximately equally distributed among private practice, out-patient clinic, and hospital based practice. In hospitals, psychologists may be on the professional staff or the affiliate staff or on the hospital salary payroll. Psychologists are part of most Health Maintenance Organizations, and are involved in most Community Mental Health Centers, sometimes as program directors. They less commonly practice in Foundations for Medical Care, although they are included in such Foundations in several states. In California, recent legislation provides that in Health Maintenance Organizations offering mental health services, the staff shall include both psychologist and psychiatrist and the consumer shall have personal choice and direct access to either provider.

Psychologists are on the staffs of all accredited Medical Schools in the United States, and will typically have clinical as well as teaching and research responsibilities in such facilities.

Fee or funding arrangements for psychological services are quite varied, being rather evenly divided between fee-for-service charges and indirect charges included under hospital costs or similar organized health settings. The fee-for-service billing by the psychologist is the most common

practice for licensed psychologists functioning as independent professionals, and is probably the least expensive to the consumer in the long run, because it does not include capital cost, overhead and other indirect expenses of an intermediary institution or professional referral.

Recognition of psychologists as independent qualified mental health service providers has recently been reflected by HEW spokesmen:

> "The tradition that all service must be provided by a physician or under his guidance is now giving way to practical reality. As an example of this trend, as of January 1, 1975, all government employees' insurance plans will permit payments to psychologists, without requiring a physician's supervision. This more practical attitude should be encouraged by all of us." [3]

A number of other federal and state programs recognize psychologists as primary health providers.

The Rehabilitation Act of 1973--Public Law 93-112--recognizes psychologists who are licensed/certified according to State statute, along with physicians, for diagnostic and restorative services to beneficiaries.

CHAMPUS recognizes the autonomous practice of clinical psychology in its nationwide health benefits program which covers dependents of military

---

[3] Address by Charles C. Edwards, M.D. Assistant Secretary for Health, U.S. Department of Health, Education and Welfare to the ADAMHA Annual Conference of the State and Territorial Mental Health, Alcohol, and Drug Abuse Authorities, Washington, D.C. on November 21, 1974. The reference is to the McGee-Waldie Act (S2619/HR9440) which became P.L. 93-363 on July 30, 1974.

personnel, retired military personnel, and other beneficiaries.

CHAMPVA is a new program for disabled veterans which recognizes psychologists as autonomous practitioners.

Community Mental Health Centers regulations provide that psychologists may serve as program directors.

Veterans Administration provides that directors of VA mental hygiene clinics may be qualified psychologists or other mental health professionals who will be responsible for the formation and general supervision of administrative activities inherent in the professional programs of the clinic.

Veterans Administration regulations provide that psychologists and other health professionals licensed/certified by the State may provide services on a fee basis to out-patients through VA clinics.

The Work Incentive Program (WIN) accepts professional evaluations by licensed/certified psychologists as well as physicians, as to evidence of determinable mental impairment.

Work Injuries Compensation of Federal Employees coverage has been broadened so that the definitions of "physician" and "medical, surgical and hospital services and supplies" include clinical psychologists. (Public Law 93-416).

The Social Security Bureau of Disability Insurance accepts the reports of psychologists without physician referral or endorsement as evidence of disability for social security benefits.

Health Maintenance Organization legislation (Public Law 93-222) includes clinical psychologists among providers of services.

Department of Defense includes psychologists in its policy which provides that "any qualified health professional may command or exercise administrative direction of a military health care facility...without regard to the officer's basic health profession."

Some major health-insurance carriers have recognized the disadvantages of mandatory medical referral/supervision and have voluntarily included psychologists as autonomous providers of services in many of their contracts. These firms include, but are not limited to Aetna, Guardian, Liberty Mutual, Massachusetts Mutual, Occidental, Prudential, Travelers, and Teachers Insurance and Annuity Association (TIAA).

At this writing twenty-three states and the District of Columbia have enacted legislation requiring private major medical health insurance plans to make direct payments to psychologists in the same manner as payments are made to physicians without prior referral or supervision in plans providing mental health coverage:

Arkansas	Massachusetts	New York	Washington
California	Michigan	Ohio	Oregon
Colorado	Mississippi	Oklahoma	Connecticut
Kansas	Montana	Tennessee	Minnesota
Louisiana	Nebraska	Utah	Maine
Maryland	New Jersey	Virginia	

Fifteen states give this kind of independent provider recognition to psychologists under their state Medicaid plans:

California	Montana	Ohio
Connecticut	New Hampshire	Oklahoma
Hawaii	New Jersey	Oregon
Maine	New Mexico	Tennessee
Minnesota	New York (except New York City)	Utah

The geographical distribution of psychology's service providers does

not differ significantly by region from the 1970 population census:

> "Psychologist service providers are distributed throughout the United States in approximately the same way that the total population of consumers of psychological services are distributed. Geographic maldistribution, at least regionally, apparently does not apply to psychologists." [4]

An in depth study of geographical distribution in one state is the 1974 Ohio study by James T. Webb, Ph.D., Ohio Psychologist, (July 1974), XX, 4, 5-12, copies of which were submitted to this committee by us on April 15, 1975 and September 26, 1975.

Utilization and Cost

At the present time, it has been estimated that in the United States we are spending around $3 billion a year for the diagnoses and treatment of mental conditions. The cost of undiagnosed, untreated conditions has been estimated at $24 billion annually, including $10 billion in lost wages, $2 billion in lost taxes, $2 billion in the transfer of spendable income and $10 billion in improper diagnosis and ineffective treatment. The cost of untreated mental conditions is eight times the costs of direct services.

