Approved Feb. 16, 1984
Date

MINUTES OF THE House COMMITTEE ON Insurance.

The meeting was called to order by Rep. Rex Hoy at
Chairperson

3:30 a.m./p.m. on February 13, 1984 in room 521 S of the Capitol.

All members were present except:
Rep. Peterson, who was excused.

Committee staff present:
Wayne Morris, Legislative Research
Gordon Self, Revisor's Office
Mary Sorensen, Committee Secretary

Conferees appearing before the committee:
Rep. Blumenthal (Sponsor)
Richard Maxfield
George Dyck, M.D.
Betty Stowers
Paul M. Klotz
David Wiebe
E. W. "Dub" Rakestraw
Kim Dewey
Dr. Erwin Janssen
Mary Goetze
Ann Etter
Dr. Clyde Rousey
Dr. Gerald T. Hannah
Elaine Brady
Gene Johnson
Glenn Leonardi
Bruce H. Beale
George Heckman
W. Walter Menninger, M.D.
Howard W. Snyder

Others Present:
See List (Attachment 1)

HB 2795--Providing reimbursement of indemnity for alcohol, drug abuse or nervous or mental conditions in policy of accident and sickness insurance.

Rep. Blumenthal, sponsor of the bill, spoke first. He referred to testimony furnished by Barbara Sabol, giving the position of the Kansas Department of Health and Environment in favor of HB 2795, which is attached and marked Attachment 2. Rep. Blumenthal then read from his own testimony in support of HB 2795, marked Attachment 3.

Richard Maxfield, President of the Kansas Psychological Association and a Certified Psychologist in the Adult Outpatient Department at the Menninger Foundation spoke next in support of HB 2795. He said he would restrict his comments to the cost effectiveness of providing mental health coverage under insurance programs, and referred to his written testimony (Attachment 4).

George Dyck, M.D., President of the Kansas Psychiatric Society and Medical Director of Prairie View, Inc., a private psychiatric hospital and community mental health center in Newton, KS, then spoke. His written testimony is attached (Attachment 5) and Dr. Dyck referred to it and urged support of the bill, with the addition of a deductible clause which he explained.

Betty Stowers, President of the Mental Health Association of Kansas, then spoke in support of HB 2795 and read from her written testimony, (Attachment 6).

Paul M. Klotz, Executive Director of the Association of Community Mental Health Centers of Kansas, referred to his written testimony (Attachment 7) and asked support of HB 2795 with first dollar coverage on outpatient treatment.

David Wiebe, Executive Director of Shawnee Community Mental Health Center, said most of his comments had already been given. He passed around Attachment 8, setting out the stand of the National Association of Social Workers, Inc. in favor of HB 2795.

E. W. "Dub" Rakestraw, Executive Director of the Family Service and Guidance Center of Topeka, passed around his written testimony in support of HB 2795 (Attachment 9) and urged the committee to vote favorably on this bill.

Kim Dewey, speaking for the Board of Sedgwick County Commissioners, read his written testimony in support of HB 2795 (Attachment 10).

Dr. Erwin Janssen, a practicing physician and child psychiatrist at the Menninger Foundation, spoke in behalf of the Medical Society and urged passage of this bill as written.

Mary Goetze, Social Action Chairman of the Mental Health Association of Johnson County, spoke in support of HB 2795, on behalf of the more than 1,000 members of their association. Her written testimony is attached and marked Attachment 11.

Ann Etter, a member of the Drug and Alcoholism Council of Johnson County, passed around her written testimony (Attachment 12) and spoke briefly in support of HB 2795.

Dr. Clyde Rousey, representing the Kansas Association of Professional Psychologists, passed around written testimony (Attachment 13) and urged passage of HB 2795.

Dr. Gerald T. Hannah, speaking for the Community Mental Health and Rehabilitation Services of the State Department of Social and Rehabilitation Services, spoke briefly in support of the bill, and referred to previous testimony of Mr. Rakestraw. He passed around a statement by Robert C. Harder, Secretary of SRS (Attachment 14).

Elaine Brady, Director, Alcohol and Drug Abuse Services of SRS, spoke briefly from her written testimony (Attachment 15) and asked the committee to consider the bill favorably.

Gene Johnson, representing the 27 Kansas Community Alcohol Safety Action Projects Coordinators Association, spoke in support of HB 2795. Their association serves for the evaluation of all DWI offenders in the State of Kansas and believe this legislation is needed. His testimony is attached (Attachment 16).

Glenn Leonardi, representing the Kansas Alcoholism and Drug Abuse Counselor's Association, passed around written testimony (Attachment 17) on behalf of over 250 members of their association, voicing the association's support of HB 2795.

Bruce H. Beale, Chairman of the Kansas Citizens Advisory Committee on Alcohol and other Drug Abuse, provided written testimony (Attachment 18) in support of HB 2795.

George Heckman, representing the Kansas Association of Alcohol and Drug Program Directors, spoke briefly from his written testimony (Attachment 19) and urged the committee to pass out HB 2975 so it could have a vote by the entire House.

W. Walter Menninger, M.D., Chairman of the Committee on Chronically Mentally Ill of the American Psychiatric Association and a member of the Professional Advisory Committee of the Mental Health Association, spoke in support of the bill. He read from his testimony (Attachment 20) and urged a favorable endorsement of HB 2795.

Howard W. Snyder, representing Families for Mental Health, Inc., spoke in support of HB 2795 and furnished written testimony (Attachment 21) which he referred to. He also furnished a photostat of an editorial in the Kansas City Times on Monday, February 13, 1984, entitled "Insurance for Mental Care" in support of the bill under consideration.

Also furnished to each committee member were the following: Letter from Sonya Yarmat, Director, Alcoholism Recovery Unit, Shawnee Mission Medical Center (Attachment 22); Letter from Diane Wertz, Director, Paul Malloy, Counselor MSW, Jennifer Workman, Asst. to Director, and Linda Layman, Evaluator, all of the Drug Abuse Education Center, Olathe, KS (Attachment 23); and letter from Melissa J. Smith, Ph.D., Topeka, KS (Attachment 24). All of these letters urged the committee to act favorably on HB 2795.

The meeting adjourned at 4:35 PM.

GUEST LIST

Attachment 1

COMMITTEE: House Insurance DATE: Feb. 13, 1984

NAME	ADDRESS	COMPANY/ORGANIZATION
Becky Talbot	Topeka	Assoc. of Community Mental Health Centers of KS
[illegible]	953 Parkland Manhattan	[illegible]
David Wiebe	2401 W. 6th Topeka	Shawnee Community Mental Health Center
Sgt. (DUB) Rakestraw	2055 Clay Topeka	Family Service and Guidance Center
Bruce Beale	Lawrence	Gov. Adv. Comm. on A & D
Glenn Leonardi	Topeka	KS. Alcoholism & Drug Abuse Counselors Assn.
Elaine Brady	TSH - Biddle Bldg. 2700 W 6th 66606	SRS - Alcohol & Drug Abuse Services
Dave Johnson	Topeka, KS	Ks. Com. ASAP coord assn
Michael A. Flyzik	Topeka KS	SRS/ADAS
GEORGE HECKMAN	Lawrence	KAAAPD
Ann Etten	Box 517 Olathe Ks	Johnson County Alcoholism Drug & Council
Dianne Pavelo	Overland Park	Jo. Co. Drug & Alcoholism Council
Annemarie Tashash	Topeka, KS	The Menninger Foundation

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Att. 1

GUEST LIST

Attachment 1

COMMITTEE: House Insurance

DATE: Feb. 13, 1984

NAME	ADDRESS	COMPANY/ORGANIZATION
Betty Stowers	Topeka	MHAC
Kay Mellner	Topeka	MHAK
Paul M. Klotz	Topeka	Assoc. CMHCs of Kansas
Richard B. Mayfield	Topeka	Ks Psychological Assoc.
Clyde L. Ramsey	Topeka	Kansas Association of Professional Psychologists
Mary Goebel	Jo. Co	M.H.A. of Jo. Co.
Helene Metzger	Topeka	Families for Mental Health in Shawnee Co.
Lou Snyder	Prairie Village, Jo. Co.	Families for Mental Health - Johnson County
Howard Snyder	" " " "	" " " "
Gary Blumenthal	Merriam	Ks Leg.
L. Allsbrook	Topeka	Menninger School Psych
G. Hansen	BBS/MHRS	Topeka
D. Dyck	Newton	Mem Mutual Aid

Attachment 2

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

STATEMENT BEFORE HOUSE COMMITTEE ON INSURANCE: 2-13-84

House Bill No. 2795

An act relating to reimbursement of indemnity for treatment of alcoholism, drug abuse, or nervous or mental conditions.

In 1979, the Statewide Health Coordinating Council completed two studies on the need for mental health services and substance abuse treatment services in Kansas. A recurrent concern in both studies was the inadequacy of public and private reimbursement for a full range of services. Specifically, the Council found that most reimbursement plans favored institutional or inpatient care and treatment, and did little to support treatment in community-based or outpatient settings. SHCC also found that insurance coverage for mental health was limited in regard to dollar amount and length of treatment. This bill addresses those concerns somewhat by providing 30 day inpatient coverage and limited reimbursement for outpatient services.

The Statewide Health Coordinating Council felt that the reimbursement problems were in a large measure due to a lack of knowledge about substance abuse and mentally ill populations. That is, the health care profession traditionally did not view mental health problems, alcoholism, or drug abuse as part of the main stream of health care. Because of this attitude, few studies were conducted to determine the needs of the at-risk populations or the effectiveness of treatment regimens. Health insurers were similarly wary of providing service coverage when so many questions could not be answered. In recent years, as more has been learned about the at-risk groups, the health profession attitude has begun to change.

In addition to the concern regarding limited coverage the basic recommendations set forth by the Statewide Health Coordinating Council call for enhanced data collection about the mentally ill and substance abuse populations within Kansas. Coupled with the recommendation is enhancement of efforts to educate the public and the health profession about the needs of both at-risk groups.

