Approved 2-10-86
Date

MINUTES OF THE House COMMITTEE ON Insurance.

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

3:30 ~~a.m.~~/p.m. on February 6, 1986 in room 521-S of the Capitol.

All members were present except:

Committee staff present:

Melinda Hanson, Research Department
Gordon Self, Revisor's Office
Deanna Willard, Committee Secretary

Conferees appearing before the committee:

House Speaker Mike Hayden
Dr. Karl Menninger
Dr. Jim McHenry, SRS
Mr. Paul Klotz, Assoc. of CMHC's of Ks.
Mr. E. W. Rakestraw, Family Serv. & Guidance Center
Dr. Sandra Shaw, Bert Nash CMHC
Mr. Howard Snyder, K.F.F.M.H.
Mr. Bryce Miller, Mental Health Assoc. in Ks.
Ms. Elizabeth E. Taylor, KAADPD
Mr. George Heckman, KAADPD
Mr. Jim Turner, Kansas League of Savings Institutions
Mr. Gene Johnson, Ks. Comm. ASAP, Inc.
Mr. Bruce McCallum
Dr. Richard Maxfield, Ks. Psychological Assoc.

HB 2737 - An act relating to reimbursement for treatment of alcoholism, drug abuse, and nervous or mental conditions.

The first proponent for this bill was House Speaker Mike Hayden, one of the bill's sponsors. He said that the concept of the bill was not new but that it contained some amendments; one is that inpatient treatment of at least 30 days would be covered under individual health policies; another is that outpatient treatment would be paid up to $1,125 per year, with a $7,500 lifetime cap. He stated that Subsection B clearly defines "mental conditions," which would limit abuse of the coverage. Though this would add to the upfront cost of health care, he feels this would be offset by the quality of life of those people who would benefit from this coverage. He thinks Line 0052 might be misinterpreted and that the language could be changed to "an amount equal to." He entertained questions about the financial cost to policyholders and about policyholders paying for court-ordered diversions.

Dr. Robert Harder, SRS, introduced the next conferee, Dr. Karl Menninger. Dr. Menninger stated that we are learning more about what mental illness looks like and we are finding that many pathological disorders can be treated.

Dr. Jim McHenry , SRS, said his department's position is that implementation of this bill would result in a long-term reduction in health care costs, that persons would receive treatment at earlier ages, and that there would be no dramatic increase in premiums. He requested amendments which would allow the inpatient coverage to apply to alternative means of treatment and provide outpatient day treatment for alcoholism and drug abuse. (Attachment 1.)

The next conferee was Mr. Paul Klotz, representing the Association of Community Mental Health Centers. He stated

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

that this coverage would provide for a class of people which has been left out of health care. He contended that mental health care costs are definable and predictable. He cited figures for yearly mental health costs per client, which he said were much lower than those in general health care categories and spoke of an Oregon study which determined overall health care costs can be cut with alcohol/drug and mental health intervention. He stated that private insurance should pay its fair share of the mental health bill; currently, it pays 58% of the general health care bill, and 49% of the mental health care bill. (Attachment 2.)

The next conferee was Mr. E. W. Rakestraw, of Family Service and Guidance Center. He spoke of the DSM-III, the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, the purpose of which is to "provide clear descriptions of diagnostic categories to enable clinicians . . . to treat various mental disorders." He talked about "V codes," conditions for which one receives treatment but which are not due to a diagnosable mental disorder. Treatment for such conditions would not be billable under this legislation. (Attachment 3.) Copies of the explanation of the various V codes were prepared at the request of Legislative Research staff. (Attachment 4.)

The next conferee was Dr. Sandra Shaw, of the Bert Nash Community Mental Health Center. She stated that there is a body of evidence which shows that this coverage would result in a cost savings. She cited the Kaiser-Permanente Health Plan, a forerunner of the modern HMO. Findings of said Plan indicated that emotionally distressed persons used medical facilities nearly twice as much as the average Plan subscriber, but these individuals who had ready access to mental health services significantly reduced their use of medical services. (Attachment 5.)

The next conferee was Mr. Howard Snyder, representing Kansas Families for Mental Health, a support group for those with family members suffering from mental illness. His position is that mental illness is a legitimate illness with a physical basis, that it is an unforeseen event, and that the risk should be spread to everyone. (Attachment 6.)

The next conferee was Mr. Bryce Miller, President, Mental Health Association in Kansas. The Association's goal is to have "equity of coverage" between health insurance for physical and mental illnesses. Mr. Miller stated that the private sector should be paying their share of treatment costs of mental illnesses of Kansas citizens. (Attachment 7.)

The next conferee was Ms. Elizabeth E. Taylor, of Kansas Association of Alcohol and Drug Program Directors. Her organization supports this mandate because alcoholism and drug abuse are very costly to society, and the cost of providing insurance coverage is low, based on recent studies which she cited. The "Aetna Study" shows alcoholism treatment costs can be offset by reduced health care costs within two to three years. (Attachment 8.)

CONTINUATION SHEET

MINUTES OF THE House COMMITTEE ON Insurance,

room 521-S, Statehouse, at 3:30 XX.m./p.m. on February 6, 1986.

The next conferee was Mr. George Heckman, President, Kansas Association of Alcohol and Drug Program Directors. His testimony spoke only to the provisions relating to alcohol and drug treatment. He cited several studies which indicated that cost for mandatory insurance is minimal and stated that practical outpatient and residential follow-up treatment for detoxification is available but that such treatment is often not received when insurance covers only actual hospital care for medical conditions. (Attachment 9.)

The next conferee was Mr. Jim Turner, President, Kansas League of Savings Institutions. His organization is supporting this bill because it contains a lifetime cap which would allow actuaries to establish reasonable premium structures. He requested deletion of the section which would allow individuals to opt out of this coverage as he felt it would result in an adverse selection process against group programs. (Attachment 10.)

The next conferee was Mr. Gene Johnson, of the Kansas Community Alcohol Safety Action Projects Coordinators Association, an organization responsible for evaluation of DUI offenders for the courts. After a second DUI in five years, a person must complete a rehabilitation program or spend 90 days in jail (at a cost to the taxpayers of $50 per day.) He stated that often an offender has insurance that does not pay for alcoholism treatment and so is treated in public facilities at government expense. (Attachment 11.)

The next conferee was Mr. Bruce McCallum, who spoke of his experience with HMO-Kansas regarding coverage for substance abuse. His contract with them did not show limitations on number of days of treatment, nor of type of treatment received; however, they have indicated they will cover only three to five days of his son's drug abuse treatment. (Attachment 12.)

The last conferee was Dr. Richard Maxfield, of the Menninger Foundation. He stated that there is widespread evidence of a reduced rate of medical expense following mental health treatment. He gave statistics to show that inclusion of mental health coverage in insurance programs will not lead to overutilization of mental health services for nonessential reasons. He concluded that the reduction of human suffering available to consumers through mental health treatment is reason enough to justify this legislation. (Attachment 13.)

The minutes of the previous meeting were approved.

The meeting was adjourned at 5:10 p.m. by the Chairman.

GUEST LIST

COMMITTEE: INSURANCE DATE: February 6, 1986

NAME	ADDRESS	COMPANY/ORGANIZATION
Gene Johnson	Topeka, Ks	Ks. Community A.S.A.P. Assoc.
Bruce Beale	Lawrence	Ks. ASAP
Bruce K. McCallum	Manhattan	Self
Terri Rosselot	Topeka	KSNA
Elizabeth E. Taylor	Topeka	Ks Assoc Alcohol/Drug Prog. Dir.
[illegible] H [illegible]	Lawrence	Ks Assn of Alcohol + Drug Program Dir.
Richard Harmon	Topeka	KS Life Assoc.
Ray Petty	Topeka	KACEH/DHR
BRYCE MILLER	TOPEKA	MENTAL HEALTH ASSOC IN KANSAS
Paul M. Klotz	Topeka	Assoc. of CMHC's of Ks.
Loretta Class	"	United Way
P. Patterson	"	Assoc of CMHC's
Sandra Shaw	Lawrence, Ks.	Bert Nash CMHC
Larry Hinton	Topeka Ks.	Kansas Alcohol & Drug Abuse Serv. SRS
Robert C Harder	Topeka	SRS
Karl Menninger	Topeka	TMF, Villages
Jim McHenry, Jr.	Topeka	SRS/ADAS
Jim Palmer	Topeka	Savings League Services
Patricia Dolbach	Lawrence	The Menninger Foundation
Nickie Stein, R.N.	1607 College, Topeka	no authority
Jim McBride	87 Peppertree Lane observer	observer
Edith B. McBride	87 Peppertree Lane	observer
Terri Brende	Topeka	Washburn Nursing
Gerald T. Hannah	Topeka	MHRS/SRS

GUEST LIST

COMMITTEE: Insurance

DATE: 2-6-86
P.2

NAME	ADDRESS	COMPANY/ORGANIZATION
Richard B. Mayfield	Topeka	KS Psychological Assoc.
Kelley Hurst	Lawrence	Legislative Intern
Jack Roberts	Topeka	BC-BS
Jim Turner	Topeka	Kansas League of Savings
[illegible]	Topeka	KC Times
Dub Rakestraw	"	Family Service and Guidance Center

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
ALCOHOL AND DRUG ABUSE SERVICES

House Bill 2737
Mandatory Insurance Coverage for Alcohol, Drug Abuse
and Nervous and Mental Conditions

I. TITLE
An act concerning insurance;relating to reimbursement or indemnity for treatment of alcoholism, drug abuse or nervous or mental conditions; amending K.S.A. 40-2,105.