William Follette, chief psychiatrist, and Nicholas A. Cummings, chief psychologist, both of the Kaiser Foundation Hospital and the Permanente Medical Group of San Francisco, California, have recently completed a study,

---

[4] Whiting, J.F., Dorken, H., Psychologists as Health Service Providers, Professional Psychology (1974, Aug.), p.p. 309-319.

yet unpublished, on utilization of psychological services in the Kaiser experience.[5]

The Kaiser Foundation Health Plan in the Northern California Region is a group-practice prepayment plan, offering comprehensive hospital and professional services on a direct service basis. The composition of the subscribers is diverse, encompassing most socio-economic groups. During the period of the study, the psychiatric clinical staff in San Francisco consisted of psychiatrists, clinical psychologists and other mental health service providers. Their eight year follow up of the program produces the following conclusions:

> Persons in emotional distress were significantly higher users of both inpatient and outpatient medical facilities as compared to the Health Plan average;
>
> There were significant declines in medical utilization in those emotionally distressed individuals who received psychotherapy as compared to a control group of matched emotionally distressed Health Plan members who were not accorded psychotherapy;
>
> These declines remained constant during the five years following the termination of psychotherapy;
>
> The most significant declines occurred in the second year after the initial interview, and those patients receiving one session only or brief psychotherapy (two to eight sessions) did not require additional psychotherapy

---

[5] Cummings, N. and Follette, W., "Brief Psychotherapy and Medical Utilization: An 8 Year Follow Up." Chapter 10 in "The Professional Psychologist Today; New Developments in Law, Health Insurance and Health Practice," Dorken, H. and Assoc. Ed. Pub. Jossey-Bass (in press 1975).

to maintain the lower level of utilization for five years;

Patients seen two years or more in regular psychotherapy. demonstrated no over-all decline in total outpatient utilization inasmuch as psychotherapy visits tended to supplant medical visits. However, there was significant decline in inpatient utilization in this long-term therapy group from an initial hospitalization rate several times that of the Health Plan average, to a level comparable to that of the general adult Health Plan population;

During the entire period of the study, as well as in the insured years before and after the eight years of this study, the utilization of mental health services was consistently for inpatient (hospitalization) one-half per thousand insureds, and nine per thousand insureds for outpatient services. The average length of hospitalization remained under eight days, and the average outpatient psychotherapy series remained at 6.6 visits;

Sixteen years of prepayment experience demonstrates that there is no basis for the fear that an increased demand for psychotherapy will financially endanger the system, for it is not the number of referrals received that will drive costs up, but the manner in which psychotherapy services are delivered that determines optimal cost-therapeutic effectiveness. The finding that one session only, with no repeated psychological

> visits could reduce medical utilization by 60% over the following five years, was surprising and totally unexpected. Equally surprising was the 75% reduction in medical utilization over a five-year period in those patients initially receiving two to eight psychotherapy sessions (brief therapy). The clinic procedure was to offer early and incisive intervention into the patient's crises problem, get beneath the manifest symptoms to his/her real concerns and offer understanding and therapy within the very first session itself.

We can, as a nation, invest more monies on direct services for mental conditions and, at the same time, obtain significant savings in tax monies, prevent loss of money to employers and employees alike while promoting human welfare! Reasonable mental diagnosis and treatment can be made available to all citizens for a reasonably low cost, and the costs of treating these mental conditions will be offset by substantial reductions in the costs of other health services.

Review of the literature shows that mental conditions can reduce efficiency on the job by 20%, tend to increase absenteeism significantly, result in the higher use of medical benefits and spuriously inflate the cost of health insurance contracts provided by employers. It has also been found that mental conditions result in under-employment and, with appropriate intervention and treatment, individuals with mental conditions can be rehabilitated into productive lives in which their incomes produce new tax money, off-setting the cost of treatment and reducing their burden to welfare rolls and state

hospital systems.

When comparing the cost of treatment for mental conditions, it becomes evident that psychological therapy is the treatment of choice in the large majority of cases, with drug therapy running a second choice and hospitalization a third. However, the utilization of mental health services currently measured by dollar costs is just the reverse. Hospitalization tends to be over-utilized and could be reduced by one-third. Medication, where prescribed, may be used ineffectively and frequently avoids getting down to the basic problem, which can be uncovered through psychotherapy. Psychotherapy, though a costly procedure, is an insurable benefit and, in the final analysis, appears to be a most effective way of intervening into mental behavioral conditions.

Failure to diagnose and treat mental conditions puts an undue burden on the delivery of other health services. There is general agreement that about 60% of the patients going to family doctors' offices for physical symptoms have a psychological problem which is either a primary problem or aggravates the physical conditions or interferes with effective treatment regimens.

Studies also indicate that high users of medical services are frequently emotionally disturbed, often suffering from mental depression. Other studies indicate that if appropriate recognition of mental conditions is made, medical utilization by these individuals can be reduced by as much as one-third, off-setting the cost of mental diagnosis and treatment. Studies further reveal that the general practice physician himself frequently does not recognize mental conditions, and, if he does, he may not know how

to treat or how to refer the patient for appropriate help.

> In one of the few studies in an industrial setting (Kennecott Copper, Utah), access to mental health and counseling services showed a before and after reduction of hospital and medical-surgical costs (55%) and absenteeism (52%) for the treated employee. A comparable control group showed no favorable change over time.

Other sets of data indicate that with appropriate treatment, people with mental conditions, including the mentally retarded, can become gainfully employed, increase their incomes, improve their job efficiency, reduce sick time and absenteeism from the job. The cost of direct services for mental conditions can be offset by new tax monies on increased earnings to these individuals.

The cost of training the necessary manpower, the making of manpower available to various segments of the population, and the cost of needed research must be borne in mind in calculating the cost of services. However, comparing the cost of mental health manpower with the cost of training physician specialists reveals that it is cheaper to train mental health specialists and have them deal with the mental conditions at the earliest entry point into the health system. Reliance upon the primary physician as a referral source for mental conditions is not only a costly, but an inefficient way to get people into treatment.

Costs of mental health benefits under various insurance programs have been surveyed by a number of sources.

As the single largest group health plan in the United States, as well as a plan with virtually unlimited mental disorder insurance, the experience of the Civilian Health and Medical Plan of the Uniformed Services should be of particular interest.

Dorken's[5] study of the CHAMPUS experience in those 10 states which constitute the concentrated use of CHAMPUS in FY 1973 reveals a great deal of information relatable to National Health Insurance.

The benefits available under CHAMPUS in 1973 for mental disorder were almost unlimited. In the 10 states studied, the insured population under CHAMPUS consisted of 3.26 million individuals. Mental disorder utilization of the benefits consisted of 1.87% of the insured. Total cost per user averaged $1,138 (government cost $929) in the year.

