Approved _____
Date

MINUTES OF THE House COMMITTEE ON Insurance.

The meeting was called to order by Dale Sprague at
Chairperson

3:30 xx a.m./p.m. on February 28, 1990 in room 531-n of the Capitol.

All members were present except:
Representative Delbert Gross, excused
Representative Theo Cribbs, absent

Committee staff present: Chris Courtwright, Legislative Research Department
Bill Edds, Revisor of Statutes
Patti Kruggel, Committee Secretary

Conferees appearing before the committee:

see attached list

The meeting was called to order at 4:10 and hearings began on HB 2888, HB 2889 and HB 3015.

HB 2888 -- an act relating to insurance; requiring certain persons or organizations to provide impact reports on legislation proposing mandated health care benefits.

HB 2889 -- an act relating to insurance; requiring certain benefits to be offered on an optional basis under policies of health and accident insurance; amending K.S.A. 40-2,100, 40-2,102, 40-2,104, and 40-2,105 and K.S.A. 1989 Supp. 40-2,114 and 40-2230 and repealing the existing sections.

HB 3015 -- an act relating to insurance; requiring certain benefits to be offered under certain accident and health insurance policies upon request of the policyholders; amending K.S.A. 40-2,100, 40-2,101, 40-2,102, 40-2,105 and K.S.A. 1989 Supp. 40-2,103, 40-2,114 40-2229 and 40-2230 and repealing the existing sections.

Chris Courtwright, Legislative Research Department gave an overview of all of the bills. Mr. Courtwright explained that HB 2888, HB 2889 and HB 3015 are interrelated bills. HB 2888 would provide that prior to the legislatures consideration of any bill mandating health insurance coverage, the proponents would be required to submit impact reports to the appropriate committees concerning the social and financial effects of the newly proposed mandate. HB 2889 would change the mandated coverages for certain mandates, to make it so that the offering of these coverages is mandated. HB 3015 similarly, would eliminate the mandate for individual and group coverages and would basically change them so that the mandate would only apply when requested by the policyholder.

Representative Elaine Wells provided testimony (Attachment 1) supporting HB 2888 and explained that this bill is not an attempt to repeal mandates that its intent is to provide necessary information needed before we pass any more mandates. It would require that when legislative mandates are introduced, they be followed by a social and financial report of the

effects of the proposed mandates. Rep. Wells also provided testimony (Attachment 2) supporting HB 2889 which would require that mandated benefits be offered on an optional basis on group or individual polices of health insurance. Rep. Wells stated that the bill would give people the right to choose what kind of insurance they wish to purchase. The insurance companies would still have to provide the mandated coverage but the choice of whether or not the insured wants that particular coverage rests with the insured.

Representative Gary Blumenthal provided testimony (Attachment 3) in opposition to HB 2889 stating that the bill would modify current state mandate laws to require that mandated areas revert back to a mandatory offer, rather than an automatic inclusion in all health policies. Rep. Blumenthal expressed that allowing mandates to become available options will result in most health insurance providers dropping to the bare coverage required and eliminating many areas of coverage.

Meyer
Myra Goldman, Kansas HMO provided testimony (Attachment 4) in support of HB 2888 which would provide important information with which to access the value and the effect of the service being required, before adoption of a proposal. Mr. Goldman's tesimony also gave support for HB 2889 and HB 3015 which will allow flexibility in the nature of the delivery of the service, or price structure and better control costs.

Next appearing in support of HB 2889 and HB 3015 was Terry Leatherman, Kansas Chamber of Commerce and Industry, (KCCI). Mr. Leatherman provided the KCCI Health Care Insurance Survey which asked large and small employers if they would offer mandated coverages in a voluntary marketplace (Attachment 5).

Collier Case, Kansas Power and Light provided testimony (Attachment 6) supporting HB 2889 which would make current mandated benefits options to be considered by plan sponsors and stated that healthcare benefits are part of the compensary agreement between the employer and employee.

Jim Schwartz, Kansas Employer Coalition on Health provided testimony (Attachment 7) supporting HB 2888, HB 2888 and HB 3015 and noted that HB 2888 would require that mandates pass inspection of social and economic impact. Mr. Schwartz also stated that HB 2889 and HB 3015 would give the optional status they should have in a voluntary system.