II. PURPOSE
This proposal will mandate that all group insurance and HMO policies include minimum coverage of 30 days per year for residential/inpatient treatment and 100% of the first $100, 80% of the next $1,125 in any year ($1000 total coverage) with a lifetime limit of $7,500 for outpatient coverage. This bill will require the above coverage be offered to all individual insurance policies, but the subscriber can refuse this coverage in an individual policy.

III. BACKGROUND
Two bills mandating this coverage were introduced into the 1984 Legislative Session. These bills were referred to Interim Study. Two bills were introduced in the 1985 session, HB 2170 and HB 2482. Both remain in the House Insurance Committee. The Current statute requires the offering of coverage for alcohol, drug abuse and nervous and mental conditions to all purchasers of group policies, but allows for the purchaser to refuse this rider. This proposal will mandate that all group policies include minimum coverage for alcohol, drug abuse and nervous and mental conditions without the option to refuse this coverage. The bill will require the above coverage be offered to all individual insurance policies, but the subscriber can refuse this coverage in an individual policy. The mandating of minimum coverage for alcohol, drug abuse and nervous and mental conditions has been cost effective in many other states and in many large plans written throughout the nation. The evidence demonstrates that the alcoholics, drug abusers and mentally ill experience greatly reduced utilization of medical and other health care services after a treatment episode.

IV. EFFECT OF PASSAGE
Passage of this bill will allow for the coverage of treatment for alcoholism, drug dependence and mental illness for many persons who would not now have these services covered by their insurance carrier. Insurance carriers and Kansas citizens would be protected from excessive premiums and costs increases by the limitation of coverage included in HB 2737 on an annual basis. Overall, the implementation of this bill will positively impact all general hospitals, psychiatric hospitals, mental health centers and all alcohol and drug abuse treatment programs.

V. SRS RECOMMENDATION
Support the amendment of Kansas Statute to include the mandating of insurance coverage for alcohol, drug abuse and nervous and mental conditions

Robert C. Harder
Office of the Secretary
Social and Rehabilitation Services
296-3271
February 6, 1986

8213B

Attachment 1
House Insurance 2/6/86

STATE OF KANSAS

JOHN CARLIN, *Governor*

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

ALCOHOL AND DRUG ABUSE SERVICES

ROBERT C. HARDER, *Secretary*

2700 West 6th Street
TOPEKA, KANSAS 66606
(913) 296-3925
KANS-A-N 561-3925

TESTIMONY FOR MANDATED INSURANCE COVERAGE

February 6, 1986

I appreciate the opportunity to appear before this committee in support of HB 2737, which would institute in Kansas the concept of mandated health insurance coverage for alcohol, drug abuse and nervous and mental conditions.

The Department of Social and Rehabilitation Services believes that implementation of such coverage would result in a long term reduction in health care costs in the state of Kansas. Mandated coverage would enhance the prospects of individuals suffering from alcohol, drug abuse or nervous and mental conditions seeking treatment in the early stages of their illness. This would improve the prospects for recovery and reduce long term physical and emotional complications.

Half of the states (25) have mandated coverage for alcohol, drug abuse, or nervous or mental conditions. Twenty two states currently have mandatory coverage for alcohol treatment. Nine states mandate both alcohol and drug treatment coverage. Eleven states have mandated coverage for nervous and mental conditions. Six states mandate coverage for alcohol, drug abuse and

nervous and mental conditions. Nearby states, including Missouri, Colorado, and Texas, have enacted mandatory coverage. The Supreme Court of the United States ruled unanimously on June 3, 1985 that states may mandate coverage of specific diseases, including alcoholism, drug addiction, and mental illness. The American Bar Association has endorsed mandated coverage.

<u>Significant Numbers of Kansans are Affected by Mental Health, Alcohol and Drug Abuse Problems.</u>

The National Institute of Mental Health reports that in any 6 month period nearly 19% of the population suffers from one or more mental disorders. Nationally, fewer than one-fifth of those individuals used any mental health service. In Kansas in FY 1985, there were 39,482 admissions to community Mental Health Centers and 3,796 admissions to state hospitals.

Research indicates that nearly 7% of the population, or 155,000 Kansas citizens, have an alcohol or drug problem. Of that number, nearly 22,000 were admitted for treatment in FY 1985. One in every three families experience alcohol abuse problems. Conservative estimates indicate $1 in every $5 spent for hospital care goes for alcohol related problems.

<u>The Cost Offset Effect of Treatment Coverage.</u>

The "Aetna Study," a recently released major research project, shows that average alcoholism treatment costs can be entirely offset by reduced health care costs within two to three years after alcoholism treatment begins. There is a rapid increase in health care costs in the six months preceding the first treatment episode. Following treatment, there is a significant drop in health care utilization and costs.

The study was conducted by Dr. Harold Holder of H-2, Inc., a research firm in Chapel Hill, North Carolina. Insurance data from a four year period on federal employees covered by the Aetna Life and Casualty Company health care plan was analyzed. Included in the study were 1,645 families with at least one member entering alcoholism treatment for the first time between 1980 and 1983, and a comparison group of a random sample of 3,598 nonalcoholic families who filed health insurance claims during that period.

The study found that on the average, alcoholic families utilize health care services and incur costs at a rate about twice that of similar families with no alcoholic members. Average monthly costs for the two groups over the 1980-1983 period were $210 person for the alcoholic families and $107 per person for families without alcoholic members.

There is a gradual rise in overall health care costs and utilization for alcoholics during the three years preceding alcoholism treatment, with the most dramatic increase occurring in the six months prior to initial treatment. Total monthly costs increase from about $150 per month two years prior to treatment, to an average of over $450 per month during the six months prior to treatment and $1,370 in the final pretreatment month. Following the initiation of treatment, the health care costs of alcoholics drop significantly and reach a level roughly comparable to pretreatment levels. Total monthly costs average $294 during the first six months after treatment, and decline to an average of $190 per month by two and one-half to three years after treatment. The most significant drop in health care costs occurs for treated alcoholics aged 44 and younger.

Using a variety of forecasting techniques, it was estimated that the average alcoholism treatment cost paid by insurance coverage could be offset by reduced health care costs within two to three years following treatment initiation.

Other studies have also demonstrated the effects of alcoholism treatment in reducing health care costs. The "Cost Simulation Study of Alcohol Insurance Benefit Packages," using a composite of findings from a number of studies, projects average annual reductions in health care costs range from $790 per person in fee-for-service plans to $1650 per person for prepaid plans.

Studies have also demonstrated that mental health services will off-set the need for medical services. The mental health services of the Kaiser-Permanente Health Plan established in California in the late 1940's has been proven effective.

The first set of findings of several investigations were released in 1967 (Follette and Cummings). Among those findings were that persons in need of mental health services were higher users of medical care than those not experiencing emotional distress. Higher medical utilization significantly decreased following mental health treatment, declines in medical utilization continued for at least five years following the termination of mental health services. Even patients who received only one visit to a mental health professional maintained lower levels of medical utilization during the following five year period.

In 1976, Cummings and Follette conducted an 8-year telephone follow-up of patients who had received mental health services during their enrollment in the Kaiser-Permanente plan and determined that successful resolution of the emotional distress was the reason for the decreased need in medical services.

There have been many other studies demonstrating that timely and competent mental health services will off-set the need for medical services. In 1985, Dorken summarized 47 such "medical off-set studies" and found very similar results to those reported by Kaiser-Permanente. The provisions of adequate mental health services on a timely basis resulted in medical savings from 5% to 78%. Cost off-set has also been confirmed by government sponsored research in both 1979 (Jones and Vischi) and 1982 (Bethesda Consensus Conference).

Premium Costs For Treatment Coverage Are Very Low.

Health insurance premiums will likely continue to increase due to rising health care costs. However, the additional premium costs for coverage can be low because of the cost offset. The benefit cost for Aetna was $1.34 per individual covered per year. Cost could have been even lower since 75% of the provided treatment was inpatient, the most costly treatment modality. Alcohol and drug abuse insurance reimbursements average an annual $2.09 in states with mandated insurance, $1.41 in states such as Kansas with required option, and $.98 with no legislation. Premium costs range can range from no cost (Kemper) to $.15 per month (California), $.36 (Virginia), $.53 (Blue Cross- Michigan). Simulation studies show a possible reduction of $.52 per year.

A six-state study on the effect of mandated alcohol/drug abuse and mental health benefits prepared for the governing body of the District of Columbia found no dramatic premium increases due to mandated benefits. Thirty five percent of insurance industry sources reported no measurable premium increases. Eleven percent reported 1-5% increases. Fifty percent reported 5-10% increases. Only 3% reported 10-15% increases in premiums.

The Mental and Nervous Disorder Utilization and Cost Survey in Washington, D.C. concluded that the most intensive outpatient utilization of a comprehensive mental health benefit would be two percent of enrollees per year for a cost per enrollee of $26.50.

Of the nearly 22,000 alcohol and drug treatment admissions in Kansas during FY 1985, a projected 3319 admissions who might have been covered under a mandatory plan were funded by other sources.

The benefit cost of treating the 3319 admissions would have been $2,577,585. This equals a reimbursement of $1.48 per person in Kansas with health insurance coverage per year or about $.13 per person per month for this coverage.

<u>Alcohol and Drug Abuse and Mental Health Treatment Should Be Delivered in the Least Restrictive Environment</u>.

Current insurance benefit costs for alcohol and drug abuse treatment may be higher than necessary. Of admissions whose reported primary source of payment is Blue Cross-Blue Shield or private insurance, 74% are admitted to the most

costly treatment modality, inpatient in a medical setting. This compares to 27% of all admissions entering inpatient. Referral of admissions to the least restrictive environment could reduce the treatment costs.

