THIRD-PARTY REIMBURSEMENT OF CLINICAL SOCIAL WORKERS

CLAIRE M. MARUMOTO
Researcher

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Legislative Reference Bureau
State Capitol, Room 004
Honolulu, Hawaii 96813

FOREWORD

This study on insurance reimbursement of clinical social workers was prepared in response to Senate Resolution No. 143, S.D. 1, adopted during the 1984 legislative session.

Senate Resolution No. 143, S.D. 1, requested the Office of the Legislative Reference Bureau to conduct a study of the most feasible means of implementing legislative changes to permit the reimbursement of clinical social workers under Medicare, Medicaid, and Hawaii insurance laws. Standing Committee Report No. 916-84, recommending the adoption of Senate Resolution No. 143, S.D. 1, stated that "conducting a feasibility study" would be the first step to correcting the inequity faced by clinical social workers in the matter of reimbursement of mental health professionals. The Bureau also felt that prerequisite to determining "the most feasible means" of making legislative changes was to study the issue of feasibility itself. Therefore, this report is in large part an examination of the possibility and advisability of including clinical social workers in federal and state insurance plans.

We wish to acknowledge with much appreciation those clinical social workers who took the time to respond to our survey and the following individuals who provided assistance, information, and guidance in the preparation of this study: Rebecca Ryan, Executive Director, Hawaii Chapter, National Association of Social Workers; Leila Whiting, National Association of Social Workers; Senator Daniel K. Inouye; Patrick H. De Leon, Executive Assistant to Senator Inouye; Eugene Fujii, Administrator, Contracts and Legal Liaison, Hawaii Medical Service Association; Charles Woffinden and Robert Bath, Health Care Financing Administration, U.S. Department of Health and Human Services; Peter A. Sybinsky, Administrative Assistant to the Director, Department of Health; Earl Motooka, Medical Care Administrator, and Masaru Oshiro, Medical Care Administration Office, Department of Social Services and Housing; Orlando Watanabe, Administrator, and Gail Hiraishi, Disability Compensation Division, Department of Labor and Industrial Relations; George Stepp, Management Services Administrator, Department of Budget and Finance; Diana Kaapu, Classification Branch Chief, Department of Personnel Services; Lester Cingcade, Administrative Director of the Courts, State Judiciary; Russel Nagata, Director, Department of Commerce and Consumer Affairs; Albert Yamane, Insurance Division, Department of Commerce and Consumer Affairs; Noe Tom, Executive Secretary, Board of Certification for Practicing Psychologists; Leo Rodby, Executive Secretary, Board of Medical Examiners; Joe Grant, Health Chairman, Hawaii State Association of Life Underwriters; Carol Eblen, former Director, Mental Health Association in Hawaii; Gail Toff, Intergovernmental Health Policy Project; Daniel Sanders, Dean, School of Social Work, University of Hawaii; Walter Fo, Director, Biodyne Center; Pat Ramia, Patient Coordinator, Island Care; and the following social workers: Ronaele Whittington, Kathi Kreinik, Irvin Cohen, Eunice Watson, Jerry Hagen, Rita Vandivort, and Gaile Kurren.

SAMUEL B. K. CHANG
Director

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INTRODUCTION

The legislative request for a study to review the reimbursement of clinical social workers under Medicaid, Medicare, and Hawaii insurance laws was premised on the following considerations:

(1) Licensed physicians (psychiatrists) and licensed psychologists are reimbursed for mental health care under Medicaid and Medicare;

(2) During the 1984 legislative session the Legislature enacted a law requiring health insurance coverage for the services of licensed psychologists, in addition to coverage already existing for licensed physicians (psychiatrists);

(3) Several other states have "Freedom of Choice" or "Equal Access" laws mandating coverage of all qualified mental health care professionals, including clinical social workers;

(4) Fees charged by clinical social workers are generally less than those charged by psychiatrists and psychologists.

(5) In some areas of the State clinical social workers are the only accessible mental health care providers.

(6) In the absence of insurance coverage for the services of clinical social workers, consumers of mental health care in Hawaii are being deprived of a choice of qualified professional providers.

Objectives and Scope of the Study

Objectives: The resolution requested that the study include an examination of the following areas:

(1) What insurance companies or plans, including self-insured employer plans and those plans offered by health maintenance organizations (HMO's), in Hawaii currently allow, and which ones do not allow, reimbursement to clinical social workers;

(2) What states have "Freedom of Choice" or "Equal Access" legislation which includes clinical social workers as providers, and what is the nature of such laws;

(3) What states currently reimburse clinical social workers under the federal Medicaid and Medicare programs; and

(4) What obstacles, if any, there are to the reimbursement of clinical social workers under Medicaid and Medicare programs and to amending chapters 431 and 433, Hawaii Revised Statutes, to include clinical social workers as providers of mental health care who may be reimbursed under health insurance policies.

Scope: In reviewing the issue of insurance reimbursement to clinical social workers for this study, the concept of insurance was limited to fee-for-service insurance and did not include prepaid health or health maintenance organization (HMO) coverage, as neither cost nor reimbursement, as relevant to this study, are involved in the latter. In discussing clinical social workers, emphasis is placed on the role of clinical social workers as providers of mental health care in private practice.

The Bureau did not conduct a patient/consumer survey on the need or demand for the services of private clinical social workers, due to time and resource constraints as well as the difficulty of framing a universe for sampling purposes.

Organization of this Report

The report is presented in six chapters:

This first chapter presents an introduction to the study, including the objectives, scope, and organization of this report.

Chapter 2 presents a historical background of social work and the development of clinical social work and the role of clinical social workers today, and a profile of clinical social workers in Hawaii based on a mail survey conducted by the Bureau.

Chapter 3 discusses the issue of health insurance in terms of provider fees and coverage as related to mental health care. An overview of the status and nature of freedom of choice legislation among the states is presented. The potential conflict of mandated health benefits with ERISA (Employment Retirement Income Security Act) is noted.

Chapter 4 discusses the CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) program and its provision of direct reimbursement to clinical social workers which developed from an experimental study conducted from 1980 to 1982. The results of this study are also presented.

Chapter 5 examines the Medicare and Medicaid programs in terms of medical social services. Also discussed are: the Medicare Demonstration Project, in which direct coverage of clinical social workers in California is being tested; Hawaii's Medicaid services and expenditures; a cost containment proposal made by clinical social workers for their services to be included in the Medicaid program; and a comparison between the services of clinical social workers and psychologists from the standpoint of Hawaii's Medicaid program.

Chapter 6 discusses the issue of licensing of social workers and presents an account of the attempts of social workers to obtain licensing in Hawaii.

Chapter 7 presents findings and recommendations for the reimbursement of clinical social workers in health insurance plans.

Chapter 2

CLINICAL SOCIAL WORKERS

Social work is a profession concerned with improving the interactions between people and their network of social relationships and the larger social environment. It is the primary profession for the delivery of "human services" or "social services" to enhance the social functioning of people by meeting individual and societal needs.

Historical Background

Social work had its beginnings in the emergence of an urban society engendered by the industrial revolution with its attendant problems of poverty, delinquency, and social maladjustment. Three nineteenth century movements were the forerunners of modern social work: the Charity Organization Society movement, which evolved into the present-day family service agencies providing individual and family casework; state and local public welfare programs which assumed the responsibility, which private charity could not always fulfill, for the "dependent, defective, and delinquent"; and the social settlement movement, in which "settlements" or neighborhood houses were established in slum areas and enabled social workers to live among the poor. As they have continued to do, social workers addressed the larger issues of public social policy and worked directly with individuals, families, and groups. In their direct counseling work, social workers came to employ the developing theories of human behavior and psychoanalytic principles.[1]

Paralleling the involvement of social work in mental health in the community was the development of social work in mental hospitals. In 1905 a social services program was created at Massachusetts General Hospital to assist in treating mentally ill patients, utilizing social studies of patients to assist physicians in diagnosis, disposition, and treatment. In 1913 New York State enacted legislation to develop in all mental hospitals aftercare services to meet the needs of patients returning to the community, a continuing function of social workers today. The term "psychiatric social worker" was first used in 1913 to apply to the social work staff at the newly opened Boston Psychopathic Hospital.[2]

Two organizations of psychiatric social workers were established in the 1920s: the American Association of Psychiatric Social Workers and the Psychiatric Social Workers Club, which became the Section on Psychiatric Social Work of the American Association of Hospital Social Workers. These were two of the seven social work organizations which merged in 1955 to form the National Association of Social Workers (NASW). Today NASW is the largest organization of professional social workers with a membership of over 95,000 in the United States, Puerto Rico, and Europe.

The term "psychiatric social work" has evolved into "clinical social work," but psychotherapy remains central to this specialty of social work. NASW has adopted the following definition of clinical social work:[3]

> Clinical social work shares with all social work practice the goal of enhancement and maintenance of psychosocial functioning of

> individuals, families, and small groups. Clinical social work practice is the professional application of social work theory and methods to the treatment and prevention of psychosocial dysfunction, disability, or impairment, including emotional and mental disorders. It is based on knowledge of one or more theories of human development within a psychosocial context.
>
> The perspective of person-in-situation is central to clinical social work practice. Clinical social work includes interventions directed to interpersonal interactions, intrapsychic dynamics, and life-support and management issues. Clinical social work services consist of assessment; diagnosis; treatment, including psychotherapy and counseling; client-centered advocacy; consultation; and evaluation. The process of clinical social work is undertaken within the objectives of social work and the principles and values contained in the NASW Code of Ethics.

Clinical social work is regarded as one of the four core professions of mental health care, together with psychiatry, psychology, and psychiatric nursing. Social workers comprise the largest single discipline providing psychotherapy in the United States.[4] Conversely, among social work specialties, the largest number of social workers--approximately 28 per cent--are employed in the mental health field.[5]

Clinical social workers have sought various means to advance recognition of their profession. The profession's primary goal is licensure in every state as a means of identifying practitioners who meet certain levels of training and experience. Such legal recognition would be an essential step for clinical social workers to attain autonomous provider status for purposes of receiving direct reimbursement for their services from insurance companies (see chapter 3). In the absence of state licensing, clinical social workers have established other avenues of professional sanction of their practice. These are briefly described below:

Academy of Certified Social Workers. The Academy of Certified Social Workers (ACSW) was created in 1960 by NASW to establish standards to certify social workers, who have attained post-graduate professional skill and experience, for independent practice.[6]

Among the Academy's goals is the acceptance of ACSW membership "as an alternative to assessment or examination procedures in states with legal regulation of social workers."[7] NASW also promotes ACSW membership as "a key to NASW's efforts to gain recognition for social workers as service providers eligible for insurance company reimbursement."[8]

NASW Register of Clinical Social Workers. The NASW Register of Clinical Social Workers is a listing of clinical social workers who meet criteria similar to those for ACSW certification with an additional requirement of two years of "direct practice."[9]

One of the objectives of the Register is to "[a]ssist third party payment vendors to improve service standards, delivery and costs through professional recognition and contract inclusion of social workers."[10]

Registry of Health Care Providers in Social Work. This listing is similar to the NASW Registry with minor differences in eligibility. It is sponsored by the Federation of Societies for Clinical Social Workers.

Profile of Clinical Social Workers in Hawaii

There are an estimated 1,500 providers of social services in Hawaii. They range in experience from recent college graduates with or without social work degrees to those with master's or doctoral degrees, and non-academically trained practitioners with many years of professional experience. An examination of social worker positions in state agencies shows a total of 677 such positions in the judiciary and the departments of education, health, and social services and housing.

There are approximately 500 NASW members in Hawaii, over 200 of whom are ACSW-certified. The NASW Register of Clinical Social Workers lists twenty-one members in Hawaii.

To examine the premise that in some areas of the State clinical social workers are the only accessible mental health care providers, the telephone Yellow Pages (1985 for Oahu and 1984 for the neighbor islands) were checked under the categories of "social workers," "marriage and family counselors," and "psychotherapists." Only those individuals with "MSW" or "ACSW" were counted as clinical social workers. The tally was as follows:

Oahu - 13
Hawaii - 3
Kauai - 0
Maui - 0

By comparison, the distribution of psychologists and psychiatrists in the Yellow Page directories were as follows.

Psychologists	Psychiatrists
Oahu - 96	Oahu - 81
Hawaii - 8	Hawaii - 10
Kauai - 1	Kauai - 3
Maui, Molokai, Lanai - 9	Maui, Molokai, Lanai - 9

(See also chapter 3, footnote 6).

The optimum distribution of clinical social workers, particularly on the neighbor islands, is probably attained through the State's mental health clinics.

For the purposes of this study, survey questionnaires were mailed to forty-five clinical social workers throughout the State, seeking information on the practitioners themselves, their clients, and the role of insurance in their individual practices. The practitioners' names were provided by the Hawaii Chapter of NASW and by other social workers as practitioners probably in private practice. While a few persons were definitely known to be in private practice, the status of many with regard to private practice--particularly those already employed by government or private agencies--was not known with certainty. Three questionnaires were returned indicating that those persons were not engaged in private practice. A total of twenty-seven

questionnaires were returned from those with a full- or part-time private practice. The breakdown by counties was as follows:

Oahu - 19[11]
Hawaii - 5
Kauai - 3
Maui, Molokai, Lanai - 0

Twenty-six of those responding have a Master of Social Work degree (one of whom also has a Ph.D. in an unspecified field) and one has a Doctor of Social Work degree. Twenty-three are members of NASW. Sixteen are ACSW-certified. Eight are in the NASW Register of Clinical Social Workers.

Twenty respondents hold other jobs, the majority (sixteen) being employed by the State or by a private, nonprofit agency in full-time social work positions.

Twelve respondents have been in private practice in Hawaii for two years or less; ten more have practiced in Hawaii for three to ten years.

Sixteen respondents are CHAMPUS-certified providers, all but one of whom practice on Oahu.

In the category of time spent per week in private practice, the highest number of respondents (ten) spend an average of five hours or less per week in their practice. The next highest number (seven) spend six to ten hours per week in their practice.

In the category of client settings--individual, group, conjoint (couples), or family therapy--the majority of respondents (ranging from fourteen to seventeen) see five or fewer patients per week in each type of therapy.

The respondents were asked to comment on the issue of direct reimbursement to clinical social workers. All responses were in favor of direct reimbursement. These comments are presented in Appendix B-1.

The respondents were also asked to fill out questionnaires on their last five consecutive patients. Comments relevant to the psychotherapeutic nature of the respondents' social work and the issue of insurance coverage were selected and are presented in Appendix B-2.

In both sets of comments it can be seen that, from the clinical social workers' point of view, the general lack of insurance coverage, other than CHAMPUS, is a significant factor in the limitations of private practice in Hawaii.

Chapter 3

INSURANCE:[1] COST AND PROVIDER COVERAGE; FREEDOM OF CHOICE; ERISA

PART I. COST AND PROVIDER COVERAGE

The escalation of health care costs in recent years has been attributed to various factors such as advances in medical practices and technology, a larger and aging population, and general inflation. One widely acknowledged factor is the role of health insurance, which is the subject of this chapter.