Bill Pitsenberger, Blue Cross and Blue Shield of Kansas testified in support of HB 2889 and HB 3015 which address not only discriminatory factor, that small employers do not have the same choices as large employers, but also the cost issue, that small employers with an optional offering would be able to choose whether they want to incur those costs or not.

Steve Robertson, Health Insurance Association of America (HIAA) briefly appeared in support of HB 2888, HB 2889, and HB 3015 for reasons previously discussed.

Larry Magill, Independent Insurance Agents provided testimony in support of HB 2888 which would require impact reports on all proposed new mandated health care benefits. Mr. Magill also testified in support of both HB 2889 and HB 3015 expressing a preference of HB 3015 because of concern of mandatory offering provisions which would increase the administrative burden to agents that handle group insurance (Attachment 8).

MINUTES OF THE House COMMITTEE ON Insurance,

room 531-N, Statehouse, at 3:30 xx a.m./p.m. on February 28, 1990.

Dick Brock, Insurance Department provided testimony (Attachment 9) as neutral to HB 2889 and HB 3015 explaining the differences between a mandated offer and mandated availability.

Paul Klotz, Community Mental Health Centers provided testimony (Attachment 10) in opposition to HB 2889 and HB 3015 stating that the bills could eliminate a whole population from mental health care treatment and could transfer much of the costs from the private sector to the taxpayer.

Dr. Dennis Petterson, American Cancer Society testified in opposition to HB 2889 and HB 3015. Dr. Petterson explained what screening mammography was and why it is critically important.

Written testimony (Attachment 11) was distributed to the Committee in opposition to HB 2889 and HB 3015 from Chip Wheelen, Kansas Psychiatric Society.

Michael Flyzik, Social and Rehabilitation Services provided testimony (Attachment 12) opposing HB 2889 and HB 3015. Mr. Flyzik stated that passage of these bills would lead to an increased burden on the State of Kansas to fund treatment for alcoholism and drug additions.

Gene Johnson, Kansas Association of Alcohol and Drug Program Directors provided testimony (Attachment 13) in opposition to HB 2889 as it appears to make treatment for alcohol and drugs abusers an option which shall be offered by the insurance company at an adjusted premium rate.

Gigi Felix, National Association of Social Workers provided testimony (Attachment 14) in opposition to both HB 2889 and HB 3015 . Ms. Felix stated that if enacted the choice of coverage will be totally taken out of the hands of any individual enrolled in a group policy and will be made for them by their employer.

Rep. Rex Hoy appeared in support of HB 2888 and HB 2889 provided testimony (Attachment 15) provided by the Department of SRS, which gives statistical information of utilization trends of specific licensed certified programs.

Written testimony in opposition to HB 2889 was distributed to the Committee from Dr. James McHenry, Topeka (Attachment 16).

There were no others wishing to testify on HB 2888, HB 2889 or HB 3015 and the hearings were concluded.

The meeting was adjourned at 5:40 p.m.

GUEST LIST

COMMITTEE: Insurance DATE: 2/28

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Dick Brock	Topeka	Ins Dept
L.M. Cornish	"	KS Life Assn
Lee Wright	Overland Park	Farmers Ins. Group
Jim Heycock	Topeka	Am. Cancer Society
Dennis G Petterson MD	"	" "
Linda J. DeCoursey	Topeka	KS Psychological Assn.
John B Sprinkle	Manhattan	Work. Times Ct. of Topeka
Kerry Larson	~~KS Alliance~~ Topeka	KS. Alliance for the Mentally Ill
Glenn Cogswell	Topeka	American Cancer Society
Jim Ludwig	Topeka	KPL
Collier Case	Topeka	KPL
Terry Leatherman	Topeka	KCCI
Kay Bahl	Topeka	Stormont Hospital
Kelly Walden	Topeka	KCA
Mayer L. Goldman	Kansas City	Kan. HMO Assn.
Jim Schwartz	Topeka	KEGH
Art Brown II	K.C. Mo	KS Lumber Dealers
Michael Flyzik	TOPEKA	SRS/ADAS
Steve Johnson	Topeka	Alcohol Program
John Peterson	Topeka	KS Assn for Psychology
ALAN COBB	TOP	Anderson County
Gigi Felix	Topeka	K-NASW
J. RIEHM	TOPEKA	KADM
Bob Williams	Topeka	KS Pharmacists Assoc.
Bill Pitsenberger	Topeka	Blue Cross