Att. 2

Attachment 3

TESTIMONY ON HOUSE BILL 2795

By Representative Gary Blumenthal
February 13, 1984

As the original sponsor of H.B. 2795, I appreciate having this opportunity to meet with the Insurance Committee to review the provisions of the bill. H.B. 2795 seeks to gain consistent minimum benefits for all Kansans regarding treatment of alcoholism, drug abuse, and nervous or mental conditions. Although there has been great success in the general community in recognizing that these illnesses are in fact illnesses, the same progress has not been achieved regarding medical insurance coverage of these illnesses.

Although the State of Kansas does require a "mandatory option", requiring insurance carriers to offer an additional mental health rider to each consumer; this "offer" rarely reaches the individual insurance consumer, as group leaders or group negotiators make insurance package decisions on behalf of the group. To further complicate this matter, many Kansans assume that mental illness coverage is automatic and thus never realize its absence or presence until its utilization is required. Ideally the concept of an optional decision made by both the employee and employer sounds like a simple common sense business approach; however, in practice, the deck seems to be stacked against those who seek to exercise this option.

Attach. 3

Often the stigma attached to those who seek psychiatric assistance will prevent an employee from approaching his employer or union colleagues in an effort to secure mental health coverage. The need for such treatment may be perceived as a sign of personal weakness or instability and thus many workers go without treatment rather than risk what they may perceive as a humiliating experience. Many consumers may not recognize the value of mental health coverage and often harbor an unrealistic feeling of immunity to mental illness. This particular consumer is faced with an uncomfortable crisis when he or she requires psychiatric hospitalization. To circumvent the absence of mental health coverage, many consumers will seek to acquire a medical diagnosis as the basis of their problems,as the only available insurable means of receiving treatment. Perhaps this accounts for the fact that it is estimated that over 60% of all visits to a physician are mental health related. It would seem obvious that when patients are not referred to the appropriate treatment specialist, that current practices could result in the mis-application and mis-use of health care dollars. Often times a general practitioner will order the only apparent options available and prescribe lab tests, x-rays, and other expensive diagnostic procedures.

Research has shown that overall, appropriate psychiatric treatment can result in decreases in physician visits, lab tests, x-rays and frequent in-patient hospitalizations. Additional

studies have often shown that the greatest reductions in health care utilization comes from those who had previously been the highest utilizers of such services.

From a fiscal perspective, the provisions of H.B. 2795 address the heart of the insurance industry. The entire concept of insurance is based on the idea of "risk sharing". The absence of mental health, alcohol and drug treatment as part of the group to determine appropriate risk sharing, seems to defeat the very nature of the insurance industry. Its absence results in those who choose to purchase mental health riders being overcharged for their coverage.

Additionally, as a legislator, I feel it is particularly important that we seek insurance coverage for these areas as we seek to reduce the strain on local and state budgets. A disproportionate amount of tax dollars is used to pay for mental health services versus the amount provided for general health care services. While insurance sources provide 25 percent of general health care costs, insurance sources only provide 11% of all mental health funding. It is estimated that taxpayers provide approximately 60% of all mental health dollars, as opposed to 42-45% for general health care costs.

The end result regarding this disproportionate level of insurance funding is that the taxpayer is asked to pick up the rest of the tab.

I also feel it is crucial that we examine the impact of mental health coverage on the business community. It is estimated (1980) by the U.S. Department of Health Statistics, that overall, the American economy loses about $40.3 billion each year to poor mental health. In 1981, the National Institute of Mental Health estimated the cost to the economy at $39.7 billion. The cost to the business community is obvious: the costs of low productivity, the high cost of absenteeism, the danger of accidents, the waste of inefficiency, the cost of high labor force turnover, plus the impact of losses due to death and suicide. Businesses that have sought to include mental health services have reaped positive results.

In conclusion, I wish to cite three specific programs:

1) The Kennecott Copper Corporation of Utah showed a 6 to 1 benefit to cost ratio per year for its mental health program. Kennecott's program was credited with a 52% worker attendance improvement record, a 74.6% decrease in weekly indemnity costs, and a 55.4% decrease in medical and surgical costs among its participants.
2) The Equitable Life Assurance Society discovered a $3.00 return in increased productivity for every dollar invested in treatment.
3) Kimberly-Clark's Employee Assistance Program showed a 70% reduction in on-the-job accidents for the year after participation as compared with the year before.

I appreciate the committee's willingness to review this critical issue and sincerely request that H.B. 2795 be reported favorably.

The Kansas City Times

A Capital Cities Communications, Inc., Newspaper

JAMES H. HALE, Publisher and Chairman of the Board
MICHAEL E. WALLER, Editor and Vice-President
JAMES W. SCOTT, Editor, Editorial Page

MEMBER OF THE ASSOCIATED PRESS

Vol. 116 Monday, February 13, 1984 No. 136

Insurance for Mental Care

It's not hard to remember when a family with a mentally ill member lived in mortal fear "people would find out."

The matter was talked about in whispers. The person might be sent out of town. Upon his or her return, those who knew took care: It might be catching. As years passed, the next generation heard only snips of gossip, not enough to know if the secret was criminal, immorality, disease or some demonic combination.

Fortunately, all that has changed.

Emotional disease is generally accepted as a sickness as much as physical affliction, one that is treatable and deserving of compassion. Facilities for care have matured. Society has ceased to ostracize victims of mental illness and to blame them for having imaginary problems. Even the most skeptical individuals view therapy as an acceptable kind of help with personal nightmares.

At least, we are moving in those directions.

But vestiges of the old attitudes toward mental illness persist in insurance coverage in Missouri and Kansas. Companies don't have to provide such treatment as part of basic medical protection although it must be available as an option. A majority of those insured do not have it. This is a plain bit of discrimination against persons disabled by emotional pains. The distinction indicates those who write the rules figure the emotionally ill are kind of sick but not *really sick* such as someone felled by a heart attack.

Bills are now before the Kansas Legislature and the Missouri General Assembly to mandate insurance coverage for mental illness. The sponsors, Rep. Gary Blumenthal in Kansas and Rep. Carole Roper Park in Missouri, believe timely mental health care in the long run will reduce the total medical bill. The U.S. Public Health Service estimates at least 60 percent of all physician visits have an emotional rather than an organic basis.

Those and other pragmatic arguments are adequate reasons for supporting the measures, in addition to correcting the bias against mental disorders. Opponents' main objection is that it will cost more. That is a weak argument. Care for heart patients inflates insurance premiums. Yet no one has suggested isolating that group.

Families no longer exile emotionally troubled members. Now the insurance industry needs some updating.

TESTIMONY OF RICHARD B. MAXFIELD, PH.D.
HOUSE BILL 2795

Attachment 4

Mr. Chairman, members of the committee, thank you for the opportunity to give testimony on House Bill 2795. I am Dr. Richard Maxfield. I am the President of the Kansas Psychological Association and a Certified Psychologist, primarily involved in direct patient care through the Adult Outpatient Department at The Menninger Foundation. I will restrict my comments to the cost effectiveness of providing mental health coverage under insurance programs.

I should note from the outset that few, if any, patients seek mental health treatment in order to reduce other medical costs. Further, one should not assume that mental health treatment will invariably lower any individual's utilization of medical services. For some people emotional illness leads to self-neglect, including neglect of their physical health. As such a person benefits from mental health treatment we should expect their appropriate use of medical services to increase somewhat. And, one should keep in mind that reduced use of medical services is a positive side effect of mental health treatment, not a usual goal of such treatment.

Despite those caveats there is considerable literature which suggests that providing mental health benefits is cost effective. In a comprehensive review of the literature Jones and Vischi found that mental health treatment had offset effects of reducing medical utilization in 24 out of 25 studies reviewed. The magnitute of the reduction ranged from 5 to 80 percent. Although a number of those studies could be criticized if one uses rigorous scientific standards, the fact that all but one of the 25 studies reviewed found mental health treatments to substantially reduce medical costs strongly suggests that providing mental health coverage is fiscally sound. In the study cited by Jones and Vischi which is most relevant to House Bill 2795, which looked at the utilization rates of subscribers to Blue Cross of Western Pennsylvania over a 4-year period, it was found that people who sought

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mental health services reduced their utilization of medical/surgical services from a pre-treatment average rate of $16.47 per month, to a post-treatment rate of $7.06 per month, a reduction of 57%. When the cost of the mental health treatment is included, the overall costs of all treatments declined from a pre-treatment rate of $20.40 per month to a post-treatment rate of $14.14 per month, a savings of 31%. It should be noted that 69% of the people treated in that study received fewer than eight psychotherapy sessions per year, which is roughly equivalent to the dollar limits of House Bill 2795.

In a more recent study done by Schlesinger and others, it was found that people who had chronic physical diseases and who utilized mental health treatments had medical charges averaging $175 less per year over a four year period than those who did not have such mental health treatments. Further, the savings of decreased charges for medical intervention exceeded the costs of the mental health treatment within three years.

Many people have feared that the inclusion of mental health coverage in insurance programs will lead to over-utilization of mental health services for "self-actualization" and the like. Statistics from the Federal Employee Health Benefit Program, which was one of the more generous packages of mental health coverage, note that only two percent of their subscribers used their mental health benefits in 1977. The average cost of providing outpatient coverage per enrollee was $26.50 per year. One half of that figure resulted from patients who were seen for more than 60 psychotherapy sessions in a year. Recently the Rand Corporation found that liberal mental health benefits were utilized by only nine percent of those covered and only five percent underwent psychotherapy. Thus, the fear that people will flock to their psychiatrist's office if mental health benefits are covered by insurance is simply not supported by the available data.

Many people have feared that the availability of mental health coverage through mandates will drive up total costs, if not utilization rates. The economist Thomas McGuire reviewed the available data on the effects of mandates. He estimated that there is a net increase of use of resources of from one to two dollars per person per year which is attributable to a mandate. However, he noted that premiums may well increase more than that figure as costs are shifted either from existing users of service newly covered, or from state budgets. McGuire also noted that in 1979, Blue Cross and Blue Shield of Massachusetts, a mandated state, paid out slightly less than 30 million dollars per year for outpatient psychotherapy. Dividing that figure by the three million enrollees in the plan, one arrives at the estimate that including those mental health benefits would cost approximately $10 per person per year.

