MAINE STATE LEGISLATURE

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Bureau of Insurance

A Report to the Joint Standing Committee on Insurance and Financial Services of the 122nd Maine Legislature

Review and Evaluation of
LD 27, An Act to Require That Licensed Pastoral Counselors Be Recognized as Licensed Professionals for Purposes of Insurance Reimbursement

And
LD 28, An Act to Require That Mental Health Workers with Family Therapist Licenses Be Recognized as Licensed Professionals for Purposes of Insurance Reimbursement

April 15, 2005

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I. Executive Summary

The Joint Standing Committee on Insurance and Financial Services of the 122nd Maine Legislature directed the Bureau of Insurance to review LD 27, An Act to Require That Licensed Pastoral Counselors Be Recognized as Licensed Professionals for Purposes of Insurance Reimbursement, and LD 28, An Act to Require That Mental Health Workers with Family Therapist Licenses Be Recognized as Licensed Professionals for Purposes of Insurance Reimbursement. The review was conducted using the requirements stipulated under 24-A M.R.S.A., §2752. This review was a collaborative effort of NovaRest, Inc. (NovaRest) and the Maine Bureau of Insurance (Bureau).

Both bills would amend sections of Maine Law pertaining to health policies and HMOs. LD 27 would require all health care plans to reimburse for mental health services provided by licensed pastoral counselors. LD 28 would require all health care plans to reimburse for mental health services provided by licensed marriage and family therapists. Both bills would apply to all policies and certificates issued or renewed on or after January 1, 2006.

There are currently 116 licensed marriage and family therapists and 20 pastoral counselors licensed in Maine. Some of these professionals may also be licensed as another type of counselor.

Although it can be anticipated that the number of licensed pastoral counselors and licensed marriage and family therapists might increase if these bills were passed, it is not anticipated that there would be a significant impact on insurance premiums from either or from the two combined. We would expect the combined impact to be less than 0.01%.

All counselors covered under the proposed mandate are required to meet state licensing standards. The law that establishes the licensing procedure states, "The license categories 'licensed clinical professional counselor,' 'licensed pastoral counselor' and 'licensed marriage and family therapist' are of equivalent clinical status. Clinical status grants the ability to diagnose and treat mental health disorders." [1] The law gives the Board of Counseling Professionals Licensure the authority to establish continuing education and supervision requirements. Additionally, the board has the authority to suspend, revoke, or refuse to renew a license for several reasons such as incompetence or unprofessional conduct. Detailed requirements can be found in Appendix C.

Approximately 14 states mandate reimbursement of marriage and family therapists. Two states, New Hampshire and North Carolina, require coverage of pastoral counselors. Three states may have pending legislation for Marriage & Family: Hawaii, Idaho and Oregon. Florida has

[1] 32 M.R.S.A. § 13858

legislation pending for pastoral counselors.

II. Background

The Joint Standing Committee on Insurance and Financial Services of the 122nd Maine Legislature directed the Bureau of Insurance to review LD 27, An Act to Require That Licensed Pastoral Counselors Be Recognized as Licensed Professionals for Purposes of Insurance Reimbursement, and LD 28, An Act to Require That Mental Health Workers with Family Therapist Licenses Be Recognized as Licensed Professionals for Purposes of Insurance Reimbursement. The review was conducted using the requirements stipulated under 24-A M.R.S.A., §2752. This review was a collaborative effort of NovaRest, Inc. (NovaRest) and the Maine Bureau of Insurance (Bureau).

Current Law

Current Maine law requires mental health benefit parity for listed mental illnesses for health plans sponsored by large groups (employee groups with more than 20 employees). Fee-for-service plans covering more than 20 employees and all HMO plans must also meet the minimum benefit standards established by rule for all other mental illnesses. Also, insurers and HMOs writing individual health plans are required to offer two standardized plans that include mental health benefits established in Bureau of Insurance Rule 750.

All policies that include health insurance coverage for counseling must cover those services whether performed by a physician, a psychologist, a psychiatrist, a certified social worker, a licensed clinical professional counselor or a psychiatric nurse.

A mandated offer is required that, at the policyholder's option, broadens the required coverage of counseling professionals to include all state-licensed, masters level counselors with at least two years experience. There is an additional charge for this coverage. For example, Anthem charges 15.5% more for a single coverage and 6.6% more for family coverage for individual policies when this rider is added.

LD 27

LD 27 would amend sections of Maine Law pertaining to health policies and HMOs. This bill would require that all health care plans reimburse for counseling services provided by licensed pastoral counselors licensed in this State. The bill would apply to all policies and certificates issued or renewed on or after January 1, 2006.

The licensing law defines “pastoral counselor” as follows:

> "Pastoral counselor" means an individual who is trained and certified to provide for a fee, monetary or otherwise, pastoral counseling, which is ministry to individuals, families, couples, groups, organizations and the general public involving the application of principles and procedures of counseling to assess and treat intrapersonal and interpersonal problems and other dysfunctional behavior of a social and spiritual nature, and to assist in the overall development and healing process of those served. [2]

LD 28

LD 28 would amend sections of Maine Law pertaining to health policies and HMOs. This bill requires that all health care plans reimburse for counseling services provided by licensed marriage and family therapists. The bill applies to all policies and certificates issued or renewed on or after January 1, 2006.

The licensing law defines “marriage and family therapist” as follows:

> "Marriage and family therapist" means a person who renders or offers to render for a fee, monetary or otherwise, marital and family therapy services.

[2] 32 M.R.S.A. § 13851, sub-§ 7-A.

III. Social Impact

A. SOCIAL IMPACT OF MANDATING THE BENEFIT

1. *The extent to which the treatment or service is utilized by a significant portion of the population.*

Mental health and counseling services are used by a significant portion of the population. According to the Center for Mental Health Services, between 2.8% and 5.3% of Maine residents have serious mental health conditions.[3] They also estimate that 22% of the population will need mental health care at some point in their lives. Previous testimony for LD 1158, provided by the Maine Psychological Association, indicates that the incidence of anorexia and bulimia nervosa among young women in the United States is 0.5% and 2.5%, respectively. The proposed mandates would not expand the amount of coverage, but would provide those persons who have existing coverage with a broader choice of providers.

2. *The extent to which the service or treatment is available to the population.*

The following chart shows the number of clinical counseling professionals currently licensed in Maine.[4] The charts included in Appendix D show the distribution of the counselors affected by the proposed mandates by county, as well as the distribution of professionals currently eligible for reimbursement under Maine insurance law. It should be noted that there are counselors licensed in more than one category and those would get counted twice on the charts. The chart does not include licensed providers who have moved out of the state.

3 MENTAL HEALTH NEWS ALERT-GRANT OPPORTUNITIES, 1999, PAGE 13.
4 SOURCE: LICENSING BOARD, DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION AND 2002 POPULATION ESTIMATES FROM THE OFFICE OF VITAL RECORDS, DEPARTMENT OF HEALTH AND HUMAN SERVICES.

PROFESSION	CURRENTLY MANDATED	MANDATED BY LD 27 OR 28	# LICENSED IN MAINE[5]
PSYCHIATRIST	YES	NO	207
PSYCHOLOGIST	YES	NO	564
PSYCHIATRIC NURSE	YES	NO	138
LICENSED CLINICAL SOCIAL WORKER	YES	NO	1842
LICENSED CLINICAL PROFESSIONAL COUNSELOR	YES	NO	750
LICENSED MARRIAGE AND FAMILY THERAPIST	NO	YES	116
LICENSED PASTORAL COUNSELOR	NO	YES	20

3. *The extent to which insurance coverage for this treatment or service is already available;*

All policies that include health insurance coverage for counseling must cover those benefits performed by a physician, psychologist, psychiatrist, certified social worker, licensed clinical professional counselor or psychiatric nurse. Current law also mandates the availability of coverage that broadens the coverage to include all state-licensed, masters level counselors with at least two years experience. LD 27 and LD 28 would extend the mandated providers to licensed pastoral counselors and licensed marriage and family therapists, which represent less than 4% of licensed mental health providers in Maine. Many insurance policies in Maine currently cover licensed pastoral counselors and licensed marriage and family therapists and would not be affected.

4. *If coverage is not generally available, the extent to which the lack of coverage results in a person being unable to obtain the necessary health care treatment.*

[5] PSYCHIATRIST: DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF DATA, RESEARCH AND VITAL STATISTICS DATED 12/31/2000; ALL OTHER: DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION, OFFICE OF LICENSING AND REGISTRATION

Coverage is available for persons with mental health coverage, but does not usually include all classes of providers included in the proposed mandates. The proposed mandates would not expand the amount of coverage, but would provide those persons who have existing coverage with a broader choice of providers.

5. *If coverage is not generally available, the extent to which the lack of coverage involves unreasonable financial hardship.*

The proposed mandates do not expand coverage, so would not affect the ability of persons to receive treatment.

6. *The level of public demand and the level of demand from providers for this treatment or service.*

The treatment and services are currently available; the mandate only expands the covered providers.