GUEST LIST

COMMITTEE: _____ DATE: _____

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Cheryl Dillard	Overland Park	Kaiser Permanente
Jack Roberts	Topeka	BC BS
Larry Magill	"	MAK
Jim Oliver	"	PIAK
Tom Bell	"	ICHA

STATE OF KANSAS

ELAINE L. WELLS
REPRESENTATIVE, THIRTEENTH DISTRICT
OSAGE AND NORTH LYON COUNTIES
R.R. 1, BOX 166
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(913) 665-7740

TOPEKA

COMMITTEE ASSIGNMENTS
MEMBER: AGRICULTURE AND SMALL BUSINESS
INSURANCE
PUBLIC HEALTH AND WELFARE
PENSIONS, INVESTMENTS AND
BENEFITS

HOUSE OF
REPRESENTATIVES

INSURANCE COMMITTEE

TESTIMONY
on
HOUSE BILL NO. 2888
February 28, 1990
by
REPRESENTATIVE ELAINE L. WELLS

Thank you Mr. Chairman for the hearing on this bill and for the opportunity to testify on it.

According to an article in this month's (February 1990) issue of Nation's Business titled "Paved With You-Know-What" by Ark Monroe III, "The flood of mandated-benefits legislation at the state level has encouraged employers to opt out of regulated health insurance and purchase unregulated insurance, if they can, and it has made insurance unaffordable for many of those employers that cannot obtain unregulated insurance. Intended to help workers, state laws mandating benefits are instead denying health insurance to millions of them."

As we heard in countless testimonies presented to the committee during the meetings we've had on the high cost of health insurance there is no substantial evidence that passing a mandate actually saves all insurers money by having the coverage available. In fact, most insurance companies have indicated that the mandates have only increased the overall costs of basic affordable health plans.

Attachment 1

H.B. 2888 is not an attempt to repeal mandates. The intent is to provide the necessary information needed before we pass any more mandates.

According to the article mentioned earlier, other states are beginning to have second thoughts on mandated benefit laws. In 1983, Washington became the first state to require that when legislation mandating benefits is introduced, it must be followed by a report to the legislature on the social and financial effects of the proposed mandate. Interestingly enough, no new mandates have been adopted by the Washington legislature since then. According to the American Legislative Exchange Council, the mandates previously passed in Washington include: Nurses, Podiatrists, Chiropractors, Alcoholism, Mental Health, Mammograms, Home Health, Hospice, Public Institutions, Newborns, Non-custodial Children, Mentally and Physically Handicapped, Conversion Privileges, Continuation for Dependents, and Continuation for Employers.

In 1985, Oregon passed similar legislation in requiring the financial and social report as did Arizona. In 1986, Nebraska and Pennsylvania passed the same law. In 1987, Florida and Hawaii followed suit. In 1988, Rhode Island and Wisconsin enacted this law. And, in 1989, Connecticut, Georgia, Maine, Nevada, Tennessee, and Virginia agreed to this trend and passed mandate evaluation laws. The Virginia Legislature has even passed a resolution stating that all mandates should be opposed. In California, New Hampshire, South Carolina, Texas and Nebraska, bills have been introduced to curb the unchecked passage of mandated employee health benefit legislation.

For its part, the NAIC (National Association of Insurance Commissions) has passed a resolution calling for an objective evaluation of mandated benefits based on the following criteria: the legislation fills a clear, current need; the short-term and long-term costs to consumers and to total health care expenditures are measured; overutilization which may result from passage of the legislation can be minimized; the mandated benefit does not create an unfair market disadvantage to insurers motivating group policy-holders to self-insure; and whenever possible, the need should be filled by mandating availability of coverage, rather than inclusion in all plans.

According to Greg Scandlen, Senior Washington Representative of Blue Cross and Blue Shield Association, "Legislators are getting tired of this never-ending parade of people who want laws passed to ensure their particular service is reimbursed by insurance companies. Increasing numbers are saying, 'Wait a minute. Let's stop and get an objective evaluation of what effect all these mandates have on the health care system.'."

