Approved March 28, 1986
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by Sen. Neil H. Arasmith at
Chairperson

9:00 a.m./~~p.m.~~ on March 27, 1986 in room 529-S of the Capitol.

All members were present except:

Sen. Reilly - Excused

Committee staff present:

Bill Wolff, Legislative Research
Bruce Kinzie, Revisor of Statutes

Conferees appearing before the committee:
Ron Todd, Kansas Insurance Department
Representative Gary Blumenthal
Bob Storey, Family Service and Guidance Center of Topeka
Dr. Karl Menninger
Paul Klotz, Association of Community Mental Health Centers of Kansas
Bryce Miller, Mental Health Association in Kansas
Dr. James McHenry, SRS, Alcohol and Drug Abuse Services
Judge Herb Rohleder, Adviosry on Alcohol and Other Drug Abuse
Jim Turner, Kansas League of Savings Institutions
Dr. Richard Maxfield, Kansas Psychological Association
Dr. Robert Harder, SRS, Alcohol and Drug Abuse Services
George Heckman, Kansas Association of Alcohol and Drug Program Directors
Representative Mike Hayden
Elizabeth Taylor, Kansas Association of Alcohol and Drug Program Directors

The minutes of March 26 were approved.

The meeting began with the hearing on HB 3049 dealing with a waiver of examination for the licensing of certain agents. Ron Todd, Kansas Insurance Department, testified in support of the bill. Currently, agents who write only on growing crops are exempted from taking the examination. At the time this was done, it was done on the basis that it was very simple coverage, but this area has been broadened and has become more complicated. Those who used to support the exemption have asked to repeal it. The department has always felt that the exemption should be repealed.

Sen. Werts made a motion to recommend HB 3049 favorable for passage. Sen. Warren seconded, and the motion carried.

Attention was turned to HB 2737 dealing with alcohol, drug abuse or nervous or mental conditions in policies of accident and sickness insurance. Those in support of the bill were scheduled to testifiy at this meeting.

First to testify was Representative Blumenthal. He said including coverage for these as a part of medical insurance is not a new concept. This bill represents a lot of work, compromise, and limits in trying to address the issue. His interest in the bill stems from his experience with a personal friend who was in need of psychiatric treatment but did not seek it because of the cost. Subsequently, he had a break down and incurred a $9,000 bill which he was not able to pay and which was depressing to him. He later committed suicide, and Rep. Blumenthal feels the inability to pay the bill was a factor in his suicide. He feels that if his friend had gotten earlier treatment perhaps his suicide would have been prevented. The bill addresses policies of accident and sickness only and limits payments to assure that there will be no abuse in the utilization of this coverage. A lifetime cap has been set. He requested that the amendment on lines 77-79 be removed.

Bob Storey, Family Service and Guidance Center of Topeka, followed. (See Attachment I.) He also referred to his association with the Alcohol Safety Action Project in which he has seen the need to get some people get help they otherwise would not get because of the cost. At this time, the chairman called the committee's attention to testimony submitted earlier by Gene Johnson of this organization. (See Attachment II.)

Dr. Karl Menninger testified saying that he wants to see things get better for the people of the state. He would like people to get better preparation for mental disease which none of us plan on, but it is a definite possibility for all. Treatment for mental illness is a modern thing just as insurance is. He has seen mental illness come to families as a double woe of the sickness and the costs involved that the family had not expected. Mental illness occurs to about as many people as does physical illness. Mental illness is curable and may came to each of us, and insurance for the cost is a comfort for families.

Paul Klotz, Association of Community Mental Health Centers of Kansas, testified further. (See Attachment III.)

Bryce Miller, Mental Health Association of Kansas, testified next. (See Attachment IV.)

Dr. James McHenry, Alcohol and Drug Abuse Services, briefly testified having distributed copies of his testimony to committee members at an earlier date. (See Attachment V.) He added that drug abuse costs employers by the loss of time employees are on the job, and anything that helps employees stay on the job saves money. Also, he requested that subsection (e) be removed.

Judge Herb Rohleder of Great Bend and Chairman of Advisory on Alcohol and Other Drug Abuse testified that Kansas is long over due in getting in the mainstream with other states that have mandated this type of insurance. He said that statistics are clear that it drives up the cost of insurance very little. As a judge, he sees people all the time with this problem and feels that these people would get earlier treatment if they could afford it.

The chairman called for Howard Snyder of Kansas Families for Mental Health. It was explained that he was not able to come today but would submit written testimony later.

Jim Turner, Kansas League of Savings Institutions, gave testimony next, saying that there is a possibility that he would have to withdraw his support. (See Attachment VI.)

The chairman called on Dr. Richard Maxfield of the Kansas Psychological Association. (See Attachment VII.)

Dr. Robert Harder, SRS Alcohol and Drug Abuse Services, declined oral testimony in the interest of saving time but submitted his written testimony. (See Attachment VIII.)

Next to testify was George Heckman, Kansas Association of Alcohol and Drug Program Directors. (See Attachment IX.)

Representative Mike Hayden followed with strong support of the bill. He said he had opposed it for years because he did not want it mandated, but he had come to the realization that mental conditions are a disease like physical diseases for which insurance has been mandated. The treatment of these illnesses will be far more cost effective to society than allowing these people to go untreated. It merely opens the door because it is limited, but perhaps it will encourage continued treatment. Rep. Hayden said abuse will be prevented by subsection (b) and (c) which specifically list mental illnesses covered. He concluded that the bill is a result of several years of work and now is the time to pass it.