Most insurance is activated by a single, often catastrophic, event. Health insurance has unique aspects in that it has come to be, for many people, an on-going subsidy for medical care. The pervasive expansion of health insurance has been recognized as fueling the upward movement of both volume and price of medical services, resulting in higher total expenditures for health care.

People are more likely to utilize medical services when they have insurance coverage, and to utilize more than they need when they do not have to pay the full cost. The presence of insurance generally produces the following effects: insurance lowers the out-of-pocket costs to the consumer for the use of covered services; thus, when the out-of-pocket cost is lowered, the consumer has more cash to expend on non-covered health care services; and insurance assures a flow of revenue to providers.[2] "Insurance coverage may make it more likely that someone seeks care, that the patient wishes to stay longer in treatment, or that the provider recommends longer treatment."[3]

Excluding any effects of government intervention, the field of health insurance is shaped basically by the interests of four groups: insurers, employers, providers, and consumers. Under Hawaii's Prepaid Health Care Act,[4] employers are required to provide health insurance coverage for their regular employees, and further, must pay at least one-half of the employee's monthly premium. Thus, both employers and insurers seek to keep costs down, providers desire expanded coverage of their services, and consumers want both minimal cost and maximum coverage.

One of the strongest arguments put forth by clinical social workers to support their position that their services should be covered by insurance is that their fees are lower than those of psychologists for comparable services, thereby benefiting consumers as well as advancing the cost-containment goals of insurers.

Twenty-three of the twenty-seven clinical social workers responding to the Bureau's survey charged set fees which averaged $56.70 for sixty minutes. Three respondents had sliding fees or times and one had not established a fee.

The average fee charged by these respondents is lower than the fees recommended by the Hawaii Chapter of the National Association of Social Workers (NASW-Hawaii). The following information was published by NASW-

Hawaii's Vendorship (Insurance) Committee in a newsletter:[5]

Chapter input is requested on standards for fees for services in Hawaii.

a. The following fees are to serve as appropriate reference points and are recommended to the profession and Hawaii public.

Collateral	90 minutes	60 minutes	30 minutes	1/4 session
Individual therapy				
Family		$75	$37.50	$20
Consultation				
Co-therapists charge their separate fees. Consultation is charged on an hourly basis.				
Group therapy				
one therapist	$60	$40	Group rates are charged to each	
two therapists	$75	$55	individual in the group.	

b. Fee standards will be reviewed each October 1, starting October 1, 1985.

c. NASW-Hawaii Chapter will keep a listing of NASW members who agree to accept maximum fee charges. This is not an endorsement of quality of services provided and should be so clarified if inquiries are made.

d. Participation on the Vendorship Committee requires:

(1) NASW membership, meeting requirements of ACSW;

(2) If in private practice, agreement to voluntarily accept maximum fees recommended;

(3) If in private practice, listing in national health registers of clinical social work.

Deliberations of this committee are open to the chapter membership.

Cost Comparison of Psychiatrists and Psychologists. It is commonly assumed that the cost of treatment by a psychologist is lower than treatment by a psychiatrist for two reasons: (1) a psychiatrist has a medical degree and therefore charges a physician's fee which presumably is higher than a psychologist's fee, and (2) since there are more psychologists than psychiatrists, the law of supply and demand would appear to dictate that psychologist services would be cheaper.[6] The experience of the Hawaii Medical Service Association (HMSA), discussed below, has shown otherwise.

HMSA. The Hawaii Medical Service Association (HMSA) is the State's largest health insurer, covering some 515,000 members (475,000 in group and individual plans and 40,000 in two HMO-type plans). Because of HMSA's dominant position in health insurance in Hawaii, its views on the expansion of mental health coverage to clinical social workers may be considered

representative of insurance companies here in Hawaii which do not now include social workers as providers.

In response to the Bureau's questions concerning costs of social worker services, HMSA stated:[7]

> Our experience and that of many other states indicate that mandatory coverage results in escalation of the fees of providers as well as the overall rates for health plan coverage.
>
> We do not have any data specific to clinical social workers costs, but can provide some information regarding escalation of fees of other mental health care providers. The cost of mental health services, as with any service, is the cost per case (cost of each visit times the number of visits to treat an injury or illness). Our information indicates that the cost per case for psychologists in 1977 ($217) was less than that for psychiatrists ($230). The cost per case for psychologists has escalated to the point where it is now higher ($323) than the cost per case for psychiatrists ($305). We also note that during this period, the number of psychologists increased more rapidly than psychiatrists.

HMSA provided a table of cost comparisons of psychologist and psychiatrist services (see Table 1). Mental health benefits under various HMSA plans cover 75 per cent of eligible charges for outpatient services, up to an annual dollar limit ranging from $500 to $1,000. In 1983 the average eligible charge by psychiatrists for a 50-minute visit was $80, with a range from $60 to $125. The average eligible charge by psychologists was $70, with a range from $50 to $100. (Cost-per-visit figures cannot be calculated from the table as the "average visits/case" figures are a mixture of different types of visits.)[8]

The following observation was made in a Virginia study:[9]

> No one has demonstrated that there is any cost savings or stabilization in the increase of costs by reimbursing non-physician practitioners in addition to physicians under the same benefit package. Rather, research has clearly demonstrated that increased coverage of services result in increased utilization, thus total health care expenditures go up. A deceiving argument is that it must save insurance companies money when the subscriber is able to go to, for example, a clinical social worker, charging $25, rather than a psychiatrist, charging $50 for psychotherapy. The flaw in the argument is that in a system where the provider (either psychiatrists or clinical social workers) is able to influence the price and the level of utilization, each is able to encourage enough utilization to assure an adequate income. The outcome is that total expenditures increase for three possible reasons:
>
> (1) the utilization of psychiatrists does not significantly decrease nor does [sic] their fees; (2) in time clinical social workers' fees begin to approach the fee levels of psychiatrists; and (3) the utilization of clinical social workers' services increase.

Table 1

PSYCHIATRISTS-PSYCHOLOGISTS

		Average Visits/Case	Average Allowance/Case	Psychologist Allow./Case as % of Psychiatrist Allow./Case
1977	Psychiatrists	7.51	$230.16	
	Psychologists	7.55	217.05	94%
1978	Psychiatrists	6.48	$215.50	
	Psychologists	6.49	206.92	96%
1979	Psychiatrists	6.64	$237.31	
	Psychologists	6.58	228.15	96%
1980	Psychiatrists	6.06	$233.90	
	Psychologists	6.08	224.41	96%
1981	Psychiatrists	6.13	$258.22	
	Psychologists	6.35	271.29	105%
1982	Psychiatrists	5.90	$271.94	
	Psychologists	6.19	294.82	108%
1983	Psychiatrists	6.13	$305.94	
	Psychologists	6.19	323.08	106%

Source: Hawaii Medical Service Association.

In response to questions posed by the Bureau, HMSA stated its position that legislation to reimburse clinical social workers is neither desirable nor appropriate for the following reasons:[10]

(1) Such legislation deprives HMSA members and the public of their right to choose the type and level of health care coverage they wish to purchase,

(2) Any such legislated coverage will increase the monthly dues of our members,

(3) There does not seem to be any great public demand for such additional coverage, and

(4) ERISA (Employment Retirement Income Security Act of 1974) preempts any state law regulating benefits offered by employers.

HMSA commented further in the same letter:

> Coverage of any service will always be of interest to particular groups of consumers or providers. Frequently, it is the provider of service who is advocating coverage rather than the consumer. If all possible services of particular interest were to be included in health plan coverage, rates for health plans would be prohibitive. And the end effect would lead to coverage with an unlimited choice of services and providers at rates no one could afford.
>
> Based on our experience, we believe that community interest in adding coverage of social workers services is very limited. Our daily Customer Service contacts with individual members reveal almost no inquiries or requests for coverage of social workers. Additionally, we have not received requests from employers for coverage of social worker services. Rather, employers, who are required to provide health coverage and who often pay the major portion of health plan dues, are greatly concerned with containing the cost of health care plans instead of adding new coverages to their health plans.

Other Carriers. Insurance carriers which have been known to reimburse clinical social workers include the following: Aetna, Bankers Life, Connecticut General, Equitable, Geico, Hartford, John Hancock, Home Life, Metropolitan Life, Mutual of Omaha, New England Mutual, New York Life, Occidental, Pacific Insurance, Provident Life, Phoenix Mutual Life, Prudential, Travelers, Union Labor Life, Union Mutual, and Blue Cross-Blue Shield of California, Colorado, Massachusetts, Maryland, New York City, Oregon, Rhode Island, Utah, and Washington, D.C.[11]

An examination of available health policies of the foregoing companies (excluding Blue Cross-Blue Shields of other states) filed with the State Insurance Commissioner showed a consistent requirement that the "doctor" or "physician", as the only provider listed under "Definitions", be a licensed practitioner of the "medical arts" or "healing arts" acting within the scope of that license. One policy went so far as to enumerate that such a licensed

practitioner includes, but is not limited to: "a physician, surgeon, psychologist, optometrist, podiatrist, dentist, osteopath or chiropractor."[12] Some policies, presumably to comply with freedom of choice legislation, contain in the definition of "doctor" or "physician" such wording as: "Where required by law, this includes the services of a duly licensed practitioner operating within the scope of his or her license."[13]

The lack of licensure of social workers in Hawaii apparently has not totally prevented the reimbursement of clinical social work services as there have been instances of such reimbursement. Some survey responses[14] answered in the affirmative to the question of direct reimbursement from insurance companies, but the question may have been misunderstood. There should have been a clarifying clause that "direct reimbursement" meant "without physician referral". A conversation with a private practitioner indicated that although reimbursements have come directly to her from an insurance company, in each instance there had been physician referral for the claim (except for CHAMPUS).[15] It has not been possible to trace the specific policies under which reimbursements have been made. There is, of course, the possibility that certain policies do not require that covered services be provided by a licensed practitioner.

Self-Insured Employer Plans. Self-insured employer plans are those health insurance plans which are financially self-contained within the employer-company, although they are frequently administered by an insurance company. Self-insured employer plans do not come within the jurisdiction of the State Insurance Commissioner. They must, however, comply with the Hawaii Prepaid Health Care Act. Thus, these plans are filed with the Prepaid Health Care Program, Disability Compensation Division, Department of Labor and Industrial Relations. It was not possible to obtain an exact count of such plans, since organizations such as sugar plantations have in recent years merged or transferred their plans to regular insurance companies. Plans which are no longer in effect are not necessarily withdrawn from the files of the Prepaid Health Care Program.

An examination of approximately thirty self-insured employer plans, filed with the Prepaid Health Care Program, showed that only three contained provisions covering the services of social workers.[16] All three plans require that the social worker be licensed. One plan permits the social worker to work within the scope of the practitioner's license, without supervision; the second plan requires that the social work service be recommended by a licensed physician; and the third requires that the social worker perform under the direction and supervision of a psychiatrist or a registered clinical psychologist. The three plans belong to mainland-based companies; one has one employee in Hawaii, the second has three, and the third did not state the number of its Hawaii employees.

Federal Employees Health Benefits Program (FEHBA). This program consists of two hundred seventeen health plans offered to federal civilian employees, annuitants and their dependents. With nearly ten million potential beneficiaries, it is the "nation's largest single purchaser of health care."[17] Of the two hundred seventeen plans, nineteen are fee-for-service plans, and the remainder are prepaid plans (comprehensive medical plans and health maintenance organizations) in which cost is not an issue. Thirteen of the fee-for-service plans provide benefits for mental health care rendered by

clinical social workers.[18] Clinical social workers providing mental health care under these plans must be under the supervision of a medical doctor.

PART II. FREEDOM OF CHOICE

Freedom of choice legislation, as advocated by psychologists, clinical social workers, and other mental health care providers, means freedom of choice of practitioners by patients whose health insurance plans include mental health benefits. The effect of freedom of choice legislation is to allow non-physician practitioners to be reimbursed by their patients' health insurance.

Twelve states have enacted freedom of choice laws covering social workers. Under these laws coverage for the services of clinical social workers is mandated or must be offered in insurance policies with mental health benefits (see Table 2).

Summary of Freedom of Choice States:

Licensing. Social workers are regulated in all twelve freedom of choice states. Of the twelve, eight have licensing statutes, four have registration statutes, and one has a registration/licensing statutory scheme (see Table 12 in chapter 6).

Physician Referral. Seven of the twelve states do not require physician referral; two require physician referral; one requires referral by a physician or psychologist; one requires physician consultation and collaboration; and one requires physician referral only if a condition is diagnosed beyond the scope of the clinical social worker's license.

Coverage. Ten of the twelve states mandate coverage of clinical social workers. In two of the states, coverage for clinical social workers must be offered.

PART III. ERISA

The Employee Retirement Income Security Act of 1974 (ERISA)[19] regulates the administration of private employee benefit and pension plans. ERISA applies to all employee benefit plans and supersedes all state laws relating to such plans, with certain exceptions. ERISA does not apply to employee benefit plans maintained solely to comply with applicable workers' compensation, unemployment compensation, or disability insurance laws. A further exception is that ERISA does not "exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."[20]

The Hawaii Prepaid Health Care Act (chapter 393, Hawaii Revised Statutes) also was enacted in 1974 and requires workers in the State to be covered by a comprehensive prepaid health care plan. In 1976 chapter 393, Hawaii Revised Statutes, was amended to include substance abuse (alcoholism and drug abuse) benefits. As the result of subsequent litigation, chapter 393, Hawaii Revised Statutes, was ruled to be preempted by ERISA.[21]

In 1982 Congress enacted a provision exempting the Hawaii Prepaid Health Care Act (excluding any amendment enacted after September 2, 1974) from ERISA.[22] This effectively precluded the substance abuse benefits from

TABLE 2

FREEDOM OF CHOICE STATES

State	Effective Date	License Required	Additional Requirements	Coverage	Covered If Insurance Written In Another State	Referral
California	January 1977 Amended 1984	Licensed Clinical Social Worker	None	Policies with mental health coverage must recognize LCSWs as reimbursable providers	Yes	By licensed physician or surgeon
Kansas	April 1982	Specialist Clinical Social Worker	None	SCSW must be reimbursed for services within their scope of practice unless policyholder refuses such coverage in writing	No	Not required
Louisiana	July 1977	Board Certified Social Worker	Must be listed in a National Clinical Social Work Registry	Policies with mental health coverage must reimburse BCSWs	No	Physician consultation and collaboration
Maine	January 1984	Certified Social Worker; Clinical Social Worker (after 1/1/85)	None	Policies with mental health coverage must reimburse CSWs	No	Not required unless a condition is diagnosed beyond the scope of CSW licensure.
Maryland	January 1978	Licensed Certified Social Worker	Must be on approved vendor list	Policies with mental health coverage Must reimburse CSWs	Yes	Physician
Massachusetts	March 1982	Independent Clinical Social Worker	None	Policies with mental health coverage Must reimburse ICSWs	Yes	Not required
New Hampshire	January 1984	Certified Clinical Social Worker	None	Coverage for CCSW must be offered to policyholders (who have mental health benefits) for a separate & identifiable premium	Yes	Not required
New York*	January 1985	Certified Social Worker	Must have a "P" (Psychotherapy) endorsement which attests to 3 years of post-masters experience	Policies with mental health coverage must reimburse CSWs	Yes	Not required
Oklahoma	October 1982	Clinical Social Worker	None	Policies with mental health coverage must reimburse CSWs	Not specifically but may be	Not required
Oregon	July 1981	Registered Clinical Social Worker	None	Benefits to be paid whether service is given by physician, psychologist or clinical social worker	No	Physician or Psychologist
Utah	July 1978	Clinical Social Worker	None	Coverage of mental health benefits must reimburse CSWs	No	Not required
Virginia	July 1979	Clinical Social Worker	None	Coverage for CSW must be offered to policyholders but a special endorsement on the policy specifying CSW coverage is required.	No	Not required

Source: National Association of Social Workers.