Congress is even considering federal legislation regarding mandated benefits. Last year Sen. Orrin Hatch, R-Utah, introduced a bill that would pre-empt state mandated-benefit laws. Under the bill, the states could continue to regulate the business practices of health insurance companies, but they could no longer dictate the content of their policies.

It is quite clear that Kansas should join the lead as we have done in the past relating to creditable insurance legislation by passing a law that benefits the consumers of this state. Requiring that a financial and social impact report on proposed mandates will insure that the mandate, if passed, will be justified.

The social impact report will include the extent to which the service or treatment is already being utilized; coverage currently available; how many who need it cannot get it causing financial hardship; public demand from both individual and group policyholders; if collective bargaining organizations are including it in their insurance contracts; and indirect costs not related to premiums. The financial impact report will include: the increase or decrease of the cost of the treatment or service; possible increase in usage of the treatment; if the mandate will serve as an alternative for more expensive treatment; the reasonably expected increase or decrease in premiums and the impact on the total cost of health care.

I don't believe that's too much to ask. The legislation is broad enough to allow those requesting the mandate to not have to report actual dollars and cents because in some situations that is unknown. But, actuarial studies can include scenarios so that we will at least have some idea as to both the financial and social impact on the high cost of health insurance in Kansas.

Mandated insurance coverage at the time of its passage was believed to be necessary to provide available coverage for specific services and treatments. Hindsight they say is always better than foresight. If mandates do not actually help the system but may hinder it, the best solution may be to do a little more research and reporting before we consider passing any more mandated benefits.

I hope you will agree with me and I urge your support of H.B. 2888.

I'll be happy to respond to questions.

STATE OF KANSAS

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COMMITTEE ASSIGNMENTS
MEMBER: AGRICULTURE AND SMALL BUSINESS
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PUBLIC HEALTH AND WELFARE
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BENEFITS

HOUSE OF
REPRESENTATIVES

INSURANCE COMMITTEE

TESTIMONY
on
HOUSE BILL NO. 2889
by
REPRESENTATIVE ELAINE L. WELLS

Mr. Chairman and committee, thank you for hearing this bill and for the opportunity to testify on it.

Simply put, H.B. 2889 requires that mandated benefits be offered on an optional basis on group or individual policies of health insurance. Or, in other words, it gives people the right to choose what kind of insurance they want to buy. The insurance companies will still have to provide the mandated coverage but the choice of whether or not the insured wants that particular coverage rests with the insured.

This seems to be a great compromise between the need for mandated benefits and the arguments against them. It takes away the decision from the insurance industry and the special interest groups and places it on the consumer who is really the one that should make the decision.

Most of what I say will be from the State Factor, December 1989 issue by the American Legislative Exchange Council. If you haven't tossed it out, I recommend you read it or get a copy. The headline is particularly interesting, "State Mandated Health Benefits: A Bad Prescription. Remember, the ALEC does not represent the

Attachment 2

insurance industry, the medical providers, or any other special interest group. It represents over 2000 legislators from all fifty states.

According to ALEC, the first mandate in a state in the nation came to pass in 1956 in Maine covering mental and physically handicaps. In 1958, another state passed their first mandate. As you can see by the attached graph, it was not until 1973 that a flood of mandates came through the gates and since their inception, 1975 had the most with 73 being passed that year in the nation. In 1989, another big jump of 70 more occurred.

I've attached a copy of the breakdown on what states have mandates and when they were enacted. Looking at the graph one can assume three things: 1) The ball started rolling in the early seventies with the beginning of mandated coverage. 2) The number of mandates enacted jumped from one in 1956 to over 800 being passed by 1989 covering over 50 types of services and treatments. 3) Enough time has lapsed to ascertain and evaluate the effects of mandated benefits.

The theory was and most likely still is, that a certain treatment or service sould be provided and covered because of the lack of availability and the high and sometimes prohibitive costs to the person needing the service or treatment. It was thought that if everyone had to pay for it (by the mandate) that the cost would be spread out, and that if the service or treatment was covered a savings would be gained by avoiding more expensive treatment or services. Yet today health care costs are skyrocketing and the premiums for insurance are beyond what most workers can afford.