Final testimony was given by Elizabeth Taylor, Kansas Association of Alcohol and Drug Program Directors. (See Attachment X.)

Sen. Werts asked regarding subsection (b) what types of mental disorders are included and excluded. Mr. Klotz said those included are BSM3 which Dub Rakestraw of the Association of Community Mental Health Centers explained is a diagnostic manual used in mental health and includes hundreds of diagnoses of mental illness. Those not included are V Codes which are problems that are not due to mental illness such as normal bereavement at the loss of a family member or an occupational problem. This concluded the hearing for the proponents of HB 2737. The hearing for the opponents of the bill will be on April 1.

The meeting was adjourned.

SENATE COMMITTEE

ON

FINANCIAL INSTITUTIONS AND INSURANCE

OBSERVERS
(Please print)

DATE	NAME	ADDRESS	REPRESENTING
3-27	Richard Harmon	Topeka	KS Life Assn.
	Gary Hinton	"	SRS/ADAS
	Bruce Beale	Lawrence	KCCA
	Herb Rohleder	GREAT BEND	Citz
	Jim McHenry	Topeka	SRS/ADAS
	GEORGE HEICKMAN	Lawrence	KAADPD
	Elizabeth E. Taylor	Topeka	KAADPD & KADACA
	J.M. McBride	Topeka	Observer
	BRYCE MILLER	TOPEKA	MENTAL HEALTH ASSOC IN KANSAS
	Paul Klotz	Topeka	Assoc. of CMHCs KS
	Bob Storey	Topeka	Family Service & Guidance Center
	Ron Todd	Topeka	KS. Ins. Dept.
	Dave Ramsey	Hillsboro	Harris News Service
	Karl Menninger MD	Topeka	
	Robt Harder	Topeka	SRS
	Jim Turner	Topeka	KCSI
	Richard B Mayfield	Topeka	KS Psychological Assoc
	ALLYN O. LOCKNER	TOPEKA	SRS
	M. Hagan	"	Cap-Journal
	Dale Rakestraw	"	Assoc. of Community Mental Hlth. Cntrs.
	Thomas L Mills	"	Blue Cross & Blue Shield
	JACK ROBERTS	"	BC-BS
	SANDRA SHAW	LAWRENCE	ASSOC OF COMMUNITY MHC
	Shawn Stockman	Lawrence	Intern, Sen Gannon

SENATE COMMITTEE

ON

FINANCIAL INSTITUTIONS AND INSURANCE

OBSERVERS
(Please print)

DATE	NAME	ADDRESS	REPRESENTING
3-27-86	Dexter Paterson	Emporia	Sen. Johnston
3-27-86	Paula McAllister	Emporia	
3-27-86	Melissa Uhls	Emporia	
3-27-86	Kathleen Burkey	Emporia	
✓	Betty Stowers	Topeka	MHAK.

FA LY SERVICE AND GUIDANCE CENTER OF TOPEKA, IN
2055 CLAY STREET TOPEKA, KANSAS 66604 234-5663

March 27, 1986

TO: SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

FROM: Bob Storey

RE: Support of HB2737 and Recommended Ammendment

As a Board of Director member of the Family Service and Guidance Center of Topeka, I appear before the committee representing the 20 members of that Board. We wish to speak in favor of HB2737.

You have or will hear testimony that clearly indicates that by mandating the coverages included in HB2737 overall medical expenditures are reduced. This reduction will more than offset the modest increase in premiums.

Without this mandate and, particularly, for outpatient services, people will continue to not access services early enough to prevent their hospitalization and the catastrophic effects mental illness often can cause.

Mental illness is not something people predict for themselves and is not going to be adequately addressed until we have mandated health insurance coverage for this very prevalent illness.

We also ask that section (e), lines 77 through 79 be removed from the bill. Those in collective bargaining units should also have this coverage and both share in and benefit from this coverage.

I appreciate this opportunity to testify and ask that you support HB2737.

mlk

S. FII 3/27/86

Attachment I

Sunflower Alcohol Safety Action Project, Inc.

Suite E, 112 S.E. 7th / Topeka, Kansas 66603 / Phone (913) 232-1415

TESTIMONY ON HOUSE BILL 2737

March 27, 1986

Mr. Chairman, and Members of the Committee, the KS Community Alcohol Safety Action Project Coordinators Association wishes to support the passage of House Bill 2737. Our organization is responsible for completing the pre-sentence evaluations as provided for in KSA 8-1000 for DUI offenders for all of the courts in the state of Kansas. Since July 1, 1982, we have been responsible for providing the courts of this state in excess of 10,000 evaluations annually for DUI offenders. As you know, the Legislature in its 1982 session, with considerable thought and wisdom, provided the mechanism necessary for the courts to firmly suggest to the DUI offender who has an alcohol problem to seek professional help. In fact, for those people who are arrested for their second DUI offense within a five year period 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.

As we progress further in the enhancement portion of the DUI bill we find there are more second and third time offenders who, according to the statute, must complete some type of an alcohol and drug rehabilitation program. We found that in 1982 and 1983 that approximately 2500 DUI offenders were court ordered to seek alcohol and drug treatment. Our most conservative

S. FII 3/27/86
Attachment II

estimates at this time indicate that approximately 34% or 3400 annually of all DUI offenders will fall in the category of being subject to alcohol and drug treatment under the mandatory penalties of the law. These treatment facilities are of either private or public nature. Those which are public in nature are government funded and operated in which the DUI offender can get a so-called free ride at government expense.