In accordance with the benefits of delivering treatment in the least restrictive environment, we propose two amendments to HB 2737.

1. Residential services (non-hospital) for 120 days of coverage, should be included in the mandated services. This service is an inexpensive alternative to hospital based services for persons not needing medical treatment. The greater number of days allows for the treatment of special needs that may not be accomplished in 30 days. An example of a special need is the treatment of youth.

2. Alcohol and drug abuse outpatient day treatment services for 30 days of coverage. This service is primarily used for employed persons and their families. Treatment often takes place in the evenings, allowing them to continue to work and remain in their homes.

It should also be noted that Health Maintenance organizations usually provide health care services and normally do not reimburse or indemnify. Even though HMO's are set forth in paragraph (c), paragraph (a) may need to be amended to clarify that HMO's are covered by the legislation when providing health care services.

Utilization of Alcohol and Drug Abuse and Mental Illness Treatment Benefits is Low.

The highest outpatient treatment mental health services utilization was 2.2 percent of the group population in a study of 12 large insurance plans. A 1974 study revealed only 5 inpatient admissions for mental disorders per 1000 covered population.

Of the nearly 22,000 Kansas admissions for alcohol and drug treatment in FY 85 only 25% were insurance funded. Forty percent were paid for with government funds.

Utilization of alcohol and drug treatment coverage is confined to a small portion of those enrolled in insurance plans. A review of three studies including alcohol treatment programs in HMO's, California state and municipal employees, and the Simulation Study revealed less than 1 percent of those enrolled utilized benefits. In the Aetna Study 7.6 persons per 10,000 covered individuals filed claims for alcoholism treatment during the four years.

Since treatment for alcoholism, drug abuse, and nervous and mental conditions results in subsequent reductions in treatment for other health disorders, and averts other harmful effects in society, SRS believes that alcohol, drug abuse, and mental health care insurance should be mandated.

In conclusion, these are the major points in favor of mandating alcohol, drug abuse, and nervous and mental condition insurance benefits.

1. Insurance coverage encourages early treatment, thereby reducing long term personal and social costs.

2. The United States Supreme Court ruled that states may mandate coverage of specific diseases. At least 20 states and prestigious groups including the American Bar Association have endorsed the concept of mandated insurance coverage.

3. The cost society pays for the effects of the illnesses is extremely high.

4. Alcoholism treatment costs can be entirely offset by reduced health care cost within 2-3 years after treatment begins.

5. Experience demonstrates that with mandated insurance benefits the use of treatment services has not been excessive, nor have premiums been significantly affected.

These facts demonstrate Mandated Health Insurance Coverage is a viable and effective prevention and treatment strategy for health care cost containment in Kansas.

Thank you for the opportunity to present this information.

6456C

Session of 1986

HOUSE BILL No. 2737

By Representatives Hayden, Blumenthal, Braden, Gjerstad, Graeber, Lacey, Lowther and Turnquist

1-24

(Health maintenance organizations usually provide health care services and normally do not reimburse or indemnify. Even though HMO's are set forth in paragraph (c), paragraph (a) may need to be amended to clarify that HMO's are covered when providing health care services.)

0017 AN ACT concerning insurance; relating to reimbursement or
0018 indemnity for treatment of alcoholism, drug abuse or nervous
0019 or mental conditions; amending K.S.A. 40-2,105 and repealing
0020 the existing section.

0021 *Be it enacted by the Legislature of the State of Kansas:*
0022 Section 1. K.S.A. 40-2,105 is hereby amended to read as
0023 follows: 40-2,105. ~~Unless refused in writing~~ *(a) On or after the*
0024 *effective date of this act,* every insurer~~,~~ which issues any *indi-*
0025 *vidual or* group policy of accident and sickness~~,~~ *insurance pro-*
0026 *viding* medical, *surgical* or hospital expense ~~insurance~~ *coverage*
0027 *for other than specific diseases or accidents only and* which
0028 provides for reimbursement or indemnity for services rendered
0029 to a person covered by such policy in a medical care facility, [inpatient]
0030 must provide for reimbursement or indemnity under such *indi-*
0031 *vidual policy, unless the individual in writing refuses such*
0032 *coverage, or under such group* policy which shall be limited to
0033 not less than ~~thirty (30)~~ *30* days per year when such person is
0034 confined for treatment of alcoholism, drug abuse or nervous or
0035 mental conditions in a medical care facility licensed under the
0036 provisions of K.S.A. ~~1978 Supp.~~ 65-429 ~~or~~ *and amendments*
0037 *thereto,* a treatment facility for alcoholics licensed under the
0038 provisions of K.S.A. ~~1978 Supp.~~ 65-4014 *and amendments*
0039 *thereto,* a treatment facility for drug abusers licensed under the
0040 provisions of K.S.A. ~~1978 Supp.~~ 65-4605 *and amendments*
0041 *thereto,* a community mental health center or clinic licensed
0042 under the provisions of K.S.A. 75-3307b *and amendments*
0043 *thereto* or a psychiatric hospital licensed under the provisions of
0044 K.S.A. 75-3307b *and amendments thereto*. ~~Unless refused in~~
0045 ~~writing,~~ Such *individual policy, unless the individual in writing*

[Proposed insertion after "thereto" (line 0044):] , not less than 120 days per year when such person is confined for residential treatment of alcoholism or drug abuse in a treatment facility for alcoholics licensed under the provisions of K.S.A. 65-4014 and amendments thereto, a treatment facility for drug abusers licensed under the provisions of K.S.A. 65-4605 and amendments thereto or a community mental health center or clinic licensed under the provisions of K.S.A. 75-3307b and amendments thereto, and not less than 30 days per year when such person is participating in an outpatient day treatment program for the treatment of alcoholism or drug abuse provided by a previously mentioned facility or by a physician licensed or psychologist certified to practice under the laws of the state of Kansas

0046 *refuses such coverage, or such group* policy shall also provide for
0047 reimbursement or indemnity of the costs of treatment of such
0048 person for alcoholism, drug abuse or nervous or mental condi-
0049 tions, limited to not less than ~~one hundred percent (100%)~~ *100%*
0050 of the first ~~one hundred dollars ($100)~~ *$100* and ~~eighty percent~~
0051 ~~(80%)~~ *80%* of the next ~~five hundred dollars ($500)~~ *$1,125* in any
0052 year *and limited to not more than $7,500 in such person's*
0053 *lifetime*, in ~~said~~ *the* facilities ~~hereinbefore~~ enumerated when
0054 confinement ~~therein~~ is not necessary for ~~said~~ treatment or by a
0055 physician licensed or psychologist certified to practice under the
0056 laws of the state of Kansas.

0057 *(b) For the purposes of this section "nervous or mental*
0058 *conditions" means disorders specified in the diagnostic and*
0059 *statistical manual of mental disorders, third edition, (DSM-III,*
0060 *1980) of the American psychiatric association but shall not*
0061 *include conditions not attributable to a mental disorder that are*
0062 *a focus of attention or treatment (DSM-III, V Codes).*

0063 *(c) The provisions of this section shall be applicable to*
0064 *health maintenance organizations organized under article 32 of*
0065 *chapter 40 of the Kansas Statutes Annotated.*

0066 Sec. 2. K.S.A. 40-2,105 is hereby repealed.

0067 Sec. 3. This act shall take effect and be in force from and
0068 after its publication in the statute book.

Presentation
On H.B. 2737/House Insurance

By:
Association of Community Mental Health
Centers of Kansas
February, 1986

The Association of Community Mental Health Centers (CMHCs) of Kansas Supports H.B. 2737, because:

(1) Citizens having disabilities as a result of mental or drug/alcohol related causes have, as a total class, sometimes been denied equal access to treatment and/or insurance coverage. Unlike other mandates that expand physical treatment and care, this mandate simply attempts to bring an entire category of citizens more into the mainstream.

(2) Mental health care costs are definable and predictable. Of total medical payments, psychiatric payments are between 1.4 and 7.0 percent of total medical payments (NIMH study, 1980).

(3) Average cost per year, per client in a Kansas mental health center for outpatient treatment is less than $167.00. The average number of visits per year, per client is 4.76. The average cost per year for inpatient treatment in a mental health center is $3,090. Mental health centers and H.B. 2737 encourage outpatient treatment. These averages are considerably lower than those found in the general health care categories.

(4) Massive and numerous studies show that mental health-alcohol/drug abuse intervention are cost containing against other medical/surgical costs. These studies report from 5 to 85 percent savings in medical care utilization subsequent to a mental health intervention. The median reduction was 20 percent.

(5) The state of Oregon in 1983, passed mandated mental/alcohol/drug coverage. In March, 1985, the Oregon State Health Planning and Development Agency (SHPDA), at the request of the State Legislature, prepared a comprehensive study, particularly as to cost findings. The report said, in part;

> "Overall, it is apparent that insurance companies, particularly those doing utilization review, have saved a lot of money as a result of Chapter 601 (the mandate law). The Blue Cross/Blue Shield data indicate that overall costs per member per month for mental health and chemical dependency services declined from $1.34 prior to July 1, 1984, to only 51 cents after this date--a decline of over 60 percent. Again, some of this decline is only apparent, not real, because there are still a number of claims outstanding. However, SelectCare figures indicate a decline in costs of nearly 30 percent."