*Updated information on New York provided by letter from Sandra Critz, Director, Senate Research Office, New York State Senate, to Claire Marumoto, July 27, 1984; and New York Times, December 23, 1984, p.22.

being enforced as part of chapter 393, Hawaii Revised Statutes, and "froze" the chapter.

ERISA has been the subject of considerable litigation nation-wide. A recent Massachusetts case[23] held that a Massachusetts statute mandating minimum mental health care benefits under certain insurance policies comes, in part, within the exception to the ERISA preemption relating to state regulation of insurance. The Massachusetts high court stated in part: "...to conclude that a State cannot mandate employee benefits indirectly through its insurance laws would require an unnaturally narrow reading of the phrase 'any law...which regulates insurance.' Mandated coverage is within the States' traditional authority to regulate insurance."[24] The U.S. Supreme Court has noted probable jurisdiction of this case.[25]

Chapter 4

CHAMPUS

In 1984 certified clinical social workers became eligible to receive direct reimbursement for their services, independent of physician referral and supervision, under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

CHAMPUS is a health benefits program for all seven uniformed services: the Army, Navy, Marine Corps, Air Force, Coast Guard, Public Health Service, and National Oceanic Atmospheric Administration. The program is administered by the Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS), an agency of the Department of Defense. CHAMPUS regulations are prescribed jointly by the Secretary of Defense and the Secretary of Health and Human Services.

The program shares most of the costs of care obtained from civilian hospitals when care is unavailable through a military hospital or clinic. CHAMPUS beneficiaries may use outpatient services of civilian doctors regardless of availability at military facilities.[1]

Generally, CHAMPUS covers dependents of active duty and deceased military personnel and retirees and their dependents. It does not cover active duty personnel. There are approximately 7.9 million persons eligible for the CHAMPUS program.[2] In Hawaii, there are an estimated 85,000 CHAMPUS eligibles.[3]

Direct reimbursement to certified clinical social workers was authorized by the Department of Defense Appropriation Act, 1983,[4] and implemented by amendment to Department of Defense Regulations on February 24, 1984. The amendment is retroactive to December 21, 1982.[5]

The term "certified social worker", for CHAMPUS purposes, means a social worker who meets the following criteria:

(1) Is licensed or certified as a clinical social worker by the jurisdiction where practicing; or, if the jurisdiction does not provide for licensure or certification of clinical social workers, is certified by a national professional organization offering certification of clinical social workers;

(2) Has at least a master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education; and

(3) Has had a minimum of two years or three thousand hours of post-master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate clinical setting, as determined by the Director, OCHAMPUS, or a designee.

Patients with organic medical problems must receive appropriate concurrent management by a physician.[6]

In the case of Hawaii, the CHAMPUS program allowed reimbursement to clinical social workers who met the certification standards of the Academy of Certified Social Workers of the National Association of Social Workers and who were approved as eligible providers by the Hawaii Medical Service Association, the in-state fiscal intermediary.

The decision to permit direct reimbursement to clinical social workers followed a test program, the CHAMPUS Experimental Study on Reimbursement of Independent Certified Clinical Social Workers, conducted from December 15, 1980 to December 20, 1982. The following information on the study is taken from the "Final Report on the Experimental Study on Reimbursement of Clinical Social Workers, April 1 to September 30, 1982", prepared by OCHAMPUS.[7] The report also contained cumulative data as reported in prior interim reports that had been submitted since the start of the study, December 15, 1980.

Background. The Department of Defense Appropriation Act, 1981, directed the Assistant Secretary of Defense for Health Affairs to conduct an experimental study for the acceptance and payment of claims for CHAMPUS covered mental health services provided by clinical social workers independent of physician referral or supervision.

Study Period. The study, originally authorized from December 15, 1980 to September 30, 1981, was extended through September 30, 1982. This extension was authorized by the Department of Defense Appropriation Act, 1982, for the purpose of assuring that sufficient claims data was acquired and compiled for formulating valid study conclusions and recommendations. As subsequently authorized under the Continuing Resolution of the Department of Defense Appropriation Act, 1983, the Assistant Secretary of Defense for Health Affairs authorized the fiscal intermediaries (insurance carriers) to continue acceptance and processing of claims from certified clinical social workers pending amendment of the CHAMPUS Regulation authorizing and recognizing clinical social workers as authorized and recognized providers.

Allowable Charges. As set forth in the study criteria, payment for services of clinical social workers were based on allowable charges. A charge was considered allowable if it did not exceed the nonspecialty area prevailing charge for the same service performed by a similarly qualified professional. Accordingly, the "amount billed" vs. the "amount allowed" as reported by the fiscal intermediaries was applied in evaluating the claims data. Prevailing fee profiles of clinical social workers that were developed and established during the course of the study are reflected in Table 7.

Claims Activity. Table 3 indicates the number of claims received and processed by each fiscal intermediary. The data indicate the following for the reporting period (April 1, 1982 to September 30, 1982):

(1) All eight fiscal intermediaries currently under contract to OCHAMPUS received and processed clinical social worker claims representing 32 of the 50 states.

(2) A total of 2,780 claims, representing 330 providers and 1,577 beneficiaries were received and processed.

Table 3

CLINICAL SOCIAL WORKER CLAIMS RECEIVED AND PROCESSED BY FISCAL INTERMEDIARY
(Period: 1 April 1982 through 30 September 1982)

FISCAL INTERMEDIARY	NO. OF CLAIMS			REPRESENTATIVE DATA		
	RECEIVED AND PROCESSED	BILLED WITHIN PREVAILING ALLOWANCE	BILLED IN EXCESS OF PREVAILING ALLOWANCE*	NO. OF STATES	NO. OF PROVIDERS	NO. OF BENEFICIARIES
CALIFORNIA, BS of	39	30	9	3	28	39
HAWAII MEDICAL SERVICE	1044	471	573	1	16	259
MUTUAL OF OMAHA	277	229	48	3	37	272
RHODE ISLAND	108	80	28	3	45	58
SOUTH CAROLINA, BC-BS of	84	82	2	2	20	28
TENNESSEE, BC-BS of	40	32	8	1	7	13
WASHINGTON-ALASKA, BC of	103	99	4	7	55	91
WISCONSIN PHYSICIAN SERVICE	1085	302	783	12	122	817
TOTALS	2780	1325	1455	32	330	1577

*Includes rejected claims, disallowed services, prevailing fee reductions, etc.

(3) Of the 2,780 claims received, 1,455 (or 52.3 per cent) contained billed charges that exceeded allowances (i.e., disallowed services and/or fees). It was noted that this was a decrease from the previously reported 67 per cent in an earlier report. In most instances, the reduced allowances were attributable to billing in excess of prevailing charges.

Volume and Trends.

(1) Table 4 shows that a total of 2,780 claims were received and processed during the reporting period (April 1, 1982 to September 30, 1982). This was a 56 per cent increase in the number of claims compared to the 1,777 claims received and processed in the previous six-month reporting period. Since the start of the study (December 15, 1980), a total of 6,200 claims were received and processed by the fiscal intermediaries.

(2) Table 5, which reflects the number of claims received and processed by state, indicates that Hawaii continues to rank first in the number of claims with Texas as second. Of the 6,200 claims received and processed during the study period, Hawaii with 2,151 claims and Texas with 1,959 claims account for 66.3 per cent of the total claims.

Type and Volume of Services. Table 6, showing the type and volume of services both by state and fiscal intermediary, indicates that 85 per cent of the billed services are for individual psychotherapy sessions of 45 to 50 minutes. Since this category of services provides the most consistent data for computing and determining comparative costs, it was applied in evaluating the cost effectiveness of this study.

Fee Profiles. Table 7 shows the area prevailing fee profiles (by state) of clinical social workers as compared to psychiatrists based on processed claims since the start of this study. Under OCHAMPUS reimbursement principles and policies, these fees are reimbursed at the 80th percentile. Fees allowed ranged from a low of $40 in the states of Nebraska and Ohio to a high of $94 in Hawaii, the latter exceeding the physician/psychiatrist fee profile of $88. (This matter was referred to the Office of Program Integrity for review).

Cost Avoidance. Table 8 presents cost avoidance figures, reflecting the difference between the prevailing physician fee and the allowed social worker fee.

Utilization Aspects. As reflected in Table 5, no claims were received by fiscal intermediaries from ten states (Arizona, Connecticut, Massachusetts, Michigan, Mississippi, Nevada, New Hampshire, New Mexico, Vermont, and West Virginia). It was conversely noted that the following ten states have the highest incidence of claims: Hawaii, 2,151 claims; Texas, 1,951 claims; Maryland, 317 claims; Colorado, 266 claims; New York, 199 claims; Washington, 145 claims; Arkansas, 138 claims; Georgia, 127 claims; Virginia, 91 claims; and California with 90 claims.

Table 4

CLINICAL SOCIAL WORKER CLAIMS RECEIVED AND PROCESSED BY FISCAL INTERMEDIARY
(From start of experimental study (15 Dec 80) through 30 September 1982)

Fiscal Intermediary	No. Claims 1st Report 12/15/80-4/30/81	No. Claims 2d Report 5/1/81-9/30/81	No. Claims 3d Report 10/1/81-3/31/82	No. Claims 4th Report 4/1/82-9/30/82	Total to Date
CALIFORNIA, BS of	7	25	26	39	97
HAWAII MEDICAL SERVICE	118	398	591	1044	2151
MUTUAL OF OMAHA	-	27	135	277	439
PENNSYLVANIA, BS of	25	165	-	-	190
RHODE ISLAND, BC of	41	5	105	108	259
SOUTH CAROLINA, BC-BS of	-	-	79*	84	163
TENNESSEE, BC-BS of	15	7	15	40	77
VIRGINIA, BC-BS of Southwest	98	(no report)	-	-	98
WASHINGTON-ALASKA, BC of	15	132	37	103	287
WISCONSIN PHYSICIAN SERVICE	44	521	789	1085	2439
TOTALS	363	1280	1777	2780	6200
% Increase	-	352%	39%	56%	

*Note: Includes previous fiscal intermediaries, BS of Pennsylvania and BC BS of Southwest Virginia.

Table 5

CLINICAL SOCIAL WORKER CLAIMS BY STATE
AS RECEIVED AND PROCESSED BY FISCAL INTERMEDIARIES
(From start of study (15 Dec 80) through 31 March 1982)

CODE*		STATE	No. Claims 1st Report 12/15/80-4/30/81	No. Claims 2d Report 5/1/81-9/30/81	No. Claims 3d Report 10/1/81-3/31/82	No. Claims 4th Report 4/1/82-9/30/82	Total to Date
C	1	Alabama	-	3	-	-	3
H	2	Alaska	-	13	2	8	23
A	3	Arizona	-	-	-	-	-
I	4	Arkansas	8	24	58	48	138
A	5	California	7	24	24	35	90
C	6	Colorado	-	8	77	181	266
A	7	Connecticut	-	-	-	-	-
DS	8	Delaware	-	1	-	-	1
GS	9	District of Columbia	17	-	-	-	17
A	10	Florida	-	-	2	4	6
C	11	Georgia	-	8	44	75	127
B	12	Hawaii	118	398	591	1044	2151
H	13	Idaho	-	7	4	5	16
I	14	Illinois	7	11	31	33	82
I	15	Indiana	-	3	3	12	18
I	16	Iowa	-	2	-	1	3
I	17	Kansas	3	12	9	11	35
I	18	Kentucky	2	9	7	9	27
I	19	Louisiana	-	43	23	23	89
A	20	Maine	-	1	-	-	1
DS	21	Maryland	25	162	65	65	317
A	22	Massachusetts	-	-	-	-	-
A	23	Michigan	-	-	-	-	-
I	24	Minnesota	3	-	1	2	6
C	25	Mississippi	-	-	-	-	-
I	26	Missouri	11	12	10	8	41
H	27	Montana	1	22	9	18	50
C	28	Nebraska	-	-	-	-	-
A	29	Nevada	-	-	-	-	-
A	30	New Hampshire	-	-	-	-	-

Table 5 (continued)

CODE*		STATE	No. Claims 1st Report 12/15/80-4/30/81	No. Claims 2d Report 5/1/81-9/30/81	No. Claims 3d Report 10/1/81-3/31/82	No. Claims 4th Report 4/1/82-9/30/82	Total to Date
E	31	New Jersey	17	-	9	17	43
A	32	New Mexico	-	-	-	-	-
E	33	New York	24	5	89	81	199
GS	34	North Carolina	4	-	2	-	6
I	35	North Dakota	1	4	-	-	5
C	36	Ohio	-	6	14	21	41
I	37	Oklahoma	5	10	6	7	28
H	38	Oregon	-	9	5	10	24
DS	39	Pennsylvania	-	2	-	-	2
E	40	Rhode Island	-	-	7	10	17
GS	41	South Carolina	17	-	-	-	17
I	42	South Dakota	-	-	1	3	4
F	43	Tennessee	15	7	15	40	77
I	44	Texas	-	393	638	928	1959
H	45	Utah	3	11	1	3	18
A	46	Vermont	-	-	-	-	-
GS	47	Virginia	60	-	12	19	91
H	48	Washington	12	64	16	53	145
C	49	West Virginia	-	-	-	-	-
I	50	Wisconsin	3	-	-	-	3
H	51	Wyoming	-	6	2	6	14
		TOTALS	363	1280	1777	2780	6200

*FI Codes:

A. California, BS of
B Hawaii Medical Service
C Mutual of Omaha
D Pennsylvania, BS of
E Rhode Island, BC of
F Tennessee
G Virginia
H Washington-Alaska, BC of
I Wisconsin Physician Service
S South Carolina, BC-BS of

Table 6

TYPE AND VOLUME OF PSYCHOTHERAPY SERVICES

FISCAL INTERMEDIARY AND STATE	"A" INDIVIDUAL 60 MINUTE	"B" INDIVIDUAL 30 MINUTE	"C" GROUP THERAPY	"D" FAMILY THERAPY	"E" PSYCHOLOGIC TESTING
CALIFORNIA, BS of					
California (South)	717	3	6	64	-
California (North)	123	2	-	6	-
Florida	28	-	-	27	-
RHODE ISLAND, BC of					
New Jersey	181	5	-	-	-
New York	645	228	-	-	-
Rhode Island	56	-	-	-	-
SOUTH CAROLINA, BC-BS of					
Maryland	1047	2	-	-	-
North Carolina	8	-	-	-	-
Virginia	226	-	-	-	-
TENNESSEE BC-BS of					
Tennessee	288	29	15	-	-
WASHINGTON-ALASKA, BC of					
Alaska	56	-	-	-	-
Idaho	32	2	-	-	-
Montana	96	2	-	-	-
Oregon	78	-	-	3	-
Utah	11	1	-	-	-
Washington	364	17	-	8	-
Wyoming	36	1	-	-	-
HAWAII MEDICAL SERVICE					
Hawaii	3335	29	205	17	-