The private treatment facilities rely on health insurance payments or personal payments for those individuals to offset the cost of alcohol and drug treatment. In many cases, we have found in the past that the 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 alcohol and drug addiction is an illness and thereby eliminated from seeking financial assistance from the insurance companies. These individuals then have to be placed back in the government supported facilities which is a burden on the Kansas taxpayer.

In addition, because of the inability for the private insurance companies to provide coverage for these DUI offenders, we find that we have a backlog of people who are waiting to get into state supported alcohol and drug treatment programs. It is not uncommon to have a three to five week delay after the Court hearing for that person to be placed in a government operated facility. This, I might add, makes some of our judges very uneasy as the DUI offender either has to be placed in jail until a treatment bed can be located or allowed to roam the streets with the possibility of getting into further difficulty with their drinking and driving.

Because of the enactment of the DUI legislation in 1982, our organization has been able to offer assistance to a much younger class of individual who has received a second DUI offense. These individuals have not endured through the 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. House Bill 2737 provides a mechanism to offer that person adequate professional help for their alcohol and drug rehabilitation program. By using 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 an in-patient treatment and the provision of an out-patient treatment programs which are included in that legislation.

Respectfully submitted,

Gene Johnson

Gene Johnson, Chairman
KS Community ASAP Coordinators Assn.

Association of Community
Mental Health Centers of Kansas
835 S.W. Topeka Ave., Suite B/Topeka, Kansas 66612/913 234-4773
Paul M. Klotz, Executive Director

TESTIMONY
on
HB 2737/Senate Financial Institutions
and Insurance Committee
Association of CMHCs of KS
March, 1986

This Association supports HB 2737 if Subsection (e) on Page 2 is removed (strike lines 0077 through 0079).

(1) HB 2737 would:

- -- Not unduly increase premiums.
- -- Not cause employers to move to self-insurance.
- -- Not cause termination of policies.
- -- Not interfere with actions of insurance companies to cost contain, such as DRG's, MAP's, CAP's co-pays and deductibles.
- -- Not hurt policy holders who already have psychiatric/drug and alcohol coverage. In fact, HB 2737 should lower their current premiums.
- -- Not break new ground; at least, 11 states have this type of mandated coverage.
- -- Not increase benefits beyond current law.
- -- Not increase opportunities for abuse of benefits.
- -- Not increase overall health care costs.

(2) HB 2737 would:

- -- Make current health insurance benefits more equitable for those who by chance suffer from a mental illness as opposed to a physical illness.
- -- Provide an offsetting cost savings against surgical and medical costs.
- -- Lessen the burden on taxpayers who are currently financing a disproportionate share of the costs for psychiatric care.
- -- Improve worker productivity.
- -- Encourage patients to use less costly outpatient treatment.
- -- Allow the risk of mental illness to be shared by all insured as is physical illness.
- -- Direct clients to proper treatment professionals.
- -- Better define what mental illness is and what it is not.
- -- Provide a life-time cap on some benefits.

Finally, HB 2737 allows cost containment beyond simple premium reductions.

Thank you for this opportunity to comment.

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S. FI 3/27/86

Attachment III

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.

S. FII 3/27/86
Attachment IV

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

limination 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

CONTRIBUTORS

Barbara Browne
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Susan T. McLaughlin,BA,MAT,USUP,EdD
Cynthia D. Wagner,CLU

SOURCES

Aetna Life & Casualty
Fred Bean, Independent Agent
Kenneth Black,Jr.,PhD,CLU, Georgia State University
Arthur Criss, Independent Agent
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

REFERENCES

"Private Health Insurance Coverage for Alcoholism and Drug Dependency Treatment Services: State Legislation That Mandates Benefits Or the Offering of Benefits for Purchase," National Association of State Alcohol and Drug Abuse Directors, Special Report, July 1983.

"Private Health Insurance Benefits for Alcoholism,Drug Abuse, and Mental Illness" Intergovernmental Health Policy Project, The George Washington University,July,1979

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.

THE NEED FOR

IMPROVED MENTAL HEALTH COVERAGE IN KANSAS

Association of Community Mental Health Centers of Kansas
835 SW Topeka Avenue/Suite B
Topeka, Kansas 66612

I. THE POPULATION AND RELATED FACTS

A) Approximately 1.8 percent of the U.S. population is receiving mental health care on an inpatient or outpatient basis. Between 15 and 20 percent of the American citizenry are estimated to need psychiatric treatment. Most require outpatient service.

Generally speaking, inpatient services are 49 times more expensive than outpatient.

B) More people are admitted to hospitals because of mental disorders than for any other illness. Many times, such admissions, are made by general practitioners into general medical hospitals with little or no specialized treatment.

C) Sixty percent or more of the visits to general medical doctors are made by patients who have an emotional rather than an organic basis for their physical symptoms.

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

E) Five and three-quarter million citizens over 65 years of age have significant mental health problems. Medicare and private insurance primarily provide inpatient treatment.

F) The social stigma of mental illness deters more people from mental health treatment than cost.

G) The American Economy loses about $40.3 billion each year due to poor mental health.
(Source: U.S. Department of Health Statistics, 1980)

II. UTILIZATION AND COST OF INSURING MENTAL HEALTH SERVICES

A) Current data overwhelmingly contradicts the fears of the insurance industry which seems to say that the provision of mental health outpatient benefits specifically, and inpatient benifits generally, will result in overutilization and runaway cost and abuse.