7. *The level of public demand and the level of demand from the providers for individual or group coverage of this treatment.*

Testimony or other communication supporting this legislation was received from licensed pastoral counselors Denis Noonan,[6] Joseph Roberts[7], Richard Hall[8], Gary Wehrwein[9], and Donald Hodgson,[10] and from family therapists James Gill[11], and H. Michael Alpren.[12] In addition testimony supporting this legislation was received from the Executive Director of the American Association of Pastoral Counselors,[13] from the Northeast Region of the American Association of Pastoral Counselors[14] and from the Roman Catholic Diocese of Portland.[15]

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[6] Noonan, Denis, Letter dated January 22, 2005
[7] Roberts, Joseph, email dated January 30, 2005
[8] Hall, Richard, email dated January 30, 2005
[9] Wehrwein, Gary, email dated January 31, 2005
[10] Hodgson, Donald, email dated January 31, 2005
[11] Gill, James, Testimony dated January 27, 2005
[12] Alpren, H. Michael, testimony dated February 1, 2005
[13] Ronshiem, Douglas, Letter dated January 31, 2005
[14] Reynolds, David, email dated January 31, 2005

8. *The level of interest in and the extent to which collective bargaining organizations are negotiating privately for the inclusion of this coverage by group plans.*

No information is available.

9. *The likelihood of meeting a consumer need as evidenced by the experience in other states.*

Fourteen states mandate reimbursement of marriage and family therapists: Alaska, California, Colorado, Connecticut, Florida, Kentucky, Maryland, Nevada, New Hampshire, North Carolina, Rhode Island, Texas, Virginia and Washington. Two states, New Hampshire and North Carolina, require coverage of pastoral counselors. Three may have pending legislation for marriage and family therapists -- Hawaii, Idaho and Oregon. Florida has legislation pending for pastoral counselors.

Pastoral counselors are able to work with a state license in most states. Only six states license the title "pastoral counselor." They are: Arkansas, Kentucky, Maine, New Hampshire, North Carolina and Tennessee. In many other states, pastoral counselors may qualify for licensure as marriage and family therapists or as professional counselors.

Virginia's analysis of state mandates indicates that the percentage of premiums reported by carriers for marriage and family therapists was 0.12% for individual coverage, while for group coverage it was 0.11% for single employees and 0.08% for family coverage. However, the percentage of claims reported for marriage and family therapists was less than 0.01% for individual coverage and 0.01% for group coverage.[16]

A report published by the Texas Department of Insurance in December 1998 reported that, having collected mandate claims costs and premium information from Texas insurers and HMOs since 1989, claims from marriage and family therapists added an imperceptible cost, if any, to the average group health insurance premium in both 1995 and 1996.

10. *The relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit.*

[15] Mutty, Marc, Testimony dated February 1, 2005
[16] Report on the State Corporation Commission on the Financial Impact on Health Insurance Benefits and Providers Pursuant to Section 38.2-3419.1 of the Code of Virginia:2003 Reporting Period, http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD1102004/$file/RD110_2004.pdf

No information is available.

11. *Alternatives to meeting the identified need.*

The current mandates do provide coverage for the services included in the proposed mandates. The proposed mandates do not expand the scope of that coverage, but provide a broader choice of providers to the insurance consumer.

12. *Whether the benefit is a medical or a broader social need and whether it is inconsistent with the role of insurance and the concept of managed care.*

The benefit expands the providers that already provide this medical need. It is consistent with the role of insurance to cover the benefits provided and it is not inconsistent that insurance cover these licensed providers.

Managed care organizations contract with the spectrum of providers that they feel best service their members for the services covered. Managed care organizations will be able to utilize the same utilization management policies that are used for other providers.

13. *The impact of any social stigma attached to the benefit upon the market.*

It has been noted anecdotally that less stigma may be attached to seeing a pastoral counselor or marriage and family therapist as opposed to a psychiatrist, psychologist or psychiatric nurse. If this is true, then the proposed mandates could help remove this stigma so more persons might seek treatment. Currently, the only covered practitioners that are not labeled as “psychiatric” or “psychologist” are licensed clinical social worker (LCSW) and licensed professional clinical counselors. There are over 1,800 LCSWs in Maine and over 700 Licensed Clinical Professional Counselors in Maine.

14. *The impact of this benefit upon the other benefits currently offered.*

There should be no impact on other benefits currently offered.

15. *The impact of the benefit as it relates to employers shifting to self-insurance and the extent to which the benefit is currently being offered by employers with self-insured plans.*

Traditionally, state mandates are listed as one of the causes for companies choosing to self-

insure. If utilization of services increased and cost increased, it may create an incentive for businesses to shift to self-insurance.

16. *The impact of making the benefit applicable to the state employee health insurance program.*

The state employee health insurance plan currently only covers those required to be reimbursed: physicians, psychologists, psychiatrists, certified social workers, licensed clinical professional counselors or psychiatric nurses. Anthem Blue Cross Blue Shield, the current carrier for the state employee plan, estimated that the average increase to premium for the state employee health plan to be 0.02% for LD 27, pastoral counselors and 0.04% for LD 28, marriage and family therapists.

IV. Financial Impact

B. FINANCIAL IMPACT OF MANDATING BENEFITS.

1. *The extent to which the proposed insurance coverage would increase or decrease the cost of the service or treatment over the next five years.*

Generally, it appears that when a lower cost provider becomes reimbursable, their cost tends to rise toward the cost of other providers. It is unknown if this will occur under the proposed mandates.

2. *The extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next five years.*

With about 136 professionals included in the categories covered by the proposed mandates, it seems unlikely that utilization of services could increase to any significant extent if the mandates were enacted. It is not known if any inappropriate use would increase.

3. *The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service.*

If used as an alternative to more expensive treatment, these mandates may actually cause a decrease in medical costs. No recent statistics of provider costs by category could be found for Maine, but in Massachusetts, treatment from social workers seems to be reimbursed at the same rates as for marriage and family therapists, while treatment by licensed psychologists costs insurers an additional $5 to $10 per session, on average.[17]

The American Association for Marriage and Family Therapy (AAMFT) states that licensed marriage and family therapists typically practice short term therapy: 12 sessions on average. They also state that "nearly 65.6% of the cases are completed within 20 sessions, and 87.9% within 50 sessions" and that "marital/couples therapy (11.5 sessions) and family therapy (9 sessions) both require less time than the average individuated treatment (13

[17] Division of Health Care Finance and Policy Commonwealth of Massachusetts, "Review and Evaluation of Proposed Legislation Related to Marriage and Family Therapy: Senate Bill No. 911 and House Bill No. 2822", January 2005

sessions).” [18]

4. *The methods which will be instituted to manage the utilization and costs of the proposed mandates.*

Most policies now contain utilization review features or managed care networks, which require approval before a treatment is considered eligible for reimbursement.

5. *The extent to which insurance coverage may affect the number and types of providers over the next five years.*

In general, the number of providers of a service increases with the availability of reimbursement for that service. In 1995, prior to mandating coverage for Licensed Clinical Professional Counselors, it was reported that there were 474 Licensed Clinical Professional Counselors in Maine[19] and currently it is reported that there are 750.[20] This may indicate that mandating the coverage of a category of providers results in an increase in the number of those providers.

6. *The extent to which the insurance coverage of the health care service or provider may be reasonably expected to increase or decrease the insurance premium or administrative expenses of policyholders.*

The providers affected by the mandate are less than 4% of the licensed mental health providers licensed in Maine. Because this mandate does not result in additional coverage but only adds a small number of additional providers to choose from, there does not appear to be much justification for large increases in premium. There may be an administrative expense to add these providers to existing managed care networks.

[18] Division of Health Care Finance and Policy Commonwealth of Massachusetts, “Review and Evaluation of Proposed Legislation Related to Marriage and Family Therapy: Senate Bill No. 911 and House Bill No. 2822”, January 2005
[19] Bureau of Insurance review of LD 68, April 1995
[20] Data received from the Professional and Financial Department, Office of Licensing and Registration and the Department of Health and Human Services, Office of Data, Research and Vital Statistics

Harvard Pilgrim HealthCare's mental health vendor, PacifiCare Behavioral Health, does not anticipate a significant impact on premiums due to LD 27 and LD 28.

Aetna currently covers any licensed professional including licensed pastoral counselors and licensed marriage and family therapists. The proposed mandate would have no impact on their premiums.

CIGNA HealthCare currently contracts with licensed pastoral counselors and licensed marriage and family therapists. These providers have the same credentialing standards and are subject to the same utilization management policies as any other provider participating with CIGNA.