In summary, there is preliminary data which suggests that providing mental health coverage may be cost effective in that it may reduce the cost of other medical interventions. There is clear data that mandating mental health coverage will not lead to skyrocketing utilization or costs of such services. Further, there are additional potential benefits of mental health treatment to society which have not yet been well established in the literature. For instance, increased worker productivity, reduced absenteeism, and improved quality of life for patients treated and those who interact with them have been noted in some studies. To my way of thinking the likelihood that mental health treatment is cost effective is the secondary reason for mandating mental health coverage. The reduction of human suffering available to consumers through mental health treatment is ample enough reason to justify this proposed legislative mandate.

Attachment

TESTIMONY TO THE KANSAS STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
INSURANCE COMMITTEE
February 13, 1984

George Dyck, M.D., Newton

I am testifying on behalf of H.B. 2795. I am President of the Kansas Psychiatric Society and the Medical Director of Prairie View Inc., a private psychiatric hospital and community mental health center in Newton.

I am also currently Chairman of the Board of Trustees of Mennonite Mutual Aid Association, an Indiana based fraternal benefit society which insures for the health care costs of over seven thousand members of Mennonites churches and employees of Mennonite agencies and businesses in this state.

Insurers have long been preoccupied with the idea that providing coverage for mental disorders somehow leads to abusive overutilization. I have come across no evidence to substantiate this idea. For an number of years, Mennonite Mutual Aid has offered a nondiscriminatory medical expense sharing plan which covers all types of illnesses, including all psychiatric disorders, at the same level. Claims for psychiatric disorders amounted to 5.6 per cent of total medical expenses, a figure which is generally accepted as being an average proportion. Our premiums for coverage in Kansas are among the lowest, somewhat lower than those of most Blue Cross/Blue Shield group policies which do not have a nondiscriminatory provision such as our policies have. We do have an upper limit of $20,000, but this is the only limitation.

There is considerable evidence that utilization of other types of medical care goes up when psychiatric benefits are not available. Blue Cross/Blue Shield, to my knowledge, has not been interested in looking at this evidence even though some of the studies, such as a recent one at the University of Colorado, have been done on their data. Instead, insurance carriers look at the claims for psychiatric benefits and regard them as additional costs instead of offset costs.

The basic reason for this attitude, I believe, is a continuing problem of discrimination against those who suffer from psychiatric disorders or alcohol and substance abuse disorders. Employee groups generally do not bargain for psychiatric benefits because no one wants to think he or she may have a mental illness. Happily, it appears that there are some employee groups that are not afraid to admit the fact that we are all subject to illnesses that we cannot predict in advance and mental disorders are no different than any other.

Having said all this, I also have to add that I believe the current bill is not workable in its present form. More and more insurance carriers are offering policies with deductibles and coinsurance so that the health care consumer will participate in making prudent decisions about when to go to a doctor. Such policies help to keep the cost of health care down without making the medical care bill an unmanageable burden. If H.B. 2795 were to be passed in its present form, Mennonite Mutual Aid would no longer be able to offer its policies in Kansas; and I am sure there would be other insurers who would follow suit.

Att. 5

This matter could be easily remedied by a small alteration in the bill which would simply ensure that there would be no discrimination against sufferers of mental disorders. If someone would want to buy a policy with a $100 deductible clause and 20 percent coinsurance for the next $5,000, he or she could do so without having to buy first-dollar coverage for mental illness alone. Mennonite Mutual Aid is now recommending its members choose policies with even higher deductibles if they can afford the unexpected out-of-pocket expense of $250, $500 or even $1,000 as a way of cutting out the overhead involved in small claims and substantially reducing the annual cost of medical care.

By simply adding a sentence such as, "Deductibles and coinsurance may be applied if they do not discriminate against nervous and mental conditions or alcohol and drug abuse disorders and are generally applied to other reimbursible costs," this would, in my opinion, be a workable bill. Prudent buyers who choose this kind of policy because they do not want first-dollar coverage would be permitted to do so.

I urge your favorable recommendation of H.B. 2795 with the qualification that it include the deductible clause I suggested in order to make it workable.

GD:js
2/7/84

Attachment 6

Testimony before Insurance Committee
February 13, 1984
on H.B. 2795

Chairman Hoy and members of the Committee:

Marion Vernon, immediate past President of National Mental Health Association, had intended to testify before you on this bill but unfortuneatly is out of the state.

No one substitutes or speaks for Marion but Betty Stowers is here today as President of the Mental Health Association of Kansas, to speak for its members in urging the adoption of H.B. 2795.

The Mental Health Association has long advocated for the inclusion in health benefit policies of mandatory minimum treatment for mental and emotional illness. Mental illness remains America's #1 health problem. Mental and emotional disabilities interfere with many Americans functioning in the workplace. However, a person with mental illness, unlike most others suffering from a physical illness and disability, will be denied access to most benefit programs. Such discriminatory policies and practices result in higher health care costs to the patient and further stigmatization of mentally ill persons.

To save your time, I shall not repeat statistics, many of which have already been made available to you. Rather, I shall stress just one important result of inclusion of coverage of mental health treatment as stipulated in H.B. 2795.

The Mental Health Assocaition has fought long and hard to reduce the stigma faced by those who suffer from mental illness. Failure to seek proper treatment is frequently caused by many forms of stigmatization. Many persons, sometimes society itself, refuse to acknowledge the extent of incidence of mental illness and there has been too little advocacy on the part of patients and their families who fear exposure to stigma as a result of such advocacy.

The mere removal of the discrimination against treatment of mental illness, currently not covered in most insurance policies and the inclusion of treatment for mental inllness as mandated in H.B. 2795 would do much to reverse the stigma. Recognition of their right to receive insurance coverage for such treatment, would "legitimatize" mental illness. This would encourage early intervention and proper care, which in turn could shorten the duration and expense of treatment.

I strongly urge that you recognize the right of the mentally ill to fair and adequate access to treatment and legislate by the adoption of H.B. 2795 appropriate mental health coverage.

Thank you for the oppurtunity to appear before you and your courteous attention.

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Attachment 7

TO:

THE HOUSE INSURANCE COMMITTEE

ON

HOUSE BILL 2795

REX HOY, CHAIRMAN

Testimony

of

Paul M. Klotz

Executive Director

Association of

Community Mental Health Centers of Kansas

820 Quincy/Suite 416

Topeka, Kansas 66612

Atch. 7

-BACKGROUND-

The Association of Community Mental Health Centers (CMHCs) of Kansas, on behalf of current and future patients, urge your support of **H.B. 2795** as written.

The Association represents all mental health centers in Kansas. Thirty-two licensed centers serve every county in the State. These centers receive funding from a variety of sources. The chief, single source of revenue is "out-of-pocket", privately paid fees. Centers also receive funding from federal, state and local goverments. Public funding is necessary because centers are, by law, required to serve all Kansas citizens seeking treatment, regardless of their ability to pay. (See attached information sheet on mental health centers.)

- Centers have a proven record of providing quality economical services to over 80,000 Kansans per year.
- Center services range from 24 hour emergency contacts to inpatient services. However, centers are primarily providers of outpatient services.
- Generally speaking, outpatient services are 49 times **less** expensive than inpatient.
- Because of the range of services, centers can provide extremely economical care and treatment of the mentally ill.
- Revenue sources for CMHCs are relatively stable and consistent except for private pay insurance.
- One of the primary goals of centers is to divert patients from unnecessary institutionalization. In fact, over the past 6 years, centers have had a formal agreement with SRS to divert and deinstitutionalize patients.
- Centers are heavily regulated by federal, state and local governments. The Association has its own peer review system, sanctioned by SRS, to control qualifications of professionals who practice in mental health centers.

-THE ISSUE-

The primary reason this Association supports **H.B. 2795** is to improve access for those in need of psychiatric treatment. The general community has increasingly recognized that mental illness, drug and alcohol abuse are in fact illnesses. Generally, the health care insurance industry has not fully recognized this fact.

The fundamental principle of insurance is to share the risks or the costs of providing acute health care among the insured populations. Such a principle does not regularly seem to apply to mental health care and treatment.

The real freedom of choice needed is not whether to purchase insurance, but rather the freedom to choose **appropriate** treatment when needed.

The issue is not so much mandating new and untried benefits, but rather the need to include the concept of holistic care and treatment. Can it be argued that the mind and nervous system are not a part of our being?

No one can argue, in the face of massive evidence, that stress is not a major contributor to general health problems.

The mental health system is primarily and heavily involved in the proper management of stress as it affects the body, mind and nervous system.

Sixty percent or more of the visits to general **medical** doctors are made by patients who have a **stress or emotional** related problem as opposed to an organic basis for their physical symptoms.

-THE COSTS-

Current national, state and local data overwhelmingly contradicts the fears of the insurance industry which seem to say that the provision of mental health outpatient benefits specifically and inpatient benefits generally, will result in over-utilization, runaway costs and abuse.

Blue Cross/Blue Shield in Kansas, having only 24 percent of subscribers covered, estimate that coverage costs an individual policy holder $30 per year or 8¢ per day.

Without arguing whether the $30 per year cost to the consumer is too high or too low, surely the total costs to the consumer has to be reduced if the total pool of risk is increased by 76 percent.

Appropriate outpatient mental health treatment has a definite affect on lowering the use of other medical services. The findings of major research overwhelmingly indicate that appropriate mental treatment results in decreases in physician visits, lab tests, x-rays and hospitalization. Reductions ranged from 5 to 85 percent with a median of 20 percent.

The care and treatment of the mentally ill is largely a burden to the patient, their families, or the tax paying public. Federal, state and local governments provide over 60 percent of all funds for such care. Private health insurance provides only 12 percent of all mental health payments compared to paying 26 percent of all medical expenses.

In recent national studies that compare states with and without mandates, it was found that increases in the cost and utilization of outpatient mental health services was raised, on the average, 15 percent. This is true in Kansas as well when comparing the populations who have psychiatric coverage and those who do not.

Fourteen states now have mandates, of one type or another. None of these states report over-utilization or abuse.