B) In twelve existing random, large insurance plans, it was learned that the

(over)

highest outpatient utilization was 2.2 percent of the group population. The weighted average for all twelve plans in the study was 9.5 visits per 100 subscribers.

C) At the above rate of utilization and with an average cost of $45 per visit, each subscriber would pay $4.26 per year or 8 cents per week to have insurance cover the full cost of treatment.

D) Without question, outpatient treatment is the most cost efficient and will no doubt reduce the cost to not only the mental health patient but also to those inappropriately seeking medical related inpatient or outpatient services.

E) Only a small proportion of existing insured populations use outpatient mental health benefits.

F) The cost of inpatient care for mental illness is generally lower than for all other conditions.

G) Total days of inpatient care for mental illness has been running at about 9 percent of all days of care provided for all illness. (Keep in mind the 60 percent or higher figure from Section I, Item C above.)

H) In a 1974 study, there were 5 inpatient admissions for mental disorders per 1,000 covered population, or 4 percent of admissions for all health conditions.

I) Community mental health centers are an excellent source of treatment from the consumer, taxpayer and insurance industry standpoint because their emphasis is primarily aimed at outpatient treatment. Sixty-five percent of CMHC's resources are aimed at outpatient services.

J) Mental health centers are required, by law, to treat all individuals regardless of ability to pay. Therefore, centers are partially, publicly financed. Increased private payments for service correspondently reduces dependency on tax subsidies.

K) In 1975, those having mental health coverage, under the Federal Employees Health Care Plan, found that mental health benefits cost each subscriber less than $20 for the year.
(Source: U.S. Department of Health Statistics)

III. REDUCED UTILIZATION OF OTHER MEDICAL SERVICES

A) Figures collected for 1975 by the Federal Alcohol and Drug Abuse and Mental Health Administration indicated that 73 percent of those treated for mental disorders were seen in a general health care setting only.

B) A recent independent study (1980) found an overall 25 percent decrease in later use of medical services when outpatient psychotherapy was provided.

C) The largest reductions in utilization occurred with former medical patients who had previously been the highest users.

D) In Minnesota, in 1980, inpatient psychiatric charges averaged $2,800 while the outpatient averages were $90; a 30 to 1 differential. For all claims related to mental health disorder, 75 percent were for inpatient treatment. The Minnesota Blue Cross/Blue Shield **initiated** a program to divert people from inpatient to outpatient by 10 percent. Minnesota's Blue Cross/Blue Shield President noted that "besides the quality and cost considerations, outpatient care often is much less disruptive to the person's family, job and normal routine".

E) Eleven states have mandated psychiatric coverage.

F) In Kansas, only 24 percent of Blue Cross/Blue Shield subscribers are covered by any psychiatric benefits.
(Source: BC/BS, quoted in the Kansas City Star, 1/25/84)

NOTE: Source materials can be obtained by contacting Paul Klotz at 913-234-4773.

FACT SHEET:
EQUAL INSURANCE
COVERAGE FOR MENTAL ILLNESS
Association of CMHCs of Kansas

Currently, eleven states regulate insurance coverage for treatment of mental and emotional problems by guaranteeing that benefits for mental illness are more nearly equal to benefits for physical illness. Most health insurance policies provide inadequate coverage for mental illness by limiting inpatient services and by providing no more than minimal outpatient services. Few, if any policies, cover partial hospitalization. Inadequate or untimely treatment of mental disorders is very costly in terms of the well-being of the individual, stability of the family and productivity in the work place. It may also result in costly and unnecessary hospitalization.

FACT: Over 60 percent of the patients who go to physicians have symptoms due wholly or in part to mental or emotional factors.

FACT: Some patients are forced to seek costly hospitalization because outpatient or partial hospitalization services are often not covered by their insurance.

FACT: Most current insurance plans provide incentives for inpatient care by paying only for inpatient care rather than for outpatient or partial hospitalization care.

FACT: Partial hospitalization and outpatient services are more effective than inpatient care in effecting client social adjustment and reducing family stress, and is comparable to inpatient care in preventing relapses.

FACT: The cost of partial hospitalization or outpatient services are usually one-half to one-third the cost of inpatient care.

Insurance coverage for mental illness will decrease medical utilization and result in a cost offset which will save consumers money.

FACT: Jones and Vischi reviewed 13 studies and found that decreased medical surgical utilization occurred in 12 of 13 studies when mental health care was insured. Reduction in utilization ranged from 5 percent to 85 percent with a median reduction of 20 percent.

FACT: Blue Cross of Western Pennsylvania instituted psychiatric benefits and found a significant reduction in medical utilization--the monthly cost per patient was reduced 50 percent.

FACT: The University of Washington Health Services Center found a 41 percent reduction in the use of outpatient medical services by individuals receiving mental health services.

FACT: The Group Health Association of Washington, DC, found that patients with mental health coverage reduced their medical-surgical utilization by 30.7 percent.

(over)

Equality of insurance coverage for mental illness has significant benefits for business and industry.

FACT: Equitable Life initiated an emotional health program for employees and increased productivity by $3.00 for every $1.00 spent.

FACT: Kimberly-Clark began an Employee Assistance Program and realized a 70 percent reduction in accidents.

FACT: Kennecott Copper started an Employee Assistance Program and found a 6 to 1 benefit to cost ratio; a 52 percent improvement in attendance; a 74.6 percent decrease in weekly indemnity costs; and a 52.4 percent decrease in medical costs.