We've heard over and over that under federal law, companies with self-insured health care plans are exempted from these state regulations and virtually all larger companies and a large percentage of medium size companies are now self-insured. Federal employers and people covered by Medicare also are exempt. As a result, the burden of mandated benefits regulations fall heavily on employees of small firms and on people who purchase individual and family policies. In general, these are people who have no economic or political power, and who are not represented by well-organized, special interest group lobbyists.

I say that because one has to look at who pushes for the enactment of mandated benefits. The number of diseases covered range from AIDS to alcoholism and substance abuse. They cover services ranging from acupuncture to vitro fertilization. In some states, they cover everything from life prolonging surgery to purely cosmetic devices--from heart transplants in Georgia and liver transports in Illinois to hairpieces in Minnesota. These laws reflect the fact that the provision of health insurance is becoming increasingly political. Powerful special interest lobbies now represent nearly every major disease and disability, virtually every important group of health care providers, and almost every type of health care service provider. As a result the health insurance marketplace is being shaped and molded by political pressures, rather than by competition and consumer choice in a free market. Who's next to come before us with another one in Kansas. I take that back, we had one presented yesterday.

An important principle of insurance is that individuals must not be able to make claims as a result of their deliberate and intentional behavior, i.e. fire insurance covers accidents but not when someone burns down their own buildings; life insurance doesn't cover suicides. Yet requiring health insurance to cover treatment for alcoholism and drug abuse for those already engaging in substance abuse at the time the policy is issued results in social drinkers, teetotalers and non-drug users paying higher premiums to cover these costs.

In most cases, related to mandated benefits, the regulations lead to more diagnosis, more procedures performed and higher insurance costs. This is a result of insurers having to reimburse certain providers at the same rate for similar services (i.e. chiropractors vs physicians) even though the fee to non-insured patients may be from one-half to one-third of that amount.

Some mandated benefits were designed to be an attempt to control costs. But, according to a survey conducted by Medical Care International, the example of cataract surgery showed the cost for inpatient was $1,350; in an outpatient facility was $2,020 - about 50% more than the inpatient hospital surgery. Second opinion surgery has also failed to save costs because second opinions are costly and usually confirm the first opinion. For many procedures, the cost may be greater than the benefit. The requirement of coverage for pap smears and mammographies as preventive medical care is being disputed because evidence indicates that the costs of such tests may exceed the benefits.

Requiring insurers to take on certain high risk individuals without balance... of a higher rate of return is simply forcing some companies

to quit selling policies in that state. In 1988, Golden Rule Insurance Company ceased marketing its policies in seven states.

To date, the only way to escape the mandates is by self-insuring. One reason big companies self-insure is that they can better manage their own health care plans and hold down rising costs. Another reason is to avoid costly and inefficient regulations. Yet, a more significant reason may be that self-insured companies bypass the regulations and costs of mandated health insurance benefits. In other words, employers who self-insure have the freedom to provide insurance tailored to the wants and needs of their employees. They are doing what any sensible consumer would do, were it not for governmental interference. Individual and group policyholders ought to have the same options. The upshot is that the burdens and costs of mandated health care benefits are falling on the shoulders of the rest of the population who are not self-insured or who are not federal employers; people who work for small firms, the self-employed and the unemployed.

Mandated benefits force insurers to pay for the health care of people who are already sick, to cover procedures more related to choices and preference rather than to well-defined, risky events, and many expand the definition of illness and its cost of treatment by expanding the range of covered providers.

A study done by Peat Marwick Main and Company found that under Hawaii's current practice of not mandating coverage for chiropractic services, there was no evidence that lack of chiropractic coverage resulted in inadequate care or financial hardship from people using those services. On the other hand, were Hawaii to mandate coverage, the total cost of the mandated benefit

would be as high as $8.1 million- The same held true for well-baby care which is not a mandate but if passed would cost $1.7 million. The study also found that only limited lack of care resulted from alcoholism and drug abuse, yet the cost for coverage would be as much as $2.3 million and inpatient mental health care would be $12.3 million and outpatient $6.8 million. Another study performed by Gail Jensen at the University of Illinois at Chicago and Maichel Morrisey at the University of Alabama at Birmingham showed that coverage for substance abuse increases premium prices by 6-8% for outpatient mental health care by 10-13% and psychiatric hospital care, including dependents by 21%.