Anthem BlueCross BlueShield of Maine estimates that including the providers mandated under LD 27 and LD 28 would increase health premiums.[21] Anthem estimates that the impact of LD 27 would be:

	MONTHLY PMPM	ANNUAL INDIVIDUAL	ANNUAL FAMILY PREMIUM	AVERAGE INCREASE
GROUP PLANS				
STATE OF MAINE	$0.09	$1.30	$3.90	0.02%
BLUE CHOICE	$0.07	$1.01	$3.03	0.02%
DIRIGOCHOICE	$0.07	$1.01	$3.03	0.02%
HMO MAINE	$0.07	$1.01	$3.03	0.02%
HMO CHOICE	$0.07	$1.01	$3.03	0.02%
INDIVIDUAL PLANS				
HEALTHCHOICE	$0.01	$0.14	$0.42	0.01%
HMO MAINE	$0.07	$1.01	$3.03	0.02%

[21] TESTIMONY OF SHARON ROBERTS DATED FEBRUARY 1, 2005

Anthem estimates that the impact of LD 28 would be:

	MONTHLY PMPM	ANNUAL INDIVIDUAL	ANNUAL FAMILY PREMIUM	AVERAGE INCREASE
GROUP PLANS				
STATE OF MAINE	$0.17	$2.45	$7.35	0.04%
BLUE CHOICE	$0.14	$2.02	$6.06	0.05%
DIRIGOCHOICE	$0.14	$2.02	$6.06	0.05%
HMO MAINE	$0.14	$2.02	$6.06	0.04%
HMO CHOICE	$0.14	$2.02	$6.06	0.04%
INDIVIDUAL PLANS				
HEALTHCHOICE	$0.02	$0.29	$0.87	0.01%
HMO MAINE	$0.14	$2.02	$6.06	0.04%

Some research suggests that costs do not rise with an increase in the number of qualified providers or, if they do, these increases are short-lived (1-2 years).[22]

7. *The impact of indirect costs, which are costs other than premiums and administrative costs, on the question of the cost and benefits of coverage.*

It is not anticipated that there would be any additional indirect costs.

8. *The impact on the total cost of health care, including potential benefits and savings to insurers and employers because the proposed mandated treatment or service prevents disease or illness or leads to the early detection and treatment of disease or illness that is less costly than treatment or service for later stages of a disease or illness.*

There are studies that have shown that mandating additional categories of mental health providers such as pastoral counselors and marriage and family therapists for increased availability of mental health treatment does not always result in higher medical care costs.[23]

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[22] Smith, D.C., & Mahaoney, J.J. (1989) McDonnell Douglas Corporation Employee Assistance Program Financial Offset Study 1985-1988. McDonnell Douglas Corporation and Alexander Consulting Group."
[23] Smith and Mahoney, 1989

Annual reports from insurance carriers in Maine reveal an ongoing shift in the percent of total claims for inpatient mental health treatment towards outpatient treatment.[24] Outpatient treatment is viewed as a less expensive and often more appropriate setting. Increasing the availability of reimbursement for pastoral counselors and marriage and family therapists as a less expensive alternative to other treatment could reduce overall cost of health care.

9. *The effects of mandating the benefit on the cost of health care, particularly the premium and administrative expenses and indirect costs, to employers and employees, including the financial impact on small employers, medium-sized employers and large employers.*

It is unlikely that the proposed mandate could increase utilization significantly enough to result in higher costs for employers or employees.

10. *The effect of the proposed mandates on cost-shifting between private and public payors of health care coverage and on the overall cost of the health care delivery system in this State.*

Health premium increases are pointed to as the reason that many employers move to self-insurance. The Governor's Office of Health Policy and Finance has gone on record as opposing this and any other mandates for health insurance in an effort to reduce the cost of health care.[25] The Maine State Chamber of Commerce testified in opposition of LD 28 based on its concern over mandated benefits increasing health care premiums.[26] The National Federation of Independent Business (NFIB) wrote a letter opposing all mandates based on the effect of mandates on insurance premiums and small businesses.[27]

[24] Maine Bureau of Insurance, LD 68 Proposed Mandated Health Insurance Benefit for Licensed Counselors, April 1995
[25] Thompson, Adam, Letter from the Governor's Office of Health Policy and Finance dated February 1, 2005
[26] Ossenfort, Kristine, Testimony dated February 1, 2005
[27] Clough, David, Letter dated February 3, 2005

V. Medical Efficacy

C. THE MEDICAL EFFICACY OF MANDATING THE BENEFIT.

1. *The contribution of the benefit to the quality of patient care and the health status of the population, including any research demonstrating the medical efficacy of the treatment or service compared to the alternative of not providing the treatment or service.*

One study of family therapist states "When hundreds of family therapies are evaluated through a meta-analytic frame, the effectiveness of marriage and family therapy is even more compelling. Marriage and family interventions are as effective or more than alternative interventions, and are consistently more efficacious than no treatment at all. Meta-analyses have shown that that family therapy is effective for schizophrenia, substance abuse, alcoholism, marital problems, child-identified problems, improving couple communication, and couple enrichment, to name a few."[28]

A national study done on marriage and family therapists shows overwhelming patient satisfaction with treatment (98.1% rated their satisfaction as good or excellent). On a self-reporting basis 63.4% reported better physical health than prior to therapy and over 70% reported better relationships with co-workers or partners.[29]

2. *If the legislation seeks to mandate coverage of an additional class of practitioners:*

   a. *The results of any professionally acceptable research demonstrating medical results achieved by the additional practitioners relative to those already covered.*

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[28] Sprenkle, D. H. (Ed.) (2002). *Effectiveness research in marriage and family therapy.* Alexandria, VA: American Association for Marriage and Family Therapy.
[29] Doherty, Willima and Deborah Simmons,, "Clinical and Practical Patterns of Marriage and Family Therapists: A National Survey of Therapists and Their Clinets", Journal of Marital and Family Therapy, 1996

One study of the impact of family therapy found that those who received marital and family therapy significantly reduced their use of health care services by 21.5 percent. These results show an "offset effect" for marriage and family therapy.[30]

PacifiCare Behavioral Health is concerned that pastoral counselors will not be able to appropriately assess and treat members with severe behavioral health problems, which could impact the quality of care. However, the law that establishes the licensing procedure states, "the license categories 'licensed clinical professional counselor,' 'licensed pastoral counselor' and 'licensed marriage and family therapist' are of equivalent clinical status. Clinical status grants the ability to diagnose and treat mental health disorders." [31]

b. *The methods of the appropriate professional organization that assure clinical proficiency.*

All categories covered under the proposed mandate are required to pass state licensing standards. The law that establishes the licensing procedure gives the Board of Counseling Professionals Licensure the authority to establish continuing education and supervision requirements. Additionally, the board has the authority to suspend, revoke, or refuse to renew a license for several reasons such as incompetence or unprofessional conduct.[32] The following table summarizes the requirements for licensure. Detailed requirements can be found in Appendix C.

[30] Law, David and Russell Crane, "The Influence of Marital and Family Therapy on Health Care Utilization in a Health Maintenance Organization"
[31] 32 M.R.S.A. § 13858
[32] 32 M.R.S.A. Chapter 119

BOARD OF COUNSELING PROFESSIONALS

LICENSURE REQUIREMENTS FOR LCPC, LMFT, AND PASTORAL COUNSELING
32 MRSA, Chapter 119 "Counseling Professionals"

License Type	Educational Qualifications	Clinical Supervision	Examination Requirements
LCPC (Licensed Clinical Professional Counselor)	32 MRSA, §13858(2)(A): Master's degree or doctoral degree in counseling or allied mental health field w/minimum core curriculum and total credit hours as adopted by board. *Current rules require 45 credit hour master's; however, proposed rules outlines transition from a 36 credit hour master's to a 45 credit hour master's and to a 60 credit hour master's.	32 MRSA, §13858 (2)(B): 2 years of experience with 3,000 hours of post-master's clinical supervision with at least 100 hours of individual supervision. *Current rules require 1,500 of direct clinical contact and individual supervision as noted in statute.	32 MRSA, §13858 (5): As determined by the board. *Current rules require passing the National Counselors Exam; however, proposed rules will require the National Clinical Mental Health Counseling Examination.
LMFT (Licensed Marriage and Family Therapist)	32 MRSA, §13858(3)(A): Master's degree or doctoral degree in marriage and family therapy or its equivalent w/minimum core curriculum and total credit hours as adopted by board. *Current rules require 36 credit hour master's; however, proposed rules outlines transition from 36 credit hour master's, to a 45 credit hour master's, and to a 60 credit hour master's.[33]	32 MRSA, §13858 (3)(B): 2 years of experience with 1,000 hours of post-master's direct clinical contact with at least 200 hours of supervision, with at least 100 hours of individual supervision. *Proposed rule requires 3,000 of total supervision with minimum direct clinical contact and individual supervision as noted in statute.	32 MRSA, §13858 (5): As determined by the board. *Current rules require passing the Marital and Family Therapy Examination.

[33] For all proposed rule changes the notice of proposed rulemaking was issued March 28, 2005, and has a deadline for comments of April 15.