Table 6 (continued)

FISCAL INTERMEDIARY AND STATE	"A" INDIVIDUAL 60 MINUTE	"B" INDIVIDUAL 30 MINUTE	"C" GROUP THERAPY	"D" FAMILY THERAPY	"E" PSYCHOLOGIC TESTING
MUTUAL OF OMAHA					
Colorado	2049	329	39	420	-
Georgia	561	22	71	153	-
Nebraska	20	-	-	6	-
Ohio	389	-	10	42	-
WISCONSIN PHYSICIAN SERVICE					
Arkansas	355	8	45	4	1
Illinois	368	27	18	4	-
Indiana	102	-	-	3	-
Kansas	95	6	-	-	-
Kentucky	60	6	-	27	-
Louisiana	183	1	-	63	14
Minnesota	16	-	6	-	-
Missouri	82	9	19	4	-
Oklahoma	70	-	-	-	-
South Dakota	16	-	-	-	-
Texas	6624	77	788	275	75
TOTALS	18317	806	1222	1126	90
% of Total	(85.3%)	(03.8%)	(05.7%)	(05.2%)	(0.4%)

Table 7

COMPARATIVE PREVAILING FEE PROFILES
for
PSYCHOTHERAPY SESSIONS OF 45 TO 50 MINUTES
(See Notes at end of table)

State	Physician (Psychiatrist)	Clinical Social Worker
	MUTUAL OF OMAHA	
Alabama	$70	$60/70
Colorado	75	50
Georgia	75	50
Mississippi	70/75	*
Nebraska	70	40
Ohio	65/70	40
West Virginia	60/65	*
	BLUE SHIELD OF CALIFORNIA	
California (North)	75/80	50/54
California (South)	85	75
Maine	70/75	45
Massachusetts	65/70	*
Connecticut	65/70	*
New Hampshire	60/65	*
Vermont	60	*
Michigan	65	*
Florida	75/96	50/60
Arizona	75	*
Nevada	85/100	*
New Mexico	68	*

Table 7 (continued)

State	Physician (Psychiatrist)	Clinical Social Worker
	BLUE CROSS OF SOUTH CAROLINA	
Maryland	$65	$50
Delaware	78	62
District of Columbia	65	60/45
North Carolina	70	50/40
Pennsylvania	60/70	40/45
Virginia	75	50/55
South Carolina	60	60
	WISCONSIN PHYSICIAN SERVICE	
Illinois	65/70	45/50
Iowa	60/70	45
Kentucky	60/64	45
Louisiana	75	45/50
Minnesota	70/80	50/55
Missouri	60/65	50/55
North Dakota	80/85	42/56
Oklahoma	60/70	45/50
Kansas	65/70	50/55
Wisconsin	72/76	44/50
South Dakota	60/70	40/44
Indiana	65/75	50
Texas	75/90	60/65
Arkansas	70/75	52/55
	BLUE-CROSS-BLUE SHIELD OF TENNESSEE	
Tennessee	65	50

Table 7 (continued)

State	Physician (Psychiatrist)	Clinical Social Worker
	BLUE CROSS OF RHODE ISLAND	
Rhode Island	$75	$50
New York	75	55
New Jersey	75	55
	HAWAII MEDICAL SERVICE ASSOCIATION	
Hawaii	88	80/94
	BLUE CROSS OF WASHINGTON-ALASKA	
Alaska	80/85	75
Idaho	60	50/55
Montana	60	50
Oregon	65/75	45/50
Utah	60/65	50
Washington	55/60	40/45
Wyoming	45/50	45

Note:

(1) Asterisk (*) indicates no prevailing fee established since no clinical social worker claims were received or processed.

(2) Amounts preceding the diagonal are profile fees established as of April 1, 1982 as cited in the previous 3d Interim Report. Amounts following the diagonal are profile fees established as of October 1, 1982.

TABLE 8

CLINICAL SOCIAL WORKER SERVICES
(INDIVIDUAL ONE HOUR VISITS/SESSIONS)

FI	STATE		NUMBER OF VISITS 1st Report	2nd Report	3rd Report	4th Report	TOTAL VISITS	COST* AVOIDANCE PER FEE	TOTAL COST AVOIDANCE
C	1	Alabama	-	28	-	28	28	$ 10/0	$ 280
H	2	Alaska	-	98	10	46	154	5/10	1,000
A	3	Arizona	-	-	-	-	-	-	-
I	4	Arkansas	17	173	76	279	545	18/20	10,368
A	5	California (North)	10	41	25	98	174	25	4,350
A	5	California (South)	40	196	312	405	953	10	9,530
C	6	Colorado	-	31	577	1472	2080	25/30	59,360
A	7	Connecticut	-	-	-	-	-	-	-
DS	8	Delaware	-	6	-	-	6	16	96
GS	9	District of of Columbia	129	-	-	129	129	5	645
A	10	Florida	-	-	32	28	60	25	1,500
C	11	Georgia	-	22	222	339	583	25	14,575
B	12	Hawaii	321	1089	1396	1939	4745	8/(6)	10,814
H	13	Idaho	-	28	10	22	60	10/5	490
I	14	Illinois	7	112	142	226	487	20	9,740
I	15	Indiana	-	5	21	81	107	15/25	2,415
I	16	Iowa	-	14	-	-	14	15	210
I	17	Kansas	3	82	39	56	180	15	2,700
I	18	Kentucky	2	35	21	39	97	15/19	1,611
I	19	Louisiana	-	426	69	114	609	30/25	17,700
A	20	Maine	-	9	-	-	9	25	225
DS	21	Maryland	163	1038	549	498	2248	15	33,720
A	22	Massachusetts	-	-	-	-	-	-	-
A	23	Michigan	-	-	-	-	-	-	-
I	24	Minnesota	3	-	4	12	19	20/25	440
C	25	Mississippi	-	-	-	-	-	-	-
I	26	Missouri	10	87	41	41	179	10	1,790

*The difference between the prevailing physician fee and the allowed social worker fee. Figures preceding the diagonal are based on fee profiles established as of 1 April 1982; figures following the diagonal are based on fee profiles established as of 1 October 1982.

TABLE 8 (continued)

CLINICAL SOCIAL WORKER SERVICES
(INDIVIDUAL ONE HOUR VISITS/SESSIONS)

FI		STATE	NUMBER OF VISITS 1st Report	2nd Report	3rd Report	4th Report	TOTAL VISITS	COST* AVOIDANCE PER FEE	TOTAL COST AVOIDANCE
H	27	Montana	17	75	22	74	188	10	1,880
C	28	Nebraska	-	-	-	20	20	-/30	600
A	29	Nevada	-	-	-	-	-	-	-
A	30	New Hampshire	-	-	-	-	-	-	-
E	31	New Jersey	85	-	68	113	266	20	5,320
A	32	New Mexico	-	-	-	-	-	-	-
E	33	New York	137	27	264	381	809	20	16,180
GS	34	North Carolina	20	-	9	28	29	20	580
I	35	North Dakota	1	36	-	-	37	38	1,406
C	36	Ohio	-	29	216	173	418	25/29	11,142
I	37	Oklahoma	5	26	38	32	101	15/20	1,675
H	38	Oregon	-	36	22	56	114	20/25	2,560
DS	39	Pennsylvania	-	21	-	-	21	20	420
E	40	Rhode Island	-	-	11	45	56	25	1,400
GS	41	South Carolina	58	-	-	-	58	0	-
I	42	South Dakota	-	-	1	15	16	20/26	410
F	43	Tennessee	43	13	63	225	344	15	5,160
I	44	Texas	-	3839	2667	3974	10461	15/25	196,515
H	45	Utah	19	34	4	7	64	19/15	675
A	46	Vermont	-	-	-	-	-	-	-
GS	47	Virginia	308	-	71	155	534	25/20	12,575
H	48	Washington	280	345	79	285	989	15	14,835
C	49	West Virginia	-	-	-	-	-	-	-
I	50	Wisconsin	3	-	-	-	3	28	84
H	51	Wyoming	-	18	17	19	54	0/5	95

TOTAL COST AVOIDANCE.....$457,071

Key, FI Codes:

A California, BS of
B Hawaii Medical Service
C Mutual of Omaha
D Pennsylvania, BS of
E Rhode Island, BC of
F Tenessee, BC-BS of
G Virginia, BC of Southwest
H Washington, Alaska, BC of
I Wisconsin Physician Service
S South Carolina, BC-BS of

In forwarding the Final Report to the House and Senate Appropriations committees, OCHAMPUS noted the following significant aspects of the study:[9]

(1) During the reporting period from April 1, 1982 through September 30, 1982, 330 clinical social workers served 1,577 CHAMPUS patients for which 2,780 claims were submitted for services rendered. As indicated by the cumulative periodic data, there has been a continuing increase in utilization since the study commenced.

(2) During the course of this study, approximately 85 per cent of the services provided were for "one hour" individual psychotherapy services, while approximately 52 per cent of the claims processed during this reporting period were billed higher than the amount allowed by the fiscal intermediaries. In most instances, the reduced allowances are attributable to billing in excess of prevailing charges.

(3) A noticeably high incidence of claims continues to prevail in the areas of San Antonio, Texas and Pearl City, Kailua, and Honolulu, Hawaii. (The respective fiscal intermediaries have been instructed to place the involved high volume and/or high cost providers on "100% review" to preclude utilization abuse.)

OCHAMPUS provided the Bureau with the following figures for the number of outpatient visits and average cost per outpatient visit, by type of provider, for mental health care under CHAMPUS in Hawaii:[8]

NUMBER OF OUTPATIENT VISITS FOR MENTAL HEALTH CARE BY TYPE OF PROVIDER FOR THE STATE OF HAWAII

	FY 81	FY 82	FY 83
Attending Physicians	1	28	60
Psychiatrists	3,744	4,083	3,594
Psychologists	5,879	6,442	6,023
Social Workers	2,205	3,889	3,821
All Others	5,878	6,450	7,009
TOTAL VISITS	17,707	20,892	20,507

AVERAGE COST PER OUTPATIENT VISIT FOR MENTAL HEALTH CARE BY TYPE OF PROVIDER FOR THE STATE OF HAWAII[10]

	FY 81	FY 82	FY 83
Attending Physicians	no claims	$48.71	$60.40
Psychiatrists	$60.98	73.50	86.21
Psychologists	64.62	64.92	80.44
Social Workers	63.06	68.29	75.78
All Others	64.31	72.57	86.10

CHAMPUS concluded from its study that some cost reduction could be reasonably computed on the bases of lower fee profiles of clinical social workers as compared with psychiatrists; however, any absolute overall net tangible savings would be difficult to establish and validate.[11]

Chapter 5

MEDICARE AND MEDICAID

PART I. OVERVIEW

In 1965 Congress passed legislation which added two new titles to the Social Security Act: Title XVIII - Health Insurance for the Aged,[1] and Title XIX - Grants to States for Medical Assistance Programs.[2] The two programs are commonly known as Medicare and Medicaid, respectively.

There are two basic differences between the two programs. Medicare is a health insurance program for the elderly and certain disabled people regardless of income, while Medicaid is a medical assistance program for the needy. Medicare is a federal program whose eligibility requirements and benefit structure are uniform throughout the nation, while Medicaid is a joint federal-state program administered by the states. Under Medicaid each state establishes, within federal guidelines, eligibility requirements of recipients and the benefits to be provided. Thus, for the fifty states, there are one Medicare program and fifty different Medicaid programs.[3]

PART II. MEDICARE

The Medicare program was substantially expanded in 1972 when Congress extended coverage to disabled beneficiaries of the social security and railroad retirement programs and to persons requiring kidney dialysis or transplant services for end-stage renal disease or permanent kidney failure.[4] The official name of the Medicare program was then changed to Health Insurance for the Aged and Disabled.[5]

Medicare consists of two parts: Part A which is hospital insurance, and Part B which is supplementary medical insurance.

While there are no provisions for the coverage of clinical social workers as independent providers under Medicare, "medical social services" are covered under Part A, or hospital insurance.

Hospital insurance helps pay for four kinds of care: (1) inpatient hospital care, (2) post-hospital extended care services in a skilled nursing facility, (3) home health services, and (4) hospice care.

In the first two categories--inpatient hospital care and extended care services--Medicare pays for "medical social services" that are ordinarily furnished as inpatient care by the hospital or skilled nursing facility.[6]

The third category--home health services--covers items and services furnished to an individual by a home health agency[7] under a plan, for that individual, established and periodically reviewed by a physician. Among the services covered are "medical social services under the direction of a physician".[8]

The last category--hospice care--covers items and services provided to a terminally ill individual by a hospice program under a written plan, for that individual, established and periodically reviewed by the individual's physician

and by the medical director and interdisciplinary group of the program. As in home health care, included in the services covered by hospice care are "medical social services under the direction of a physician".[9]

The term "hospice program" means a public agency or private organization which is primarily engaged in providing care for terminally ill individuals and bereavement counseling for the immediate family of such individuals.[10] Among the requirements of a hospice program is that it have an interdisciplinary group of personnel which includes at least one physician, one registered professional nurse, and one social worker employed by the agency or organization, and which also includes at least one pastoral or other counselor.[11]

Coverage under Part B, Supplementary Medical Insurance, comprises a variety of medical services: physicians' services, home health services, outpatient physical therapy and speech pathology services, rural health clinic services, ambulatory surgical centers, and comprehensive rehabilitation facility services. "Home health services" under Part B is identical to the term as used in Part A. "Comprehensive rehabilitation facility services" includes social and psychological services under a physician's plan.[12]

Part A is financed primarily through a payroll tax levied on earnings covered by the Social Security Act. Part B is a voluntary program financed jointly by premiums paid by enrollees and by contributions of the federal government from the general fund of the Treasury.

As state moneys are not involved, and Congress has not delegated any authority to the states, state legislatures are not empowered to affect the administration of Medicare within their respective states.

Medicare Demonstration Project. As evidenced by the CHAMPUS experiment and the subsequent decision to reimburse clinical social workers as independent providers in that program, Congress is cognizant of the cost-saving potential of clinical social workers in providing mental health care. Under the Omnibus Reconciliation Act of 1980, Congress directed the Department of Health and Human Services to conduct a demonstration project to determine the effects of making the services of clinical social workers more generally available under Medicare.[13] The project would allow direct reimbursement to clinical social workers for their services rather than through a physician or clinic.