(over)

Attachment 2
House Insurance 2/6/86

"Two of the seven insurers responding to SHPDA's survey claim that Chapter 601 has forced them to raise their rates. Apparently, such claims are made on a subjective basis, rather than resulting from actually tracking costs. In both cases, these insurers claim that Chapter 601 increased the benefit levels. One respondent claims that the 'new law increased benefit levels by approximately 50 percent.' Actually, this may be true for outpatient benefits; but the data show that such services make up only a small portion of an insurance company's overall mental health and chemical dependency reimbursement expenses. Inpatient mental health benefit levels were slashed to a third of their previous level. Therefore, such claims by insurance companies are not supported by the facts."

The Oregon study shows that overall health care costs can be cut with alcohol/drug and mental health intervention. These reductions can be strengthened even further if outpatient services such as partial hospitalization and day treatment can be encouraged as opposed to inpatient services. Also, if providers and insurers can agree on an effective utilization review process, the cost reductions can be very dramatic.

(6) Private insurance should pay its fair share of the mental health bill. Currently, approximately 65 percent of CMHC revenues come from taxpayers. Nationwide only 51 percent of the funds for mental health care come from public sources. Forty-two percent of the funds for general health care come from public services.

(7) H.B. 2737 does nothing to preclude existing or new efforts on the part of insurers to develop cost containing measures of their own.

Thank you!

For further information or complete copies of studies referenced to above, contact:

Paul M. Klotz
Executive Director
Association of Community Mental Health Centers of Kansas
835 SW Topeka Avenue, Suite B
Topeka, KS 66612
(913) 234-4773

-/-/-

A SIX STATE STUDY
OF THE EFFECT OF MANDATED
DRUG, ALCOHOL, AND MENTAL HEALTH
BENEFITS ON GROUP HEALTH INSURANCE PREMIUMS

THE BROWNE COMPANY
WASHINGTON, D.C.
FALL 1985

INTRODUCTION

There exists within the health care sector a considerable controversy over the issue of how to meet the costs of providing care for mental illness, alcoholism, and drug dependency. A major issue in this debate is the trend towards legislative mandates to include certain maximum benefits for mental illness, alcoholism, and drug dependency in insurance plans offered by insurers and health maintenance organizations. At this writing, over twenty states mandate some form of these benefits and such legislation is under consideration in a number of other states.

There is significant reluctance on the part of many insurers and health maintenance organizations to embrace any form of mandatory benefits. The insurers and health maintenance organizations have expressed the belief that provision of such benefits should be the choice of the individual or group purchaser.

The care providers for such illnesses, and other advocates of such care, contend that the social stigma and general denial systems of these illnesses prevent a groundswell of demand for such benefits by the public. They further contend that employers who are aware of this public perception do not feel meaningful pressures to voluntarily provide or expand benefits of this nature.

Against this background, a chorus of claims and counterclaims has arisen from both camps. Central among these claims are four issues which this report attempts to explore. They are:

1. A number of insurers and health maintenance organizations claim that mandating benefits for mental illness, alcoholism, and drug dependency will dramatically increase premium costs for health care protection and be disruptive to the health care delivery system.

2. Some insurers and health maintenance organizations indicate that mandating these benefits will accelerate a trend by employers towards self-insurance as a means of avoiding the impact of mandates, since at this time there is a legal question as to whether self-insured plans must comply with most existing legislation.

3. Many insurers and health maintenance organizations also contend that individuals and employers faced with the increased costs of health coverages because of mandated benefits will severely curtail or terminate their existing group insurance programs.

4. A number of providers of care for mental illness, alcoholism, and drug dependency claim that mandating such benefits will lead to significantly increased utilization of such benefits. While conceeding that this increased usage may result in modest increases in costs for such protection

they contend that there will be an offset in savings through less general medical and hospital services utilization.

It is the purpose of this paper to explore these four issues by reviewing the actual health insurance experience in six states which have had mandated benefits in some form for a period of time. The six states reviewed in our report are Arkansas, Connecticut, Maryland, Massachusetts, Oregon, and Wisconsin. These states were selected for their many diverse characteristics to provide balance to the report. They differ in region, population, economy, and other important social measurements. Their mandated benefits were incepted at different points in time and differ widely in structure.

METHODOLOGY

The relatively short period of time since Wisconsin enacted the first mandated health insurance legislation in 1972, has made it difficult to obtain hard data on claim experience on mental health, alcohol, and drug claims in post-mandated benefit periods as contrasted to pre-mandated benefit periods. In the absence of such data, we conducted our study by contacting sources located in the six study states who had been actively involved in the pricing, administration, and marketing of large numbers of group health insurance plans during both pre-mandated and post-mandated periods. No individual coverage experience was studied.

A total of thirty-one sources were contacted. All of the sources responded. These sources administered 84,500 plans in the study states covering a total of 8,822,100 participants. The sources have access to very significant data from both a quantitative and qualitative standpoint. The major carrier responded in each state. The largest national private carrier responded in each state. A national actuarial consulting firm responded for all states. A large national employer with locations in five of the six states responded for those five states. The balance of the responses were from major group insurers and independent agents located in the states studied. The respondents answers were recorded exactly as given; however, it is obvious the respondents tended to round their numerical responses.

We have utilized data on mandated legislation that is aged for several years. This was done to present a mandated benefit structure for each state that would track as closely as possible with the period studied. The period studied was from the effective date of the mandates to a point thirty-six months after the mandates became effective. There may well be differences in the mandated benefits illustrated in the study and some legislation now in place.

Certain clarifications as to terminology are important. In questioning the

experience of the respondents as to cost history, the respondents were asked not only if premiums increased but if premiums would have decreased in the absence of the mandated mental health, alcohol, and drug dependency benefits. This is important because respondents indicated some leveling of costs in recent years due to cost containment programs. We are also aware that it might not be desirable politically or from a marketing standpoint for an insurer to acknowledge cost increases for mandated benefits. It would not be difficult for the insurer to make internal rate adjustments to reach desirable pricing levels.

In regard to "mandated benefits", the term has a different meaning in different states. For example, in some states legislation requires inclusion of the mandated benefits in all group insurance provided in the state. In other states, the insurer or health maintenance organization must provide the benefit as an option for an employer to elect. In yet a third arrangement, an employer has the option, by written refusal, to waiver the mandated benefits.

It should be noted as a point in interest, there are many other mandated benefits that do not deal with mental illness, alcohol, or drug abuse issues which are in place in the states we studied.

It should also be noted that in accessing the move from insured to self-insured health plans by employers, we measured the movement that solely attributable to mandated benefits or where mandated benefits were the major causitive factor in the respondents view. This is important because there are two points to consider in evaluating the movement of plans from insured to self-insured status. The first point relates to the size of the group involved. The respondents indicated a group of less than 100 participants was not generally appropriate for self-insurance. This fact has particular significance in that the number of employers with less than 100 employees generally significantly outnumbers those employers with more than 100 employees. The second point is that mandated benefits are only one of the reasons, according to respondents, that such plans change status.

SUMMARY

COMPOSITE RESULTS FOR ALL SOURCES

1. 35% of the sources indicated there was no measurable premium increase in the plans they covered attributable to the inception of mandated benefits.

   11% of the sources indicated that they had experienced premium increases in the 1-5% range in the plans they covered attributable to the inception of mandated benefits.

   50% of the sources indicated that they had experienced premium increases in the 5-10% range in the plans they covered attributable to the inception of mandated benefits.

   3% of the sources indicated that they had experienced premium increases in the 10-15% range in the plans they covered attributable to the inception of mandated benefits.

2. 98% of the sources indicated there had been no change from insured to self-insured status due solely to the mandated benefits in the plans which they administered.

   2% of the sources indicated changes from insured to self-insured status due solely to the mandated benefits in the plans which they administered.

3. None of the sources in our study states indicated that there had been any plans terminated due to the implementation of mandated benefits.

4. 14% of the sources indicated they had experienced measurable cost reductions in other areas since the implementation of mandated benefits in plans which previously did not offer coverage in the mandated benefit areas or offered limited coverage in those areas.

   43% of the sources indicated there had been no offsetting cost reductions in other coverage areas since the inception of mandated benefits.

   43% of the sources indicated that it was too early to determine if there had been savings in other coverage areas since the inception of mandated benefits.

OBSERVATIONS

The composite figures indicate a consistency of response throughout the six states studied despite their aforementioned differences.

PREMIUM INCREASES

We found no dramatic premium increases in the states studied due to mandated mental health, alcohol, and drug benefits. Some respondents indicated that a reason for this was that although individual claims for the mandated benefits may be significant, the number of claims for these benefits as a percentage of the total claim exposure was not significant in their experience. Another reason given for the moderate premium increases is that many plans already had benefits in place for mental health, alcohol, and drug abuse which approached, equaled, or exceeded the mandated benefits. The major carrier reported premium decreases in two states after mandated benefits were enacted.

TREND TO SELF-INSURANCE

The two percent of the respondents reporting plans changed solely due to mandated benefits indicated only five plans were actualy changed. The respondents reported a modest trend to self-insurance in plans of over one hundred lives; however, reported that mandated benefits were a minor consideration in that trend. Cash flow, plan design flexibility, and elimination of premium taxes in states where they exist, were cited as the main reasons for the movement to self-insurance.

PLAN TERMINATIONS

Without exception the respondents indicated there had been no plan terminations due to mandated mental health, alcohol, and drug benefits.

OFFSET SAVINGS

No conclusion as to whether meaningful offset savings had been experienced could be reasonably determined from the sources responses. The respondents differed more on this question than any other. It was interesting to note that those sources reporting offset savings were associated with the administration of plans with large numbers of participants. These respondents noted that outpatient costs had increased with utilization after mandates, however, inpatient costs had decreased and the total of outpatient and inpatient costs had decreased. A reason cited for this result was that many participants no longer had to enter a hospital in order to receive benefits for mental health, alcohol, or drug abuse.