LP (Licensed Pastoral Counselor)	32 MRSA, §13858 (3-A): Master of Divinity degree or Doctoral of Divinity degree, or equivalent degree w/20 credit hours of counseling and human relations and 400 hours of clinical pastoral education. *Current rules require a 57 credit hour master's; however, proposed rules outlines requirements for a 36 credit hour master's.	32 MRSA, §13858 (3-A)(C, D, E): 2 years of experience with 1,000 hours of direct clinical contact with at least 200 hours of individual supervision. *Proposed rules require 3,000 of total supervision with minimum direct clinical contact and individual supervision as noted in statute.	32 MRSA, §13858 (5): As determined by the board. *Current rules require passing the National Counselors Exam; however, proposed rules will also require the National Clinical Mental Health Counseling Examination.

Prepared by the Department of Professional and Financial Regulation / Office of Licensing and Registration

VI. Balancing the Effects

D. THE EFFECTS OF BALANCING THE SOCIAL, ECONOMIC, AND MEDICAL EFFICACY CONSIDERATIONS.

1. *The extent to which the need for coverage outweighs the cost of mandating the benefit for all policyholders.*

   The proposed benefit will not expand coverage for services, but only provide for a wider choice of providers.

2. *The extent to which the problem of coverage can be resolved by mandating the availability of coverage as an option for policyholders.*

   Current law already mandates the availability of coverage that broadens the required coverage of counseling professionals to include all state-licensed, masters level counselors with at least two years experience. Anthem Blue Cross and Blue Shield of Maine charges 15.5% more for single coverage and 6.6% more for family coverage on individual policies to add this option.

3. *The cumulative impact of mandating this benefit in combination with existing mandates on costs and availability of coverage.*

   It is not possible to precisely measure the impact of mandated benefits. However, it is possible to estimate an outside limit, the maximum possible increase in health insurance premiums resulting from mandates. Because various mandates apply to different categories of coverage, this maximum likewise varies.

   The proposed mandates LD 27 and LD 28 are not anticipated to significantly impact insurance premiums. The estimated cost of current mandates is detailed in Appendix B. For most of these mandates, our estimate is based on the net impact on premiums as estimated at the time the mandates were enacted. However, four of the most costly mandates – mental health, substance abuse, chiropractic, and screening mammograms – were enacted before cost estimates were required. These

four statutes require carriers to report annually the amount of claims paid for these benefits. Our estimates are based on these reports. However, the true cost of these four mandates impact is less than this for two reasons:

1. Some of these services would likely be provided and reimbursed even in the absence of a mandates, although we have tried to reflect some of this in the cost; and

2. It has been asserted (and some studies confirm) that covering certain services or providers will reduce claims in other areas. For instance, covering mental health and substance abuse may reduce claims for physical conditions. Covering social workers may reduce claims for more expensive providers such as psychiatrists and psychologists. Covering chiropractic services may reduce claims for back surgery. Covering screening mammograms may reduce claims for breast cancer treatment.

While both of these factors reduce the cost impact of the mandates, we are not able to estimate the extent of the reduction at this time. However, a recent General Accounting Office (GAO) report[34] gives some indication of the magnitude of the reduction. The GAO report used the terms “total cost” and “marginal cost” in discussing item (1) above. The total cost is the cost of the benefits that are mandated. The marginal cost is the difference between this cost and that portion that would have been covered even without the mandates. The GAO report cited two studies that estimated the marginal cost:

- Maryland, which has more mandated benefits than any other state, found that the total costs of its mandates were about 15% of premiums, while the marginal costs were about 4.2%.[35]
- In a 2000 report, the Congressional Budget Office (CBO) concluded that the total cost of state mandates ranged from 5.4% to 22.0% of total claim costs while the marginal cost ranged from 0.28% to 1.15%.[36]

[34] General Accounting Office, *Private Health Insurance: Federal and State Requirements Affecting Coverage Offered by Small Businesses*, 2003
[35] Mercer Human Resource Consulting, *Mandated Health Insurance Services Evaluation*, prepared at the request of the Maryland Health Care Commission, 2002
[36] Congressional Budget Office, *Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and HealthMarts*, 2000

VII. Appendices

Appendix A: Letter Requesting Study with Proposed Legislation

Appendix B: Cumulative Impact of Mandates

Following are the estimated claim costs for the existing mandates without the reductions:

- ***Mental Health*** (Enacted 1983) – The mandate applies only to groups of more than 20. Mental health parity for listed conditions was effective 7/1/96. The list of conditions for which parity is required was expanded effective 10/1/03. The amount of claims paid has been tracked since 1984 and has historically been in the range of 3% to 4% of total group health claims. The percentage had been decreasing in recent years from a high of 4.16% in 1997 to 3.02% in 2003. For 2002, this broke down as 2.72% for HMOs and 5.11% for indemnity plans. For 2003, this disparity decreased to 2.87% for HMOs and 3.39% for indemnity plans. We assume an average of the 2002 and 2003 levels going forward, but add ¾ of a percentage point to reflect the expansion of the list of conditions for which parity is required. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent.

- ***Substance Abuse*** (Enacted 1983) – The mandate applies only to groups of more than 20 and originally did not apply to HMOs. Effective 10/1/03, substance abuse was added to the list of mental health conditions for which parity is required. This applies to HMOs as well as indemnity carriers. The amount of claims paid has been tracked since 1984. Until 1991, it was in the range of 1% to 2% of total group health claims. This percentage showed a downward trend from 1989 to 2000 when it reached 0.31% and increased to 0.37% in 2001 and to 0.59% in 2003. The long-term decrease was probably due to utilization review, which has sharply reduced the incidence of inpatient care. Inpatient claims decreased from about 93% of the total in 1985 to about 55% in 2003. The 0.59% for 2003 broke down as 0.65% for HMOs and 0.45% for indemnity plans. We estimate substance abuse benefits to remain at the current level, but add ¼ of a percentage point to reflect the expansion of the list of conditions for which parity is required. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent.

- ***Chiropractic*** (Enacted 1986) – The amount of claims paid has been tracked since 1986 and has been approximately 1% of total health claims each year. However, the percentage increased from 0.84% in 1994 to 1.51% in 2000. Since then, it decreased to 1.32% in 2001, 1.45% in 2002 and 1.36% in 2003. The level varies significantly between group and

individual and between HMOs and indemnity plans. We estimate that going forward. The level will be continue at the 2003 level of 1.54% for group HMO plans, 1.05% for group indemnity plans, 0.63% for individual HMO plans, and 0.55% for individual indemnity plans. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent.

- ***Screening Mammography*** (Enacted 1990) – The amount of claims paid has been tracked since 1992. It increased from 0.11% of total claims in 1992 to 0.68% in 2003, which may reflect increasing utilization of this service. This figure broke down as 0.66% for HMO plans, 0.73% for indemnity plans,. We estimate the 0.70% in all categories going forward. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent.

- ***Dentists*** (Enacted 1975) – This mandate requires coverage to the extent that the same services would be covered if performed by a physician. It does not apply to HMOs. A 1992 study done by Milliman and Robertson for the Mandated Benefits Advisory Commission estimated that these claims represent 0.5% of total health claims and that the actual impact on premiums is "slight." It is unlikely that this coverage would be excluded in the absence of a mandate. We include 0.1% as an estimate.

- ***Breast Reconstruction*** (Enacted 1998) – At the time this mandate was being considered in 1995, Blue Cross and Blue Shield of Maine estimated the cost at $0.20 per month per individual. We have no more recent estimate. We include 0.02% in our estimate of the maximum cumulative impact of mandates.

- ***Errors of Metabolism*** (Enacted 1995) – At the time this mandate was being considered in 1995, Blue Cross estimated the cost at $0.10 per month per individual. We have no more recent estimate. We include 0.01% in our estimate.

- ***Diabetic Supplies*** (Enacted 1996) – Our report on this mandate indicated that most of the 15 carriers surveyed in 1996 said there would be no cost or an insignificant cost because they already provide coverage. One carrier said it would cost $.08 per month for an individual. Another said .5% of premium ($.50 per member per month) and a third said 2%. We include 0.2% in our estimate.

- ***Minimum Maternity Stay*** (Enacted 1996) – Our report stated that Blue Cross did not believe

there would be any cost for them. No other carriers stated that they required shorter stays than required by the bill. We therefore estimate no impact.

- ***Pap Smear Tests*** (Enacted 1996) – No cost estimate is available. HMOs would typically cover these anyway. For indemnity plans, the relatively small cost of this test would not in itself satisfy the deductible, so there would be no cost unless other services were also received. We estimate a negligible impact of 0.01%.

- ***Annual GYN Exam Without Referral*** (managed care plans) (Enacted 1996) – This only affects HMO plans and similar plans. No cost estimate is available. To the extent the PCP would, in absence of this law, have performed the exam personally rather than referring to an OB/GYN, the cost may be somewhat higher. We include 0.1%.

- ***Breast Cancer Length of Stay*** (Enacted 1997) – Our report estimated a cost of 0.07% of premium.

- ***Off-label Use Prescription Drugs*** (Enacted 1998) – The HMOs claimed to already cover off-label drugs, in which case there would be no additional cost. However, providers testified that claims have been denied on this basis. Our 1998 report did not resolve this conflict but stated a "high-end cost estimate" of about $1 per member per month (0.6% of premium) if it is assumed there is currently no coverage for off-label drugs. We include half this amount, or 0.3%.