California was selected as the demonstration site. Seven counties in Southern California for which Transamerica Occidental Life Insurance Company is the Medicare Part B carrier comprise the experimental site. The rest of California, which is served by Blue Shield, is the control site.[14] Eligibility for the experiment is limited to clinical social workers licensed in the state of California who have a practice with a mailing address in one of the seven Southern California counties served by Transamerica Occidental.[15] Any psychiatric service now approved for reimbursement by Medicare and which clinical social workers are legally permitted to perform would be covered.[16]

Phase I of the demonstration project, the development phase, covered the period from October 1, 1982 through December 31, 1983. Phase II, the implementation period, will extend from January 1, 1984 through December 31,

1985. The final phase, Phase III, is a three-month post-implementation period during which time a final report on the demonstration will be prepared.[17]

PART III. MEDICAID

Medicaid is the largest item in the welfare budgets of most states, and its rapidly rising cost has placed a great strain on both federal and state finances. Because Medicaid is a federally supported program, the federal government has established certain guidelines which states must follow in administering their Medicaid programs.

Eligibility. All states must provide Medicaid coverage to the "categorically needy", that is, those persons who are eligible to receive cash payments under the Aid to Families with Dependent Children (AFDC) program or the Supplemental Security Income (SSI) program for the aged, blind, and disabled. Additionally, states have the option of extending Medicaid coverage to the "medically needy", that is, those persons who meet the criteria for AFDC or SSI assistance with the exception of income, but whose medical expenses have reduced their income to qualify for such assistance.

Benefits. Every state Medicaid program must provide certain basic services: inpatient and outpatient hospital services, laboratory and X-ray services, skilled nursing facility services, home health care services, physicians' services, family planning services, rural health clinic services, and early and periodic screening, diagnosis and treatment services for individuals under twenty-one years of age.

States may also elect to provide certain "optional" services, such as medical or other remedial care provided by licensed practitioners within the scope of practice as defined under state law.[18]

No state presently reimburses clinical social workers as independent providers under Medicaid. Social work services are covered only if under the direction of a physician or within the range of services provided by mental health clinics.[19]

Medicaid in Hawaii. Hawaii offers one of the most comprehensive Medicaid programs in the country. It extends coverage to the "medically needy" and provides an array of optional services. Medicaid payments constitute the largest item of public welfare expenditures (see Tables 9 and 10).

The federal share of state medical vendor payments ranges from fifty per cent for states with relatively high per capita incomes to a statutory maximum of eighty-three per cent for states with relatively low per capita incomes. In fiscal year 1983 Hawaii was one of thirteen states to receive the minimum fifty per cent federal matching share.[20]

The most recent annual report of the Department of Social Services and Housing stated with regard to the high costs of Medicaid:[21]

> The cost of the medical assistance program continued to rise dramatically. Although the number of monthly average eligibles for the program decreased by 4% to 84,339, the cost of the program rose to nearly $158 million. The administration imposed drastic cuts in

Table 9

AVERAGE NUMBER OF INDIVIDUALS SERVED MONTHLY

Fiscal Year 1983

Medicaid

County	Individuals	Percentage of Population
Oahu	64,042	8%
Kauai	3,469	9%
Hawaii	13,304	14%
Maui	6,269	10%

MEDICAID SERVICES

Fiscal Year 1983

Number of Recipients (Unduplicated)

Type	Oahu	Hawaii	Maui	Kauai	State
Hospital Inpatient	11,662	2,773	1,086	907	16,428
Nursing Home Care	1,443	197	237	146	2,023
Intermediate Care Facility	1,325	347	261	141	2,074
Physician Services	63,874	15,484	6,255	3,883	89,496
Dental Service	33,849	8,013	3,074	1,860	46,796
Other Practitioners	8,513	1,715	430	289	10,947
Hospital Outpatient	25,283	4,312	2,278	2,374	34,247
Lab X-Ray	43,447	10,495	3,546	1,452	58,940
Home Health	317	86	67	32	502
Drug	58,879	14,072	5,399	3,593	81,943
Other Care	6,700	1,517	632	371	9,211
Family Planning	4,980	1,201	434	301	6,916
Screening Service	2,950	763	407	65	4,185
Sterilization	230	160	21	11	422
Medical Payments for Pensioners	2	3	2	3	10
Kaiser-DSSH Health Plan Project	2,146*	-	436*	-	2,582*

*average number of recipients per month

Source: Hawaii, Department of Social Services and Housing, Annual Report 1983.

Table 10

HOW PUBLIC WELFARE FUNDS WERE SPENT, BY COUNTY
Fiscal Year 1983

Oahu	Total $268,267,994	
43%	Medical Assistance (Medicaid)	$115,353,649
31%	Financial Assistance	$ 82,250,522
21%	Food Stamps	$ 55,251,385
3%	Administration	$ 9,013,546
2%	Services	$ 6,398,892
Hawaii	Total $54,243,452	
38%	Medical Assistance (Medicaid)	$20,809,231
32%	Financial Assistance	$17,147,079
26%	Food Stamps	$13,860,256
3%	Administration	$ 1,792,478
1%	Services	$ 634,408
Maui	Total $28,796,613	
47%	Medical Assistance (Medicaid)	$13,624,021
27%	Financial Assistance	$ 7,829,564
20%	Food Stamps	$ 5,810,477
4%	Administration	$ 995,294
2%	Services	$ 537,257
Kauai	Total $17,277,321	
48%	Medical Assistance (Medicaid)	$8,208,756
23%	Financial Assistance	$3,957,397
22%	Food Stamps	$3,861,248
5%	Administration	$ 835,436
2%	Services	$ 414,484

Source: Hawaii, Department of Social Services and Housing, Annual Report 1983.

the medical assistance budget in an effort to curb the rapid escalation of this program's costs.

In the category of "optional" services, the Department has approved the following professionals, who are regulated by statute, to participate as providers in the Medicaid program: dentists, psychologists, optometrists, opticians, podiatrists, physical therapists, occupational therapists, speech therapists, audiologists, pharmacists, and nurse-midwives. Including physicians, whose services are mandatory and who numbered 1,743 in 1983, there are approximately 3,000 Medicaid-certified providers in Hawaii. Among professionals who are licensed in Hawaii but who are not certified to participate in Medicaid in Hawaii are chiropractors, naturopaths, and private duty nurses. The Department has made a policy decision not to expand the Medicaid program to include those licensed professionals as providers.[22]

Mental health care under Medicaid is now provided by psychiatrists, psychologists, and mental health clinic staffs. The dollar amounts and number of providers reimbursed by Medicaid for the last five years is shown in Table 11.

In March 1984 the Hawaii Chapter of NASW submitted to the Department of Social Services and Housing a proposal entitled, "A Cost Containment Measure for the Delivery of Mental Health Services Under Medicaid". Its proposal was as follows:[23]

A COST CONTAINMENT MEASURE FOR THE DELIVERY OF
MENTAL HEALTH SERVICES UNDER MEDICAID

PROPOSAL PURPOSE:

The primary purpose of this proposal is to maintain coverage of high quality mental health care services under the Medicaid program while at the same time reducing costs.

PLAN:

Mental health care services would be reimbursed in the following manner:

1) A client/patient certified eligible under Medicaid in need of mental health care services would be seen by either a physician (psychiatrist) or a non-medical qualified provider (clinical social worker, licensed psychologist, or [registered psychiatric nurse, or marriage & family therapist, if acceptable eligibility criteria for these providers are established by the Department]) for the initial 3 visits for the purposes of intake, diagnostic assessment, development of a treatment plan, and referral.

The rate for reimbursement to any provider for these initial 3 visits will be $32 for each visit. (25% less than is currently being paid)

2) The provider completing the diagnostic assessment will determine whether the client/patient is in need of follow-up medical

Table 11

REIMBURSEMENTS FOR MENTAL HEALTH CARE UNDER MEDICAID

	1979	1980	1981	1982	1983
Psychiatrists					
Amount Paid Out	$1,895,466.74*	$2,062,845.01*	$2,790,980.58*	$2,775,122.96	$3,077,606.82
Number of Providers Reimbursed	124*	141*	140*	122	122
Psychologists					
Amount Paid Out	$ 573,537.23	$ 783,504.01	$1,114,684.53	$1,098,214.00	$1,157,445.52
Number of Providers Reimbursed	83	84	99	101	116
Mental Health Clinics					
Div. of Mental Health, Dept. of Health:					
Amount Paid Out				$ 112,541.96	$ 41,448.83
Number of Providers Reimbursed				22	18
Private Clinics:					
Amount Paid Out				$ 18,508.62	$ 60,872.61
Number of Providers Reimbursed				2	2
Total Dollars	$2,469,003.97	$2,846,349.02	$3,905,665.11	$4,004,387.54	$4,337,373.78
Total Providers	207	225	239	247	258

*Includes mental health clinics.

Source: Hawaii Medical Service Association, Medicaid Section.

services such as the prescription and monitoring of medication or of psychological testing and evaluation.

A) If it is determined to be medically necessary, the client/patient will be referred to an appropriate physician.

The rate of reimbursement to the physician provider will be $42 per visit (current rate).

B) If it is determined that the client/patient is in need of psychological testing and evaluation, the client/patient will be referred to an appropriate psychologist.

The rate of reimbursement to the psychologist provider will be $42 per visit (current rate).

C) Those clients/patients not requiring medical or psychological referrals, but in need of additional mental health care services may choose either a medical or a non-medical qualified provider.

The rate of reimbursement to any provider will be $32 per visit.

In support of the proposal, NASW-Hawaii argued that it was not necessary for patients to be seen for initial diagnosis and treatment planning by a physician. Their proposal, NASW-Hawaii claimed, followed current practice within the Mental Health Division, Department of Health, where intakes and assessments are completed by non-medical staff (usually clinical social workers) and only patients in need of medical services are referred to a physician. Generally, this referral is only for the prescription and monitoring of medications. NASW-Hawaii asserted that most follow-up therapy is still provided by the non-medical staff.

The position of the Department of Social Services and Housing is that Hawaii's Medicaid program has traditionally paralleled the federal Medicare requirements and benefits, and clinical social work services are not presently encompassed by Medicare. Moreover, social workers are not licensed practitioners of health care services in this State, as required under Medicaid provisions. In practical terms, the Department is reluctant to expand the scope of Medicaid services because of funding constraints. The Department acknowledges that while clinical social work services may be more cost-effective on a case-by-case basis, experience has demonstrated that expansion of services and practitioners merely serves to increase total Medicaid expenditures.[24]

Psychologists under Medicaid

Under Hawaii's Medicaid rules, psychotherapy provided by a licensed psychologist must be by physician referral. The applicable section states:[25]

> Psychological service provided by an authorized psychologist shall be limited to patients that are referred to a psychologist by a practicing physician, and to providing only the service requested

by the physician.

State law sets forth the following requirements for the licensing of psychologists:[26]

Every applicant for a license as a psychologist shall submit evidence satisfactory to the board that the applicant:

(1) Is professionally competent and has demonstrated knowledge in the practice of psychology.

(2) Holds a doctoral degree from an accredited institution of higher education with training and education in the field of psychology adequate to the satisfaction of the board.

(3) Holds a diplomate certificate in good standing granted by the American Board of Examiners in Professional Psychology.

(4) Has passed an examination as may be prescribed by the board.

Given that psychologists must have doctoral degrees, among other requirements, in order to be licensed and must have physician referral[27] to treat Medicaid patients, from the standpoint of the Medicaid program it would be incongruous to permit clinical social workers, even if they were licensed, to have independent practitioner status in the Medicaid program.

Waiver of Licensure. It has been suggested that the State request from the federal authorities a waiver from the requirement that Medicaid providers be licensed. According to the Health Care Financing Administration of the Department of Health and Human Services, which administers the Medicaid program at the federal level, the licensure requirement is not waiverable.[28]

Freedom of Choice. Both Medicare and Medicaid laws contain provisions permitting freedom of choice of providers to recipients of each program.[29] However, providers must be "qualified" to perform the services required. Thus, only those providers certified for participation in either program may be selected by their respective patients under the freedom of choice provisions.

To stem the rapid increase in Medicaid costs, the Omnibus Budget Reconciliation Act (OBRA) of 1981 permitted states to request waivers to limit freedom of choice in their Medicaid programs[30] and to conduct freedom of choice demonstration projects with Medicaid patients.[31] In 1983 the Hawaii legislature requested the Department of Social Services and Housing to study the feasibility of limiting freedom of choice to recipients under the Medicaid program.[32] Several avenues of restricting freedom of choice were presented, but none have as yet been implemented.[33]

Chapter 6

LICENSING

Professional and vocational regulation in Hawaii is governed by the Hawaii Regulatory Licensing Reform Act of 1977, chapter 26H, Hawaii Revised Statutes, known as the Sunset Law. This law incorporates both "sunset" and "sunrise" provisions to evaluate the need to continue an existing regulatory program ("sunset") or to establish a new regulatory program ("sunrise") for a profession or vocation. In enacting the Sunset Law, the Legislature adopted the following policies:[1]

(1) The regulation and licensing of professions and vocations by the State shall be undertaken only where reasonably necessary to protect the health, safety, or welfare of consumers of the services; the purpose of regulation shall be the protection of the public welfare and not that of the regulated profession or vocation.

(2) Where regulation of professions and vocations is reasonably necessary to protect consumers, government regulation in the form of full licensure or other restrictions on the professions or vocations should be retained or adopted.

(3) Professional and vocational regulation shall be imposed where necessary to protect consumers who, because of a variety of circumstances, may be at a disadvantage in choosing or relying on the provider of the services.

(4) Evidence of abuses by providers of the services shall be accorded great weight in determining whether government regulation is desirable.

(5) Professional and vocational regulation which artificially increases the costs of goods and services to the consumer should be avoided.

(6) Professional and vocational regulation should be eliminated where its benefits to consumers are outweighed by its costs to taxpayers.

(7) Regulation shall not unreasonably restrict entry into professions and vocations by all qualified persons.

In response to a Senate resolution adopted during the 1981 legislative session,[2] the then Department of Regulatory Agencies (now the Department of Commerce and Consumer Affairs) conducted a study on the need for regulation of the practice of social work. The findings and recommendations of the study were submitted to the Legislature in a report dated January 13, 1982.[3] The request for this study came after several bills for licensing social workers were introduced but failed to pass, and as required by section 26H-6, Hawaii Revised Statutes.

The following historical perspective of the pursuit of licensing by the Hawaii Chapter of the National Association of Social Workers (NASW) is based on a memorandum prepared by the Chapter.[4]

Licensing has long been a priority goal for NASW at both national and local levels. In 1964 the national NASW Delegate Assembly developed and approved a policy statement which defined "title protection" as its immediate goal. In 1969 this was revised to endorse the pursuit of licensing.

In 1973 the Hawaii Chapter of NASW began working on legal regulation and in 1974 the Executive Committee designated it as the top priority for the Chapter. For the 1975 legislative session the Chapter Personnel Standard & Practice Committee drafted a licensing bill which would license social workers on four levels (certified social worker, social worker, social work associate, and social work technician). The bill was introduced in both the House of Representatives and the Senate.[5] The House bill was amended to license only social workers engaged in private practice. The Senate bill was amended to include work experience equivalencies at all four levels for the education requirement. In neither house did the bills reach a final vote.