On a per capita basis these extensive mental health services were at an annual cost of $19.82 (CHAMPUS cost $16.15 or on a monthly basis, $1.35) per capita.

The total mental health services absorbed 12.8% of the total health benefit funds before any adjustment for the savings they afforded from the decrease in utilization of physical health benefits, such as have been demonstrated in every program tracing the adjusted cost of mental health benefits.

Of the unadjusted 12.8%, 58% was expended for hospital services, 30.5% for outpatient visits (all procedures, all professions). Of the outpatient visits, 46% were to psychiatrists, 23% psychologists, 10% social workers, 2% attending physicians, and the 19% balance distributed among all

---

[5]Dorken, H., "CHAMPUS Ten State Claim Experience for Mental Disorder FY 1973." Paper presented to American Psychological Convention, New Orleans, 1974.

other therapists and clinics.

The unadjusted percentage of the total health benefit funds utilized by CHAMPUS is nearly twice as high as most plans report. This is probably due to two factors, the nearly unlimited extent of the benefits and the special make-up of the patient population.

The 1974 hearings before the Senate Post Office and Civil Service Committee on the 1973 Federal Employees Health Benefit Act found Blue Cross and Aetna reporting much lower figures. Policies under these two plans provide coverage for about 80% of the insured under FEHBA. Aetna reported a mental disorder utilization experience of 1.2% and the Blues reported 1.1%.

Mental disorder cost for Blue Shield-Blue Cross represented an unadjusted 7.3% of total claims and have for several years remained in the 7% range. The plans cover over 5 million beneficiaries and based on the 1972 utilization rates for mental health services, 65% of which were utilized by hospitalized inpatients, show a cost of $11.92 per covered person (or less than one dollar a month).

In 1971 Aetna cost allocated 8.6% to mental disorder coverage; and in 1972, with psychologists recognized directly, without physician referral, the cost dropped to 8.5%.

Clearly, there is variance in utilization among age groups, sex, type of employment, socio-economic level, and type of insurance coverage available. Such variance notwithstanding, the growong body of reports, make it evident that meaningful mental health benefits are well within feasible fiscal limits. Indeed, there is some evidence, particularly from service in

organized settings that the provision of mental health services can reduce other health plan utilization. These findings speak clearly to the need for comprehensive health benefits with continuity of care and incentives to community based alternatives to hospital care.

Spiro (Am. J. Pub. Health, 1975, 65, 139-43) compared fee service to cost financing in a union program and found that over the four-year period only 2.73% of the population at risk used mental health benefits. Utilization never exceeded 1.3% per year. Cost remained well under 50 cents per month per capita. "The removal of restrictive deductibles and early co-insurance produced none of the predicted dire effects." Hospitalization was found to be substantially higher in fee service clients. Removing barriers to hospitalization while placing restrictions on outpatient care, is a good way to run program costs up.

Scheidmandel summarized considerable utilization experience (Psychiatric Annals, 1974, 4, 58-74). She notes that all the group practice plans have much lower rates of hospital admissions and days of care than do fee service plans. Of plans reporting office visits, these ranged from an average of 4 to 15 per patient. Less than 10% of patients had more than 20 visits to a psychiatrist in a year.

Cohen and Hunter (Am. J. Orthopsychiatry, 1972, 42, 146-53) compared a fee service indemnity coverage to a community mental health center (CMHC) for retail clerk union groups in Los Angeles over a seven year period intended to provide saturation level services. Different patterns of utilization were apparent. Inpatient services accounted for 33% of costs in the Merged Trust Indemnity Plan, 8% at the center though overall utilization was higher

1.6% vs. 5.6%. The greater utilization through the center yielded higher costs but a lower cost per user, $345 vs. $245. It is concluded that hospitalization can only be avoided when community services are available in meaningful quantity unless the community is to become a dumping ground for hospitalized patients.

Mendel (American Psychiatric Association Convention, 1973) reported on prepaid experience with 6,000 welfare patients in Southern California. Utilization averaged 5.8% of the population with only one case hospitalized. The psychiatric care cost 41 cents per member per month. The importance of this study is that it contradicts the conventional wisdom that the indigent population is a higher risk for coverage than the employed.

Substantial evidence indicates that utilization of mental health benefits do not produce an unwarranted demand for services that will financially endanger a health insurance program.

The utilization of mental health benefits reduces medical and surgical utilization of the program and early availability of mental health treatment in outpatient facilities reduces the utilization of high cost institutional care.

Quality of Service

Psychologists are licensed or certified by statute in 47 states and the District of Columbia. The three states without statutes (Missouri, Vermont, and South Dakota) presently have legislation pending.*

The standard for licensing developed by the American Psychological

---

*NOTE: (Since the time of this testimony the legislation has been enacted in the three remaining states.)

Association consists of a doctoral degree, a comprehensive written and oral standard examination, as well as supervised experience.

The Council for the National Register of Health Service Providers in Psychology was established at the request of the Board of Directors of the American Psychological Association to the American Board of Professional Psychology. The National Register of Health Service Providers in Psychology, a voluntary listing, is designed to identify psychologists who are licensed or certified to practice in their states and who are health service providers. Though only recently published, the Register has already been adapted by Blue Cross-Blue Shield for its governmentwide federal employee plan.

Certification or licensure of psychologists under state law is not by specialty designation per se, no more than are physicians, dentists or lawyers licensed by specialty practice under their applicable state laws. The Register is designed to complement such statutes by identifying those licensed/certified psychologists who are health service providers.

The Council for the National Register has developed a very careful review process to assure that psychologists who are included in the Register will have had the minimum training and experience in the health services field. Specifically, to be included in the Register, the psychologists must have a doctorate degree from an accredited university (except for a few who have many years of practice and have been licensed at other academic levels) and must be licensed or certified by the Boards of Examiners of Psychology at the independent practice level.in their states or the District of Columbia, and have a minimum of two years of supervised health service experience.