- ***Prostate Cancer*** (Enacted 1998) – No increase in premiums should be expected for the HMOs that provide the screening benefits currently as part of their routine physical exam benefits. Our report estimated additional claims cost for indemnity plans would approximate $0.10 per member per month. With the inclusion of administrative expenses, we would expect a total cost of approximately $0.11 per member per month, or about 0.07% of total premiums.

- ***Nurse Practitioners and Certified Nurse Midwives*** (Enacted 1999) – This law mandates coverage for nurse practitioners and certified nurse midwives and allows nurse practitioners to serve as primary care providers. This mandate is estimated to increase premium by 0.16%.

- ***Coverage of Contraceptives*** (Enacted 1999) – Health plans that cover prescription drugs are required to cover contraceptives. This mandate is estimated to increase premium by 0.8%.

- ***Registered Nurse First Assistants*** (Enacted 1999) – Health plans that cover surgical first

assisting are mandated to cover registered nurse first assistants if an assisting physician would be covered. No material increase in premium is expected.

- ***Access to Clinical Trials*** (Enacted 2000) – Our report estimated a cost of 0.46% of premium.

- ***Access to Prescription Drugs*** (Enacted 2000) – This mandate only affects plans with closed formularies. Our report concluded that enrollment in such plans is minimal in Maine and therefore the mandate will have no material impact on premiums.

- ***Hospice Care*** (Enacted 2001) – No cost estimate was made for this mandate because the Legislature waived the requirement for a study. Since carriers generally cover hospice care already, we assume no additional cost.

- ***Access to Eye Care*** (Enacted 2001) – This mandate affects plans that use participating eye care professionals. Our report estimated a cost of 0.04% of premium.

- ***Dental Anesthesia*** (Enacted 2001) – This mandate requires coverage for general anesthesia and associated facility charges for dental procedures in a hospital for certain enrollees for whom general anesthesia is medically necessary. Our report estimated a cost of 0.05% of premium.

- ***Prosthetics*** (Enacted 2003) – This mandate requires coverage for prosthetic devices to replace an arm or leg. Our report estimated a cost of 0.03% of premium for groups over 20 and 0.08% for small er groups and individuals.

- ***LCPCs*** (Enacted 2003) – This mandate requires coverage of licensed clinical professional counselors. Our report on mental health parity indicated no measurable cost impact for coverage of LCPCs.

These costs are summarized in the following table.

COST OF EXISTING MANDATED HEALTH INSURANCE BENEFITS

Year Enacted	Benefit	Type of Contract Affected	Est. Maximum Cost as % of Premium	
			Indemnity	**HMO**
1975	**Maternity** benefits provided to married women must also be provided to unmarried women.	All Contracts	0[1]	0[1]
1975	Must include benefits for **dentists'** services to the extent that the same services would be covered if performed by a physician.	All Contracts except HMOs	0.10%	--
1975	Family Coverage must cover any **children** born while coverage is in force from the moment of birth, including treatment of congenital defects.	All Contracts except HMOs	0[1]	--
1983	Benefits must be included for treatment of **alcoholism and drug dependency**.	Groups of more than 20	0.70%	0.90%
1975 1983 1995	Benefits must be included for **Mental Health Services**, including psychologists and social workers.	Groups of more than 20	5.00%	3.54%
		Groups of 20 or fewer	--	1.77%
1986 1994 1995 1997	Benefits must be included for the services of **chiropractors** to the extent that the same services would be covered by a physician. Benefits must be included for therapeutic, adjustive and manipulative services. HMOs must allow limited self referred for chiropractic benefits.	Group	1.05%	1.54%
		Individual	0.55%	0.63%
1990 1997	Benefits must be made available for screening **mammography**.	All Contracts	0.70%	0.70%
1995	Must provide coverage for **reconstruction of both breasts** to produce symmetrical appearance according to patient and physician wishes.	All Contracts	0.02%	0.02%
1995	Must provide coverage for **metabolic formula** and up to $3,000 per year for prescribed modified low-protein food products.	All Contracts	0.01%	0.01%
1996	Benefits must be provided for **maternity (length of stay)** and newborn care, in accordance with "Guidelines for Prenatal Care."	All Contracts	0	0
1996	Benefits must be provided for medically necessary equipment and supplies used to treat **diabetes** and approved self-management and education training.	All Contracts	0.20%	0.20%
1996	Benefits must be provided for **screening Pap tests**.	Group, HMOs	0.01%	0
1996	Benefits must be provided for **annual gynecological exam** without prior approval of primary care physician.	Group managed care	--	0.10%
1997	Benefits provided for **breast cancer treatment** for a medically appropriate period of time determined by the physician in consultation with the patient.	All Contracts	0.07%	0.07%
1998	Coverage required for **off-label use of prescription drugs** for treatment of cancer, HIV, or AIDS.	All Contracts	0.30%	0.30%
1998	Coverage required for **prostrate cancer screening**.	All Contracts	0.07%	0

1999	Coverage of nurse **practitioners and nurse midwives** and allows nurse practitioners to serves as primary care providers.	All Managed Care Contracts	--	0.16%
1999	Prescription drug must include **contraceptives**.	All Contracts	0.80%	0.80%
1999	Coverage for **registered nurse first assistants**.	All Contracts	0	0
2000	Access to **clinical trials**.	All Contracts	0.46%	0.46%
2000	Access to **prescription drugs**.	All Managed Care Contracts	0	0
2001	Coverage of **hospice care services** for terminally ill.	All Contracts	0	0
2001	Access to **eye care**.	Plans with participating eye care professionals	0	0.04%
2001	Coverage of **anesthesia** and facility charges for certain **dental** procedures.	All Contracts	0.05%	0.05%
2003	Coverage for **prosthetic devices** to replace an arm or leg	Groups >20	0.03%	0.03%
		All other	0.08%	0.08%
2003	Coverage of licensed clinical professional counselors	All Contracts	0	0
	Total cost for groups larger than 20:		**9.57%**	**8.92%**
	Total cost for groups of 20 or fewer:		**3.92%**	**6.30%**
	Total cost for individual contracts:		**3.41%**	**3.52%**

Appendix C: Licensure Requirements

02 DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

514 BOARD OF COUNSELING PROFESSIONALS LICENSURE

Chapter 2: LICENSURE REQUIREMENTS AND EXAMINATION PROCEDURE

SUMMARY: This Chapter outlines the education requirements, examination procedure, and the supervision and supervisor requirements for each license category governed by the Board.

Section 2 - Licensed Clinical Professional Counselor

A. Education Requirements: To be qualified as a Licensed Clinical Professional Counselor, an applicant shall have completed an earned master's degree in counseling or an allied mental health field consisting of a minimum of forty-five (45) semester hours or quarter-hour equivalents, or an earned doctoral degree in counseling or an allied mental health field; and three-thousand (3,000) hours of post masters supervised counseling experience with a minimum of one-hundred (100) hours of individual supervision.

1. A graduate degree in counseling is defined as a degree that meets all of the following criteria:

a. The official transcript must clearly indicate by title that the degree awarded is a degree in counseling or an allied mental health field. Examples of such acceptable titles include, but are not limited to, the following: counseling, psychology, pastoral counseling, counselor education or marriage and family therapy.

b. The educational requirements contained in this rule must be completed prior to the date of application for licensure.

c. The graduate degree program must be an organized sequence of study that includes three graduate semester hours or quarter-hour equivalents in each of the following nine core areas of study. Each course must have an in-depth study solely devoted to a particular core area. No core area credit will be given for a course which contains only

components or some aspects of the core area. A single course will be counted only once (except internship) in granting credit for study in a core area. No core course credit will be granted for practicum, internship, workshops, reading courses, or correspondence courses.

i. Human Growth and Development: Studies that provide a broad understanding of the nature and needs of individuals at all developmental levels throughout the life span.

ii. Helping Relationships: Studies that provide a broad understanding of philosophic bases of helping processes, counseling theories and their applications, basic and advanced counseling skills, consultation theories and skills, self-understanding and self-development, and facilitation of client or consultee change.

iii. Groups: Studies that provide a broad understanding of group development, dynamics, group counseling theories, group leadership styles, and group counseling methods and skills.

iv. Measurement: Studies that provide a broad understanding of group and individual educational and psychometric theories and approaches to measurement, data and information-gathering methods, validity, reliability, psychometric statistics, factors influencing measurements, and use of measurement results in the helping process.

v. Research and Evaluation: Studies that provide a broad understanding of the types of research, basic statistics, research report development, research implementation, program evaluation, needs assessment, and ethical and legal consideration associated with research and evaluation.

vi. Diagnosis and Treatment: Studies that provide a broad understanding of psychopathology, the diagnosis and statistical manual and its use in counseling, psychopathology, the development of

treatment plans and the use of related services, and the role of assessment, intake interviews, and reports.

vii. Professional Orientation: Studies that provide a broad understanding of professional roles and functions, professional organizations and associations, history and trends within the profession, ethical and legal standards, and professional preparation standards and professional credentialing.

viii. Social and Cultural Foundations: Studies that provide a broad understanding of the development of multicultural awareness, cultural foundations of human growth and development, and cultural values and traditions covering the life span.

ix. Lifestyle and Career Development: Studies that provide a broad understanding of career development theories, occupational and educational information services, career counseling, and career decision-making.