As the cost of insurance rises, more and more low risk people are not buying it leaving the pool of insured increasingly risky. Another factor which encourages people (especially low risk) not to insure is that mandated benefits prevent them from buying insurance tailored to their needs. Couples who cannot have children cannot buy policies that do not provide for newborn infants coverage. Moderate drinkers and people who abstain from using drugs cannot buy policies that do not cover alcoholism and drug abuse. People who do not intend to see chiropractors, psychologists or counselors cannot buy policies that exclude such coverage. As a result, people cannot buy the type of insurance they want for a price which reasonably reflects their needs.

By 1985 over 30 million Americans had no health insurance coverage-either public or private. Who are the uninsured? Primarily, they are people who are unemployed, self-employed and employees of small firms. About half of the uninsured population is not working. Among

those who are working, about two-thirds were either self-employed or employees of firms with fewer than 25 workers. The uninsured population also tends to be a low-income population. Among full-time workers, 69% earned less than $10,000 in 1985. Nearly 92% earned less than $20,000.

An econometric model of the health insurance marketplace has been developed by Gerald Musgrave. According to ALEC it is the first model ever developed that produces statistical estimates of the factors causing people to be without health insurance. Although certain information about the market for health insurance is not available to researchers, the model nonetheless explains 94% of the variation in the percent of the population without health insurance across the 50 states.

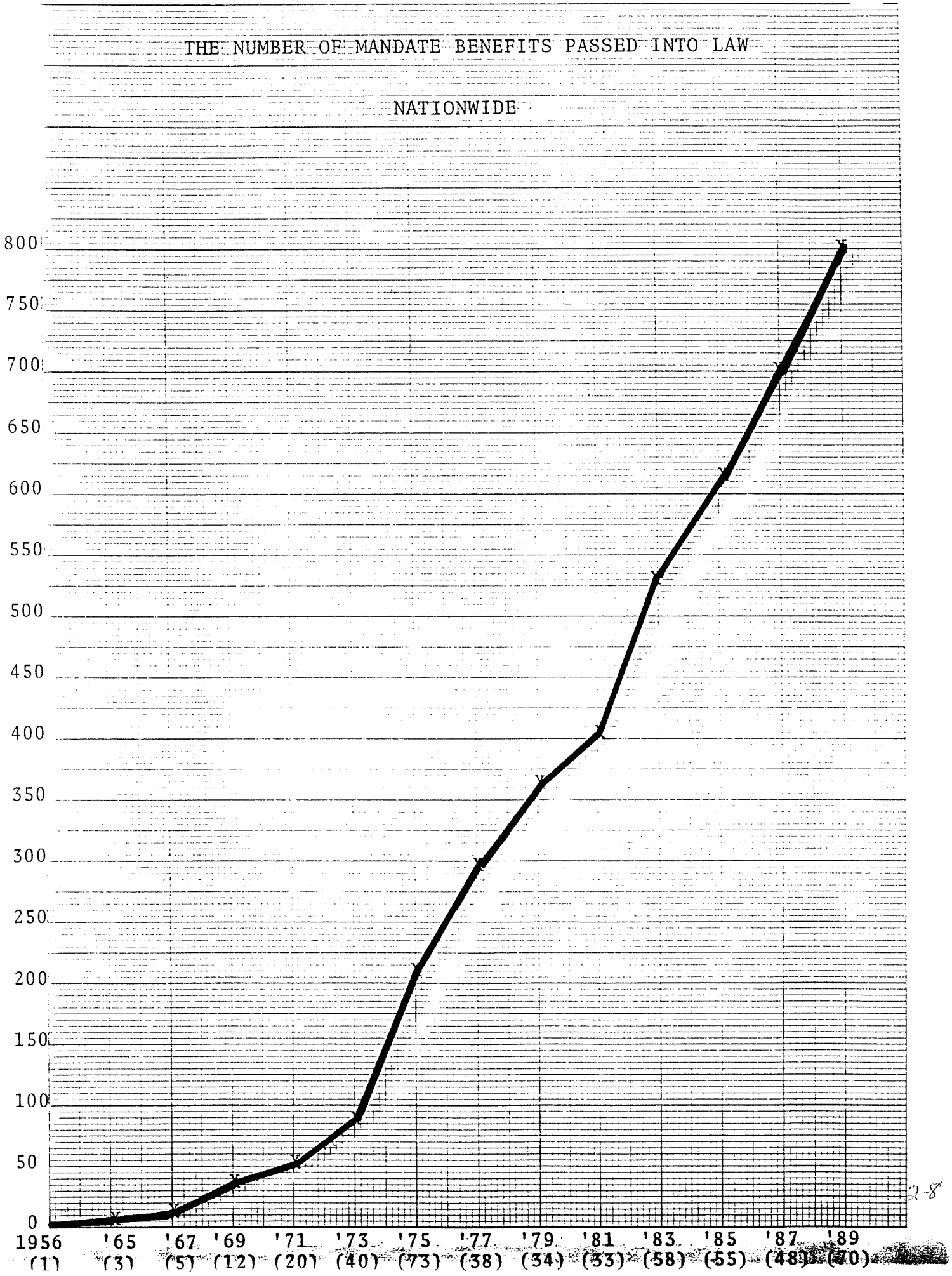
Various versions of the model were tested, and in each test the number of mandated benefits was a strong and statistically significant cause for a lack of health insurance. Specifically, as many as 25.2% of all uninsured people nationwide lack health insurance because of mandated benefits. This means that mandated benefits are causing as many as 9.3 million people to be without health insurance.