Limitations found in current law and H.B. 2795 have equal or more conservative limitations compared to other states which have mandates.

-THE CONSUMER-

Emotional illness accounts for more absenteeism from work than any other illness, except the common cold.

The social stigma of mental illness deters more people from mental health treatment than cost. This same stigma prevents many from seeking insurance coverage.

All national studies indicate that one in five people will require some type of mental health intervention at some point in their life.

Why should many of the emotionally ill and their families have the added burden and stress of being singled out as a population denied the choice of adequate health care coverage?

The single most frequently asked question in a mental health center is; "Oh, you mean my insurance won't cover this, why?".

On behalf of these clients, we also ask "Why?".

Thank you!

NOTE: Those wishing a packet of materials containing national studies and statistical reports, should contact Paul Klotz at 913-234-4773.

INFORMATION SHEET
COMMUNITY BASED MENTAL HEALTH SERVICES

Association of Community Mental Health Centers of Kansas, Inc.
820 Quincy / Suite 416
Topeka, Kansas 66612
(913) 234-4773

WHAT IS COMMUNITY MENTAL HEALTH?

- Under K.S.A. 19-4001 et. seq., 32 licensed community mental health centers (CMHCs) are currently operational in the state. These centers have a combined staff of over 1,200 providing mental health services in every county of the state and are an integral part of the total mental health system of Kansas. Federal support has been drastically reduced or eliminated, thus posing a very real threat to the continued delivery of some of the services provided by these centers. Growth in Medicaid funding for community mental health care has been reduced over the past two years.

- The primary goal of CMHCs is to provide quality care, treatment and rehabilitation to the mentally disabled in the least restrictive environment. Many arguments can be advanced for treatment at the community level, chief of which is to keep individuals functioning in their own homes and communities, and at a considerable reduced cost to them and/or the taxpayer.

WHO NEEDS IT?

- Between 350,000 (15%) to 468,000 (20%) of the Kansas population are suffering from varying degrees of mental disabilities that require treatment. The combined private and public sectors of mental health treatment are probably not reaching all of those needing service.

- Demand for community based mental health care has been growing at an average rate of approximately 12% per year. During times of economic distress, the need for mental health services typically rise dramatically.

- A large number of the CMHC clientele are chronic patients who require ongoing care and treatment. Traditionally, CMHCs have not developed programs for the chronic patient. Only recently, have centers been asked to serve this client. Growth in this type of service has been quite rapid over the past five years. Although CMHCs are not always providing totally adequate service to chronic patients, centers are seeing 90% of the chronically mentally ill seeking public service. Without CMHCs, many chronically mentally ill would hve no services available to them.

WHO USES IT?

- In 1983, Kansas CMHCs provided care to approximately 80,000 Kansas citizens. The number of patients has doubled over the past eight to ten years largely as a result of deinstitutionalization. During the period of 1969-1979, the state hospital average daily census declined by more than half. Many of these former hospital patients now rely on CMHCs for mental health services.

- By 1985, if present trends continue, CMHCs will be providing care for over 90,000 Kansas citizens.

- Of the total patients in the public sector having diagnoses of psychotic conditions (severely disabled), over 57% are being served by CMHCs.

- In Kansas, 96.4% of all citizens seeking public mental health care are seen at community mental health centers.

- The major national and state change in mental health care over the last 15 to 20 years has been the shift from state institutional care to community based care.

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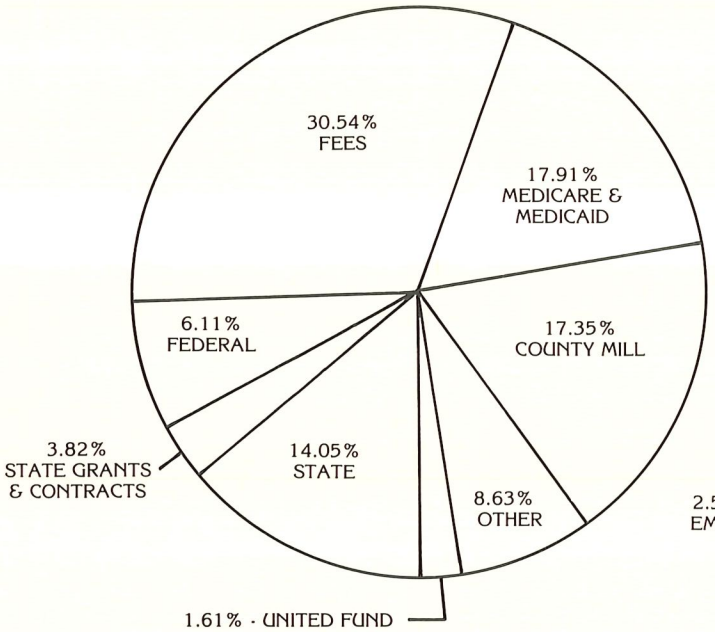
WHO PAYS FOR IT?

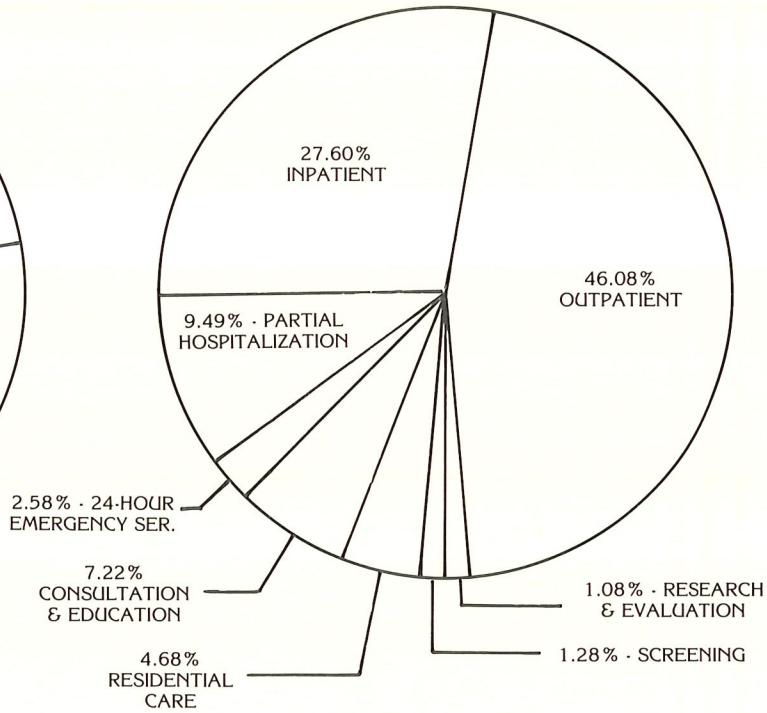
- No person, by law, can be denied community mental health care because of the inability to pay; consequently, public support is required.
- In 1983, county mill levies provided CMHCs with approximately $7 million. County funding is the single largest direct source of public support. Counties currently provide not only mill levy support, but other substantive funding as well. Mill levy support alone averages $3.54 per capita on a statewide basis.
- In FY 1984, direct state support for CMHCs is $5.6 million. Nationwide, the average state contribution to CMHCs as a percentage of total budget, is over 30%. In Kansas, about 13¢ of every CMHC dollar is provided by the state.
- The majority of CMHC costs were paid from community sources, with the largest share coming from the patient or his/her insurance provider.

CMHC REVENUE



1983 BUDGET ESTIMATE

CMHC EXPENDITURES



1983 BUDGET ESTIMATE

BUDGET NOTES

- "1983" Budget Year" means calendar year 1983.
- Some of the amounts do not reflect the 1983 Budget cuts, but do reflect what was appropriated by the 1982 Legislature.
- During calendar year 1983, CMHCs showed tremendous growth in the area of "partial hospitalization" programs. Total new expenditures for this category came too late to be included in this report. "Partial hospitalization" programs probably have the greatest potential to divert clients away from institutionalization.

MILY SERVICE AND GUIDANCE CENTER OF TOPEKA IC.
2055 CLAY STREET TOPEKA, KANSAS 66604 234-5663

Attachment 9

February 13, 1984

PRESENTATION TO THE HOUSE INSURANCE COMMITTEE

RE: House Bill 2795 Presiding: The Honorable Rex Hoy

I am Dub Rakestraw, Executive Director of the Family Service and Guidance Center of Topeka. I extend my appreciation to the Committee for this opportunity to ask you to support HB 2795 as it is currently written.

I am sure the Committee has some concern over how this bill might impact on the health care expenditures for the citizens of Kansas. I am equally sure you will hear representatives of the health insurance industry making comments suggesting this will significantly increase insurance premium rates, result in many more dollars being spent on health care and other standard comments usually heard when you mandate coverage.

However, I want to plead with this Committee to take into consideration both or all sides of the argument and to use your wisdom and intelligence to look beyond the "It will raise premiums" mentality.

If you look at the research that has been done, the clear question that emerges isn't, "Can we afford the coverage?" but rather "How can we possibly afford the costs by not having the coverage?"

Study after study has shown clearly that coverage of psychiatric disorders actually reduces other health care costs and provides a net cost savings. Please, allow me to give some examples.

A Kennecott Corporation study found that after psychotherapeutic services were applied there was a 74.6% decrease in medical/surgical costs for those receiving psychotherapy.

Blue Cross of Western Pennsylvania studied the medical/surgical utilization of a group who used outpatient psychotherapy in community mental health centers compared to a group of subscribers who didn't have this service coverage. The medical/surgical utilization rate went down significantly for those with psychiatric benefits. The monthly cost per patient for medical services was more than halved - from $16.47 to $7.06!

The Kaiser Plan in California also compared two groups of patients each having similar levels of psychological distress. One group received psychiatric care, one group did not. The savings per year per patient receiving psychiatric care was approximately $250 - No savings for

Hse. 2

those not receiving psychiatric care. In addition, the group receiving psychiatric care reduced its non-psychiatric outpatient visits to a doctor by 62% and its inpatient days by 68%.

Group Health Association of Washington found patients receiving mental health care reduced non-psychiatric physician usage by about 31% the first year after this coverage was made available. They also found laboratory and x-ray services decreased by 29%.