Additional course work must include at least one graduate course of three semester hours or quarter-hour equivalents in at least two (2) of the following:

Marriage and Family Counseling: Studies that provide a broad understanding of the structure and dynamics of the family, and methods of marital and family intervention and counseling.

Human Sexuality for Counselors: Studies that provide a broad understanding of human sexual function and dysfunction, the relationship between sexuality, self-esteem, sex roles and life styles over the life cycle, and counseling treatment approaches and techniques.

Supervision: Studies that provide a broad understanding of approaches and conceptual models, individual and group supervision, clinical

evaluation, and ethical and legal considerations.

Consultation: Studies that provide a broad understanding of consultation skills, evaluation of organizational structure and individual client management, and theoretical orientation.

Crisis Intervention: Studies that provide a broad understanding of the theory and practice of crisis intervention, short-term crisis counseling strategies, and the responsibilities of all those involved in the intervention.

Addictive Disorders: Studies that provide a broad understanding of the stages, processes, and effects of addictions, social and psychological dynamics of chemical dependency, and the professional's role in prevention, intervention, and aftercare.

Treatment Modalities: Studies that provide an understanding of specific treatment approaches (for example, cognitive, client-centered, expressive therapy, feminist).

d. Practicum: At least one (1) course of clinical instruction is required that provides practical experience in counseling for the purpose of developing individual counseling skills and for developing group counseling skills. These experiences allow students to perform, on a limited basis, some of the counseling activities that a regularly employed Licensed Clinical Professional Counselor would be expected to perform.

e. Internship: Studies that require students to complete a full academic year, at least nine-hundred (900) clock hours, of a supervised internship. The internship provides an opportunity for the student to perform all the activities that a regularly employed clinical counselor would be expected to perform.

f. Alternative Experience: In lieu of (d) and (e) above, an applicant may provide documentation of one-thousand (1,000) hours of supervised clinical counseling.

g. Course work for the Licensed Clinical Professional Counselor includes general principles and practices of diagnosis, treatment, and prevention of mental and emotional disorders.

h. Course work includes specific theories of psychotherapy for initiating, maintaining, and terminating therapy in a variety of settings and with different populations.

i. Course work provides guidelines for conducting an interview with a complete mental health history and developing and maintaining a treatment plan, and complete and accurate records.

j. Course work includes practice in mental health counseling techniques (e.g. crisis counseling, brief therapy, intermediate, and long-term counseling modalities) applied to various populations (e.g. individuals, groups, families, and couples) and various lifestyles.

2. All applicants must submit written evidence that their degree programs and any additional course work meet the criteria for graduate degrees in counseling set forth in Section 2, paragraphs A(1)(a) to A(1)(j) of this chapter.

3. All applicants must furnish to the Board an official college/university transcript documenting all training related to his or her application for licensure. If the official transcript does not indicate the number of contact hours in the internship program, a letter from the university/program official documenting the number of hours will be required.

B. Examination Procedure:

1. Examinations shall be held at such times as the Board directs.

2. To qualify for licensure as a Licensed Clinical Professional Counselor, an applicant shall pass one of the following examinations:

a. National Counselor Examination (NCE); or

b. Certified Clinical Mental Health Counselor Examination (CCMHCE);

3. Passing scores: For applicants completing the NCE or the CCMHCE as the state examination, the passing scores will be as determined by the National Board of Certified Counselors.

4. The Board shall notify the applicant by mail of the results of the examination.

5. Reexamination: In the event that an applicant fails to receive a passing grade on the examination, the applicant may reapply to take subsequent examinations.

C. Supervision and Supervisor Requirements:

Supervised experience in counseling, for licensure as a clinical professional counselor is defined as three-thousand (3,000) hours of post masters counseling experience in the procedures of clinical counseling that has taken place in a counseling setting performed over a period of not less than two (2) years under the supervision of an approved supervisor as defined in Chapter 1, Section 2 D.

Pertaining to the supervised experience in counseling, the applicant must demonstrate to the Board that the three-thousand (3,000) hours of required supervised experience:

1. was performed under the supervision of an approved supervisor;

2. included a minimum of one-thousand five-hundred (1,500) hours of direct counseling with individuals, couples, families, or groups;

3. included a minimum of one-hundred (100) hours spent in individual supervision with an approved supervisor. No more than 50% of the total hours of supervision may be group supervision.

4. Supervision by relatives of applicants will not be approved.

Section 3 - Licensed Marriage and Family Therapist

A. To be eligible for licensure as a Marriage and Family Therapist, an applicant shall have a masters or doctoral degree in marriage and family

therapy, or its equivalent, from a regionally accredited institution The equivalent master's degree includes, but is not limited to, the following: counseling, psychology, pastoral counseling, mental health counseling, or counselor education.

1. The graduate degree program shall include thirty-six (36) graduate semester hours or quarter-hour equivalents of the following core curriculum. (Official transcripts must be sent to the Board.) If the official transcript does not indicate the number of contact hours in the clinical practicum, a letter from the university/program official documenting the number of hours must be submitted.

   a. Marital and Family Studies: Each applicant shall have completed at least nine (9) graduate semester hours or quarter-hour equivalents. Course work includes theories of family development, general systems theory, theories of family functioning, the family life cycle, sociology of the family, families under stress, contemporary family forms, family subsystems, family of origin and external societal influences, family pathology such as addiction, child abuse and sexual abuse, and other related topics. Three (3) of the nine (9) semester hours or quarter-hour equivalents must be in general systems theory.

   b. Marital and Family Therapy: Each applicant shall have completed at least nine (9) graduate semester hours or quarter-hour equivalents. Course work includes the study of major marital and family therapy treatment approaches and techniques to provide a substantive understanding of systems change. The course work may include strategic, structural, object relations, integrative, experiential, systems, neoanalytic, communications and behavioral treatment modalities.

   c. Human Development: Each applicant shall have completed at least nine (9) graduate semester hours or quarter-hour equivalents. Course work includes the study of human development across the life cycle, personality theory, cognitive development, and psychopathology, its diagnosis and treatment.

   d. Human Sexuality: Each applicant shall have three (3) graduate semester hours or quarter-hour equivalents.

Course work includes the study of human sexuality over the life cycle, sex roles, sexual function and dysfunction.

e. Professional Orientation and Ethics: Each applicant shall have completed at least three (3) graduate semester hours or quarter-hour equivalents in this area. Courses are intended to contribute to the professional development of the therapist. Areas of study should include the therapist's legal responsibilities and liabilities, professional ethics as a marriage and family therapist, professional socialization, the role of the professional organization, licensure or certification legislation, independent practice and interprofessional cooperation.

f. Research and Evaluation: Each applicant shall have completed at least three (3) graduate semester hours or quarter-hour equivalents in this area. Course are intended to provide the broad understanding of the types of research, basic statistics, research implementation, program evaluation, need assessment, and evaluation.

g. Clinical Practicum: Each applicant shall have completed a one (1) year clinical practicum. Such a practicum is defined as a minimum of three-hundred (300) hours of direct client contact. Such contact shall deal with a wide range of marital and family therapy cases and shall be under supervision. Supervision includes, but is not limited to, direct observation by a supervisor using a one-way mirror, video-audio tapes, or co-therapy.

2. All applicants must submit written evidence that their degree programs and course work meet the criteria for graduate degrees in counseling set forth in Section 3, paragraphs A(1)(a) to A(1) (g) of this chapter.

B. Examination Procedure:

1. Examinations shall be held at such times as the Board directs.

2. Applicants for licensure must submit proof of a passing score on the Marital and Family Therapy Examination prepared by the Association of Marital and Family Therapy Regulatory Boards (AMFTRB).

3. The passing score for applicants completing the Association of Marital and Family Therapy Examination is determined by the Association of Marital and Family Therapy Regulatory Boards.

4. The Board shall notify the applicant in writing of the results of the examination.

5. Reexamination: In the event that an applicant fails to receive a passing score on the examination, the applicant may reapply to take subsequent examinations.

C. Supervision and Supervisor Requirements:

Supervised experience in counseling as a qualification for licensure as a Marriage and Family Therapist is defined as three-thousand (3,000) hours of post masters counseling experience in marriage and family therapy that has taken place in a counseling setting and performed over a period of not less than two (2) years under the supervision of an approved supervisor as defined in Chapter 1, Section 2D.

Pertaining to the supervised experience in marriage and family therapy, the applicant must demonstrate to the Board that:

1. the three-thousand (3,000) hours of post masters counseling experience was performed under the supervision of an approved supervisor;

2. the supervised clinical experience was composed of one-thousand five -hundred (1,500) hours of direct counseling, one-thousand (1,000) hours of which must be with couples and families -- A maximum of five-hundred (500) hours may be with individuals and/or groups; and

3. a minimum of two-hundred (200) hours was spent in supervision, of which a minimum of one-hundred (100) hours shall be in individual supervision. All supervision must be with an approved supervisor.