Currently, most insurance policies have higher co-payments, more restrictions and lower limits for mental health care than are placed on physical illness. As a result, the mentally ill, and in some cases the taxpayer, must bear a far greater burden for the cost of mental illness than for physical illness. Equality of insurance coverage for mental illness will ensure that the private sector shares in the cost of providing mental health, thus freeing limited state dollars to fund services for the chronically mentally ill.

FACT: Nationwide, public funding sources provide 51 percent of the funds for mental health care, compared with 42 percent of the funds for general health care. In Kansas, over 60 percent of mental health care costs are paid from public sources.

FACT: Insurance coverage accounts for only 15 percent of the total expenditures for mental health care compared with 25 percent of the expenditures for general health care.

FACT: In 1980, fee collections in mental health centers in New Hampshire increased 100 percent since insurance coverage for mental health care was mandated in 1977.

FACT: In Kansas, only 24-25 percent of BC/BS subscribers are covered by any psychiatric benefits. (Source: BC/BS, quoted in the Kansas City Star, 1/25/84.)

More equal insurance coverage for mental and nervous conditions prevents unnecessary and costly hospitalization, benefits employers, reduces medical costs by reducing utilization, and saves tax dollars.

-/-/-

Presentation
H.B. 2737

By:
Association of Community Mental Health
Centers of Kansas
March 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)

"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

-/-/-

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

I. 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 second $100, and 50% of the next $1640 in any year ($1000 total coverage) with a lifetime limit of not less than $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.

II. BACKGROUND

Bills mandating this coverage were introduced into the 1984 and 1985 Legislative Sessions. 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.

III. 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 cost increases by the limitation of coverage included in HB 2737 on an annual basis.

For further information contact Ron Eisenbarth (913-234-3448) or Bruce Beale (913-841-4138).

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STATE OF KANSAS
DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
ALCOHOL AND DRUG ABUSE SERVICES

JAMES A. McHENRY, JR., PH.D.
COMMISSIONER

Call if you have any questions.

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Attachment V

COMMON ARGUMENTS IN OPPOSITION TO MANDATORY ALCOHOL AND DRUG TREATMENT BENEFITS AND SOME ANSWERS TO THOSE ARGUMENTS

1. "Mandatory benefits may increase costs/premiums to such an extent that individual and group subscribers may not be able to afford comprehensive insurance coverage."

   The experience in the states that have mandated coverage shows that there is no appreciable increase in premiums. In fact, with treatment, health care costs go down. Blue Cross Blue Shield has estimated that the mandated coverage in HB 2737 will cost $5,582,000 in benefits. Monthly premium cost increases would be $2.37 for individuals and $3.97 for families.

2. "The overwhelming majority of insurance subscribers do not misuse alcohol or drugs and they should not be forced to pay for the self-inflicted problems of those persons who choose to drink and abuse alcohol or other drugs."

   Even if people do not drink to excess or use drugs, they still pay for the health care costs of those who do, if the abusers remain untreated. By mandating coverage, as demonstrated in the "Aetna Study", we get the substance abusers into treatment and all health care costs go down. In addition, many health care problems are "self-inflicted," including pregnancy, and heart attack from stress. So why the objection to treating substance abuse? Substance abuse has more of a stigma and people just don't know how treatable it is. Mandating coverage helps clear up the stigma.

3. "The mandating of alcoholism and drug services will hasten the trend to self insurance by companies resulting in the loss of quality and comprehensive health insurance for many subscribers."

   A six state study of the effects of mandated insurance revealed only five plans were changed. Cashflow, plan design flexibility, and elimination of premium taxes were noted as the main reasons for moving to self insurance. Mandated benefits were a "minor consideration."

4. "Many alcoholism and drug service providers reside outside the traditional health care system where there is no quality assurance and little hard evidence that treatment is effective."

   This argument is out of date. In Kansas all programs available to the public are licensed or certified by the state or are JCAH accredited. Individual providers are licensed/certified by the state or credentialed by professional credentialling bodies. Many studies document the effectiveness of treatment. The "Aetna Study" demonstrated that average alcoholism treatment costs can be entirely offset by reduced health care costs within two to three years after alcoholism treatment begins.

Documentation is available to substantiate the costs and effects of mandated alcohol and drug abuse treatment. For further information contact Ron Eisenbarth (913-234-3448) or Bruce Beale (913-841-4138).

7028C

STATE OF KANSAS

JOHN CARLIN, *Governor*

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

ALCOHOL AND DRUG ABUSE SERVICES

ROBERT C. HARDER, *Secretary*

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Alcohol and Drug Abuse Treatment Insurance Coverage: Premium and Benefit Costs, Cost Offset, Utilization of Benefit

Numerous Studies Have Shown Alcohol and Drug Coverage Does Not Significantly Affect Premiums or Benefit Costs.

1. Premium additions necessary to cover alcoholism treatment were projected to range from $.09 to $1.15 per month in a review of three studies of cost and utilization of alcoholism treatment under health insurance.(1)

2. A State of California pilot project to test the feasiblity of providing health insurance for alcoholism found monthly costs per subscriber for the 4 year observation period were 9 cents, 15 cents, 19 cents, and 9 cents for the respective years.(1)

3. The projected premium cost for alcoholism costs for Virginia state employees was $.36 per family per month. The same study reported a cost of $.53 per family per month for the coverage by Blue Cross of Michigan.(2)

4. Kemper Group added coverage of alcohol and drug treatment benefits at no additional cost to the policy holders in 1964.(3)

5. The overall benefit cost of Aetna's alcoholism treatment coverage was found to be $1.34 per covered individual per year in an extended study.(4)

6. A six state study of the effect of mandated alcohol, drug and mental health benefits on group health insurance premiums yielded the following: 35% of the sources reported no measurable premium increase; 11% experienced increases in the 1-5% range; 50% experienced 5-10% increases; and 3% experienced 10-15% increases.(5)

Studies have Demonstrated a Cost-Offset: Reduced Health Care Costs Following Treatment.