CONTRIBUTORS

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SOURCES

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Blue Cross (Little Rock)
Blue Cross (Hartford)
Blue Cross (Baltimore)
Blue Cross (Boston)
Blue Cross (Portland)
Blue Cross (Milwaukee)
Crown Life Insurance
Fringe Benefit Plans,Inc.
Lincoln National Life
MEGA of Wisconsin
Metropolitan Life
F. Barrie Montague,Natl.Institute on Alcohol Abuse
Phoenix Mutual Insurance
William M. Stanton,V.P.,Mercer-Meidinger,Inc.
State Mutual Insurance
Ronald Stebbins, Independent Agent
Travelers Insurance Company
United States Life

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"Mandated Mental Health Benefits Under Private Insurance: A Review of State Laws" Center for Health Policy Studies, 5865 Robert Oliver Place,Columbia MD 21045

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Footnotes

Some sources provided both statistical data and background. A number of Organizations had sources reporting in more than one state. One source omitted one question due to premium tracking difficulty.

3

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM - III)

WHAT IS THE DSM - III?

The DSM - III is the third (and most current) edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.

It is a "diagnostic dictionary" that classifies the various mental disorders and reflects the most current state of knowledge regarding diagnostic criteria. It was also designed to provide a basis for research and administrative use. As the manual states, "The purpose of DSM - III is to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat various mental disorders".

The DSM - III Table of Contents is attached. It reflects the general diagnostic categories under which the various mental disorders fall.

WHAT ARE V CODES?

The DSM - III also includes over a dozen different "V" Codes. When a V code is used for diagnostic purposes, it indicates that the condition for which one is receiving attention or treatment is not due to any particular mental disorder. An example of this is a V code diagnosis for "marital problem". This indicates the individual(s) is receiving services for a marital problem that is not due to a mental disorder. A second V code example is "uncomplicated bereavement" wherein one would be receiving services due to a normal reaction to the death of a loved one.

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Diagnostic and Statistical Manual of Mental Disorders

(Third Edition)

Attachment 4
House Insurance 2/6/86

V Codes For Conditions Not Attributable To a Mental Disorder That Are A Focus of Attention Or Treatment

The ICD-9-CM includes V Codes for a "Supplementary Classification of Factors Influencing Health Status and Contact with Health Services." A brief list of V Codes adapted from ICD-9-CM is provided here for conditions that are a focus of attention or treatment but are not attributable to any of the mental disorders noted previously. In some instances one of these conditions will be noted because, after a thorough evaluation, no mental disorder is found. In other instances the scope of the diagnostic evaluation has not been adequate to determine the presence or absence of a mental disorder but there is a need to note the reason for contact with the mental health care system. (With further information, the presence of a mental disorder may become apparent.) Finally, an individual may have a mental disorder, but the focus of attention or treatment is on a condition that is not due to the mental disorder. For example, an individual with Bipolar Disorder may have marital problems that are not directly related to manifestations of the Affective Disorder but are the principal focus of treatment.

V65.20 Malingering

The essential feature is the voluntary production and presentation of false or grossly exaggerated physical or psychological symptoms. The symptoms are produced in pursuit of a goal that is obviously recognizable with an understanding of the individual's circumstances rather than of his or her individual psychology. Examples of such obviously understandable goals include: to avoid military conscription or duty, to avoid work, to obtain financial compensation, to evade criminal prosecution, or to obtain drugs.

Under some circumstances Malingering may represent adaptive behavior, for example, feigning illness while a captive of the enemy during wartime.

A high index of suspicion of Malingering should be aroused if any combination of the following is noted:

(1) medicolegal context of presentation, e.g., the person's being referred by his attorney to the physician for examination;
(2) marked discrepancy between the person's claimed distress or disability and the objective findings;
(3) lack of cooperation with the diagnostic evaluation and prescribed treatment regimen;
(4) the presence of Antisocial Personality Disorder.

The differentiation of Malingering from Factitious Disorder depends on the clinician's judgment as to whether the symptom production is in pursuit of a goal that is obviously recognizable and understandable in the circumstances. Individuals with Factitious Disorders have goals that are not recognizable in

light of their specific circumstances but are understandable only in light of their psychology as determined by careful examination. Evidence of an intrapsychic need to maintain the sick role suggests Factitious Disorder. Thus, the diagnosis of Factitious Disorder excludes the diagnosis of the act of Malingering.

Malingering is differentiated from Conversion and the other Somatoform Disorders by the voluntary production of symptoms and by the obvious, recognizable goal. The malingering individual is much less likely to present his or her symptoms in the context of emotional conflict, and the symptoms presented are less likely to be "symbolic" of an underlying emotional conflict. Symptom relief in Malingering is not often obtained by suggestion, hypnosis, or intravenous barbiturates, as it frequently is in Conversion Disorder.

V62.89 Borderline Intellectual Functioning

This category can be used when a focus of attention or treatment is associated with Borderline Intellectual Functioning, i.e., an IQ in the 71-84 range. The differential diagnosis between Borderline Intellectual Functioning and Mental Retardation (an IQ of 70 or below) is especially difficult and important when certain mental disorders coexist. For example, when the diagnosis is of Schizophrenic Disorder, Undifferentiated or Residual Type, and impairment in adaptive functioning is prominent, the existence of Borderline Intellectual Functioning is easily overlooked, and hence the level and quality of potential adaptive functioning may be incorrectly assessed.

V71.01 Adult Antisocial Behavior

This category can be used when a focus of attention or treatment is adult antisocial behavior that is apparently not due to a mental disorder, such as a Conduct Disorder, Antisocial Personality Disorder, or a Disorder of Impulse Control. Examples include the behavior of some professional thieves, racketeers, or dealers in illegal substances.

V71.02 Childhood or Adolescent Antisocial Behavior

Same as above. Examples include isolated antisocial acts of children or adolescents (not a pattern of antisocial behavior).

V62.30 Academic Problem

This category can be used when a focus of attention or treatment is an academic problem that is apparently not due to a mental disorder. An example is a pattern of failing grades or of significant underachievement in an individual with adequate intellectual capacity, in the absence of a Specific Developmental Disorder or any other mental disorder to account for the problem.

V62.20 Occupational Problem

This category can be used when a focus of attention or treatment is an occupational problem that is apparently not due to a mental disorder. Examples include job dissatisfaction and uncertainty about career choices.

V62.82 Uncomplicated Bereavement
This category can be used when a focus of attention or treatment is a normal reaction to the death of a loved one (bereavement).

A full depressive syndrome frequently is a normal reaction to such a loss, with feelings of depression and such associated symptoms as poor appetite, weight loss, and insomnia. However, morbid preoccupation with worthlessness, prolonged and marked functional impairment, and marked psychomotor retardation are uncommon and suggest that the bereavement is complicated by the development of a Major Depression.

In Uncomplicated Bereavement, guilt, if present, is chiefly about things done or not done at the time of the death by the survivor; thoughts of death are usually limited to the individual's thinking that he or she would be better off dead or that he or she should have died with the person who died. The individual with Uncomplicated Bereavement generally regards the feeling of depressed mood as "normal," although he or she may seek professional help for relief of such associated symptoms as insomnia and anorexia.

The reaction to the loss may not be immediate, but rarely occurs after the first two or three months. The duration of "normal" bereavement varies considerably among different subcultural groups.

V15.81 Noncompliance with Medical Treatment
This category can be used when a focus of attention or treatment is noncompliance with medical treatment that is apparently not due to a mental disorder. Examples include failure to follow a prescribed diet because of religious beliefs or to take required medication because of a considered decision that the treatment is worse than the illness. The major differential is with Personality Disorders with prominent paranoid, passive-aggressive, or masochistic features.

V62.89 Phase of Life Problem or Other Life Circumstance Problem
This category can be used when a focus of attention or treatment is a problem associated with a particular developmental phase or some other life circumstance that is apparently not due to a mental disorder. Examples include problems associated with going to school, separating from parental control, starting a new career, marriage, divorce, and retirement.

V61.10 Marital Problem
This category can be used when a focus of attention or treatment is a marital problem that is apparently not due to a mental disorder. An example is marital conflict related to estrangement or divorce.

V61.20 Parent-Child Problem
This category can be used when a focus of attention or treatment is a parent-child problem that is apparently not due to a mental disorder of the individual (parent or child) who is being evaluated. An example is child abuse not attributable to a mental disorder of the parent.

V61.80 Other Specified Family Circumstances
This category can be used when a focus of attention or treatment is a family

circumstance that is apparently not due to a mental disorder and is not a Parent-Child or a Marital Problem. Examples are interpersonal difficulties with an aged in-law, or sibling rivalry.

V62.81 Other Interpersonal Problem
This category can be used when a focus of attention or treatment is an interpersonal problem (other than marital or parent-child) that is apparently not due to a mental disorder of the individual who is being evaluated. Examples are difficulties with co-workers, or with romantic partners.

4/5

PRESENTATION ON H.B. 2737 TO HOUSE INSURANCE COMMITTEE

February 6, 1986

Extensive research has demonstrated that ready access to appropriate treatment for mental and addictive disorders (1) saves money; and (2) often is the only way of assuring effective treatment for some health problems.

Because the Kaiser-Permanente Health Plan of California has the longest history and most comprehensive program of research activity in this area, this presenation will highlight their findings. However, the findings have been replicated dozens of times in a wide variety of settings nationwide and even internationally.