   NOTE: Supervision by relatives of a prospective applicant will not be approved.

Section 4 - Licensed Pastoral Counselor:

A. Educational Requirements

To be eligible for licensure as a Pastoral Counselor, an applicant shall have successfully completed a Master of Divinity degree, or masters or doctoral degree in Pastoral Counseling, or the equivalent of either, from a regionally accredited institution.

In addition to the degree, the applicant shall document graduate level studies in both theology and in the fields of counseling and human relations as indicated by the core requirements of this cross-disciplinary license.

1. Academic Courses:

a. Religious Foundations: Graduate level course work in this area must include, but is not limited to, at least fifteen (15) graduate semester hours or quarter-hour equivalents in the following areas: Biblical studies, theology, religious history, theological and social ethics, theology of culture, sociology of religion, world religion and spirituality.

b. Core Clinical Theory: Graduate level course work in this area must include at least three (3) graduate semester hours or quarter-hour equivalents in each of the following areas: Human Growth and Development, Psychopathology, Theories of Counseling, Assessment (Diagnosis and Treatment) and Professional Ethics.

c. Theory and Practice of Pastoral Counseling: Graduate level course work in this area must include at least three (3) graduate semester hours or quarter-hour equivalents in each of the following areas of study:

Pastoral Theology and Psychology

Psychology of Religion

Testing and Measurement or Research Methods

Cross Culture Issues and;

At least six (6) graduate semester hours or quarter-hour equivalents in the following areas of study:

Basic Pastoral Care, History of Pastoral Care and Counseling.

Faith Development, Spiritual Formation and Direction.

Testing and Measurement or Research Methods.

Grief Counseling, Hospital Ministry, Crisis Intervention, Life Cycle Rituals.

d. Treatment Modalities and Specialized Issues: Graduate level course work in this area must include at least nine (9) graduate semester hours or quarter-hour equivalents in not fewer than two (2) of the following areas of study: Psychoanalysis, Jungian psychology, marriage and family, humanistic, cognitive, behavioral, belief therapy, group therapy, human sexuality, addictive disorders and dream work.

2. Clinical Pastoral Education: One (1) unit of four-hundred (400) contact hours in clinical pastoral education as part of a program accredited by the Association of Clinical Pastoral Education or its equivalent, is required for licensure as a pastoral counselor. Clinical pastoral education is a-supervised internship in ministry to persons in crisis. Under the supervision of a certified supervisor and with a small group of peers, the student practices ministry to persons and reflects on that ministry in individual and group supervision. Development of a pastoral identity and the integration of the person of the student chaplain into the ministry is a central goal. Counseling skills used in pastoral counseling are an essential element to the program.

A typical program of clinical pastoral education would include ministry to individuals and their families, written reports of visits reviewed in individual and/or group supervision, group dynamics sessions, and didactic seminars. The ministry is in the context of teamwork with other professionals. Written evaluations by the student and supervisor are required.

3. Internship: Completion of a regionally or nationally certified training program comprising a minimum of nine-hundred (900) clock hours of participation, including four-hundred (400) hours of clinical pastoral education, documented by a certificate and a copy of the candidate's final evaluation. Alternative experience may be submitted for Board review. This experience must be documented by supervisor affidavits and final evaluations and must consist of at least one-thousand (1,000) hours of supervised clinical counseling.

4. An official transcript(s) is required to document the educational requirements. If the official transcript does not indicate the number of contact hours in the internship programs, a letter from the university/program official documenting the number of hours must be submitted.

5. Educational requirements must be completed prior to application for licensure.

B. Examination Procedure:

1. Examinations shall be held at such time as the Board directs.

2. To qualify as a Licensed Pastoral Counselor, the applicant shall submit proof of a passing score on the national examination of the Pastoral Counselors Examination Board.

3. Passing scores: The passing score for the examination shall be determined by the agency which developed and maintains the examination.

4. The Board shall notify the applicant in writing of the results of the examination.

5. Reexamination: In the event that an applicant fails to receive a passing grade on the examination, the applicant may reapply to take subsequent examinations.

C. Supervision and Supervision Requirements:

To be licensed as a pastoral counselor, applicants are required to have completed at least three-thousand (3,000) hours of post masters supervised counseling experience with a minimum of one-thousand five-hundred (1,500) clinical client contact hours of pastoral counseling while receiving a minimum of two-hundred (200) hours of supervision during those hours of pastoral counseling over a period of not less than two (2) years under the supervision of an approved supervisor as defined in Chapter 1, Section 2D of these rules.

Pertaining to the supervised experience in pastoral counseling, the applicant must demonstrate to the Board that the three thousand (3,000) hours of required supervised experience:

1. was performed under the supervision of an approved supervisor;

2. included a minimum of one-thousand five hundred (1,500) hours of direct counseling with individuals, couples, families, or groups; and

3. two-hundred (200) hours of supervision, at least fifty (50) hours of which must be interdisciplinary, thirty (30) hours of which must be individual supervision by one supervisor of no more than three (3) cases from intake to termination, and one-hundred (100) hours of which must be individual supervision of multiple case material.

4. One-third of the supervision hours shall be with an approved supervisor certified at the level of Fellow or Diplomate in good standing of the American Association of Pastoral Counselors.

   Supervision by relatives of a prospective applicant will not be approved.

A Call to Ministry of Pastoral Counseling:

A call to the ministry of Pastoral Counseling is signified by: the applicant's membership in a denomination or local faith group that recognizes the applicant's status as a rabbi, priest, minister or religious advisor; evidence that he or she has been ordained or otherwise affirmed in accordance with the tenets of the applicant's denomination or faith group; and has been endorsed as a pastoral counselor. This endorsement must take the form of a letter or

certificate from an individual or group in authority within the denomination or faith group of which the applicant is a member.

Section 5 - Foreign Trained

Applicants who are licensed, certified or registered professional counselors in a jurisdiction outside the United States and/or who have received their counselor training at an institution outside of the United States must submit their educational credentials for evaluation to an evaluating service approved by the Board. After course equivalency is established, the Board will evaluate the educational credentials to determine whether the program is equivalent to a program of professional counseling in the State of Maine as defined by standards contained in Sections 1-4 of this chapter. Any cost related to this evaluation is to be the responsibility of the applicant.

Appendix D: Counseling Professionals in Maine

Licensed Marriage and Family Therapist

County	Population Estimates (July 1, 2002)	Number of Licensed Marriage & Family Therapists	Percent of Licensed Marriage & Family Therapists	Licensed Marriage & Family Therapists per 100,000 Population	Percent of County Population to Total State Population
ANDROSCOGGIN	104,805	4	3.4%	3.82	8.10%
AROOSTOOK	73,122	2	1.7%	2.74	5.65%
CUMBERLAND	269,083	65	56.0%	24.16	20.79%
FRANKLIN	29,683	2	1.7%	6.74	2.29%
HANCOCK	52,359	4	3.4%	7.64	4.04%
KENNEBEC	118,244	11	9.5%	9.30	9.13%
KNOX	40,477	3	2.6%	7.41	3.13%
LINCOLN	34,407	0	0.0%	0.00	2.66%
OXFORD	55,604	1	0.9%	1.80	4.30%
PENOBSCOT	146,015	5	4.3%	3.42	11.28%
PISCATAQUIS	17,203	0	0.0%	0.00	1.33%
SAGADAHOC	35,983	2	1.7%	5.56	2.78%
SOMERSET	50,963	0	0.0%	0.00	3.94%
WALDO	37,628	5	4.3%	13.29	2.91%
WASHINGTON	33,401	2	1.7%	5.99	2.58%
YORK	195,487	10	8.6%	5.12	15.10%
TOTAL	**1,294,464**	**116**	**100.0%**	**96.97**	**100.00%**

Licensed Clinical Professional Counselor

County	Population Estimates (July 1, 2002)	Number of Licensed Clinical Professional Counselor	Percent of Licensed Clinical Professional Counselor	Licensed Clinical Professional Counselor per 100,000 Population	Percent of County Population to Total State Population
ANDROSCOGGIN	104,805	29	3.9%	27.67	8.10%
AROOSTOOK	73,122	5	0.7%	6.84	5.65%
CUMBERLAND	269,083	257	34.3%	95.51	20.79%
FRANKLIN	29,683	17	2.3%	57.27	2.29%
HANCOCK	52,359	36	4.8%	68.76	4.04%
KENNEBEC	118,244	69	9.2%	58.35	9.13%
KNOX	40,477	30	4.0%	74.12	3.13%
LINCOLN	34,407	12	1.6%	34.88	2.66%
OXFORD	55,604	24	3.2%	43.16	4.30%
PENOBSCOT	146,015	98	13.1%	67.12	11.28%
PISCATAQUIS	17,203	6	0.8%	34.88	1.33%
SAGADAHOC	35,983	25	3.3%	69.48	2.78%
SOMERSET	50,963	7	0.9%	13.74	3.94%
WALDO	37,628	25	3.3%	66.44	2.91%
WASHINGTON	33,401	16	2.1%	47.90	2.58%
YORK	195,487	94	12.5%	48.09	15.10%
TOTAL	**1,294,464**	**750**	**100.0%**	**814.19**	**100.00%**