Millions of Americans lack health insurance today because of government regulations and controls. Rather than enacting more misguided regulations and more controls, we would do better to eliminate the distortions government already has imposed on the market for health insurance, and give the market a chance to work. Above all, government should encourage individuals in the private sector to use their intelligence and creativity to find imaginative solutions to health care problems, and give the private sector the freedom of choice to implement those solutions.

Requiring insurance companies to provide mandated benefits but allowing the policyholder to choose the coverage he wants will put a real test to the need for mandates in Kansas. It will decrease the cost of basic health coverage which is what most of us would like to see happen.

I hope you agree with me and support H.B. 2889.

I'll be happy to respond to questions.


THE NUMBER OF MANDATE BENEFITS PASSED INTO LAW
NATIONWIDE
800
750
700
650
600
550
500
450
400
350
300
250
200
150
100
50
0
1956 (1)
'65 (3)
'67 (5)
'69 (12)
'71 (20)
'73 (40)
'75 (73)
'77 (38)
'79 (34)
'81 (53)
'83 (58)
'85 (55)
'87 (48)
'89 (70)

MANDATED COVERAGES

	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY
ALL LICENSED HEALTH PROFESSIONALS	80			85						71
NURSES							81			
NURSE MIDWIVES	80			79			81	83		
NURSE PRACTITIONERS	80						81			
NURSE ANESTHETISTS						87				
PHYSICAL THERAPISTS										
OCCUPATIONAL THERAPISTS		88	81/83			89				
SPEECH/HEARING THERAPISTS			89			87				
PROFESSIONAL COUNSELORS	86	74	77	75		77				85
PSYCHOLOGISTS						89		77		
PSYCHIATRIC NURSES	88	85	87	75		87				
SOCIAL WORKER		74	83						75	
DENTISTS										
ORAL SURGEONS		65	79	75		77			75	
OPTOMETRISTS		65	77	75		79	83		75	
PODIATRISTS		81	79	75		79*/88	83		76/87	
CHIROPRACTORS			58			77				71
OSTEOPATHS										
NATUROPATHS	79	79	81		82/85	77/80	74/87	82	74/88	
ALCOHOLISM			81			77/80			74/88	
DRUG ABUSE		79/80			76	76/77	83	77*	74/88	
MENTAL HEALTH		89	87			89	89	89		
MAMMOGRAPHY SCREENING							83/85			
BREAST RECONSTRUCTION		84	77			78			82	
MATERNITY										
PRESCRIPTION DRUGS										
ORTHOTIC AND/OR PROSTHETIC DEVICES										
CLEFT PALATE			89						89	
TEMPOROMANDIBULAR JOINT DISORDER									84	
DIABETIC EDUCATION									82	
DIABETIC OUTPATIENT										
SECOND OPINION							83		78	
HOME HEALTH			87		76		83			
HOSPICE								86		
LONG TERM CARE										
INVITRO FERTILIZATION			87							
AMBULATORY SURGERY										
ANTI-ABORTION							87		80	75
PUBLIC INSTITUTIONS			81							
AMBULANCE/TRANSPORT FOR NEWBORNS										
PREVENTIVE CARE FOR CHILDREN/INFANTS				85					75	
OTHER HEALTH CENTERS			83							
DEPENDENT STUDENTS										89
ADOPTED CHILDREN	83			85						
NEWBORNS	76	74	73	77	76	76	74/84	75	76	75
MENTALLY/PHYSICALLY HANDICAPPED		69	81	75		74	69		75	71
NON-CUSTODIAL CHILDREN										89
CONVERSION PRIVILEGE	79	80	77	79		82/88	84		80	83
CONTINUATION FOR DEPENDENTS	80	86	79		84		80	83	80	
CONTINUATION FOR EMPLOYEES							73	82	73/80	
CATASTROPHIC COVERAGE										
MANDATE EVALUATION		89				89	84		88	