The Kaiser-Permanente Health Plan, a forerunner of the modern HMO whose plan initially excluded mental health benefits, discovered 30 years ago what has now become a commonly acknowledged fact; that well over 60 percent of physician visits were made by people with complaints for which organic causes could not be identified.

Further study of these apparently physically healthy individuals suggested they were emotionally distressed. Kaiser-Permanente introduced mental health services as a Plan benefit and investigated the effect of use of these services on medical care usage (such as physician visits; laboratory and x-ray

procedures; hospitalization) by the emotionally distressed members of the Plan. The findings indicated:

1. Emotionally distressed individuals used inpatient and outpatient medical facilities nearly twice as much as the average Health Plan subscriber.

2. Emotionally distressed individuals who had ready access to mental health services significantly reduced their use of medical services and maintained this reduction for at least 18 years following termination of service.

3. Fifty percent of these individuals were seen for one therapy session only and reduced medical utilization 60 percent. Twenty-five percent were seen for 2-8 therapy sessions and reduced medical utilization 70 percent. The 25 percent seen for over 9 therapy sessions reduced usage of inpatient services by 86 percent.

4. Eighty-four percent of the people referred to mental health services came 15 sessions or less, the average being 8.6. They reported the mental health services had been effective. A follow-up study 8 years later indicated that the experience of effective treatment had been maintained.

5. By contrast, the control group, matched for level of distress but not referred for mental health services, increased medical utilization slightly over the five year period of study.

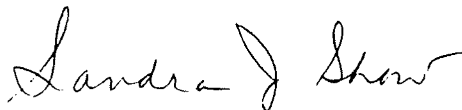
6. Finally most recently, the application of the basic Kaiser-Permanente model to a Medicaid population, considered a hard to treat group, indicates a 37 percent reduction in usage of medical services contingent upon timely referral to mental health services and brief, focused intervention.

As noted, these results have reportedly been replicated dozens of times in a wide variety of settings. Cost-savings estimates,

measured by reduction in medical utilization, vary from 5 - 78 percent. The indications are that a fairly modest 15 percent cost savings is necessary to break even over the cost of providing mental health benefits.

In short, the research is considered to forcefully and clearly demonstrate that nontreatment or inadequate treatment of mental health and addictive disorders places a far greater strain on our health care economy than timely access to appropriate intervention. (Attention now is turning to the development of greater specificity of treatment.) It has, in fact, been argued that the so-called medical offset realized by decreasing medical usage through access to psychological services is the only natural method of cost containment available to our health care economy.

Submitted by,



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K.F.F.M.H.

Kansas Families For Mental Health

4811 W. 77th Place
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913-642-4389

Februray 6, 1986

HB 2737

My name is Howard Snyder and I'm from Prairie Village. I am testifying today in support of House Bill 2737. I am President of KFFMH which is a statewide organization of local family support groups who have family members suffering from long term mental illness. We have local chapters in Lawrence, Topeka, Johnson County, Kansas City, Wichita, Hiawatha, Concordia, Manhattan, Hutchinson, Newton, Emporia, Phillipsburg, Leavenworth, Baxter Springs, Marion, Winfield, Humboldt and Kingman.

I have a 26 year old son who has suffered a brain disease for the last 7 years. Just prior to the onset of this disease-schizophrenia-he was named top freshman in the College of Earth Sciences at the University of Arizona and showed great promise for a bright future in Geology.

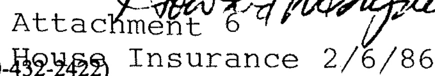
Our belief is that, if insurance were available, many people would get treatment earlier than they do now. This alone could result in less cost in the future both for mental and physical treatment. Our personal experience with this is that our son went through the agony of having his tonsils out at age 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.

I was lucky to have any coverage at all, because in Kansas it is left up to an employer or other group leader as to whether mental illness coverage will be included. Employers are no different from the rest of the population. Most have no medical training and most are ignorant of the disease of mental illness, unless they themselves have been directly affected. But, we rely on them to make informed medical decisions about the needs of their group members. We suspect that in most instances the decision is based on cost rather than needs.

Our position is that mental illness is a legitimate illness and that it has a physical basis. Recent research in this area fortifys this position. When a family member suffers mental illness the whole family suffers with them. Suffering is made up of the frustration, pain and anger in having a loved one who cannot function in society. In addition, many families then find that they have no insurance coverage, and their assets are soon used up trying to help their loved one. Thus, mental illness is both anemotional and economic burden on the family. Some steps are being taken to help with the emotional burden. Now it is time to help with the financial burden.

Insurance is a method of spreading the risk of loss due to an unforseen event. Mental illness is an unforseen event. It can cause great cost to all of those directly involved. That risk should be spread to everyone. The National Institute of Mental Health predicts that some one 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.

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. With the 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.



Attachment 6
House Insurance 2/6/86

I'm Bryce Miller and I'm President of the Mental Health Association in Kansas. We are a statewide organization composed of over 3,000 volunteer advocates unified together to improve mental health services for the mentally ill citizens of the State of Kansas. We are also affliated with the National Mental Health Association which works on a national level to improve mental health services.

The stated goal of the Mental Health Association in Kansas is to have "equity of coverage" between health insurance for physical illnesses and mental illnesses.

Therefore the Mental Health Association in Kansas strongly supports HB 2737 as a positive step toward "equity of coverage." Too long victims of mental illness in Kansas have been forced to curtail or forgo prompt mental health treatment because of a lack of adequate mental health insurance. Based upon my twelve years of working as an advocate with the mentally ill citizens of Kansas the lack of expedient mental health treatment causes the illness to worsen and ends up in hospitalization.

I myself in 1975 became a victim of a crack in mental health insurance coverage because of a loophole in the state law. I was working in Kansas at the time and the services were performed by a certified mental health professional in Kansas. It turned out the contract was a Missouri contract and therefore the insurance company would not pay the $912.00 mental health services bill even though it was required by Kansas law. Incidentally this bill of nearly $1,000.00 was quite a trauma to pay due to my employment status at that time. In other words when I needed my mental health insurance benefits most, there came the loophole, even though I thought I had adequate insurance.

I enlisted the aid of the Kansas Insurance Department to no avail. The last paragraph of the letter stated "We sincerely regret our ability to have been of more direct assistance to you on this problem, but if upon some future occasion, the Department may be of help to you in any question involving the insurance industry, please do not hesitate to contact us."

Ten years has gone by since that letter was written. Sadly, only slow improvement has occurred in mental health insurance coverage during those ten years.

Several of us met last fall to discuss mental health insurance coverage with the President of Blue Cross and Blue Shield of Kansas and his staff. There was also a representative from the Kansas Insurance Department present.

It was a cordial meeting and surprisingly we agreed on a number of items.

One of the items I have thought about since was the admonition that the volunteers in the Mental Health Association in Kansas should contact all of the employers in Kansas to sell them on the importance of having adequate mental health insurance for their employees.

I think the goal is laudable but can you imagine how long it will take 3,000 volunteer advocates to contact the some 68,000 employers in Kansas.

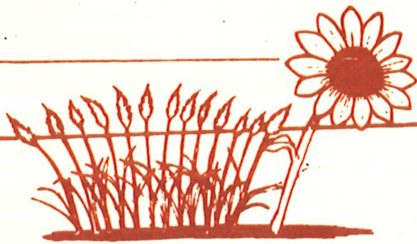
The time has come for the Kansas Legislature to take a bold step forward to provide adequate mental health insurance coverage for the citizens of Kansas. Too long the taxpayers of Kansas have been required to subsidize the treatment of this major illness, namely mental illness. You will note there are no cancer state hospitals or heart state hospitals; obviously it is time for the private sector including the insurance companies operating in Kansas to start picking up their share of treatment costs of mental illnesses of Kansas citizens.

This is not only fair and long overdue, but will also be a step forward in

elimination of the stigma and myths surrounding mental illness.

Therefore the statewide membership of the Mental Health Association in Kansas strongly support and recommend passage of HB 2737.

Thank you



Kansas Association of Alcohol and Drug Program Directors

February 6, 1986

TO: House Insurance Committee
FROM: Elizabeth E. Taylor, Legislative Consultant - **KS Alcohol and Drug Program Directors** and
Association Director - **KS Alcoholism and Drug Abuse Counselors Association**

RE: **House Bill 2737 - Mandatory Insurance**

The Kansas Association of Alcohol and Drug Program Directors, which represents 45 agencies, as well as the Kansas Alcoholism and Drug Abuse Counselors Association, which represents almost 300 certified alcoholism and drug abuse counselors, support the concept of mandatory insurance coverage for alcoholism and drug abuse treatment.

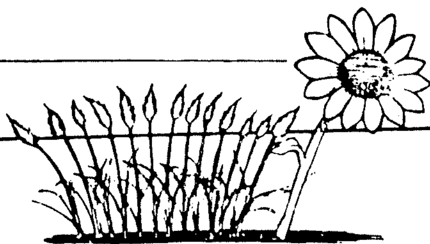
Our support of this mandate stems from the following:

- The disease of alcoholism and the illness of drug abuse are very costly to society from the standpoint of
  - loss of productivity,
  - medical consequences of the disease, and
  - destruction and even death caused by the disease.

- The cost of providing insurance coverage is low. We have heard over and over again in the past that this coverage would simply be too expensive for the insurance providers. Recent studies by insurance providers have shown that this coverage for alcoholism and drug abuse is indeed low and quite cost-effecient. The New York State employee benefit package which includes this coverage shows costs of under $2 per person per year in 1982. Other insurance carriers, specifically Kemper Insurance Company and Blue Cross Blue Shield also offer the coverage at no additional cost. The "Aetna Study" completed as late as the summer of 1985 further shows that average alcoholism treatment costs can be entirely offset by reduced health care costs within two to three years after alcoholism treatment begins.