The Council for the National Register was established in recognition of the need for the development of a system by which various governmental, health services, other organizations, and individual consumers can identify psychologists who meet the standards of practice in their states and who have training and experience in the health services field. The National Register, working closely with the statutory State Boards of Examiners of Psychologists throughout the country and with other public and professional organizations identify psychologists who maintain the standards of their profession through state licensing and certification, and who are trained and experienced in the delivery of health services.

The first National Register of Health Service Providers in Psychology was published in July of 1975. This Register identifies psychologists throughout the country who meet the above-mentioned standards, assures the public, government agencies, and others that the persons included meet the criteria established by the Council for the National Register, based on the professional Standards of the American Psychological Association. The Register and supplement list approximately 7,500 licensed psychologists who meet the criteria of health service provider.

There are other safeguards within the profession of psychology to insure responsible professional service.

For twenty years the American Psychological Association with its affiliated state organizations has operated a system enforcing its Code of Ethical Conduct.

Organized psychology is developing a system of Professional Standards Review Committees at the Federal PSRO system, to review the quality, cost, and appropriateness of service beyond the strictures of ethical conduct. This system is currently operational in all fifty states and the District of Columbia, and even at this early stage in its development, it is obvious that it is very effective in identifying and controlling excessive cost, over-utilization and questionable practices. It has also proved helpful in verifying the utility of conventional and innovative therapeutic techniques.

Psychology believes that peer review is an absolute necessity in the continuing development of mental health services as well as in insuring economical and responsible treatment for those who seek mental health services today. We view the government's PSRO system with great hope and believe that if properly developed, PSRO will be a mechanism for determining more effective and appropriate treatment procedures in an area of health service where many questions remain unanswered. Psychologists do not believe that a great deal can be accomplished for the future under a peer review system and a mental health delivery system which retards the effectiveness of an open relationship between the professions working in the mental health area. By assuring access to the different disciplines in mental health, thereby imposing on them the responsibility of working together to find better ways of treating emotional and mental disorders, through PSRO, the Congress will have established the groundwork for rapid future progress in mental health. By failing to adequatly recognize the interdisciplinary nature of mental health service, the Congress will have not so much damaged the profession of psychology as it will have damaged the opportunities for better service to the public in the future.

"79"

SUMMARY OF THE STATEMENT
to the
INTERIM STUDY COMMITTEE
KANSAS STATE SENATE AND HOUSE OF REPRESENTATIVES
SPECIAL COMMITTEE ON COMMERCIAL AND FINANCIAL INSTITUTIONS

on the subject of

PROPOSAL 13

A Study to Determine the Desirability of Mandating that Group Health Insurance Contracts Provide Coverage for Nervous or Mental Conditions, Drug Abuse and Alcoholism

June 28, 1977

on behalf of

THE KANSAS ADVISORY COMMISSION ON DRUG ABUSE
and
Personal and Professional Interests in Problems of
Drug Abuse, Alcoholism and Nervous and Mental Conditions

Mr. Chairman, my testimony today may be summarized by these statements.

1. The mandatory inclusion of nervous and mental conditions, drug abuse and alcoholism in health insurance contracts is both necessary and feasible.

2. Health insurance is a necessary part of the broad array of funding resources required for coping with drug problems.

3. Drug abuse, alcoholism and nervous and mental conditions are inter related and treatable as are other health problems.

4. Both consumers and providers need the resources available through health insurance.

5. The nature of the problems make it necessary that inclusion be mandatory rather than optional.

6. There is clear and adequate data, and precedence for positive and decisive action on this legislation.

Atch. H

TESTIMONY

by

THE KANSAS ADVISORY COMMISSION ON DRUG ABUSE

and

Personal and Professional Interests in Drug Abuse, Alcoholism and Nervous and Mental Conditions

to the

INTERIM STUDY
KANSAS STATE SENATE AND HOUSE OF REPRESENTATIVES
SPECIAL COMMITTEE ON COMMERCIAL AND FINANCIAL INSTITUTIONS

on the subject of

PROPOSAL 13

A Study to Determine the Desirability of Mandating that Group Health Insurance Contracts Provide Coverage for Nervous or Mental Conditions, Drug Abuse and Alcoholism

JOINT KANSAS STATE SENATE AND HOUSE OF REPRESENTATIVES

INTERIM STUDY
SPECIAL COMMITTEE ON COMMERCIAL AND FINANCIAL INSTITUTIONS

June 28, 1977

Mr. Chairman, members of the Joint Interim Study Special Committee on Commercial and Financial Institutions, I am James W. D. Hartman, Ph.D., a psychologist and Chairman of the Kansas Advisory Commission on Drug Abuse. I am here to strongly urge passage of the legislation being studied. I serve as member of the Kansas Advisory Commission on Alcoholism and the Kansas Psychological Association PSRO. (Peer Review) In my professional work I am in my 34th year of Federal service at the Veterans Administration in Wichita, Kansas, and 23rd year of private practice in clinical psychology. My professional work has involved problems of nervous and mental conditions, drug abuse and alcoholism which are interrelated in many ways, particularly in treatment areas. My activities in recent years have related to the establishment and development of the effort against drug abuse in Wichita and throughout the State of Kansas. These activities have been in part responsible for the establishment and development of a variety of things including the Kansas State Authority on Drug Abuse which enabled Kansas to participate in Federal funding of drug abuse efforts.

Federal funding of the drug abuse effort was from the beginning seen by those of us working on the Commission as pump priming funding. The purpose was to provide financial support to do the start up work at the

state and community level. It was not and is not considered appropriate or possible for federal funds to maintain community and state drug abuse programs.

A part of the start up work needed is the identification and establishment of appropriate local funding resources to maintain a system to handle the problems associated with drugs.

It seems clear that in addition to state and Federal resources a broad array of funding resources are needed to combat problems associated with drugs.

Some aspects of the problems will always need Federal, State and/or Community tax money assistance. Other aspects will always need to be private, personal responsibility. Too much reliance on either resource area is bound to fail. It is unlikely, for example, that any state could provide more state tax money for drug problems than New York state has under Governor Nelson Rockerfeller's administration. The lack of efficacy of this program should prove to be a valuable learning experience regarding one resource domain fundings.