NASW-Hawaii felt that the primary reason the bills did not succeed was due to the opposition of the Hawaii Government Employees Association (HGEA) because of possible adverse effects on its members who were performing social work duties without having a Master of Social Work degree. Other problems concerned the definition of social work, the educational requirements, and little support and some active opposition by social workers.

In 1976 NASW-Hawaii reassessed the need for licensing and surveyed HGEA Unit 13 members in social work positions in the State. Two hundred thirty-five questionnaires were returned (an estimated 2/3 of the total social workers employed by the State). Fifty-seven per cent were found to oppose licensing, primarily because licensing appeared to discriminate against those social workers without a Master of Social Work degree. Questions were also raised regarding the definition of social work and the composition of professional standards.

In 1977 the Mental Association in Hawaii proposed a bill to license private mental health practitioners (master's or doctorate in clinical social work, psychiatric nursing, or marriage and family counseling plus a minimum of 3,000 hours of supervised clinical experience). The then president of NASW-Hawaii testified against the bill because it was limited to those social workers engaged in private practice doing psychotherapy. NASW-Hawaii maintained its position for the need to license social workers on all levels which would provide broader protection to the consumer. The bill was not reported out of committee.[6]

It should be noted that in 1977 the Sunset Law was passed.

In 1978 NASW-Hawaii drafted a three-level licensing bill (social work associate, social worker, and social worker in independent practice).[7] At a committee hearing, the Department of Regulatory Agencies testified against the bill, stating its opposition to the licensing of any new group that could not clearly demonstrate that the absence of regulation would significantly harm the health, safety, and welfare of the public, and further, that regulation should be solely for the protection of the public and not for the protection of the profession and should be as unrestricted as possible. The bill was not reported out of committee.

In 1979, based upon HGEA's opposition to licensing and the position of the Department of Regulatory Agencies, NASW-Hawaii drafted a "Registration Bill" that would ensure "title protection" rather than a licensing bill. Extensive efforts were made to work with the national NASW office regarding deviation from its "Standards for the Regulation of Social Work Practice", and a waiver was requested from the national board of directors to pursue certification (registration) rather than licensing. The national board did not grant the waiver and the Hawaii Chapter withdrew the bill from consideration.

In the fall of 1980 NASW-Hawaii conducted another licensing survey, attempting to reach all social workers in the State. Approximately two hundred questionnaires were returned. Among the findings were that: NASW-Hawaii members were very supportive of licensing efforts; many of those who were neutral or nonsupportive of licensing favored certification (title protection); and the private sector particularly favored licensing clinical social workers. Also, a large number of state social workers were opposed to licensing for several reasons: persons without a Master of Social Work degree did not want to take an examination; as state workers they did not identify with the profession as a whole and did not see any relevance of licensing to their own jobs; and many saw licensing (fees, examinations, continuing education requirements) as an imposition.

Thus in 1981 came the legislative request for the study of the licensing issue by the Department of Regulatory Agencies.

While the then Department of Regulatory Agencies recognized that the role and functions of social workers have significant impact on individuals and the general public who receive social work services, it saw the central issue of its study to be: "whether regulation and control are required to protect individuals and the public from the unprofessional, unauthorized and unqualified practice of social work and from professional misconduct arising from the authorized or unauthorized practice of social work."[8]

The Department's report analyzed the need for regulation under four criteria: potential harm to the public; consumer disadvantage; relationship between licensing and protection; and benefit-costs.

Potential Harm. The licensing of an occupation or profession is warranted only if there exists an identifiable potential danger to the public health, safety, or welfare arising from the operation or conduct of that occupation or profession. The exercise of the State's licensing powers is justified only when the potential harm is to the consuming public and not to the occupation or profession to be regulated.

NASW-Hawaii identified the following general categories of potential harm to consumers of social work services: unethical abuses resulting in monetary damages to clients; abuses resulting from inadequate training and experience, and doing indirect behavioral (emotional) damage to clients; and fraud and/or waste to the State of Hawaii and to private charities in committing the aforementioned abuses;

NASW-Hawaii could not present statistics with respect to dollar losses to individual clients or institutions. The Office of Consumer Protection could find no record of complaints against social workers of the nature indicated by NASW-Hawaii.

Consumer Disadvantage. Consumers do not require the protection of the State's licensing powers if the potential harm is one from which they can reasonably be expected to protect themselves. They are assumed to be knowledgeable and able to make rational choices and to assess the quality of services being provided them. Consumers are expected to be able to protect themselves unless they are at a disadvantage in selecting or dealing with the provider of services.

NASW-Hawaii claimed that consumer disadvantage was particularly significant among recipients of social work services since such clients are the economically or socially disadvantaged, children, the elderly, and the mentally ill. They frequently are not able to judge the quality of the services they receive. They are generally the least resourceful members of the community, unaware of their rights or unable to pursue the remedies due them. If they receive social services from a public agency, as is often the case, their motivation to complain would be very low.

The Department of Regulatory Agencies felt that NASW-Hawaii's argument indicated the need for some kind of consumer advocacy function for recipients of public services which is not the purpose of and would not be provided through the licensing process. The Department of Regulatory Agencies questioned whether clients whose motivation to complain is low to begin with would be any more inclined to carry their complaints to a licensing board or other public agency.

The Department of Regulatory Agencies found even less justification for licensing the private practitioner since NASW-Hawaii indicated that social workers in the private sector have a higher proportion of middle and upper-middle class clients who are able to pay for the services they receive and do not share the disadvantages characteristic of public sector clients.

Relationship Between Licensing and Protection. Presently, most social services are dispensed through public and private agencies. The consumer can seek recourse for complaints through these agencies, which have the responsibility over the performance of their social workers as employees. State social agencies establish the criteria for social worker positions, and these social workers are presumably properly supervised and subject to dismissal for fraud or other abuse.

The Department of Regulatory Agencies believed that the private practitioner would be most likely to feel threatened by a license being in jeopardy and would probably be the most affected, but their number appeared to be too small to sustain a licensing program.

Benefit-Costs. The exercise of the State's licensing powers may not be justified if the costs of doing so outweighs the benefits to be gained. The Department of Regulatory Agencies surmised that a regulatory program for social work would be financed from fees paid by the licensees and therefore no public funds would be spent. Since the cost for regulating the profession would be borne by the providers and not the consumers, the cost benefit factor to the State of Hawaii and to the consumer would not be a major consideration. However, the Department of Regulatory Agencies concluded, this would probably be true only if all social workers were to be licensed. If, however, only private practitioners were licensed, the program would probably not be cost-effective.

It was the Department of Regulatory Agency's position that licensing should not be utilized if less stringent measures would suffice. Because there was no evidence to substantiate the need for regulating social workers at the time of the study, the Department of Regulatory Agencies presented alternative methods of consumer protection for the Legislature to consider. Among the alternatives suggested as possibly more appropriate or more effective in protecting the consumer were: self-regulation through voluntary certification, registration or certification by a public authority, bonding requirements, and general and specialized laws.

The conclusion and recommendation of the Department of Regulatory Agency's study were as follows:[9]

> "Conclusion. Despite NASW's contention of abuses, there are no documented cases of fraud or of complaints involving social workers in Hawaii on public record. Thus, the primary criterion to judge the need for regulation is lacking. Moreover, public and private agencies which provide the majority of social services have established standards for hiring qualified social workers and provide proper supervision. While private practitioners may be more likely to be involved in abuses since they are not supervised by an agency, they generally attract clients who can afford to pay for services and would not meet the criterion of consumer disadvantage. It appears that if any class of social workers may need to be licensed, it should be limited to those in independent clinical practice but the number of such private practitioners would appear to be too small to consider licensure at the present time.
>
> "Recommendation. The DRA believes that what consumer problems which arise at the present time with regard to the provision of social services can be rectified by the application of existing general law aimed at deterring abuses. This method should be considered an effective alternative to any form of regulation, licensure or registration, since the present number of private practitioners and the lack of documented complaints do not warrant regulation."

In 1982 a bill to license social workers was again submitted to the Legislature.[10] The Senate Committee on Consumer Protection and Commerce passed the bill after, among other amendments, deleting the category of "licensed independent social worker (LISW)", leaving three remaining categories: (1) Licensed Clinical Social Worker (LCSW); (2) Licensed Master Social Worker (LMSW); and (3) Licensed Social Worker (LSW). The committee noted that the purpose of that amendment was to satisfy the Hawaii Government Employees Association which felt that four categories of social work were excessive but agreed to three categories. The committee report also noted that, at the hearing, the department of regulatory agencies reaffirmed its opposition to the creation of a part-time regulatory board and to licensure of social workers in general.

The Senate Committee on Ways and Means passed the bill after amendments deleting the board of social workers and requiring the Department of Regulatory Agencies to assume the function of regulating social workers. The bill was then sent to the House of Representatives where it died.

A similar bill was introduced in the House of Representatives but did not reach second reading.[11]

Regulation Nationally. Currently there are 33 states (plus Puerto Rico and the Virgin Islands) which have enacted laws regulating social work (see Table 12).

Puerto Rico was the first jurisdiction to enact a regulatory law--for licensing--in 1934. California was the first state to enact a regulatory law--for registration--in 1945. In 1968 California enacted a licensing law. In 1981 California amended its registration act to terminate the registration level in 1983, thus maintaining licensing as the sole regulatory measure.

In 1984 alone four states passed regulatory laws: Georgia, Iowa, Ohio, and West Virginia. However, Georgia's law becomes effective only when funded, and it was not funded this year.[12] Both the Iowa and Georgia NASW chapters, in pursuing passage of bills that did not meet the NASW model for licensure acts, obtained waivers of the NASW policy from the Board of Directors based on previous efforts to pass policy-based proposals.[13]

Hawaii is thus among a decreasing minority of states that does not regulate social workers.

Table 12

YEAR OF ENACTMENT AND TYPE OF STATE STATUTE

State (In Order of Enactment)	First	Amended	Type[1]
1. Puerto Rico	1934	1940	L
2. California	1945	1971[2]	R
	1968	1973	L
3. Rhode Island	1961	1984	R
4. Oklahoma	1965	1982	L
5. New York	1965		R
6. Virginia	1966	1975[3]	L
7. Illinois	1967		R
8. South Carolina	1968		R
9. Maine	1969	1978	R/L
10. Michigan	1972	1981	R
11. Louisiana	1972		L[4]
12. Utah	1972	1977	L
13. Kansas	1974	1980	L
14. Kentucky	1974	1976	L
15. Arkansas	1975	1981	L
16. South Dakota	1975		L
17. Maryland	1975	1983[5]	L
18. Colorado	1975	1981[6]	R/L[7]
19. Idaho	1976		L
20. Delaware	1976		L
21. Alabama	1977	1984	L
22. Oregon	1977	1979	R
23. Massachusetts	1977		L
24. Tennessee	1980	1984[8]	R
25. Texas	1981	1983	R
26. Florida	1981		R
27. Montana	1983		R
28. North Dakota	1983		L
29. North Carolina	1983		R
30. New Hampshire	1983		R
31. Virgin Islands	1983		L
32. Georgia	1984[9]		R
33. West Virginia	1984		R/L[10]
34. Iowa	1984		R
35. Ohio	1984		R/L[11]

[1]R=Registration of certification of a use of a title; L=License to practice.

[2]Act amended to end RSW registration level in 1983. No new registrations issued. (Cal.)

[3]Legislature dismantled Board of Behavioral Science Examiners in 1983. (Va.)

[4]Law actually grants "right to practice and use the title" but prohibits only misuse of title. (La.)

[5]Sunset review reenactment expanded coverage to public employees (Md.)

[6]Law reenacted following Sunset review. (Ala., Tenn., Colo.)

[7]Act establishes registration of MSW or BA + 2 years level and licensure of other levels. (Colo.)

[8]Law reenacted following Sunset review. (Tenn., Colo.)

[9]Implementation of act delayed pending appropriation act scheduled for 1984 session. (Ga.)

[10]Title protection for "Social Worker", "Graduate Social Worker", and "Certified Social Worker"; Licensure of "private, independent practice of social work." (W.Va.)

[11]Licenses practice of social work and authorizes registration of "Social Work Assistants". (Ohio)

Source: National Association of Social Workers.

Chapter 7

FINDINGS AND RECOMMENDATIONS

PART I. FINDINGS

Senate Resolution No. 143, S.D. 1, requested the Bureau to study the most feasible means of implementing legislative changes to permit the reimbursement of clinical social workers under Medicare, Medicaid, and Hawaii insurance laws. In conducting this study the Bureau, consistent with the committee report adopting the resolution, approached the matter as a feasibility study to examine the possibility and advisability of including clinical social workers in insurance plans.

The Bureau's findings are as follows:

1. The lack of insurance coverage appears to be a significant factor in restricting the services of private practice clinical social workers in Hawaii. While the response to the Bureau's survey may not be an accurate measure of the number of clinical social workers in private practice, it is indicative of the small size of the practitioner population. As the social workers' survey comments indicate, the lack of insurance coverage is a major, if not the primary, factor in creating limitations on private practice in Hawaii. On the other hand, HMSA reports little interest from individual members or employers for coverage of social worker services.

2. The premise that in some areas of the State clinical social workers are the only accessible mental health care providers is not borne out by listings in the telephone Yellow Pages. Greater accessibility to clinical social workers, particularly on the neighbor islands, appears to be due to the State's mental health clinics and services.

3. Fees of psychiatrists, psychologists, and clinical social workers are not in significantly, nor necessarily, descending order. For 1983 HMSA's records show that psychiatrists' and psychologists' fees were $80 and $70, respectively, for 50-minute visits. From 1981 through 1983 the allowance per case for psychologists exceeded that for psychiatrists. In the Bureau's survey, the twenty-three social workers who charged set fees averaged $56.70 for 60 minutes. NASW-Hawaii's current fee recommendation for individual or family therapy is $75 for 60 minutes.

4. The experience of HMSA, Hawaii's Medicaid program, and other health insurers has demonstrated that expansion of coverage to new groups of providers results in increased utilization of services, escalation of fees, and therefore increased total expenditures by insurers. Mental health benefits under various HMSA plans have annual ceilings ranging from $500 to $1,000. Most of HMSA's members who utilize mental health benefits do not now reach the annual ceilings. Expanding mental health coverage to clinical social worker services would, in all likelihood, result in increased costs and create the probability of increases in premiums.

5. Policies of other insurance companies and self-employed plans examined by the Bureau which cover the services of social workers all require that providers be licensed practitioners.

6. There are twelve freedom of choice states, ten of which mandate coverage of clinical social workers, and two of which require that coverage be offered. Seven states require physician referral. In all twelve states, social workers are regulated either by licensing or registration statutes.

7. One objection to mandating coverage of clinical social work services is that ERISA preempts any state law regulating benefits offered by employees. In 1982, Congress exempted the Hawaii Prepaid Health Act (chapter 393, Hawaii Revised Statutes), excluding any amendment enacted after September 2, 1974, from the provisions of ERISA. Whether a state can mandate employee benefits through its insurance laws is a question which the U.S. Supreme Court is expected to review in the case of Attorney General v. The Travelers Insurance Company, 463 N.E. 2d 548 (1984).