For these reasons, we urge your support of HB 2737.

Attachment 8
House Insurance 2/6/86



Kansas Association of Alcohol and Drug Program Directors

February 6, 1986

TO: House Insurance Committee Members

FROM: George Heckman, KAADPD President

RE: Support for HB 2737

The Kansas Association of Alcohol and Drug Program Directors represents more than 40 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.

This testimony speaks only to our support of the provisions of this bill relating to alcohol and other drug treatment.

If someone in your family has heart disease or diabetes, you can count on your health insurance to cover treatment costs. Your insurance will pay for treatment needed to reduce the impact of the disease and it will probably pay for a variety of other services needed to help you or your loved ones regain a reasonable normal life.

But if your family needs treatment for alcoholism or drug dependence, you can't count on your insurance for help - at least not in Kansas. Some policies may pay for a limited stay in the hospital if you've deteriorated to the point that you must have acute medical care. But your policy probably won't pay for treatment in a less expensive non-hospital facility for alcoholism and other drug dependence or for follow-up outpatient treatment to help you on the difficult road back from alcoholism to a normal life.

Alcoholism is the third most serious health problem in the country after heart disease and cancer. Over 155,000 Kansans are estimated to be problem drinkers. Their drinking negatively affects many others in their families, on their jobs and in their communities. Alcohol and other drug abuse destroys families, undermines job performance, maims people on our highways and strains our health care system. The price tag on this problem in lost work time and reduced productivity, increased health and welfare costs, property damage, accidents and medical expenses is enormous. And that doesn't begin to count the human costs of broken homes, ruined careers and personal anguish.

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Some people use the argument that alcoholism is a self-inflicted condition. It is hard to understand why most health insurance covers conditions as diverse as suicide attempts, athletic injuries, accidents due to carelessness and cancers caused by smoking. Technically these conditions can be considered self-inflicted and yet are covered by health insurance. Why then should alcoholism and drug dependence be singled out for exclusion on this basis, when so many other health problems are covered? Distinguished health care orgnizations such as the American Medical Association and the World Health Organization have long recognized that alcoholism is a disease. However, many health insurance organizations have failed to acknowledge this fact by extending their coverage.

Several studies indicate that cost is minimal for providing mandatory insurance. In 1973, the Kemper Insurance Company extended coverage for hospital alcoholism treatment at no additional charge to its policyholders and continues to do so today.

In 1977, the mandated insurance package for Wisconsin was evaluated by Blue Cross at the request of the Wisconsin legislature. The monthly costs were determined to be $.42 for a single policy and $1.21 for the family. This information is based on actual cost experience of five years.

In 1978, the State of Virginia asked for a bid from BC/BS for 3 comprehensive benefit plans for substance abuse treatment. The premium bids were given at $.067 cents per month for an individual and $.17 per month for a family.

In 1981, an analysis of 337,000 participants in the California alcoholism treatment benefits package indicated that the projected premium addition fluctuated from .09 to .19 per subscriber per month.

In 1983, an analysis of the New York State employee alcoholism benefit covering 700,000 persons established the cost of the benefit to be under $2 per person per year for a plan begun in 1979.

As of January 1, 1983, Blue Cross of Northeastern New York began providing coverage of alcoholism services to all its community rated subscribers at no specific additional charge.

Kansas is playing "catch-up" when the question of coverage for alcoholism and drug dependence is raised. Practical outpatient treatment and residential rehabilitation programs are available and cost much less than acute care in general hospitals. There is no longer any need to put up with the costly and frustrating "revolving door" in which an alcoholic goes through detoxification again and again with no follow-up treatment because his or her insurance only covers actual hospital care for the medical conditions caused by alcoholism.

Your support of mandatory health insurance coverage for alcoholism and drug dependence will save lives and increase the likelihood that people will seek help for these illnesses. Over twenty other states have realized that providing mandatory insurance coverage for alcoholism and drug dependence is a good investment in thefuture of their state. Let's have legitimate coverage for a very real public health problem.

KLSI Kansas League of Savings Institutions

JAMES R. TURNER, President • Suite 612 • 700 Kansas Ave. • Topeka, KS 66603 • 913/232-8215

February 6, 1986

TO: HOUSE COMMITTEE ON INSURANCE

FROM: JIM TURNER, KANSAS LEAGUE OF SAVINGS INSTITUTIONS

RE: H.B. 2737 (MANDATED HEALTH INSURANCE)

The Kansas League of Savings Institutions appreciates the opportunity to appear before the House Committee on Insurance in support of H.B. 2737 which would mandate coverage in group health contracts for alcoholism, drug abuse, or nervous or mental conditions.

Presently KLSI has over 1,400 employee participants in our group health program and we take great pride in the options and benefits available at a competitive premium structure. The quality of our program is a result of committed efforts by our Insurance Committee, staff, and members to constantly monitor the program and to promote cost containment efforts. We presently offer the aforementioned illness benefits as an option in our program.

In the past we have opposed such legislation as H.B. 2737 because of the absence of lifetime caps on dollar expenditures and the correspondent inability of actuaries to establish reasonable premium structures, particularly in the area of nervous and mental disorders. We have always recognized that optional coverage was not successful in these areas due to limited response. These two factors combined has led to frightening projections that such a premium structure would have resulted in numerous employees terminating group health insurance as an employee benefit.

The $7,500 lifetime cap contained in H.B. 2737 allows for a defineable premium increase amount which is acceptable in an effort to meet the health care needs of including the aforementioned mandated coverages. However, we would like to suggest that the committee consider some amendments to the bill.

HOUSE COMMITTEE ON INSURANCE
JIM TURNER, KANSAS LEAGUE OF SAVINGS INSTITUTIONS
H.B. 2737 (MANDATED HEALTH INSURANCE)

We feel that allowing individuals to opt out of such coverage.... lines 31 and 32 as well as lines 45 and 46....will result in an adverse selection process against group programs. For this type of coverage to be successful, at affordable premiums, we feel that such provisions should be mandated in all health contracts. Accordingly, we would request the committee's consideration of deleting lines 31, 32, 45, and 46.

Further, there have been questions raised as to whether a person could avoid the $7,500 cap by switching carriers. We would suggest consideration to the inclusion of language that would clarify that the lifetime cap is applicable to such coverage from any and all carriers utilized by such persons.

While the League's support of H.B. 2737 is not conditioned on the inclusion of such amendments to the bill, we do feel that such language would be an improvement. However, our support is contingent upon the maintanence of the $7,500 lifetime cap.

Finally, we commend the parties involved in achieving the compromising solution as evidenced by H.B. 2737 and would join with these groups in requesting that the committee report H.B. 2737 favorably for passage.

James R. Turner
President

JRT:jc

HOUSE COMMITTEE ON INSURANCE

Testimony on House Bill 2737

February 6, 1986

Mr. Chairman, and Members of the Insurance Committee, my name is Gene Johnson and I represent the Kansas Community Alcohol Safety Action Projects Coordinators Association. Our organization is responsible for completing the evaluations for DWI offenders for the Courts of the state of Kansas. Our organization, for the past three and a half years, has been responsible for providing the Courts of the state of Kansas in excess of 10,000 evaluations annually for DUI offenders. The Legislature in its 1982 Session, with considerable thought and wisdom, provided the mechanism necessary for the Courts to firmly suggest that the DUI offender who has an alcohol problem seek professional help. In fact, for those people who are arrested for their second DUI in a period of five years, the Court has no other alternative but to order that person to complete an alcohol and drug rehabilitation program or face a mandatory minimum of 90 days in jail.

It is our estimation that approximately 3,000 DUI offenders will be referred by the Courts to treatment facilities this year. These treatment facilities are either of private or public nature. Those which are of public nature are state funded and state operated in which the DUI offender can get a so-called free ride at government expense. The private facilities rely on health insurance payments or personal payments by those individuals to offset the cost of the alcohol and drug treatment. In many cases, we have

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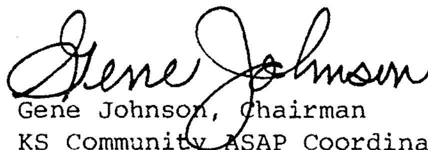
found in the past, that a DUI offender who has been ordered by the Court to complete a treatment program does not have adequate insurance, or, has insurance that completely ignores the fact that alcoholism and drug addiction is an illness and is thereby eliminated from seeking financial assistance from their insurance company. These individuals then have to be placed back in the state supported system which is a burden on the Kansas taxpayer.

Because of the enactment of the DUI legislation in 1982, our organization has been able to offer assistance to a much younger class of individuals who have received their second DUI offense. These individuals have not endured through long years of hard drinking and could benefit from various out-patient treatment programs available at private institutions throughout the state. It is our contention that the younger individuals who are not that addicted to the drug of their choice can receive the necessary treatment from these programs that specialize in out-patient treatment. By this method we are able to keep that person on the job providing for their family, paying their taxes, and receiving help for the third largest illness in the nation.

Our organization wholeheartedly supports House Bill 2737 both from the standpoint of in-patient treatment and the provision for the out-patient treatment programs which are included in that proposed legislation.

Thank you,



Gene Johnson, Chairman
KS Community ASAP Coordinators Association

#12

TO: House Committee on Insurance

FROM: Bruce K. McCallum

SUBJECT: Insurance Coverage

DATE: February 6, 1986

I would like to take this opportunity to thank you for allowing me to appear before your committee today.

I would like to share with you my experiences with HMO-Kansas, Inc. regarding their coverage for substance abuse.