It also seems clear that resources for funding in the area of prevention effort has been the slowest to surface both in terms of what is needed and what resources are available to meet those needs.

The subject of your study is a means of establishing an important rung in the ladder we are building to get to the top of the drug problem. It is a means, a resource for people to take care of their own problems at a preventive or early stage of development. It is a means of preventing families with such problems from being forced on to welfare rolls requiring tax money support.

Health insurance does assist a person and family to be self reliant, to avoid exhausting their resources financially, physically, mentally, to continue working, to maintain family relationships, to maintain physical health, to maintain mental health. Drug problems threaten all of these.

My first meeting where mandatory health insurance was discussed was The Little White House Conference held in Wichita in 1954. Since then health insurance has become a reality that is widely accepted. Its availability as a natural part of being employed in many instances has provided persons affected by health crises with life saving and life easing assistance.

As acceptance of health insurance increases, planning and reliance on health insurance has also increased. Today most people who are gainfully employed rely on health insurance to prepare for their health service needs. To the extent that this works satisfactorily people are healthier and happier because of it. Frequently, when problems of nervous

and mental conditions, drug abuse and alcoholism occur, the individual discovers - too late - that his insurance doesn't cover it.

The bills that accumulate for him to pay can be more depressing and more defeating than the illness. The illness itself, by its nature, if not treated in early stages, depletes the person's resources (mental, physical, financial) for providing for his health needs.

Making inclusion mandatory gives recognition to and preventive constructive action against problems created by the illnesses involved. Nervous and mental conditions, drug abuse and alcoholism are not accompanied by the rational judgment and good planning necessary for voluntary decisions to include these benefits in an individuals health insurance policy.

Such persons typically avoid concern for the future, willingness to plan and work for long term goals and generally support the attitude of letting someone else worry about the future, paying bills, etc. That's what happens. They deplete their resources, let themselves get so run down before they get help that someone else has to take responsibility for it. Relatives, friends and welfare get stuck with the bills. The community gets stuck with derelicts on the streets. Industry loses people with skills they can use. Insurance assures a way for the individual to provide for his own needs.

As health insurance provides nervous and mental conditions, drug abuse and alcoholism care, professional help is utilized earlier and earlier in the progression of the illness. The earlier treatment is provided, the greater is the success. Where parents have health insurance that covers

their adolescent children - drug abuse can be treated at the time in early stages before drugs have contributed to the development of a personality handicap and a necessary dependence on some kind of crutch the rest of their lives. Financial support for early treatment also prevents parents from becoming bankrupted physically, mentally or financially by the effects of the problem.

Typically people who receive treatment in the later stages of the problem are on welfare and need continued treatment as they get rehabilitated enough to become employable. Unless health insurance is available treatment cannot be continued when the person returns to work and they lose welfare assistance. Hence, the vicious revolving door process occurs in which they lose their job, return to welfare, re-initiate treatment, etc. Health insurance provides a means of continuing treatment as needed to become stabilized on the job and stay off welfare.

Another important factor is the availability of professional people prepared to help with such problems. If a professional person is to become adequately prepared to treat drug abuse problems he must do enough of it to become proficient. Without health insurance to cover the costs of providing his services - the professional would become financially bankrupt. Hence, many professionals cannot treat these problems and the services needed by the consumer are not available.

Some of you no doubt read a recent article in the Wichita Eagle entitled: "Drug Abuse Programs Aren't Working". The article was based on observations of heroin programs for hard core addicts only. The

article did not include observations on early intervention and non-narcotic drugs. The article did not pertain to the kinds of programs being conducted by the Kaiser Foundation, Kennecot Copper and others that show as high as an 80% cure rate for alcohol problems.

Such early intervention programs are being pursued by Kansas corporations including Beech Aircraft, Pizza Hut and Lear Jet. These extremely effective programs are dependent upon adequate insurance coverage of services needed for treatment and rehabilitation. Such companies are providing the necessary coverage for their employees because it is cost effective, and saves valuable human beings.

Most individuals are unprepared to handle the costs involved without insurance assistance. Most people are not aware they need it or may need it, or that it takes special action to get such needs covered.

The need is clear.

Is it feasible to mandate inclusion of drug abuse in health insurance coverage? The answer is yes. It is feasible. It is not only feasible, it is humanly warranted, economically advantageous.

Much data has been accumulated nationally over the last few years as a result of efforts by the Mental Health Association of America, the American Psychological Association, other mental health professional organizations as well as the organizations specifically concerned with drug abuse, such

as the National Association of State Drug Abuse Coordinators and the National Institute on Drug Abuse. Within Kansas the state drug abuse and alcoholism units, the state Mental Health Association, the Kansas Psychological Association and other health professionals organizations and private sector programs have both utilized and participated in the development of national data.

At this point, Mr. Chairman, I would like to provide you with bibliographies, reports, summaries, etc. of data on such questions as:

1. Precedence for such a legislative step by other states. Included are data on 19 other states, 16 since 1973, who have such legislation; active or pending.
2. Cost of providing such coverage.
3. Decreasing effect on cost of covering other health needs.
4. Relevance to pending National Health Insurance legislation.
5. Importance of professional standards review committees to review the quality, cost and appropriateness of service beyond the guidelines of professional codes of ethics.
6. Control over what treatment is to be provided.
7. Identification of who provides the treatment.
8. Precedence for establishing drug abuse and alcoholism as well as nervous and mental conditions as a treatable illness on an equal level with physical illness.

Your research staff may find this resource material useful. If your deliberations raise questions I can help resolve, please feel free to call on me.

Mr. Chairman my testimony today may be summarized by these statements.

1. The mandatory inclusion of nervous and mental conditions, drug abuse and alcoholism in health insurance contracts is both necessary and feasible.

2. Health insurance is a necessary part of the total array of funding resources required for coping with drug problems.

3. Drug abuse, alcoholism and nervous and mental conditions are interrelated and treatable as are other health problems.

4. Both consumers and providers need the resources available through health insurance.

5. The nature of the problems make it necessary that inclusions be mandatory rather than optional.

6. There is clear and adequate data, and precedence for positive and decisive action on this legislation.

"9"

Mr. Chairman, Committee Members

Over the past years the members of the Association of Directors of Community Mental Health Centers of Kansas have worked very closely with the Mental Health Association in our attempts to develop legislation that will make it possible for health insurance policies to provide for all types of psychiatric treatment to the insured.