A study conducted between 1973-77 in Texas demonstrated that for a group of people over 65 that having access to treatment for mental illness reduced their stays in inpatient facilities from 111 days to 53 days. The estimated cost reduction was over $1.1 million.

The savings go far beyond the expenditure of dollars for health care. Dollar amounts needlessly lost through reduced productivity of the millions in our workforce who are suffering from some form of mental illness is staggering.

Again studies show that productivity is greatly enhanced as a result of receiving psychotherapeutic services.

In one study a 52% work attendance improvement resulted.

In the Equitable Life Assurance Association study, they found a $3.00 return in increased productivity for every $1.00 of treatment costs.

The Washington Business Group on Health analyzed data compiled from a number of large companies which had coverage of psychiatric disorders for their employees. They concluded the resultant benefits of this coverage was improved employee productivity, reduced absenteeism, improved employee morale, reduced hospital/surgical/medical utilization, and lower insurance premiums.

This is but a very small example of the conclusions from but a few studies on the benefit of having psychiatric treatment coverage for consumers.

Again, if our interest is in the overall reduction of health care expenditures can we afford not to support HB 2795? I think not. I urge you to vote favorably on this bill.

Thank you, for your interest and attention.

E. W. (Dub) Rakestraw, M.S.
Executive Director

Attachment 10

SEDGWICK COUNTY, KANSAS

BOARD OF COUNTY COMMISSIONERS

JACK SPRATT
CHAIRMAN
COMMISSIONER THIRD DISTRICT

DONALD E. GRAGG
CHAIRMAN PRO-TEM
COMMISSIONER FIRST DISTRICT

TOM SCOTT
COMMISSIONER
SECOND DISTRICT

COUNTY COURTHOUSE • SUITE 320 • WICHITA, KANSAS 67203-3759 • TELEPHONE (316) 268-7411

Testimony of Kim C. Dewey
Sedgwick County
House Insurance Committee
HB 2795
February 13, 1984

The Board of Sedgwick County Commissioners are the governing body of the Sedgwick County Department of Community Mental Health. They approve the budget for this operation and levy ad valorem tax to support a substantial portion of that budget. The State of Kansas provides a substantial amount of support through State matching funds.

The Sedgwick County Department of Community Mental Health serves between 7,000 and 8,000 patients per year. We feel that it is an integral part of the health care system. For this reason, we feel that mental health care should be recognized by the insurance industry as a reimbursable expense. We encourage favorable action on HB 2795

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Attachment 11

THE MENTAL HEALTH ASSOCIATION OF JOHNSON COUNTY

7208 West 80th Street • Room 208 • Overland Park, Kansas 66204 913 • 381-2707

TO: House Insurance Committee, Rex Hoy, Chairman

Larry Turnquist	Dennis Spaniol
Theo Cribbs	Burt DeBaun
Mary Jane Johnson	Bill Fuller
Michael Peterson	Leary Johnson
John Sutter	Marvin Littlejohn
Patricia Weaver	J.C. Long
Dale Sprague	David Webb

RE: HB 2795

On behalf of the more than 1000 members of the Mental Health Association of Johnson County, we urge your support of HB 2795 which would mandate private insurance carriers to include inpatient and outpatient psychiatric and substance abuse treatment in basic benefits.

Attached are supporting documents to our position.

A UNITED WAY AGENCY

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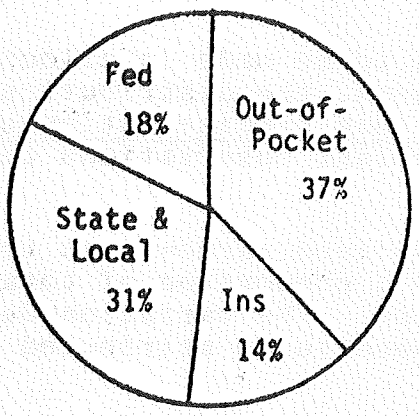
THE MENTAL HEALTH ASSOCIATION OF JOHNSON COUNTY
7208 West 80th Street • Room 208 • Overland Park, Kansas 66204 913 • 381-2707

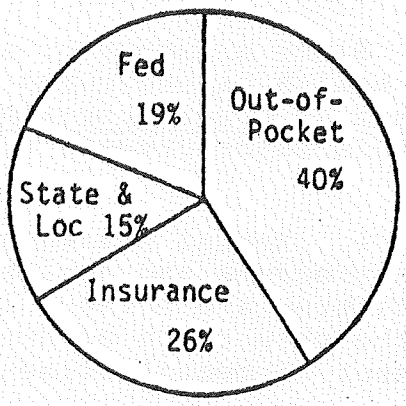
WHO PAYS FOR MENTAL HEALTH TREATMENT

A Comparison of Total Personal Medical and Personal Mental Health Expenditures for 1971 and 1980 by Payor

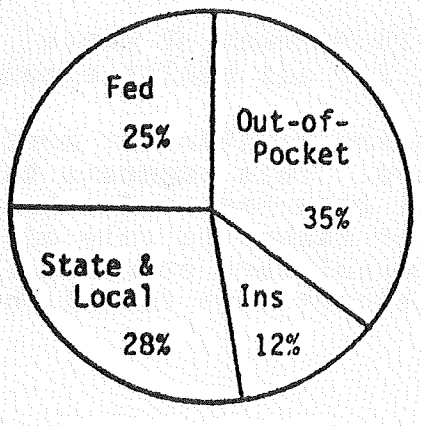


MENTAL HEALTH

1971

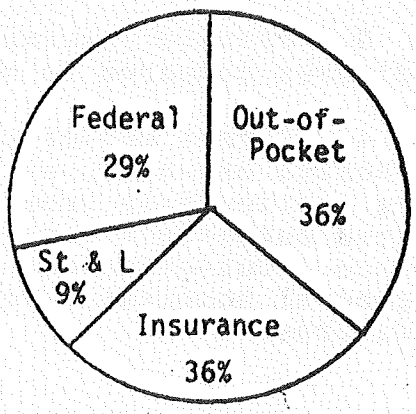


ALL HEALTH



MENTAL HEALTH

1980



ALL HEALTH

See reverse for Source and Conclusions.

Source: Division of Public Service Activities, American Bar Association: Collection of Data on Public Expenditure for Care of the Mentally Disabled: An Exploratory Review For ABA Commission on the Mentally Disabled, Washington, D.C., 1976.

CONCLUSIONS (Quoted from the Review):

"Since a number of assumptions had to be made in allocating total health expenditures to mental illness, the distributions should be taken as crude approximations rather than precise estimates. Even with this major caveat, a number of important observations can be made.

1. Mental health expenditures (defined narrowly as traditional health programs and health providers) as a proportion of total health expenditures are between 13 and 15 percent. The variation depends upon the proportion of nursing homes expenditures attributed to the treatment of mental illness.

2. Governments (Federal, State, and Local) account for over 50 percent of expenditures for mental illness and for about one-third of total health expenditures. This is because of much higher state and local expenditures for mental illness. Within the governmental sector, the Federal government's share has been increasing because of the closing down of state and local mental institutions over the past 15 years.

3. Private insurance pays about 13 percent of mental illness expenditures compared to over 25 percent for all health expenditures.

4. Direct out-of-pocket payments are similar for mental and total health expenditures, about one-third. This suggests that public funding particularly from state and local governments for hospital and organized outpatient care has preempted or taken the role of private insurance. Out-of-pocket payments for mental care provided in short-term general hospitals are considerably higher than for all hospital expenditures."

THE MENTAL HEALTH ASSOCIATION OF JOHNSON COUNTY
7208 West 80th Street • Room 208 • Overland Park, Kansas 66204 913 • 384-2707

MENTAL HEALTH SERVICES REDUCE PHYSICAL HEALTH CARE COSTS

Perhaps the most critical question which arises when expanded coverage of mental health services is proposed is cost. However, numerous studies have demonstrated that coverage of mental health services reduces utilization of other health services and in fact reduces the total cost of health care:

- Blue Cross of Western Pennsylvania assessed the impact of mental health outpatient treatment on medical/surgical costs. Such services were not made available to a comparison group of subscribers. The findings showed that the medical/surgical utilization rate was reduced significantly for the group which had available the psychiatric benefits. The monthly cost per patient for medical services was more than halved -- dropping from $16.47 to $7.06. The overall cost to the insurer (with mental health treatment factored in) was reduced by 31 percent.

- A study by Rosen and Wiens at the Medical Psychology Outpatient Clinic at the University of Oregon Health Science Center studied both children and adults (using a control group) and found significant group effects for changes in the number of medical outpatient visits, pharmaceutical prescriptions and diagnostic services. For each of these three measures, those receiving mental health services reduced their use of medical outpatient services by 41%. Data indicated that this change was taking place with all patients, not just high-utilizers of medical services.

- Group Health Association of Washington indicated that patients treated by mental health providers reduced their non-psychiatric physician usage within the HMO by 30.7 percent in the year after referral for mental health care compared to the previous year. Use of laboratory and x-ray services declined by 29.8 percent.

- Kaiser Plan in California estimated that the subsequent savings for each patient receiving psychiatric treatment were on the order of $250 per year.

(OVER)

- In a study detailed at the April 1978 Southwestern Psychological Association Meeting it was found that among children specifically, the presence of reimbursable mental health care reduced the mean number of physician visits for other purposes by 36 percent. Indeed, a matched control group, for whom such mental health services were not made available, suffered an increase of 30 percent in the mean number of other physician visits during the same period.

- An unpublished study by Shapiro and Goldensohn (NIMH contract) using the Health Insurance Plan of New York (a comprehensive prepaid group practice) compared a study group with three comparison groups regarding utilization of family doctor, specialist, x-ray and laboratory services. The study group, which received mental health treatment, showed a significant decline in utilization of family doctor and specialist services compared to the comparison groups, and a decrease in x-ray and laboratory services which was not statistically significant.

- A study to explore the impact on general outpatient medical care utilization resulting from outpatient mental health intervention was conducted by Group Health Cooperative of Puget Sound. This study used two study groups: one with prepaid members and one consisting of fee-for-service patients.