8. Under CHAMPUS, qualified clinical social workers are eligible to receive direct reimbursement for their services, independent of physician referral and supervision. Such direct reimbursement is an outgrowth of an experimental study conducted from 1980 to 1982. Hawaii was notable in the study in that it had the highest fee profile ($94 which exceeded the physician/psychiatrist fee profile of $88), and it had three of the four areas of highest incidence of claims.

9. Medicare is a federal program with uniform nation-wide regulations, over which Congress has sole legislative authority. No state can affect the administration of Medicare within its boundaries.

Medicare is exploring the possibility of direct reimbursement to clinical social workers in its Medicare Demonstration Project currently in progress in California.

10. Medicaid is a joint federal-state program administered by each state within federal guidelines. The threshold reason social work services are not covered under Hawaii's Medicaid program is that social workers are not licensed in Hawaii. Federal rules require that Medicaid providers be licensed, and this requirement cannot be waived. No state presently reimburses clinical social workers as independent providers under Medicaid.

Even without the licensure requirement, budgetary constraints dictate against any expansion of Medicaid services. Medicaid payments constitute the largest item of public welfare expenditures in Hawaii. The Department of Social Services and Housing has imposed drastic cuts in the Medicaid budget in order to curb the program's escalating costs. In keeping with its cost containment measures, the Department has elected not to expand the Medicaid program to include certain categories of otherwise-eligible licensed professionals as providers.

11. With regard to the issue of licensure, a 1982 study by the then Department of Regulatory Agencies (now the Department of Commerce and Consumer Affairs) concluded that the small number of private practitioners and the lack of documented complaints did not warrant the regulation of social workers.

PART II. RECOMMENDATIONS

1. If the Legislature wishes to have the services of clinical social workers included in the State's Medicaid program, it must first license social workers. Pursuant to section 26H-6, Hawaii Revised Statutes, any such new regulatory measure "shall be referred to the legislative auditor for analysis," that is, a sunrise study. The Legislature must realize, however, that the inclusion of additional licensed providers in the Medicaid program may require sufficient additional funding to the Department of Social Services and Housing, which administers the program, to cover the services of the additional providers.

2. The Legislature may mandate insurance coverage for clinical social workers under chapters 431 and 433, Hawaii Revised Statutes, as it did for psychologists. Because social workers are not licensed, the Legislature would then have to provide for some means, such as certification by a national professional organization as CHAMPUS does, to ensure that only qualified social workers would be eligible for reimbursement.

3. The Legislature may deem it wise to await the decision of the U.S. Supreme Court in the Travelers Insurance Company case referred to in finding number 5 as to the impact of mandated mental health benefits on employee benefit health plans under ERISA.

4. In considering the issue of cost-effectiveness, the Legislature may also wish to wait for the results of the California Medicare Demonstration Project described in chapter 5 of this study. The final report on the project is expected in 1986.

Chapter 2

1. Metropolitan Washington, D.C. Chapter, National Association of Social Workers, The Legal Regulation of the Social Work Profession, A Background Report (Washington: 1983), pp. 5-6.

2. James W. Callicutt and Pedro J. Lecca (eds.), Social Work and Mental Health (New York: The Free Press, 1983), p. 31.

3. NASW Standards for the Practice of Clinical Social Work, Professional Standards (Silver Spring, MD: 1984), p. 4.

4. Paul M. Saxton and Maureen Dunn, The Place of Clinical Social Work in Reimbursement for Health Care Services (Sacramento: National Association of Social Workers, California Chapter, 1983), p. 6.

5. U.S., Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook 1984-1985 Edition (Washington: 1984), p. 89.

6. An applicant must meet the following requirements for ACSW certification:

   (1) Be a member of the National Association of Social Workers.

   (2) Hold a master's or doctoral degree from a graduate school of social work accredited by the Council on Social Work Education.

   (3) Have accumulated at least two years of full-time experience in social work practice.

   (4) Submit three professional references.

   (5) Take the ACSW written examination which is administered twice a year by the Educational Testing Service.

7. National Association of Social Workers, Academy of Certified Social Workers Information Bulletin 1984-1985 (Silver Spring, MD: 1984), p. 5.

8. Ibid.

9. The eligibility criteria for listing in the Register are as follows:

   (1) Education: A master's or doctoral degree in social work from a graduate school accredited or recognized by the Council on Social Work Education.

   (2) Supervision: Two years of full-time experience or 3,000 hours accumulated over a period of not less than twenty-four months of post-master's clinical social work practice, which is supervised by a master's level social worker.

   (3) Currency: At least two years of full-time experience of 3,000 hours accumulated over a period of not less than twenty-four months of direct practice within the last ten years.

   (4) (a) ACSW: Be a current member of the Academy of Certified Social Workers (ACSW); or

   (b) Licensure or Certification: Be licensed or certified in a state at the appropriate level. The Board of the NASW Register of Clinical Social Workers, Application Material for the Fourth Edition of the NASW Register of Clinical Social Workers (Silver Spring, MD: 1984), p. 4.

   There have been three editions of the Register. The first was published in 1976, the second in 1978, and the third in 1982. The third edition listed over 9,000 clinical social workers. A fourth edition is due to be published in 1985.

10. Ibid.

11. In the questionnaire, Oahu was divided into "Honolulu" and "Oahu, other than Honolulu." Eleven respondents checked "Honolulu" only, four checked "Oahu, other than Honolulu," and four checked both.

Chapter 3

1. Health insurance, as discussed in this chapter, refers to fee-for-service coverage and not prepaid health care or health maintenance organization (HMO) coverage.

2. John G. Larson, Mandated Health Insurance Coverage--A Study of Review Mechanisms, Report to the Bureau of Insurance, State of Virginia (Richmond: Virginia Commonwealth University, 1979), pp. 21-22.

3. Thomas G. McGuire, Financing Psychotherapy, Costs, Effects, and Public Policy (Cambridge, Mass.: Ballinger Publishing Company, 1981), p. 34.

4. Hawaii Rev. Stat., chapter 393.

5. Ka Hulili, National Association of Social Workers, Hawaii Chapter, Newsletter, May 1984, p. 6.

6. There were 254 psychologists on the roster of the Board of Certification for Practicing Psychologists as of August 1984. Of the 254, 21 had neighbor island addresses, and 58 had out-of-state addresses.

   The number of psychiatrists was more difficult to ascertain. Physicians licensed to practice in Hawaii are not categorized by specialty. It was suggested by the executive secretary of the Board of Medical Examiners that a count of psychiatrists in the telephone Yellow Pages would be the most expedient way of approximating their numbers. There were found to be 81 psychiatrists listed in the Oahu Yellow Pages and 22 in the neighbor island directories, for a total of 103 psychiatrists thus listed.

7. Letter from Eugene Fujii, Hawaii Medical Service Association, to Claire Marumoto, September 11, 1984.

8. Letter from Fujii, February 21, 1985; telephone conversation with Fujii, February 25, 1985.

9. Larson, pp. 65-66.

10. Letter from Fujii, September 11, 1984. HMSA does, however, indirectly pay for the services of social workers when paying benefits for institutional services such as hospitals and skilled nursing facilities which employ social workers in the rendering of these services. Letter from Fujii, February 21, 1985.

11. Letter from Leila Whiting, Senior Staff Associate, National Association of Social Workers, to Claire Marumoto, August 27, 1984; brochure of Ronaele Whittington, D.S.W., Hawaii; responses to the Bureau's survey of clinical social workers in private practice in Hawaii.

12. Equitable Life Assurance Society of the United States, Lifetime Medical Expense Policy.

13. Metropolitan Life Insurance Co., Personal Health Insurance Policy.

14. The Bureau's survey of clinical social workers in private practice in Hawaii.

15. Telephone conversation with Ronaele Whittington, D.S.W.

16. For reasons of confidentiality, the names of the companies cannot be revealed. Hawaii, Department of Labor and Industrial Relations, Administrative Rules, sec. 12-1-52(a)(3).

17. Patrick H. DeLeon and Gary R. VandenBos, "The New Federal Health Care Frontiers: Cost Containment and 'Wellness,'" Psychotherapy in Private Practice, Summer 1983, p. 21.

18. The plans are:

    Government-Wide Plans--Open to All Employees and Annuitants: Indemnity Benefit Plan (Aetna Life), Service Benefit Plan (Blue Cross/Blue Shield);

    Employee Organization Plans--Open to All Employees and Annuitants: Alliance Health Benefit Plan, APWU (American Postal Workers Union) Plan, NAGE (National Association of Government Employees) Health Benefit Plan, NALC (National Association of Letter Carriers) Benefit Plan, Postal Supervisors Health Benefit Plan, Postmasters Benefit Plan;

    Employee Organization Plans--Limited to Specific Groups: AFGE (American Federation of Government Employees) Health Benefit Plan, Foreign Service Benefit Plan, GEBA (Government Employees Benefit Association) Health Benefit Plan, NAPUS (National Association of Postmasters of the United States), SAMBA (Special Agents Mutual Benefits Association [FBI]) Health Benefit Plan.

    Letter from Donald J. Devine, Director, U.S. Office of Personnel Management, to Senator Daniel K. Inouye, August 15, 1984; U.S., Office of Personnel Management, 1984 Enrollment Information Guide and Plan Comparison Chart, BRI 41-331 (Washington: January 1984).

    According to HMSA, the classifications (prepaid and fee-for-service) used by the federal government may be confusing. HMSA has two FEHBA plans, both of which are classified as prepaid, but one is actually fee-for-service. Letter from Fujii, February 21, 1985; telephone conversation with Fujii 25, 1985.

19. 29 U.S.C.A. sec. 1001 et seq. (1975).

20. 29 U.S.C.A. sec. 1144(b)(2)(A) (1975).

21. Standard Oil Company of California v. Agsalud, 442 F. Supp. 695 (1977); aff'd, 633 F.2d 760 (1980); aff'd 454 U.S. 801 (1981).

22. 29 U.S.C.A. sec. 1144(b)(5)(A) (Supp. 1983).

23. Attorney General v. The Travelers Insurance Company, 463 N.E.2d 548 (1984).

24. 463 N.E.2d at 551.

25. 53 U.S. Law Week 3323 (October 30, 1984); Wall Street Journal, October 30, 1984, p. 10.

Chapter 4

1. Letter from Eugene Fujii, Hawaii Medical Service Association, to Claire Marumoto, February 21, 1985.

2. Patrick H. DeLeon and Gary R. VandenBos, "The New Federal Health Care Frontiers: Cost Containment and 'Wellness'," Psychotherapy in Private Practice, Summer 1983, p. 19.

3. "Issue Paper, Hawaii: Tripler Enrollment and HMO Option," by Dane S. Wert (OCHAMPUS, March 16, 1983).

4. Pub. L. No. 377, 97th Cong., 2nd Sess., Sec. 741 (Dec. 21, 1982).

5. 49 Fed. Reg. 7561 (1984) (to be codified at 32 C.F.R. §199).

6. Ibid. (to be codified at 32 C.F.R. §199.12).

7. U.S., Department of Defense, Office of Civilian Health and Medical Program of the Uniformed Services, "Final Report on the CHAMPUS Experimental Study on Reimbursement of Clinical Social Workers, April 1 through September 30, 1982" (Aurora, Colo.: 1983).

8. Draft letters to Honorable Mark O. Hatfield, Chairman, Senate Appropriations Committee, and Honorable Jamie L. Whitten, Chairman, House Appropriations Committee, from John F. Beary III, Acting Assistant Secretary of Defense (Health Affairs), drafted by Theodore D. Wood, Director, Office of Civilian Health and Medical Program of the Uniformed Services, April 21, 1983, provided to Claire Marumoto by NASW-Hawaii.

9. CHAMPUS annual psychiatric reports, FY 81-FY 83.

10. The cost figures include deductibles and patient's cost share. Cost share varies with the category of beneficiary. For an active duty family, for example, the deductible is $50 per

patient per year or $100 per family maximum per year, and the patient's cost share is 20%. For retirees and their families, the deductible is the same as for active duty families but the cost share is 25%. For FY 1981, the government's share was estimated to be 74% of cost figures. Telephone conversation with Ken Zimmerman, Statistics Branch, OCHAMPUS, November 19, 1984.

11. The Hawaii Medical Service Association (HMSA) has been the CHAMPUS fiscal intermediary in Hawaii since CHAMPUS began in 1956. When asked for its comments on the CHAMPUS study, HMSA responded: "Data relating to claims volume may be distorted since at least one high volume provider submitted 1 claim for each service or session. Most providers submitted 1 claim per month per patient consolidating all of the services rendered during the month for that patient. The office of CHAMPUS may have been inconsistent in selecting data in categorization of psychotherapy services from Fiscal Intermediary to Fiscal Intermediary." Letter from Eugene Fujii, Hawaii Medical Service Association, to Claire Marumoto, September 11, 1984.

Chapter 5

1. 42 U.S.C.A. sec. 1395 et seq. (1983).

2. 42 U.S.C.A. sec. 1396 et seq. (1983).

3. The District of Columbia, Guam, Puerto Rico, the Virgin Islands, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and American Samoa also have Medicaid programs.

4. 42 U.S.C.A. sec. 1395c (1983).

5. U.S., Department of Health and Human Services, Health Care Financing Administration, Darwin Sawyer, et al., The Medicare and Medicaid Data Book, 1983 (Baltimore: 1983), p. 45.

6. 42 U.S.C.A. sec. 1395x(b)(2) and (h)(4) (1983).

7. A "home health agency" is a public agency or private organization which is primarily engaged in providing skilled nursing and other therapeutic services. 42 U.S.C.A. sec. 1395x(o)(1) (1983).

8. 42 U.S.C.A. sec. 1395x(m)(3)(1983).

9. 42 U.S.C.A. sec. 1395x(dd)(1)(D) (1983).

10. 42 U.S.C.A. sec. 1395x(dd)(2)(A)(i)(1983).

11. 42 U.S.C.A. sec. 1395x(dd)(2)(B)(i) (1983).

12. 42 U.S.C.A. sec. 1395x(cc)(1)(D) (1983).

13. 42 U.S.C.A. sec. 13951l note (1983).

14. "Design and Implementation of Direct Reimbursement of Clinical Social Workers Demonstration Project under Section 958 of Public Law 99-499--The Omnibus Reconciliation Act of 1980," Vol. II: Final Implementation Plan (SRI International, Menlo Park, California, July 1984), p. 2.

15. Ibid., p. 16.

16. Ibid., p. 21.

17. Ibid., p. iii.

18. 42 U.S.C.A. sec. 1396d(a)(6) (1983).

19. Gail E. Toff, Mental Health Benefits under Medicaid: A Survey of the States (Washington: George Washington University, Intergovernmental Health Policy Project, 1984); letter from Gail E. Toff to Claire Marumoto, undated, received August 23, 1984; letter from H. Rupert Theobald, Chief, Legislative Reference Bureau, Madison, Wisconsin, to Claire Marumoto, July 20, 1984).