Currently, insurance policies invariably have exclusion clauses eliminating psychiatric and mental health services, and it is felt that this then discriminates toward this kind of disability and hence, restricts necessary treatment in many instances.

Our Association would very much like to eliminate this exclusion, and at this point, I will not go into all of the other reasons for such insurance measures, as they have already been provided you by Harriet Griffith, President of the Sedgwick County Mental Health Association Board of Directors in her testimony to you yesterday. Instead, I wish to strongly underscore her remarks and add that our Association is in full concurrence with her recommendations.

Clinton D. Willsie, President
Association of Directors of Community
Mental Health Centers of Kansas
June 29, 1977

Atch. I

BLUE CROSS AND BLUE SHIELD

FEDERAL EMPLOYEE PROGRAM

NERVOUS AND MENTAL BENEFITS

AS A PERCENTAGE OF TOTAL BENEFITS, BY CONTRACT PERIOD

CONTRACT PERIODS	AMOUNT OF BENEFITS	PERCENT OF TOTAL BENEFITS
JULY 1, 1960 THROUGH OCTOBER 31, 1961	$ 3,763,000	2.41%
NOVEMBER 1, 1964 THROUGH DECEMBER 31, 1965	$13,649,000	4.51%
JANUARY 1, 1966 THROUGH DECEMBER 31, 1966	$13,205,000	4.76%
JANUARY 1, 1969 THROUGH DECEMBER 31, 1969	$29,777,000	6.20%
JANUARY 1, 1971 THROUGH DECEMBER 31, 1971	$49,107,000	7.04%
JANUARY 1, 1974 THROUGH DECEMBER 31, 1974	$92,000,000 *	10.00% *

* ESTIMATED

Atch. 4

June 29, 1977

TO: Jack Roberts

FROM: Tom Miller

SUBJECT: ESTIMATED ADDITIONAL COST TO BLUE CROSS AND BLUE SHIELD TO COMPLY WITH HOUSE BILL 2381 AT 1978 COSTS AND ENROLLMENT LEVELS

	Monthly Rate		
	Single	Family	Total Annual Cost
Basic Coverage	$0.70	$1.75	$1,740,000
Major Medical (With No Psychiatric Coverage Now)	1.60	3.52	4,549,000
Sub Total	$2.30	$5.27	$6,289,000
Major Medical (With Some Psychiatric Coverage Now)	(0.62)	(1.82)	725,000
Total			$7,014,000

Note: There are different numbers of Subscribers on Basic and on Major Medical.

TM:nk

"K"

SOCIAL AND REHABILITATION SERVICES
Alcohol and Drug Abuse Section
June 29, 1977

1. 15 States have mandatory group health insurance coverage for alcohol and drug abusers.

2. Alcoholism and drug abuse are the most treatable of all diseases with a recovery rate of 75 to 85%.

3. Costs for treatment in non-hospital settings ranges between $20 to $45 per day as compared with $65 to $190 per day in hospital treatment. (See Attachment A).

4. Less loss of time and money from on-the-job accidents and down time.

5. The data show that substantial increased costs by companies in their group hospital costs simply have not materialized.

6. Alcoholism and Drug addiction are diseases. Insurance coverage should not discriminate against these two diseases. 42 CFR 86 of May 4, 1977, prohibits discrimination against alcoholics and drug addicts.

Atch. K

Coverage Questions

Employers Insurance of Wausau, Wisconsin, makes the statement that, "We think insurance ought to work for a living." If you are seriously considering a loss control program for alcoholism in your company, then one of the areas you should investigate is your insurance coverage, particularly that of group hospitalization. Ask yourself this question: Is your group hospitalization coverage working to the disadvantage of both the company and your employees? Are you presently paying for the repetitive hospitalizations resulting from the complications arising out of alcoholism?

Somewhere in your early deliberations you will be called upon to make a decision either to cover alcoholism as a legitimate illness or perpetuate the system which says, "Call it by some other name and we will cover it under our group contract." While you are looking at your group contract, you may also wish to investigate how you are going to use your insurance dollar in terms of alcoholism treatment coverage. Merely indicating that alcoholic employees will be treated in *any licensed hospital* will resolve the immediate physical problem arising out of alcoholism, but it does very little to resolve the chronic alcoholism unless the employee has received proper rehabilitation treatment. Certainly the act of sending employees to a hospital merely to dry out should be discouraged. During the past two or three years, some companies are beginning to designate those treatment centers properly staffed and programmed to meet the needs of this particular disability. Increasingly, alcoholism is being included under company health benefits. The next step is to see that such benefits are channeled toward treatment centers staffed and equipped to resolve two-thirds of the repetitive problems.

Once you have decided to include alcoholism coverage in your loss control program, you have every right to expect more than kind words from your insurance company. You are entitled to practical help *designed to show you how to reduce repetitive losses.* You have every justification in demanding this type of help. Your insurance company should not be alarmed that offering alcoholism coverage will result in mountains of claim forms.

No Increases Noted

Companies which include alcoholism under health benefits are not reporting a substantial increase in their group hospitalization rates as a result of alcoholism claims. Because of social stigma, it is still difficult to get employees to use this health benefit. Therefore, we should have no fear that legions of alcoholics will somehow march forward to use the coverage for alcoholism when it is included in the group hospitalization contract. It is a paradox that this is one coverage which we should encourage employees to use, knowing that it will help to resolve many future claims, and yet it has been extremely difficult to get employees to use group hospitalization under the true label of "alcoholism."