1. The Aetna Study demonstrated that average alcoholism treatment costs can be entirely offset by reduced health care costs within two to three years after alcoholism treatment begins.(4)

2. Using aggregate data from 4 HMO's, alcoholics utilization of ambulatory health care dropped from seven times the encounters of a matched comparison group prior to treatment to three times the utilization through 4 year followup.(6)

3. The Five-Year California Pilot project yielded an average pre-treatment total cost per person per month of medical care of $96.47 for alcoholics, and for nonalcoholic members of the same family, $38.17. At the study's end, costs were reduced to $11.34 and $10.35, respectively.(1)

Studies Have Not Shown Massive and Inappropriate Utilization of Coverage.

1. An average of 7.6 persons per 10,000 covered individuals filed claims for alcoholism treatment during the four years of the "Aetna Study."(4)

2. Utilization of alcoholism treatment coverage seems confined to a small proportion -less than 1 percent- of those enrolled in prepaid or fee-for-service plans.(1)

3. An examination of studies of Aetna federal government coverage, Blue Cross Blue Shield of South Carolina, and California State employees yielded a range of 0.02-0.1 percent of the total beneficiary population using inpatient treatment services.(2)

4. The number of patients seeking alcoholism treatment was less than 1% of the total health plan enrollment in a seven year study of four prepaid practice HMOs.(6)

References

1 Cost and Utilization of Alcoholism Under Health Insurance: A Review of Three Studies, "Alcohol Health and Research World" 9(2): 45-52, 1985.

2 A Rationale for Development of HMO Regulations Concerning Alcoholism and Drug Abuse. Jerome Hallan, Dr. P.H., Director, Health Care Management Program, Appalachian State University, Study for Illinois Department of Alcoholism and Substance Abuse, May 18, 1984.

3 Testimony of Gary Graham, M.D. Corporate Medical Director. Kemper Group. Delivered to Insurance Committee, Senate of Connecticut, March 15, 1984.

4 Alcoholism Treatment Impact on Total Health Care Utilization and Costs. Analysis of the Federal Employee Health Benefit Program with Aetna Life Insurance Company. Executive Summary. National Institute on Alcohol Abuse and Alcoholism. February 1985.

5 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.

6 Alcoholism Treatment Programs Within Prepaid Group Practice HMOs: A Final Report. National Institute on Alcohol Abuse and Alcoholism. May 1982.

Compiled by Larry Hinton, SRS/Alcohol and Drug Abuse Services, 913-296-3925.

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Kansas League of Savings Institutions

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

March 27, 1986

TO: SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE

FROM: JIM TURNER, KANSAS LEAGUE OF SAVINGS INSTITUTIONS

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

The Kansas League of Savings Institutions appreciates the opportunity to appear before the committee to present testimony pertaining to H.B. 2737 which would mandate health insurance coverage for alcohol abuse, drug abuse, and mental illness.

The Kansas League appeared before the House Insurance Committee in support of H.B. 2737 provided that such mandated coverage was required of all health insurance contracts. It was the concensus of KLSI's Insurance Committee that such coverage was an appropriate health insurance benefit for our employees if a reasonable premium structure could be achieved. There are actuarial projections to indicate that if all health contracts include these mandated coverages that reasonable premiums were probable.

However, H.B. 2737 continues to allow for individuals to opt out of such coverage thereby resulting in adverse selection against group contracts (Lines 49 and 50). This adverse selection was further compounded by the floor amendment in the House to exclude bargaining units of labor organizations (Lines 77 to 79). The result is that the provisions of H.B. 2737 now apply only to selected group offerings and we must seriously question if reasonable and affordable premium levels can be achieved.

also 35+36

We are requesting that the Senate FII Committee consider deleting lines 49, 50, 77, 78, and 79 if the mandated coverage in H.B. 2737 is to be made applicable. Otherwise, we do not feel that we can continue to support the passage of H.B. 2737.

James R. Turner
President

JRT:bw

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KANSAS PSYCHOLOGICAL ASSOCIATION

March 27, 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 this 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 suggests 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 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 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 interventions 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

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"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 the 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 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 mentalh health benefits, similar to the ones encouraged in House Bill 2737 would result in a cost of approximately $10.00 per person per year. That economists estimate of the potential increase in insurance premiums, based on existing data, is considerably lower than the projections which have been offered by Blue Cross and Blue Shield of Kansas.

One of the most important reasons for mandating benefits has to do with "Adverse Selection." When one group of policies does not offer a certain coverage, such as mental health benefits, people who do not expect to use those benefits buy that insurance, do not use the benefits, and "artificially" lower the cost. Conversely, those who do expect to use the benefits buy packages which cover the needed services and drive up the costs. There is good evidence that people can anticipate the need for mental health services thus artificially inflating the cost of policies which cover mental health treatment. One wonders if Blue Cross and Blue Shield of Kansas took into account Adverse Selection in their estimates of premium increases.