20. U.S., Department of Health and Human Services, p. 126.

21. Hawaii, Department of Social Services and Housing, Annual Report 1983, (Honolulu: 1984), p. 6.

22. Telephone conversation with Masaru Oshiro, Medical Care Adminstration Office, Department of Social Services and Housing, November 7, 1983.

23. "A Cost Containment Measure for the Delivery of Mental Health Services under Medicaid" (National Association of Social Workers, Hawaii Chapter, March 1984), p. 1.

24. Clinical social workers are not alone in requesting to be included in the Medicaid program as reimbursable practitioners. Chiropractors, naturopaths, faith healers, masseurs, private nurses, etc. "are all clamoring to be participants in medicaid at no small expense to the State." Letter from Earl Motooka, Medical Care Administrator, Department of Social Services and Housing, to Claire Marumoto, November 19, 1984. Telephone conversation with Earl Motooka, November 21, 1984.

25. Hawaii, Department of Social Services and Housing, Administrative Rules, sec. 17-749-15(a)(5).

26. Hawaii Rev. Stat., sec. 465-7.

27. The purpose of an initial examination by a physician is to rule out any organic disorder which can only be determined by a physician. Interview with Earl Motooka, Medical Care Administrator, Department of Social Services and Housing, August 3, 1984.

28. Telephone conversation with Robert Bath, Pacific Area Representative, Health Care Financing Administration, Department of Health and Human Services, December 4, 1984.

29. 42 U.S.C.A. sec. 1395a and 1396a(a)(23) (1983).

30. 42 U.S.C.A. sec. 1315 (1983).

31. 42 U.S.C.A. sec. 1396n (1983).

32. House Resolution No. 18, Twelfth Legislature, 1983, State of Hawaii.

33. The recommendations were: obtaining waivers to deal with certain dental and prescription drug

providers on a "preferred provider" basis; obtaining a waiver to "lock-in" all Medicaid recipients to Health Maintenance Organizations on Kauai; a demonstration project to test the feasibility of case management in an HMO; and reviewing the current "lock-in" system of restricting Medicaid overutilizers to one primary physician. Hawaii, Department of Social Services and Housing, Report on House Resolution 18, undated, pp. 8-9. Telephone conversation with Earl Motooka, Medical Care Administrator, Department of Social Services and Housing, November 21, 1984.

Chapter 6

1. Hawaii Rev. Stat., sec. 26H-2.

2. Senate Resolution No. 120, S.D. 1, Eleventh Legislature, 1981, State of Hawaii.

3. Hawaii, Department of Regulatory Agencies, Relating to a Study of the Need for Regulation of the Practice of Social Work (Honolulu: 1982).

4. "Why Don't We Already Have Licensing of Social Workers in Hawaii?", National Association of Social Workers, Hawaii Chapter, undated.

5. House Bill No. 148 and Senate Bill No. 169, Eighth Legislature, 1975, State of Hawaii.

6. The bill was submitted in the Senate as Senate Bill No. 709 and in the House as House Bill No. 565, Ninth Legislature, 1977, State of Hawaii.

7. Senate Bill No. 2112-78, Ninth Legislature, 1978, State of Hawaii.

8. Hawaii, Department of Regulatory Agencies, p. 7.

9. Ibid. pp. 17-18.

10. Senate Bill No. 2286-82, Eleventh Legislature, 1982, State of Hawaii.

11. House Bill No. 2462-82, Eleventh Legislature, 1982, State of Hawaii.

12. Letter from Doug Carlyle, Office of Legislative Counsel, Atlanta, Georgia, to Claire Marumoto, July 20, 1984.

13. NASW News, May 1984, p. 3.

Appendix A

(To be made one and seven copies)

THE SENATE

TWELFTH ..... LEGISLATURE, 1984..

STATE OF HAWAII

S.R. NO. 143 S.D. 1

SENATE RESOLUTION

REQUESTING A STUDY TO REVIEW THE REIMBURSEMENT OF CLINICAL SOCIAL WORKERS UNDER MEDICAID AND MEDICARE AND PRESENT INSURANCE LAWS.

WHEREAS, federal legislation currently allows the reimbursement of licensed physicians (psychiatrists) and licensed psychologists for the provision of clinical mental health care under the Medicaid and Medicare programs; and

WHEREAS, chapters 431 and 433, Hawaii Revised Statutes, currently provide for the reimbursement of licensed physicians (psychiatrists) for services which would be covered by an individual or group accident or sickness policy and hospital and medical service plan contract; and

WHEREAS, the Legislature, during this session, has passed and sent to the Governor a bill to require similar reimbursements for services of licensed psychologists; and

WHEREAS, there is no such uniformity of insurance coverage for the services provided by clinical social workers in either federal or state insurance plans; and

WHEREAS, clinical social workers are, in some areas of the State, the only mental health care providers accessible, and consumers are being unduly deprived of their services; and

WHEREAS, several other states have "Freedom of Choice" or "Equal Access" legislation, mandating coverage of all qualified mental health care professionals, including clinical social workers; and

WHEREAS, the fees that clinical social workers generally charge for their services are less than for comparable services provided by licensed physicians or licensed psychologists; and

WHEREAS, in Hawaii, consumers of mental health care are currently being deprived of a choice of qualified professional providers; now, therefore,

BE IT RESOLVED by the Senate of the Twelfth Legislature of the State of Hawaii, Regular Session of 1984, that the Legislative Reference Bureau is requested to conduct a study of the most feasible means of implementing legislative changes to allow for the reimbursement of clinical social workers under the federal Medicaid and Medicare plans; under the requirements of chapters 431 and 433, Hawaii Revised Statutes, and reimbursements under self-insured employer plans and those plans offered by health maintenance organizations (HMO's); and

BE IT FURTHER RESOLVED that the study address, but not be limited to:

(1) What insurance companies or plans, including self-insured employer plans and those plans offered by health maintenance organizations (HMO's), in Hawaii currently allow the reimbursement of clinical social workers;

(2) What insurance companies or plans, including self-insured employer plans and those plans offered by health maintenance organizations (HMO's), in Hawaii do not allow the reimbursement of clinical social workers and what are the reasons for such exclusions;

(3) What states have "Freedom of Choice" or "Equal Access" legislation which includes clinical social workers as providers and what is the nature of such laws;

(4) What states currently reimburse clinical social workers under the federal Medicaid and Medicare programs; and

(5) What obstacles, if any, are there to the reimbursement of clinical social workers under the federal Medicaid and Medicare programs and to amending chapter 431 and 433, Hawaii Revised Statutes, to include clinical social workers as providers of mental health care who may be reimbursed under health insurance policies;

and

BE IT FURTHER RESOLVED that the Insurance Division of the Department of Commerce and Consumer Affairs, Department of Social Services and Housing, National Association of Social Workers, Inc., Hawaii Chapter, and Hawaii Society for Clinical Social Work, Inc., cooperate with the Legislative Reference Bureau in the conduct of the study; and

BE IT FURTHER RESOLVED that certified copies of this Resolution be transmitted to the Director of the Legislative Reference Bureau, Director of Commerce and Consumer Affairs, Director of Social Services, National Association of Social Workers, Inc., Hawaii Chapter, and Hawaii Society for Clinical Social Work, Inc.

Appendix B-1

SURVEY RESPONSES

Practitioners' comments on direct reimbursement:

Will help establish freedom of choice. Will increase competition amongst providers. Will reduce costs in general. Will broaden treatment options.

In order to build a private practice without recourse to third party payments, I have had to make the decision to set my fee considerably below the "going rate" for such professional services. Even at $25 per hour, however, this is a hardship for my clients and prospective clients. My training as a social worker has prepared me to give specialized services to clients that many psychiatrists and psychologists are neither well-trained nor interested in providing, namely, knowledge of community resources and linkages to these services, "systems" approval to the impact of the larger environment on the client(s), including contact, for example, with a child's school, and a problem-solving approach within the family that provides practical strategies for hope and change to troubled families. Families that are seeking help have a right to optional choice in selecting a provider of mental health services just as they do in choosing medical services and if this provider has met the standards set for his/her profession, there is no reason to assume that services will be any less professional than those of other mental health practitioners. Social workers deserve to be reimbursed for professional services at the same rates and fee scales as other mental health practitioners.

I feel it is essential if the cost of medical care is to be contained. Many research projects have shown that when people receive mental health care other medical costs are drastically reduced. In addition I feel the cost of mental health care can be lowered by including social workers as direct providers.

I also have a position at a mental health clinic. My current caseload is around 30 patients. I am not supervised, am responsible for all aspects of appropriate treatment including referring out to others. Identical to what psychologists and psychiatrists do in private. I am responsible for writing disability reports (signed only by M.D.'s). The State has me and others like me stuck working in a system taking care of what most private providers do not desire as patients. It is interesting that we are qualified and able to provide the services at controlled rates, but not as independent practitioners. We only provide contrast to treatment. I would also like to see a mechanism for better control of providers. Recently a social worker opened up practice in California. California had no office here to obtain information to deny his application for license. They are not in the process of revoking his license. He had a poor record here in Hawaii.

I have not been pursuing my private practice because of primary job requirements. The one family I saw would not have been able to afford $25 or less for a session and were referred to an agency.

Many of my clients have insurance coverage for psychiatrists and psychologists--but choose to see me anyway (fortunately).

Social workers should qualify for direct reimbursement. They are qualified to do the psychotherapy that other professionals are reimbursed for. Social workers' fees are less and can be more cost-effective for reimbursement sources.

Clinical social workers have been demonstrated to be capable of independent practice. See CHAMPUS study. If we were truly interested in open competition in the mental health marketplace, there would be recognition of social workers. If we were truly interested in freedom of choice for clients and interested in reaching all clients to get them well, there would be recognition of a variety of health care professionals.

This would be a cost-savings measure for the State. Clients should have freedom of choice as to therapist.

Like in California, Hawaii social workers have a right and should be eligible for third party insurance payments other than CHAMPUS. It is an important social issue for equitable services across all of the helping professions.

I feel in all fairness to the community and to the social workers who wish to pursue a private practice, that consideration be given for the reimbursement to clinical social workers.

Clearly, it would be of great benefit to the State and to all citizens to provide client reimbursement to cinical social workers. Our training is equal, if not superior, to other helping professions and our fees are cheaper.

Its worked well with CHAMPUS clients so it should be standard throughout insurance companies.

I work in a private agency seeing clients daily in the role of counselor/case manager. I want a private practice. I want to be licensed by the State of Hawaii so I may have my services reimbursable by HMSA and other insurance companies.

I have been employed as a clinical social worker in a private nonprofit agency for 10 years where my work has been reputable and proven more than satisfactory. Through this employment, I have provided services to hundreds of clients. It baffles me, therefore, to have direct reimbursement an issue.

Direct reimbursement would certainly be helpful towards paying me what I'm worth. I would hope it would have an impact on "quality control" of services provided by our profession.

A most needed resource, giving many people access to a wide variety of practice methodologies and increasing the insured person's range and freedom of choice.

I think direct reimbursement to clinical social workers is an appropriate method of funding quality mental health services. It is far more cost-effective than our current set-up. More clients would utilize services of clinical social workers, rather than psychologists and psychiatrists, if insurance payments could be made directly to the clinical social workers, thus saving the insurance company money.

Appendix B-2

SURVEY RESPONSES

Practitioners' comments on clients/patients:

Client is now functional in occupation but needs further Rx re family and social problems; is under extended payment schedule.

Seeking help in developing social/emotional problem-solving skill particularly concerning child management.

Client separated for two years, very recently divorced. Working on grief issues re divorce and concerns about 7 year old daughter's fears and anxiety about separation. Child was visiting father on mainland during summer; now returned to adjusting to new school. Expect to see child soon for play therapy. Mother's parenting ability lowered by finality of divorce but motivated to improve relationship with child. Is open to supportive intervention.

Troubled marital relationship and mother-middle child relationship. Mother sexually molested by uncle as a child; initially very resistant to Rx but have recently broken some barriers; some improvement in mother-child relationship through several sessions with mother and child cojointly. Father travels and hasn't been available for Rx although this will be necessary if family health is to be improved.

Seriously impaired family that will need long-term support. Child in a supportive school environment. Working on networking and assertiveness skills with mother; working on improving communication between marital pair.

Highly motivated client, capable of looking introspectively at faulty parenting of her child, recognizing similarities with her own parenting; quickly learning new skills and strategies in guidance and discipline. Anticipate termination within next few months with "check-up" in 6 months.

Mother is an incest victim by her father; recently raped by acquaintance of husband; husband subsequently raped wife. Couple is immature and extremely dependent; husband physically abused as child. Through outreach work with this family, I was able to establish trusting relationship and both responded favorably--mother became less depressed, more assertive, joined AMAC group; father became less hostile, more expressive of feelings. Family recently unable to pay for services; have referred to community Mental Health Clinic, completed termination (at reduced fee) and aided in their making transfer. They have informed me that they are continuing to get Rx.

Patient is on Medicare only and due to no coverage has declined to return although family wants her to do so.

Client makes small regular payments on bill. Family has helped with expense travel (client happens to be on neighbor island and is treated there--the therapist flying in from Oahu).

Family has been very aware of its insurance limitations and keeps a close eye on it--money and coverages is always a factor.

Patient was seen on a cash basis because I am not a CHAMPUS provider and not eligible for HMSA or other insurance plans. Would continue further counseling if had insurance that covered social worker.

Services to client paid for through a contract with the county.

Tx (Rx) lasted 9 months. Spouse and child abuse by husband. He also abused alcohol--now in residential alcohol Tx (Rx) in military. She went home to mom although plan is to reunite.

Had Kaiser coverage (and CHAMPUS). However, CHAMPUS refuses to pay if client has Kaiser. I serviced anyway. CHAMPUS and Kaiser refused to pay. She terminated Kaiser 8/1/84. CHAMPUS now pays for current Tx (Rx) with me. Original six sessions now outstanding re collection.

Client has HMSA--which does not cover S.W. fee.

This patient can and does pay for therapy. She would not be able to if she quit prostitution. She would have to seek counseling elsewhere if she had no income, as all drug/alcohol programs are tied to in-patient "halfway house" concepts. State coverage of private social work practitioners' fees would probably result in this girl leaving the field of prostitution.

This is the category of patient which should be covered by disability benefits that include coverage for private practice. Social workers--in other words I should be able to bill medicare/medicaid for his treatment. As it is, I provide the person with free treatment.

Insurance would have been a great boon in this case, as the patient has had severe and chronic financial problems. I have seen him many times for no fee and have never charged him over $50 per visit.

This client sought counseling recently from a community agency but felt they knew little about the treatment of incest and/or sexual assault victims. She sought specialized treatment from the Sex Abuse Treatment Center and was referred to me for long-term counseling (vs. crisis intervention via-SATC).

This client was seen by a school counselor, CPS worker, and psych as a child, however, none removed her from the home where the incest continued until she moved out at age 18. She then sought specialized treatment on her own and was referred to me for long-term follow-up by the Sex Abuse Treatment Center.

This client would be unable to continue in therapy without CHAMPUS coverage due to financial difficulties, i.e., she is an emancipated minor finishing her senior year in high school and currently 2 months pregnant.