Consideration of a loss control program for alcoholism entails a careful look at company fringe benefits, particularly that of group hospitalization. How can we honestly say in a policy statement that alcoholism will be considered "as any other illness" if we make an exception by indicating that it will be denied under the group hospitalization coverage? The inconsistency of this approach soon becomes apparent to employees. It serves to perpetuate the unwritten policy of concealment. Certainly insurance is not a cure-all for your loss control system, but it is an important component. If your loss control system is working in terms of referring people for treatment, then you can be reasonably sure that your insurance program is working in a preventive manner, namely, to prevent next week's auto accident, injury on the job, injury at home, a possible lawsuit involving product liability or a fire in the company warehouse.

The point here is that insurance ought to work for you in helping to resolve some of the repetitive costs connected with this illness. And it can if you give serious consideration to the loss control methods outlined in the National Council on Alcoholism's pamphlet, "A Cooperative Labor-Management Approach to Employee Alcoholism Programs."

The above pamphlet may be obtained by writing to Labor Management Division, National Council on Alcoholism, Inc., 2 Park Ave., New York, N.Y. 10016.

N A S M H P D

STUDIES

- MENTAL HEALTH
- MENTAL RETARDATION

Study #324

June 1, 1977

"L"

STATE STATUTES ON MENTAL HEALTH COVERAGE IN PRIVATE HEALTH INSURANCE

Harry C. Schnibbe
Executive Director
NASMHPD

Attach. 4

1001 Third St., S. W., Washington, D. C. 20024 Phone 554-7807

NATIONAL ASSOCIATION STATE MENTAL HEALTH PROGRAM DIRECTORS

A SUMMARY OF STATE LAWS ON MENTAL HEALTH COVERAGE IN HEALTH INSURANCE

Insurers and Insurance Plan Administrators have accepted the premise that Health Insurance coverage for treatment of Nervous and Mental Disorders is different and unique from Health Insurance coverage for the treatment of other health problems. Much has been written both confirming and refuting this premise. To date, no definitive statement has been made and health insurance policies continue to contain various types of exclusions and limitations designed to limit the liability of the insurer with respect to treatment of nervous and mental disorders. Since the method of financing is a stong determinant in the provision of treatment, and insurance payments constitute a considerable portion of funds available for the treatment of all illnesses, the mental health treatment coverage exclusions and limitations provide barriers to treatment. To overcome these barriers, political activities of providers, consumers and advocates have been directed at reducing or eliminating these barriers. Many States have enacted laws regulating the mandatory inclusion of benefits for the treatment of nervous and mental disorders. A staff search through the codes of the States was conducted and a brief description of the various statutes affecting the insurance benefits available for the treatment of nervous and mental disorders is attached.

BY →

f. dee goldberg
12008 HITCHING POST LANE
ROCKVILLE, MARYLAND 20852
(301) 770-5734

Prerequisite to an understanding of the summary is a familiarity with the types of exclusions and definitions of the classes of treatment. A list of definitions and a list of frequently used exclusions and limitations are attached. Most of the exclusions and limitations are designed to restrict coverage to acute short term treatment in the psychiatric unit of a general hospital and to limit reimbursements to the hospital and to licensed physicians. Services of other mental health practitioners, Community Mental Health Centers, State Institutions, Partial Hospitalization Programs, Alcoholism and Drug Dependence Rehabilitation Facilities and long term supportive outpatient therapies are frequently effectively excluded from insurance coverage.

This report summarizes the laws which have been enacted to restrict the use of exclusions and limitations pertinent to the insurance coverage of services to persons with nervous and mental disorders.

COMMON EXCLUSIONS AND LIMITATIONS

1. Coverage for Inpatient Hospitalization for Nervous and Mental Disorders is limited to 30 days.
2. Services of a State Mental Institution are excluded from this contract.
3. Outpatient services are limited to physician services, laboratory tests, xrays.
4. Outpatient services of an Accredited and Licensed General Hospital are covered.
5. Coinsurance is limited to 20% except for nervous and mental disorders for which coinsurance is limited to 50%.
6. A maximum of $1,000 for treatment of nervous and mental disorders on an outpatient basis.
7. After a deductible of $100, this policy will provide coverage for 50% of a physician's services for nervous and mental disorders for a maximum charge of $20 per session and a maximum liability of $250.00. (This is thought to mean up to $10/visit; up to 25 visits.)

# # #

DEFINITIONS

1. Coinsurance - that percentage of the cost of services for which the patient and not the insurer must pay.
2. Deductible - the first dollar expense for which the patient must pay before the insurer will assume any liability.
3. Inpatient Hospitalization - patient resides in a hospital 24 hours a day.
4. Outpatient Services - services provided to patients not hospitalized and usually for periods of less than 1 hour.
5. Partial Hospitalization - a daily treatment program of usually no less than 4 hours of treatment nor more than 12 hours of treatment. It may or may not provide sleeping arrangements. It is for patients who don't need to be confined to a hospital but need more than one hour of outpatient treatment per day.
6. Psychiatric Nurse Practitioner - Registered Nurse with training and experience in the treatment of nervous and mental disorders.
7. Psychiatric Social Worker - Clinical Social Worker specializing in the treatment of nervous and mental disorders.
8. Psychiatrist - Physician licensed to practice medicine specializing in psychiatry.
9. Psychologist - Clinical Psychologist with a Doctoral Degree.

# # #

STATE	
Idaho	None
Illinois	None - Carriers may not deny claims for treatment or services for mental illness rendered in a hospital solely because such hospital lacks surgical facilities.
Indiana	None
Iowa	None
Kansas	None
Kentucky	None
Louisiana	At higher premium option of policyholders, at benefits equal to other illnesses or accidents for services by psychiatrist; licensed psychologist; or licensed Social Worker under prescription of a physician.
Maine	None - Must provide for services of licensed psychologist as a physician.
Maryland	Mandatory, Acute Mental Illness subject to improvement through short term therapy - Minimum Benefits is 30 days inpatient, 50% outpatient - maximum 80% outpatient. Must offer Optional coverage for Partial Hospitalization as an inpatient benefit. Must offer optional coverage for Alcoholism Rehabilitation Treatment.
Massachusetts	Yes 60 days confinement. Outpatient - $500 over 12 month period. Services of a Comprehensive health service organization, licensed or accredited hospital CMHC or licensed psychiatrist or psychologist.
Michigan	None

MORE

IS MENTAL HEALTH* INSURANCE COVERAGE MANDATED IN THE INSURANCE LAWS OF THE SEVERAL STATES, AND, IF SO, TO WHAT EXTENT?