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

FACT SHEET

COST EFFECTIVENESS AND UTILIZATION OF PSYCHOLOGICAL SERVICES

- THE USE OF MEDICAL SERVICES DECREASES WHEN APPROPRIATE MENTAL HEALTH SERVICES ARE PROVIDED. NUMEROUS STUDIES SHOW A DECREASE FROM 5 TO 80 PERCENT IN MEDICAL SERVICE USE FOLLOWING MENTAL HEALTH TREATMENT. THIS "OFFSET" EFFECT HAS BEEN DOCUMENTED WITH A VARIETY OF PATIENTS IN HMOs AND IN FEE-FOR-SERVICE SETTINGS. (Jones and Vischi, Impact of Alcohol Drug Abuse & Mental Health Treatment On Medical Care Utilization, Medical Care Supplement, Vol. 17(12), Dec., 1979).

- PRELIMINARY DATA FROM A PILOT PROJECT UNDERWAY IN HAWAII PROJECT A 37% REDUCTION IN MEDICAL USE WILL RESULT FROM EVEN BRIEF PSYCHOTHERAPEUTIC INTERVENTION. THE AUTHOR CONCLUDES THAT PREPAID SYSTEMS WILL NOT CONTAIN COSTS UNTIL THE ESTIMATED 60% OF DOCTOR VISITS BY THE "WORRIED WELL" ARE ADDRESSED. (Cummings' "Saving Health Care Dollars Through Psychological Service," June, 1985)

- THERE IS A DOCUMENTED RELATIONSHIP BETWEEN DISTRESS, MEDICAL USE, AND MENTAL HEALTH. AS MANY AS 60 PERCENT OF TOTAL PATIENT VISITS TO PHYSICIANS ARE DUE TO EMOTIONAL PROBLEMS, NOT PHYSICAL AILMENTS. (Cummings and VandenBos, The Twenty Year Kaiser-Permanente Experience with Psychotherapy and Medical Utilization, Healtn Policy Quarterly, Vol. 1(2), Summer 1981)

- MENTAL HEALTH SERVICES COMBINED WITH TREATMENT FOR PHYSICAL DISORDERS RESULTS IN DECREASED HOSPITAL COSTS AT LEAST EQUAL TO THE COST OF THE MENTAL HEALTH SERVICES. A RECENT STUDY OF SEVERAL CHRONIC DISEASES SHOWED THAT THE USE OF MENTAL HEALTH SERVICES "IMPROVES THE QUALITY AND APPROPRIATENESS OF CARE AND ALSO LOWERS COSTS OF PROVIDING IT." (Schlesinger, et. al., Mental Health Treatment & Medical Care Utilization in a Fee-for-Service System, AJPH, Vol. 73,(4) 1983; and D.F. Jacobs, Toward a Formula for Professional Survival in Troubled Times, Public Service Psychology, December, 1983.)

- A REVIEW OF 13 STUDIES THAT USED POST-SURGERY OR POST-HEART ATTACK HOSPITAL DAYS AS OUTCOME INDICATORS SHOWED THAT PSYCHOLOGICAL INTERVENTION REDUCED HOSPITALIZATION APPROXIMATELY TWO DAYS. (Mumford, et. al., The Effect of Psychological Intervention On Recovery From Surgery and Heart Attacks: A Review of the Literature, AJPH, Vol. 72(2) 1982).

- AN EFFECTIVE SYSTEM OF UTILIZATION REVIEW AND QUALITY ASSURANCE EXISTS FOR PSYCHOLOGICAL SERVICES THROUGH THE FEDERAL CHAMPUS PROGRAM AND BY CONTRACT WITH PRIVATE CARRIERS. THE CHAMPUS PEER REVIEW SYSTEM FOR MENTAL HEALTH SERVICES HAS HAD A DRAMATIC IMPACT ON QUALITY OF CARE, AND HAS SAVED THE P[illegible]M AT LEAST $6 MILLION BETWEEN 1977 AND 1983.

- DEMAND FOR MENTAL HEALTH SERVICES WOULD NOT RISE DRAMATICALLY WITH NEEDED, RESPONSIBLE INCREASES IN INSURANCE COVERAGE. A RECENT STUDY SHOWED ONLY 9% OF THOSE WITH GENEROUS MENTAL HEALTH COVERAGE SOUGHT TREATMENT. (Wells, et. al., Cost Sharing and the Demand for Ambulatory Mental Health Services, 1982, Rand Corporation)

- RESEARCH SUGGESTS THAT PSYCHOLOGICAL TREATMENTS CAN: PREVENT PHYSICAL ILLNESS BY CHANGING POOR HEALTH HABITS; FACILITATE COMPLIANCE WITH MEDICAL TREATMENT AND; POSSIBLY REPLACE MORE COSTLY MEDICAL PROCEDURES. (Yates, B.T. How Psychology Can Improve Effectiveness and Reduce Costs of Health Services, Psychotherapy, 21(4), Winter 1984)

- HOSPITALIZATION ACCOUNTS FOR OVER HALF OF MENTAL HEALTH SERVICES COSTS. PSYCHOLOGISTS TYPICALLY PROVIDE TREATMENT ON A LESS EXPENSIVE, OUTPATIENT BASIS.