In October, 1985, my son was admitted to Stormont-Vail Hospital for substance abuse. At the time of his admittance I was advised that there had been some problems with HMO-Kansas providing coverage for substance abuse treatment. Following my son's admittance, I contacted HMO-Kansas for their clarification of their coverage. I have attached a copy of correpondence from HMO-Kansas, dated November 14, 1985, for your review. You will note on page 1 of the correspondence that they outlined their contract coverage for abuse of alcohol and drugs. It was my opinion in reviewing the contract, that coverage was provided and that my cost would be subject to a $25.00 co-payment per day for in-patient care received. Nowhere in their contract do they have limitiations on days of treatment, nor type of treatment received. I would like to direct your attention to page 2 of the correspondence where HMO-Kansas indicated that they will only cover three (3) to five (5) days of my son's hospital admittance. I believe this is completely contrary to the contract of coverage which I thought I had with HMO-Kansas.

As of this date I have incurred expenses from Stormont-Vail in excess of $15,000.00, and HMO-Kansas has refused to even acknowledge receipt of billing from Stormont-Vail.

In summary, I strongly encourage your support of the bill for mandatory insurance coverage on substance abuse.

HMO KANSAS, INC.

November 4, 1985

Bruce K. McCallum
3217 Highland Circle
Manhattan, Kansas 66502

RE: Brian K. McCallum
MEMBER #: HMO 01027302

Dear Mr. McCallum,

Douglas Scott, an enrollment representative for HMO Kansas, has asked that I address your concerns regarding the coverage available under the contract for substance abuse.

Doug has advised me that your son, Brian, has recently been admitted to Stormont-Vail Hospital for six weeks for substance abuse. The HMO Kansas contract is very specific as to the coverage available for alcohol and drug abuse or addiction services. Page 1, #10 of the Schedule of Benefits outlines the coverage available as follows:

> "Coverage is provided for diagnosis and medical treatment for alcoholism and for abuse of drugs when ordered or approved by the Member's Primary Care Physician. This includes detoxification for alcoholism or drug abuse on either an out-patient or in-patient basis (based on the Member's Primary Care Physician's determination of what is medically appropriate). Out-patient care for the above services is subject to a Copayment of $25 per visit. In-patient care for the above services is subject to a $25 Copayment per day of in-patient care received.
>
> Ancillary medical services provided by the Member's Primary Care Physician or arranged through appropriate referral are also provided. Referral for non-medical ancillary services (such as vocational rehabilitation and employment counseling) may be made but services provided the Member after such referral are not provided.
>
> Long-term rehabilitative services for treatment of alcoholism or drug addiction (including prolonged rehabilitation services in a specialized in-patient or residential facility) are not provided."

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The detoxification period is normally three to five days and is the length of time required to remove the chemical substance from the patient's system.

Therefore, the only portion of your son's stay in Stormont-Vail for substance abuse that could be eligible for payment under the HMO Kansas contract, provided that Primary Care Physician approval has been received, would be the detoxification period.

The balance of the admission constitutes long-term rehabilitative services and is not eligible for contractual reimbursement. The charges will remain your financial responsibility for payment should you elect to continue Brian's participation in the program at Stormont-Vail.

You indicated to Doug that the contractual language outlined previously was vague in your opinion. I would also like to ask you to review Item 19 on Page 4, Section B under Exclusions - "Non-medical ancillary services and long-term rehabilitative services in a specialized in-patient or residential facility".

I am enclosing a Grievance Form for your use since you advised Doug that you wished to appeal the lack of coverage available for Brian's six-week stay in Stormont-Vail for substance abuse. Our members are always encouraged to contact HMO Kansas if the performance of the HMO does not meet their expectations. HMO Kansas management will promptly and fairly consider all complaints and grievances that are brought to our attention.

The Grievance Form should be filed within 90 days after the incident occurred. Upon receipt of the form, the Executive Director of HMO Kansas will conduct a thorough review of the situation and you will be notified in writing of the decision.

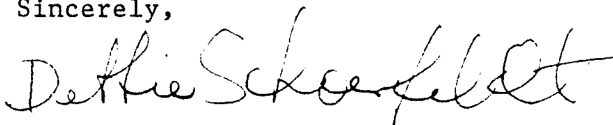
If the outcome is unsatisfactory in your opinion, you may submit a written request within 30 days for a review by the Grievance Committee of the HMO Board of Directors. This written request should outline your reason for appeal, including your reason for dissatisfaction with the first grievance response.

The Committee will be convened within 30 days following the receipt of the appeal and you would then be invited to appear before the Committee to explain your position. The Committee will also review all previous findings of the HMO Kansas Staff.

The decision of the HMO Board Grievance Committee is final and you would be notified of their decision within 15 days following the review.

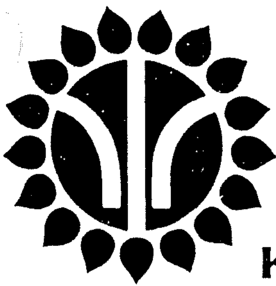
If I can provide any additional clarification, please let me know.

Sincerely,



Debbie Schoenfeldt
Supervisor, Membership Services

cc: Douglas Scott
HMO Kansas Enrollment Rep.



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KANSAS PSYCHOLOGICAL ASSOCIATION

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February 6, 1986

TESTIMONY OF RICHARD B. MAXFIELD, Ph.D.
REGARDING HOUSE BILL 2737

Mr. Chairman, Members of the Committee,

Thank you for the opportunity to give testimony regarding House Bill 2737. I am Dr. Richard Maxfield. I am the Chief Psychologist of the Adult Diagnostic and Consultation Service at the Menninger Foundation. I am here today representing the Kansas Psychological Association. Although I believe that the major reason that this bill should be enacted into law is that it appropriately covers patients who suffer from psychiatric difficulties and will enable them to get the treatment which they deserve and which will decrease their suffering, I will restrict my comments today to the economic impact of enacting this legislation.

In recent years a body of literature has emerged in answer to the question: "Does providing mental health treatment reduce the utilization of covered medical/surgical procedures?" I should note from the outset that few, if any, patients seek mental health intervention to reduce their use of medical services. Nevertheless, there is a considerable and growing body of scientific literature which suggest that there are cost offset benefits to providing mental health treatment. In a comprehensive review of the literature, Jones and Vischi found that mental health treatment had offset effects of reducing medical utilization in 24 of the 25 studies they reviewed. The magnitude of the reduction of medical utilization 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 a study which most closely resembles the requirements of House Bill 2737 the investigators found that utilization rates of subscribers to Blue Cross of Western Pennsylvania over a four-year period dropped 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 percent. When

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the cost of the mental health treatment was included, the overall costs of all treatments (both medical/surgical and psychological) 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 percent.

In another 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 $175.00 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. Thus, looking at that data it would be reasonable to assume that the mental health treatment contained in that study "paid for itself" through reduced rates of medical/surgical intervention in the years following the treatment.

In a comprehensive review of the literature concerning the cost offset effects of providing mental health treatment Mumford and others found an overall effect across the various studies reviewed of a 33.10 percent reduction in utilization of medical services when one compared the pre-treatment rate to the post-treatment rate. In conclusion they authors note: "Retrospective analysis of health insurance claims data and meta-analyses of time series studies and prospective controlled experimental studies converged to provide evidence of a general cost offset effect following outpatient psychotherapy. The wide-spread and persistent evidence of reduced rate of medical expense following mental health treatment argues for the inseparability of mind and body in health care and it also argues specifically for the likelihood that mental health treatment may improve patient's ability to stay healthy enough to avoid hospital admission for physical illness." Thus, one could expect if this legislation is enacted that although the costs associated with outpatient psychotherapy and which are borne by insurers will increase, one can also expect a decrease in the costs associated with and utilization of medical treatments as well as hospital medical treatments.

Many people have feared that the inclusion of mental health coverage in insurance programs will lead to overutilization of mental health services for nonessential reasons. Statistics from the Federal Employees Health Benefit Program, which was one of the more generous packages of mental health coverage, note that only 2 percent of their subscribers used their mental health benefits in 1977. More recently the Rand Corporation, in an experimental study, found that liberal mental health benefits were utilized by only 9 percent of those covered and only 5 percent underwent psychotherapy. Thus, the fear that people will flock to their psychiatrist's office if mental health treatments are covered by insurance is simply not supported by the available data. I would like to note from a personal

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point of view that I have never had a patient consult with me who was not suffering from obviously notable psychiatric difficulties. The fear that people will use mental health coverage for "self-actualization" and the like is simply not true based on my clinical experience and, more importantly, the literature which is available.

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, from an economic point of view. He estimated that there is a net increase of use of resources from $1.00 to $2.00 per person per year which is attributable to a mandate. That is, we can expect the overall increase in utilization of mental health benefits in Kansas to increase by $1.00 to $2.00 per citizen per year if this legislation is enacted. Doctor McGuire also noted that premiums may well increase more than that figure as costs are shifted either from existing users who are paying for the mental health treatments out-of-pocket and/or from State budgets. Based on figures which he examined for the State of Massachusetts, which is a mandated State, and from Federal figures he estimated that including mental health benefits, similar to the ones encouraged in House Bill 2737 would result in a cost of approximately $10.00 per person per year. His estimate closely parallels the estimate which Blue Cross & Blue Shield of Kansas offered to this Committee in 1984. Thus, the realistic estimate of increases in premiums due to this legislation is that it would cost subscribers around $1.00 per month to cover these services.

In summary, there is evidence which suggest that providing mental health coverage may be cost effective in that it may reduce the cost of other medical interventions. There is clear evidence 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, the 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.