  The study groups began with high utilization rates, as compared to the controls, and after receiving treatment declines in their utilization rates were found to be very substantial. Medical care utilization for these study groups dropped to a level comparable to the controls. The study found little difference in the overall utilization patterns of prepaid and fee-for-service study groups.

- In an unpublished NIMH contract study, the impact of psychiatric treatment for Medicaid enrollees in a prepaid plan on their utilization of outpatient medical services was studied. The treatment group reduced utilization of family doctor, and specialist services by 11% and 15%, and of laboratory and x-ray services by 25%. In contrast, a comparison group diagnosed as having mental, emotional or psychological problems, but not receiving treatment under the group plan for such disorder, increased their utilization of other services, particularly of specialists, laboratory and x-ray services.

THE MENTAL HEALTH ASSOCIATION OF JOHNSON COUNTY
7208 West 80th Street • Room 208 • Overland Park, Kansas 66204 913 • 384-2707

IT PAYS TO PROVIDE MENTAL HEALTH CARE!

Recent research has shown the important relationship between mental and physical health; between behavior and biology. For instance:

- different personality factors cause certain kinds of cardiac disease;
- in grief, people's immune mechanism alters so that they cannot defend themselves as well against infectious diseases;
- people with good mental health tend to live longer and have fewer diseases than people with poor mental health.

A wealth of studies support the assertion that patients seen by medical doctors for physical complaints can often be helped by psychotherapeutic intervention. Many physical ailments have been linked to emotional problems, and practitioners are beginning to understand that emotional and physical health are highly interrelated. Yet:

- 55% of people with mental health problems go exclusively to the general health sector;
- 27% of people who walk into a general health practitioner's office are people suffering from a mental disorder;
- only 10% of those 27 percent are recognized as having a mental disorder;
- psychiatric disorders account for much general hospital work. (Over half a million persons were discharged from psychiatric units in general hospitals in 1975, but another one million with primary psychiatric diagnoses were treated in other parts of the hospital; and a further one million had psychiatric diagnoses as secondary diagnoses).

Numerous studies have now shown that when a mental health service is incorporated into the delivery of general health services, there is a substantial cost-offset resulting from reduced utilization of medical/surgical services. For example:

- a review of 13 such studies showed a 20% median reduction in general health service use when a mental health service is incorporated;
- when mental health treatment was made available to post-operative elderly patients who underwent surgery for fractured femurs and these patients were compared to a control group which had no mental health intervention, the treatment group showed an average length of stay 12 days shorter than the controls; twice as many patients in the treatment group returned home rather than being discharged to a nursing home or other institution and a substantial reduction in the cost of their medical care was effected;

-OVER-

- recent studies show that for certain chronic medical disorders, such as emphysema, hypertention, asthma, those people who have mental health treatment as part of their overall mix will show a reduced amount of general health service utilization as well;

- in 1968 four controlled studies of pre-surgical therapy on cardiac patients were conducted. One hour interview, 2 to 3 days before surgery, followed by specific recommendations for post-operative care accounted for a 50% reduction in abnormal responses to surgery;

- when group psychotherapy was provided to alleviate stress for patients treated for ulcerative colitis it was found, over a two year period and across a variety of hard criteria (e.g. operations required), that those who received group therapy were less likely to require medical treatment than those who did not; there was also a lower morbidity rate for therapy patients as well.

When American business addresses the need for adequate mental health services for employees, studies indicate substantial cost savings are achieved. Based on data compiled by large companies the Washington Business Group on Health concluded that the benefits of psychiatric coverage were: improved employee productivity; reduced absenteeism; improved employee morale; reduced hospital/surgical/medical utilization; lower insure premiums.

Some such programs showing specific benefits are:

- The Kennecott Cooper Corporation of Utah estimated a 6 to 1 benefit-to-cost ratio per year for its Insight Psychotherapy Program. The program produced a 52% attendance improvement; a 74.6% decrease in weekly indemnity costs, and a 55.4% decrease in medical/surgical costs among its 150 participants;

- The Equitable Life Assurance Society found that for every dollar of treatment cost incurred by their "Emotional Health Program", there was $3.00 return in increased productivity;

- Kimberly-Clark's Employee Assistance Program showed a 70% reduction in on-the-job accidents for the year after participation as compared with the year before

Finally, a study which directly assessed the economic impact of furnishing effective mental health treatment demonstrates the enormous savings to society when appropriate mental health care is available to all:

- the introduction of the drug lithium (used to treat manic-depression) has saved $2.55 billion direct treatment costs in ten years and resulted in a $1.28 billion gain in production, for a conservative total of over $4 billion saved.

Attachment 12

Drug and Alcoholism Council

of Johnson County

5311 Johnson Drive Shawnee Mission, Kansas 66205 913-432-8424

TO : Members of the House Insurance Committee

FROM: Ann Etter
Drug and Alcoholism Council of Johnson County

DATE: Monday, February 13, 1984

RE : House Bill 2795

The Drug and Alcoholism Council is a citizen volunteer organization that conducts planning and community education on substance abuse issues for Johnson County. We annually conduct a review of substance abuse services available in the county. Each year the need for affordable treatment for persons without insurance or other means of private payment is identified.

Passage of HB 2795 will enable more people to receive needed treatment through the increased availability of adequate insurance coverage. The average cost for a 21 - 30 day inpatient alcohol and drug treatment program is $5,000 - $5,500. Mandatory insurance coverage is a measure that will have its greatest impact on the middle income/working class population. These are the people who have jobs, have insurance, but simply do not have the personal financial resources necessary to obtain treatment.

The need for appropriate insurance coverage was evidenced in the results of a public opinion survey conducted by the Drug and Alcoholism Council at Oak Park Mall during a two-day drug and alcohol awareness fair in October, 1983. One hundred thirty-four respondents were asked if they were in favor of guidelines compelling insurance companies to cover drug and alcohol treatment.

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Sixty-four percent responded positively, 11% negatively and 25% were not sure. Survey respondents were from all age groups, family situations, and lived in Johnson County and surrounding communities.

While mandated insurance coverage for substance abuse treatment is not a total solution to the problem, it is a necessary component. With proper coverage many persons wanting treatment, but who could otherwise not afford it, will be able to seek help.

Thank you for your consideration of this very important issue.

Attachment 13

My name is Dr. Clyde Rousey. I am in the private practice of clinical psychology in Topeka. Today I am appearing before your committee as a representative of the Kansas Association of Professional Psychologists. This association is composed of more than 100 doctoral level psychologists in all areas of our state who are certified by the State of Kansas to provide diagnosis and treatment on a private basis to those of our citizens who become incapacitated in varying degrees by emotional disturbances. Along with our other colleagues and citizens who are appearing before you we wish to commend Representative Blumenthal for the change he has proposed and to urge you to support him not only in this committee but on the floor when the bill is considered.

Since we are both providers and consumers in the health care system we are acutely aware of the need for insurance companies to be cost efficient and prudent as well as for the consumer to benefit from the advances in health care. None of us ever plan to be mentally ill, just as none of us ever plan to have appendicitis. While we all know the catastrophe which ensues if one's appendix ruptures and no treatment is available for lack of insurance, most of our friends and neighbors have only a faint awareness of the potential trouble which exists for an individual, his or her family and society in mental illness that goes undetected and untreated. While health plans would not even think of offering an option for being treated for appendicitis, the present situation where only optional care for mental illness is offered is a problem Representative Blumenthal is attempting to correct. It is unfortunate that there is a general lack of awareness of the savings awaiting each of us in medical costs and economic productivity that

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ensues with early and proper intervention for emotional problems. The continuance of the optional provision for psychological care encourages in each of us the fantasy that we will never have emotional problems. From a cold statistical basis, this flies in the face of reason.

This committee has a unique opportunity to do something for our fellow citizens. It can at one and the same time both make it possible for your friends and neighbors to have more easily available improved health care while at the same time reducing our total health bill which is presently at least partially inflated by physical reactions to our emotional distress. The Kansas Association of Professional Psychologists is pleased to endorse Representative Blumenthal's efforts and asks your help in promoting the health of not only your constituents, but also yourself.

Attachment 14

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Statement Regarding House Bill No. 2795

I. Short Title of Bill

The bill relates to insurance reimbursement for treatment of alcoholism, drug abuse or nervous or mental conditions. This bill amends K.S.A. 40-2105 and repeals the existing section which permits every insurer unless refused in writing to include psychiatric coverage and treatment of alcohol and drug abuse in their insurance coverage.

II. Background

This legislation is being introduced to mandate minimum insurance coverage for psychiatric illness and treatment of alcohol and drug abuse for all Kansans holding group or individual medical policies. During the last few years the trend has been to reduce benefits for psychiatric illness and substance abuse problems. This bill will help prevent the future decline in third party coverage for psychiatric and alcohol and drug abuse problems. If the trend toward decreased insurance coverage is not reversed, the financial status of community mental health centers that provide psychiatric and substance abuse services will certainly be adversely affected. Under present statutes minimum mental health insurance coverage is included in insurance policies however an employer may delete the coverage for mental illness. House Bill No. 2795 will make coverage mandatory in all employee policies.

III. Discussion

A benefit for the citizens of Kansas will be that they will have more choices for psychiatric care. Currently 60% of general medical care patients have emotional rather than organic bases for the physical symptoms. By having mandated coverage, consumers will be more likely to respond to a referral for mental health services and not over utilize general medical service. In addition, by having outpatient mandated coverage many consumers will choose to get psychiatric care on an outpatient basis through community mental health centers rather than waiting until problems increase and inpatient hospitalization is required. In addition, in a time when the insurance industry is making cuts in coverage provided as a cost saving, this legislation will prevent further cuts in psychiatric and drug abuse coverage for our citizens.

IV. SRS Position

The Department of Social and Rehabilitation Services would support this bill because it would enable community mental health centers to recover their fair share of the costs for the psychiatric and substance abuse services they provide by preventing the further decline in insurance coverage for these services. Lastly, it is important that our agency advocate for our citizens that suffer from mental illness and substance abuse problems since they can not advocate for themselves.