- THE USE OF PSYCHOLOGISTS HAS A SUBSTITUTION EFFECT ON THE MENTAL HEALTH SERVICES OF PSYCHIATRISTS AND PHYSICIANS IN THE MENTAL HEALTH ARENA, TOTAL COSTS ARE THEREFORE REDISTRIBUTED. (Report Says Health Care Plans Can Add Psychologists Cheaply, APA Monitor, January 1984)

- A SURVEY OF USE AND EXPENDITURES FOR AMBULATORY MENTAL HEALTH SERVICES IN 1980 REVEALED: 4.3% OF THE POPULATION HAD ONE OR MORE MENTAL HEALTH VISITS: EXPENDITURES AVERAGED $253 PER PERSON AND $11 PER CAPITA; THE AVERAGE NUMBER OF MENTAL HEALTH VISITS WAS 8.2 PER CALENDAR YEAR (ranging from 10.9 and 12.5 for office visits to 5.3 and 4.4 for organized setting visits); MORE THAN 95% OF THE POPULATION HAD NO EXPENDITURES, ALMOST 48.8% OF THOSE USING MENTAL HEALTH SERVICES HAVE LESS THAN THREE VISITS WHILE 9.8% OF THE USERS HAVE 25 VISITS OR MORE (Taube, C.A., Kessler, L., and Feuerberg, M.: Utilization and expenditures for ambulatory mental health care during 1980. National Medical Care Utilization and Expenditure Survey Data, Report No. 5. National Center for Health Statistics. Public Health Service. Washington. U.S. GPO, June 1984).

- RESEARCH HAS FOUND THAT DEMAND FOR MENTAL HEALTH CARE RESPONDS TO COST SHARING TO THE SAME EXTENT AS THAT FOR OTHER MEDICAL CARE. (Frank, R.G., and T.G. McGuire. A Review of Studies of Demand and Utilization of Specialty Mental Health Services, American Psychiatric Association, [in press], 1984).

- FEARS OF OVERUTILIZATION AND RUNAWAY COSTS FOR MENTAL HEALTH SERVICES ARE UNFOUNDED. YEARS OF RESEARCH SHOWS THAT ONLY A SMALL PROPORTION OF INSURED INDIVIDUALS USE OUTPATIENT MENTAL HEALTH BENEFITS: THE NUMBER OF VISITS IS GENERALLY LOW, PARTICULARLY WHEN CONTROLLED BY COPAYMENTS OR DEDUCTIBLES; EXPENDITURES FOR MENTAL HEALTH SERVICES ARE NOT DISPROPORTINATE TO OTHER HEALTH CARE SERVICES.

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 second $100, and 50% of the next $1640 in any year ($1000 total coverage) with a lifetime limit of not less than $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. The provisions of the act will not apply to group policies covering group members in a collective bargaining unit represented by a labor organization.

III. BACKGROUND

Bills mandating this coverage were introduced into the 1984 and 1985 Legislative Sessions. 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 cost increases by the limitation of coverage included in HB 2737 on an annual basis.

V. SRS RECOMMENDATION

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

Robert C. Harder
Office of the Secretary
Social & Rehabilitation Services
296-3271
March 27, 1986

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Attachment VIII

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 HB 2737, Mandatory Health Insurance Coverage
For Alcohol, Drug Abuse and Nervous and Mental Condition Treatment

March 27, 1986

I am speaking today in favor of mandatory health insurance coverage for treatment of alcohol, drug abuse, nervous and mental conditions. There is growing recognition of the tremendous impact on society, the economy, family and individual lives of alcohol, drug abuse and mental conditions. The March 17 issue of "Time" magazine is typical of many articles appearing in the press. As the "Time" article indicates, aggressive, proactive strategies are needed. Mandatory insurance coverage is a link in the chain that signals a committment to intervention. More than half (26) of the states have mandated coverage for one or more of these diseases.

Mandatory Insurance facilitates intervention through Employee Assistance programs and other strategies, according to conversations with officials in states that have enacted mandatory insurance. Many states believe mandatory insurance results in people entering treatment earlier, before social margin is lost. An increase in intervention programming with mandatory insurance is also believed to get young people, adolescents, into treatment earlier.

The "Time" article points out the importance of EAPs in intervention and treatment. Many state officials believe development of EAPs is facilitated by mandatory insurance.

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.

In conclusion, there are compelling reasons to enact mandated alcohol, drug abuse, and nervous and mental condition insurance benefits.

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

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

3. There is increasing recognition of the extremely high cost society pays for the effects of the illnesses.

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, intervention and treatment strategy for health care cost containment in Kansas.

Thank you for the opportunity to present this information.

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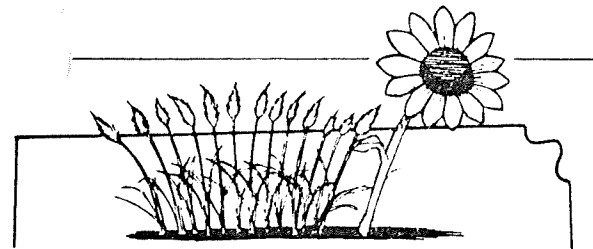

Kansas Association of Alcohol and Drug Program Directors

March 27, 1986

TO: Senate Financial Institutions and Insurance Committee Members

FROM: George Heckman, KAAPD 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 to our support of the provisions of this bill relating to alcohol and other drug treatment as that is our area of expertise.

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 primary or 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 organizations 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 give 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 costs 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. Outpatient treatment, inpatient 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 alcohol 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.

Our association supports the deletion of section (e) lines 077-079 as we believe the original purpose of this bill was to provide coverage across all groups for very real health care problems. Lines 077-079 seem to put the burden of this insurance only on small businesses not covered by collective bargaining agreements.

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 the future of their state. Let's have legitimate coverage for a very real public health problem.

Kansas Association of Alcohol and Drug Program Directors

March 27, 1986

TO: Senate Financial Institutions and 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.

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Attachment X