STATE	
Alabama	None
Alaska	None
Arizona	None
Arkansas	None
California	May Provide or Exclude Coverage for Mental Health Services. If it includes services, must treat licensed psychologist and licensed Social Workers in same way treats psychiatrists.
Colorado	Mandatory Benefits - 45 days inpatient, 90 days partial hospitalization (defined in Colorado reg.).
Connecticut	Mandatory, 60 days inpatient, 1,000@ 50% Major Medical for outpatient.
Delaware	None
Florida	Mandatory at appropriate additional premium for group policies only, 30 days inpatient benefit, mandatory if outpatient benefits provided must have maximum of 50% patient coinsurance; may be limited to $500.
Georgia	None
Hawaii	None

*"Mental health" may or may not include alcoholism and drug abuse.

MORE

STATE	
Minnesota	(a) Group Plans Alcoholism - 28 days inpatient, 130 hours outpatient. (b) Emotionally handicapped children - same as other medical illness. (c) Ambulatory Mental Health - 90% of first $600.00, if by Hospital, CMHC, licensed psychologist or psychiatrist.
Mississippi	Mandatory Alcoholism to $1,000 benefit, licensed psychologists covered as physicians.
Missouri	None
Montana	None
Nebraska	None
Nevada	None
New Hampshire	Mandatory, benefits equal to hospitalization for other illnesses, outpatient coverage for at least 15 visits - first two visits may be excluded. If coverage is under major medical then same coinsurance and deductibles as other illnesses to an optional maximum of $3,000 per individual per year and $10,000 per individual per lifetime.
New Jersey	None
New Mexico	None
New York	None
North Carolina	May not exclude State operated Nervous and Mental Institutions - No Minimum benefits.

MORE

STATE	
North Dakota	Mandatory coverage, groups of 50 or more, same as other illnesses with minimum benefits of 70 days inpatient or 140 days partial hospitalization - 2 for 1 trade of partial hospitalization for inpatient.
Ohio	None
Oklahoma	None
Oregon	Coverage of Mental and Nervous Disorders must be offered in group plans.
Pennsylvania	None
Rhode Island	Mandatory Outpatient of 50% copayment not to exceed $1,000.
South Carolina	None
South Dakota	None
Tennessee	Mandatory inclusion for Mentally Retarded - if excludes Mental Illnesses must specify.
Texas	None - cannot exclude tax supported hospitals if benefit is offered.
Utah	None
Vermont	Must offer as option and at additional premium if necessary; 45 days inpatient and outpatient of 100% first 5 visits to 80% thereafter to maximum of $500 - for partial hospitalization benefit shall be equal to 45 day equivalents.
Virginia	Mandatory 30 days inpatient

MORE

STATE	
Washington	"The right to be free from discrimination because of race, creed, color, national origin, sex or the presence of any sensory, mental or physical handicap is recognized and declared to be a Civil Right. This right shall include .....(e) The right to engage in insurance transactions"
West Virginia	None
Wisconsin	Mandatory - 30 days inpatient including Nervous and Mental Disorders, drugs and alcoholism outpatient - first $500.
Wyoming	None

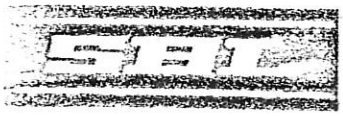
TOTAL	None = 31
	Something = 19

LIST OF STATUTORY CITATIONS

Colorado	(Section 10-8-301) - Alcoholism - Mandated Offering Section 10-8-116
Connecticut	(Section 38-262b(b)(c)(d)) - Alcoholism Section 38-174d - Mental Illness
Florida	(Section 627.668) - Mental & Nervous - Mandated Offering
Illinois	(73 Section 979(10)) - Alcoholism
Louisiana	(Section 215.5) - Alcoholism - Mandated Offering
Maryland	(Section 477L) - Alcoholism - Mandated Offering (Section 477M) - Psychiatric Care - Mandated Offering
Massachusetts	(C. 175 Section 110 H) - Alcoholism - Commercial Insurance Companies (C. 176B Section 4A) - Mental Illness - Blue Cross Blue Shield (C. 176B Section 4A) - Alcoholism - Blue Cross Blue Shield
Michigan	(Section 500.3609) - Alcoholism - Mandated Offering
Minnesota	(Section 62A.149) - Alcoholism & Drug Abuse (Section 62A.152) - Mental Health
Mississippi	(Section 83-9.27, 29, 31) - Alcoholism
Nevada	(Section 689B.030(5)); Section 689B.037 - Alcoholism & Drug Abuse Mandated Offering
New Hampshire	(Section 420:5-a) - Mental or nervous
North Dakota	(Section 26-39-01, 02, 03) - Alcoholism, Drug Abuse, Mental Illness
Oregon	(Section 743.557) - Alcoholism (Section 743.558) - Mental & Nervous - Mandated Offering
South Dakota	(Section 58-18-7.1, 7.2, 7.3) - Alcoholism - Mandated Offering
Tennessee	(Section 56-1167) - Alcoholism, Drug Abuse, Mental & Nervous - Covered unless excluded
Vermont	(CH. 107, Section 4089) - Mental Illness - Mandated Offering
Virginia	(Section 38.1 - 348.7) - Mental Disorders
Washington	(Section 48-44-240) - Alcoholism
Wisconsin	(Section 632.89) - Alcoholism, Drug Abuse, Mental & Nervous

Atch. M

"M"



SECURITY BENEFIT LIFE INSURANCE COMPANY
FOUNDED IN 1892 • 913/354-8461 • TOPEKA, KANSAS 66636

July 13, 1977

Bill Wolf
Legislative Research Department
State Capitol Building
Topeka, KS 66612

Re: Legislative Proposal #13

Dear Bill,

Enclosed is a listing of the statutory citations of similar laws that are presently in force as well as copies of those laws.

If we can provide any additional information, please advise.

Yours truly,

Ross R. Freeman
Vice President, Secretary and General Counsel

Encls.

RRF:jml