Robert C. Harder, Secretary
Office of the Secretary
Social and Rehabilitation Services
296-3271
February 8, 1984

Att. 14

Attachment 15

To: House Committee on Insurance

RE: HB 2795

House Bill 2795 would benefit the citizens of Kansas by helping remove the stigma associated with alcoholism and drug abuse and by improving accessibility to services for the alcoholic, the drug abuser and their families.

In Kansas, we are seeing people who are having difficulty getting admitted to alcohol and drug abuse treatment if they do not have insurance coverage but have income/assets over the cutoff level for MediKan. These may be the persons who are now overloading the State Hospital ATU's because the hospital programs can only accept so many who can not pay and the Intermediate programs are designed for those people who are GA eligible.

This bill would benefit many groups of persons needing alcohol and drug abuse services, including youth and elderly. The earlier a person is confronted with the fact that he/she has an alcohol and/or drug problem, the easier it is to treat them. Also with young people, if the illness is arrested at an early age, that is less years of costs incurred in treating the symptoms of the illness in medical care and other facilities (jails, etc.). The mandates of House Bill 2795 will allow parents of troubled youth to refer their children to appropriate treatment without having to bear the high cost of these services out of their pocket at one time.

Studies have shown that at least 10% and maybe as high as 20% of the elderly have a serious problem with alcohol and/or drugs. Among those elderly that that have additional medical, family or emotional problems, the rate may be higher than 25%. As we age, the body goes in to a general state of decline. Elderly who continue to drink heavily can put further strain on the liver and kidneys, and illnesses, such as heart disease, are definately aggravated by alcohol. If many of the elderly had coverage through their insurance, they would be able to receive treatment for their problem, and not continue to incur high medical bills to continue to treat the symptoms of their problem.

Statistics have shown that only about 15% of the persons who need alcohol and drug treatment actually receive these needed services. Many groups support and recommended passage of mandated insurance coverage, including, most recently, the Presidential Commission on Drunk Driving.

Overall the cost of this mandated service is minimal and should show a decrease in the overall utilization of the health care treatment system if enacted. I urge you to support this bill and help to enact House Bill 2795 into law.

I would like to thank the chairman and the members of this committee for permitting me to share these views.

Elaine Brady, Director,
Prevention Division
For
James A. McHenry, Jr., Ph. D.
Commisioner
SRS/Alcohol and Drug Abuse Services
296-3925
February 13, 1984

1306B

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Attachment 16

Testimony H.B. 2795

February 13, 1984 **Gene Johnson**

Mr. Chairman, and members of the committee, I am Gene Johnson representing the 27 Kansas Community Alcohol Safety Action Projects Coordinators Association. We serve all of the 31 Judicial Districts in the State of Kansas for the evaluation of all DWI offenders.

During the 1982 Legislative session, a more severe DWI law was passed. Part of that legislation also mandated either alcohol and drug information/education school or alcoholism or drug addiction treatment for the first time offender. For those offenders who have been convicted of DWI during the previous five years, the offender must serve a minimum of five days in jail, and then he can be paroled at the direction of the court to an alcohol/drug treatment program. In addition, the offender's driving privileges are suspended until he completes that court ordered treatment program to the court's satisfaction.

The main thrust of the change in our DWI laws was to place the financial responsibility on the offender rather than the taxpayers in general.

A majority of the DWI offenders have some type of hospital-medical insurance which should cover a disease which has been recognized for over thirty years by our foremost health organizations. That disease being alcoholism. Many reputable treatment centers are "free standing" and not affiliated with any hospital or medical center. Other treatment centers offer "first class" out-patient treatment for those who are afflicted with alcoholism. These centers have to

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rely on private pay or public funds in order to maintain their programs. Third party pay would allow these programs to offer better and more complete treatment.

We support H.B. 2795 as a positive step forward in the treatment of the disease of alcoholism and drug addiction. Our hope is that this committee will pass this proposed legislation favorably to combat what the former U.S. Representative Wilbur Mills stated over the weekend is the "nation's biggest problem."

Thank you.

Gene Johnson

Gene Johnson

Kansas Community ASAP Coordinators Association

Attachment 17

KANSAS ALCOHOLISM AND DRUG ABUSE COUNSELOR'S ASSOCIATION

TO: House Insurance Committee

FROM: Glenn Leonardi, Representing the Kansas Alcoholism and Drug Abuse Counselor's Associaiton G.L.

SUBJECT: House Bill No. 2795

DATE: February 13, 1984

I appear before you today on behalf of the Kansas Alcoholism and Drug Abuse Counselor's Association (KADACA) to voice our association's support of House Bill No. 2795.

KADACA is a professional organization of over two hundred and fifty certified alcoholism and drug abuse counselors representing the entire state of Kansas. The association's purpose is to develop and maintain professional standards and to insure delivery of quality services by the members of this profession.

In the last decade the stigma associated with alcohol and other drug abuse problems has been greatly reduced. As a result, fewer clients and their families are prolonging the suffering related to such problems. Our society is gradually understanding and dealing with what has become our nation's third major health problem. Your consideration of House Bill No. 2795 clearly reflects our need to establish social policy that can effectively address the needs of Kansas.

Our association is aware and supportive of the techinical points addressed by the Kansas Association of Alcohol and Drug Program Directors and we respectfully request your support of this legislation.

Feb. 13

Attachment 18

Kansas Citizens Advisory Committee on Alcohol and other Drug Abuse

P.O. BOX 4052 TOPEKA, KANSAS 66604

February 13, 1984

Rep. Rex Hoy
Chairman
House Insurance Committee
Kansas State Capitol
Topeka, Kansas 66612

Re: HB 2795

Dear Committee Members:

The Kansas Citizens Advisory Committee on Alcohol and Drug Abuse is very much in support of HB 2795. The majority of alcohol and drug abuse patients currently being treated in Kansas do not have insurance coverage for their condition. Consequently, the financial responsibility falls on the Kansas taypayer. We feel that it is only logical that the third major health problem in Kansas be covered by medical insurance. A number of studies have concluded that it is most cost-effective to treat alcoholism in its early stages. It might be appropriate to reinerate a slogan used on TV "You can pay me now or you can pay me later."

Respectfully submitted,

Bruce H. Beale
Chairman

Feb. 13

Attachment 19

Kansas Association of Alcohol and Drug Program Directors

February 13, 1984

To: House Insurance Committee Members

From: George Heckman, KAADPD

Re: Support for HB 2795

The Kansas Association of Alcohol and Drug Program Directors represents more than forty-five agencies providing alcohol and drug abuse services in our state. The member agencies operate treatment, prevention and alcohol-drug safety action programs in a variety of settings across our state.

Our association strongly supports HB 2795. This testimony is directed primarily at the alcohol and drug dependency coverage outlined in the bill. Each of you has received earlier information about the potential benefits and projected costs of providing mandatory insurance coverage for alcoholism and drug dependency which I will highlight.

A five year study by Holder and Hallen in California pointed out the following trends, among the 337,000 members involved:

A) About ½ of 1% of the entire enrolled population used the alcoholism services each year.

B) The projected premium addition fluctuated from 9¢ to 19¢ per month per subscriber.

C) Outpatient care utilization increased over time.

In studying the families of alcoholics and matched non-alcoholic families, the following was discovered:

A) Total medical care costs for members in an alcoholic family (both inpatient and outpatient care) decreased substantially over time as the effect on the family of treatment of its alcoholic member occurred. ...At the end of the study, the inpatient cost per person per month of both the contract families and the alcoholic familes were similar and the outpatient costs of the control families were actually higher.

Attach. 19

While most authorities agree that alcoholism and drug dependency are illnesses, concern will undoubtedly be expressed that alcoholism and drug dependency are self inflicted conditions. I would call your attention to present insurance coverage of maternity benefits. Health insurance groups have long been willing to finance maternity benefits, a self inflicted condition, which involves less than 1% of the insured population. It's time to overcome the stigma and ignorance surrounding alcohol and drug dependence and provide coverage for those who need it.

You're all aware of the tremendous cost alcoholism and drug dependency incurs upon our society. I don't need to go through this long list of problems and pain.

In closing, a 1982 Gallup poll showed that 4 out of 5 Americans viewed alcohol abuse as a major national problem and 59% feel that alcoholism treatment should be covered by medical insurance the same as any other disease.

This bill effects too many Kansans to not get a vote by the entire house. We urge your support for HB 2795.

Attachment 20

Statement Regarding House Bill No. 2795
Before the Insurance Committee of the Kansas House of Representatives

By: W. Walter Menninger, M.D.
13 February 1984

Thank you for the opportunity to comment on HB 2795. In speaking before you, I wear a number of hats - as a concerned citizen, as a psychiatrist who works with emotionally troubled persons, as a member of the professional Advisory Committee of the Mental Health Association, and as the Chairman of the Committee on the Chronically Mentally Ill of the American Psychiatric Association.

Those of us who work with the mentally ill are keenly aware of the reluctance of most people to acknowledge that they might have any kind of emotional illness. The stigma of admitting to oneself and to others that something is not working right in oneself mentally is hard to overcome. This stigma contributes to the reluctance of many people to face up to problems which they have and to get the kind of help that would best resolve the problems. The result is that many people with emotional problems either refuse to acknowledge them or instead experience some kind of physical distress which prompts them to seek help from a general physician. Studies have repeatedly demonstrated that a substantial proportion of patients who go to see primary care physicians - family physicians, internists, and the like - do not have anything physically wrong with them; rather, their complaints are a function of emotional problems played out in some physical complaint. This same stigma about mental illness limits people speaking out. It is for this

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reason that I feel obligated to speak out to you on their behalf. As much as we all tend to separate the mind from the body and operate as if there were no connection between the two, we disregard reality when we do so.

Although it is generally couched in terms of cost, I submit that the exclusion of coverage for mental illness is an extension and reinforcement of the stigma against mental illness. Somehow it is easier to deal with and acknowledge an obligation to pay for the diagnosis and treatment of a stomach ulcer or persistent problems with the bowels than it is to diagnose and treat the basic emotional problem which may underlie those symptoms - anxiety, depression, etc. - or emotional problems which do not have associated physical complaints.