Licensed Pastoral Counselor

County	Population Estimates (July 1, 2002)	Number of Licensed Pastoral Counselor	Percent of Licensed Pastoral Counselor	Licensed Pastoral Counselor per 100,000 Population	Percent of County Population to Total State Population
ANDROSCOGGIN	104,805	0	0.0%	0.00	8.10%
AROOSTOOK	73,122	0	0.0%	0.00	5.65%
CUMBERLAND	269,083	9	45.0%	3.34	20.79%
FRANKLIN	29,683	0	0.0%	0.00	2.29%
HANCOCK	52,359	0	0.0%	0.00	4.04%
KENNEBEC	118,244	1	5.0%	0.85	9.13%
KNOX	40,477	0	0.0%	0.00	3.13%
LINCOLN	34,407	1	5.0%	2.91	2.66%
OXFORD	55,604	2	10.0%	3.60	4.30%
PENOBSCOT	146,015	3	15.0%	2.05	11.28%
PISCATAQUIS	17,203	0	0.0%	0.00	1.33%
SAGADAHOC	35,983	1	5.0%	2.78	2.78%
SOMERSET	50,963	0	0.0%	0.00	3.94%
WALDO	37,628	0	0.0%	0.00	2.91%
WASHINGTON	33,401	1	5.0%	2.99	2.58%
YORK	195,487	2	10.0%	1.02	15.10%
TOTAL	**1,294,464**	**20**	**100.0%**	**19.54**	**100.00%**

Psychiatric Clinical Nurse

County	Population Estimates (July 1, 2002)	Number of Licensed Psychiatric Clinical Nurses	Percent of Licensed Psychiatric Clinical Nurses	Licensed Psychiatric Clinical Nurses per 100,000 Population	Percent of County Population to Total State Population
ANDROSCOGGIN	104,805	4	2.9%	3.82	8.10%
AROOSTOOK	73,122	4	2.9%	5.47	5.65%
CUMBERLAND	269,083	51	37.0%	18.95	20.79%
FRANKLIN	29,683	1	0.7%	3.37	2.29%
HANCOCK	52,359	4	2.9%	7.64	4.04%
KENNEBEC	118,244	9	6.5%	7.61	9.13%
KNOX	40,477	5	3.6%	12.35	3.13%
LINCOLN	34,407	1	0.7%	2.91	2.66%
OXFORD	55,604	4	2.9%	7.19	4.30%
PENOBSCOT	146,015	26	18.8%	17.81	11.28%
PISCATAQUIS	17,203	0	0.0%	0.00	1.33%
SAGADAHOC	35,983	2	1.4%	5.56	2.78%
SOMERSET	50,963	2	1.4%	3.92	3.94%
WALDO	37,628	4	2.9%	10.63	2.91%
WASHINGTON	33,401	5	3.6%	14.97	2.58%
YORK	195,487	16	11.6%	8.18	15.10%
TOTAL	**1,294,464**	**138**	**100.0%**	**130.39**	**100.00%**

Psychiatrist

County	Population Estimates (July 1, 2002)	Number of Licensed Psychiatrists	Percent of Licensed Psychiatrists	Licensed Psychiatrists per 100,000 Population	Percent of County Population to Total State Population
ANDROSCOGGIN	104,805	19	9.2%	18.13	8.10%
AROOSTOOK	73,122	8	3.9%	10.94	5.65%
CUMBERLAND	269,083	86	41.5%	31.96	20.79%
FRANKLIN	29,683	2	1.0%	6.74	2.29%
HANCOCK	52,359	3	1.4%	5.73	4.04%
KENNEBEC	118,244	20	9.7%	16.91	9.13%
KNOX	40,477	9	4.3%	22.23	3.13%
LINCOLN	34,407	3	1.4%	8.72	2.66%
OXFORD	55,604	1	0.5%	1.80	4.30%
PENOBSCOT	146,015	30	14.5%	20.55	11.28%
PISCATAQUIS	17,203	2	1.0%	11.63	1.33%
SAGADAHOC	35,983	3	1.4%	8.34	2.78%
SOMERSET	50,963	0	0.0%	0.00	3.94%
WALDO	37,628	5	2.4%	13.29	2.91%
WASHINGTON	33,401	2	1.0%	5.99	2.58%
YORK	195,487	14	6.8%	7.16	15.10%
TOTAL	**1,294,464**	**207**	**100.0%**	**190.11**	**100.00%**

Psychologist

County	Population Estimates (July 1, 2002)	Number of Licensed Psychologists	Percent of Licensed Psychologists	Licensed Psychologists per 100,000 Population	Percent of County Population to Total State Population
ANDROSCOGGIN	104,805	27	4.8%	25.76	8.10%
AROOSTOOK	73,122	12	2.1%	16.41	5.65%
CUMBERLAND	269,083	190	33.7%	70.61	20.79%
FRANKLIN	29,683	9	1.6%	30.32	2.29%
HANCOCK	52,359	19	3.4%	36.29	4.04%
KENNEBEC	118,244	76	13.5%	64.27	9.13%
KNOX	40,477	23	4.1%	56.82	3.13%
LINCOLN	34,407	19	3.4%	55.22	2.66%
OXFORD	55,604	4	0.7%	7.19	4.30%
PENOBSCOT	146,015	89	15.8%	60.95	11.28%
PISCATAQUIS	17,203	2	0.4%	11.63	1.33%
SAGADAHOC	35,983	13	2.3%	36.13	2.78%
SOMERSET	50,963	7	1.2%	13.74	3.94%
WALDO	37,628	12	2.1%	31.89	2.91%
WASHINGTON	33,401	16	2.8%	47.90	2.58%
YORK	195,487	46	8.2%	23.53	15.10%
TOTAL	**1,294,464**	**564**	**100.0%**	**588.67**	**100.00%**

Licensed Clinical Social Worker

County	Population Estimates (July 1, 2002)	Number of Licensed Clinical Social Worker	Percent of Licensed Clinical Social Worker	Licensed Clinical Social Worker per 100,000 Population	Percent of County Population to Total State Population
ANDROSCOGGIN	104,805	98	5.3%	93.51	8.10%
AROOSTOOK	73,122	55	3.0%	75.22	5.65%
CUMBERLAND	269,083	705	38.3%	262.00	20.79%
FRANKLIN	29,683	21	1.1%	70.75	2.29%
HANCOCK	52,359	72	3.9%	137.51	4.04%
KENNEBEC	118,244	160	8.7%	135.31	9.13%
KNOX	40,477	65	3.5%	160.59	3.13%
LINCOLN	34,407	39	2.1%	113.35	2.66%
OXFORD	55,604	54	2.9%	97.12	4.30%
PENOBSCOT	146,015	176	9.6%	120.54	11.28%
PISCATAQUIS	17,203	15	0.8%	87.19	1.33%
SAGADAHOC	35,983	57	3.1%	158.41	2.78%
SOMERSET	50,963	20	1.1%	39.24	3.94%
WALDO	37,628	50	2.7%	132.88	2.91%
WASHINGTON	33,401	33	1.8%	98.80	2.58%
YORK	195,487	222	12.1%	113.56	15.10%
TOTAL	**1,294,464**	**1842**	**100.0%**	**1895.97**	**100.00%**

Total of All Counselors

County	Population Estimates (July 1, 2002)	Number of All Licensed Counselors	Percent of All Licensed Counselors	All Licensed Counselors per 100,000 Population	Percent of County Population to Total State Population
ANDROSCOGGIN	104,805	181	5.0%	172.70	8.10%
AROOSTOOK	73,122	86	2.4%	117.61	5.65%
CUMBERLAND	269,083	1363	37.5%	506.54	20.79%
FRANKLIN	29,683	52	1.4%	175.18	2.29%
HANCOCK	52,359	138	3.8%	263.57	4.04%
KENNEBEC	118,244	346	9.5%	292.62	9.13%
KNOX	40,477	135	3.7%	333.52	3.13%
LINCOLN	34,407	75	2.1%	217.98	2.66%
OXFORD	55,604	90	2.5%	161.86	4.30%
PENOBSCOT	146,015	427	11.7%	292.44	11.28%
PISCATAQUIS	17,203	25	0.7%	145.32	1.33%
SAGADAHOC	35,983	103	2.8%	286.25	2.78%
SOMERSET	50,963	36	1.0%	70.64	3.94%
WALDO	37,628	101	2.8%	268.42	2.91%
WASHINGTON	33,401	75	2.1%	224.54	2.58%
YORK	195,487	404	11.1%	206.66	15.10%
TOTAL	**1,294,464**	**3637**	**100.0%**	**3735.84**	**100.00%**