I am keenly aware that the costs of all medical care have skyrocketed in recent years. It is understandable that earnest efforts have been made to contain some of the rising costs. It is, however, unconscionable that in the efforts to contain the costs there is an exclusion of coverage for mental illness. It is a myth that treating mental illness will break the bank when some appropriate limits are applied to that coverage. I will not attempt to repeat some of the information which I know you have heard or will hear from others about the cost factors and the comparison of the cost for mental health coverage versus the cost of physical coverage. I would draw attention to the fact that emotional illness remains an extremely costly problem for business and industry, reflected as it is not only in sick leave due to physical complaints which are based in emotional distress, but also in absenteeism, accidents and alcoholism. Enlightened executives will acknowledge that

investment in mental health care is a sound business investment and can generate greater productivity. Walter Wriston, Chief Executive Officer of Citicorp and Chairman of the Business Roundtable Task Force on Health, affirms this view: "There is a persuasive case to be made that providing effective prevention and treatment services is not only the right and humane thing to do, it is also a sound business investment.... When a manager sees absenteeism rising or coronary events increasing, he or she knows that it is not only a human problem, but a business challenge. Setting up mental health services to remedy these human problems and restore these employees to full productivity is a rational and legitimate business decision. The more sensitive such programs are to early detection, the better - for the employee, the company, and the whole society."

May I urge you to favorably endorse HB 2795 and refer it for passage.

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Attachment 7

F. F. M. H.

Families For Mental Health, Inc.

JOHNSON COUNTY

P. O. Box 2452 Shawnee Mission, Kans. 66201

February 13, 1984

I am testifying today in favor of House bill 2795. As Past President of Families For Mental Health of Johnson County and as a father of a 24 year old son who suffers from mental illness. I am also representing 5 other Families For Mental Health groups in Kansas City, Wichita, Topeka, Newton and McPherson. All of these groups are made up of families who have family members suffering from mental illness and when a family member suffers the whole family suffers. Suffering is made up of the pain, frustration and anger in having a loved one who cannot function in society, and the problems involved in coping with this person and trying to find the services that can help our family member. Most of our families are not wealthy but are people who have struggled to gather together the resources just to take care of their own daily lives and don't have the extra resources to care for an ill family member from their own pockets. Insurance is not a luxury for these families--it is a necessity.

Our position is that mental illness is a legitimate illness, and it has a physical basis. Almost all the recent research into this area fortifies this position. Our position further is that as a legitimate illness mental illness should be insured on the same basis as the traditional physical illnesses, however, we are practical and know that this will not be accomplished overnight, therefore, we are proponents for House Bill 2795, as a step in the right direction.

Our personal belief is that, if insurance were available, many people would get treatment earlier than they do now. This alone could result in less cost in the future both for mental and physical treatment. Our personal experience with this is that our son went through the agony of having his tonsils out at age 19 when it was not necessary, because he was looking for a solution to his mental problems. Had that same cost been applied to mental treatment, he might be a better functioning member of society today. This preventive treatment could well reduce the population of mentally ill people living on the streets. A population that is now estimated at 1 million people creating a situation which is fast becoming a national disaster.

Our families are not trying to feather our own nest in this matter. For those of us who had insurance benefits, they have run out long ago, and we now have no way of insuring a preexisting condition. Our concern is with the future. Withthe persons who are unlucky enough to have mental illness and with the families who are unlucky enough to be directly involved. They could be your families.

Insurance is a method of spreading the risk of loss due to an unforeseen event. Mental illness is an unforeseen event. It causes great cost to all of those directly involved. That risk should be spread between everyone. The National Institute of Mental Health predicts that someone in 1/3 of all families will suffer some kind of mental illness. This is a large group of people to continue to ignore. It is time to recognize that this segment of our population has as much right to be insured as does the rest of the population.

It is an unfortunate fact that many people do not want to, or cannot psychologically accept the fact that they are at risk, therefore, when they select health insurance they ignore mental health coverage. The other fact is that when a person's employer selects the group coverage for the group the bottom line cost may be the predominent factor, and mental health coverage is not considered important. Therefore, until people become more mental health orianted it will be necessary to provide them with this coverage on a mandatory basis.

Howard W. Snyder

Howard W. Snyder

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The Kansas City Times

A Capital Cities Communications, Inc., Newspaper

JAMES H. HALE, Publisher and Chairman of the Board
MICHAEL E. WALLER, Editor and Vice-President
JAMES W. SCOTT, Editor, Editorial Page

MEMBER OF THE ASSOCIATED PRESS

Vol. 116 Monday, February 13, 1984 No. 136

Insurance for Mental Care

It's not hard to remember when a family with a mentally ill member lived in mortal fear "people would find out."

The matter was talked about in whispers. The person might be sent out of town. Upon his or her return, those who knew took care: It might be catching. As years passed, the next generation heard only snips of gossip, not enough to know if the secret was criminal, immorality, disease or some demonic combination.

Fortunately, all that has changed.

Emotional disease is generally accepted as a sickness as much as physical affliction, one that is treatable and deserving of compassion. Facilities for care have matured. Society has ceased to ostracize victims of mental illness and to blame them for having imaginary problems. Even the most skeptical individuals view therapy as an acceptable kind of help with personal nightmares.

At least, we are moving in those directions.

But vestiges of the old attitudes toward mental illness persist in insurance coverage in Missouri and Kansas. Companies don't have to provide such treatment as part of basic medical protection although it must be available as an option. A majority of those insured do not have it. This is a plain bit of discrimination against persons disabled by emotional pains. The distinction indicates those who write the rules figure the emotionally ill are kind of sick but not *really sick* such as someone felled by a heart attack.

Bills are now before the Kansas Legislature and the Missouri General Assembly to mandate insurance coverage for mental illness. The sponsors, Rep. Gary Blumenthal in Kansas and Rep. Carole Roper Park in Missouri, believe timely mental health care in the long run will reduce the total medical bill. The U.S. Public Health Service estimates at least 60 percent of all physician visits have an emotional rather than an organic basis.

Those and other pragmatic arguments are adequate reasons for supporting the measures, in addition to correcting the bias against mental disorders. Opponents' main objection is that it will cost more. That is a weak argument. Care for heart patients inflates insurance premiums. Yet no one has suggested isolating that group.

Families no longer exile emotionally troubled members. Now the insurance industry needs some updating.

Attachment 22

SHAWNEE MISSION MEDICAL CENTER

February 9, 1984

House Committe on Insurance
State of Kansas

RE: House Bill number 2795

Shawnee Mission Medical Center has had a mission to treat chemically dependent persons in their addiction recovery unit since 1977 and has treated well over 2000 persons in that time. The unit has the potential to treat just less than 400 patients per year. For each patient admitted to the program, there is probably one who does not have insurance that will cover their recovery treatment. Coverage for outpatient is even less likely. The cost of this quality recovery program, without insurance, is almost always prohibitive for the individual and the family. This is especially so since the disease of addiction is ordinarily accompanied by financial, occupational, medical, family, social and legal problems and complications.

Considering the enormous financial "fallout" from substance abuse that falls on the taxpayer, treatment for recovery seems to be a very cost effective solution. Therefore, at least those chemically dependent who are fortunate enough to have insurance, should have coverage and access to alcohol and other drug treatment programs.

People do not plan on having certain specific injuries or diseases when they purchase health care insurance. We should expect that the third largest health problem would be covered by health insurance. It does not make sense that eighty percent of the Kansans seeking treatment (statistics quoted by Task Force on Youth Treatment), do not receive it. Therefore, we certainly support House Bill number 2795 and urge you to support this concept, in general.

Sincerely,

Sonya Yarmat

Sonya Yarmat, Director
Alcoholism Recovery Unit
Shawnee Mission Medical Center

SY/ss

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Attachment 23

Diane Wertz, Director

DRUG ABUSE EDUCATION CENTER
803 Clairborne
Olathe, Kansas 66062

February 13, 1984

Committee On Insurance
House of Representatives
Kansas State Capitol
Topeka, Kansas 66612

To The Committee On Insurance,

RE: HOUSEBILL #2795

The Drug Abuse Education Center wishes to express thier endorsement of Housebill #2795.

We especially have concerns for the patient who receives no reimbursement for out-patient treatment for alcoholism and/or drug abuse. Many people who would benefit from such services must forego treatment because of financial reasons.

During the year of 1983 we received payment from only three insurance companies for client services out of serveral claims that were submitted.

Cost of out-patient treatment and length of time varies. At the beginning of treatment, for six months with 2-3 visits a week, estimated costs vary between $500 and $2500 depending on the intensity of the individual need for treatment.

Again we wish to express our endorsement of Housebill #2795, specifically for the concerns of out-patient treatment.

Sincerely,

Diane Wertz

Diane Wertz, Director

Paul Malloy

Paul Malloy, Counselor, MSW

Jennifer Workman

Jennifer Workman. Asst. to Director

Linda Layman

Linda Layman, Evaluator

DW/11

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Attachment 24

Melissa J. Smith, Ph.D.
213 Fillmore
Topeka, Kansas 66603

February 10, 1984

Representative Elizabeth Baker
180-W, State Capitol
Topeka, Kansas 66612

Dear Representative Baker:

I am writing to urge your support of H.B. 2795. There is evidence that treatment for alcohol problems or mental disorders is closely associated with a subsequent reduction in medical care utilization in at least employee-based alcohol programs and organized health care settings. Medical care was reduced in these studies by a greater percent than in comparison groups. It is often very difficult to predict in adults and children when a mental condition, nervous condition, or drug abuse problem will occur. Therefore, having some kind of mental health rider in the insurance policy allows individuals to get help for these kinds of difficulties before they intensify to the extent that there is interference with job performance and other aspects of daily living. For these reasons, I urge you to support HB 2795.

Thank you very much for your attention to this matter.

Sincerely,

Melissa J Smith PhD
Melissa J. Smith, Ph.D.

MJS/kf

Dr. Smith spoke with me on the phone and I promised her I would get copies of this letter to each of you.

Thank you.

Elizabeth Baker

Attach 24