X = Year unknown

* = Commercials only

MANDATED COVERAGES

	AL	AK	AZ	AR	A	CO	CT	DE	FL	
ALL LICENSED HEALTH PROFESSIONALS				75						
NURSES						87				
NURSE MIDWIVES		83	85				84	88	83	
NURSE PRACTITIONERS		88	85				84			
NURSE ANESTHETISTS			85							
PHYSICAL THERAPISTS		87					75			
OCCUPATIONAL THERAPISTS		87			78		82			
SPEECH/HEARING THERAPISTS				85	78					
PROFESSIONAL COUNSELORS					80/81					
PSYCHOLOGISTS	82		83/87	75	80	79	75			80
PSYCHIATRIC NURSES					82	88	84			
SOCIAL WORKER					76		79			
DENTISTS	75	83	77/89		76		75			
ORAL SURGEONS										
OPTOMETRISTS	67	83			80		75/89	X*	74/89	88
PODIATRISTS	76		77	75	76			X*	74	
CHIROPRACTORS	75	83	83/87		76		71/89	X*	76/86	80
OSTEOPATHS		83								
NATUROPATHS		87					75			
ALCOHOLISM	79	88		87	78/88	76	74/77		79	
DRUG ABUSE	79	88		87	88		76		79	
MENTAL HEALTH				82	73	76	75/87		81/84	
MAMMOGRAPHY SCREENING			88	89	87	89	88/89		88	
BREAST RECONSTRUCTION			81	78	78				87	
MATERNITY				76	76	75/89	76			78
PRESCRIPTION DRUGS							75			
ORTHOTIC AND/OR PROSTHETIC DEVICES					85		87		87	
CLEFT PALATE						87				
TEMPOROMANDIBULAR JOINT DISORDER										
DIABETIC EDUCATION					81					
DIABETIC OUTPATIENT										
SECOND OPINION										
HOME HEALTH			82		78	84	75/89		87	
HOSPICE						84	76			
LONG TERM CARE										
INVITRO FERTILIZATION				87			89			
AMBULATORY SURGERY			71						77	
ANTI-ABORTION						85	82			
PUBLIC INSTITUTIONS										
AMBULANCE/TRANSPORT FOR NEWBORNS										
PREVENTIVE CARE FOR CHILDREN/INFANTS				89	74		89		86	
OTHER HEALTH CENTERS										
DEPENDENT STUDENTS							82			78
ADOPTED CHILDREN			85						85/88	88
NEWBORNS	75	75	74	75/83	71	75	74	74	80/84	74
MENTALLY/PHYSICALLY HANDICAPPED			77	69	71		71		70	72
NON-CUSTODIAL CHILDREN							84		89	
CONVERSION PRIVILEGE			85	79/85	83		75			
CONTINUATION FOR DEPENDENTS				85	76		75/76			80/81
CONTINUATION FOR EMPLOYEES				85	77	84			75	
CATASTROPHIC COVERAGE							86			87
MANDATE EVALUATION			85				89		87	89

15

X = Year unknown
* = Commercials only
Bold Print = Mandated offerings
Source: Blue Cross and Blue Shield Plans

08/8

2-10

MANDATED COVERAGES

	HI	ID	IL	IN	IA	KS	KY	LA	ME	MD
ALL LICENSED HEALTH PROFESSIONALS			82							83
NURSES					89					
NURSE MIDWIVES								84		78
NURSE PRACTITIONERS										79
NURSE ANESTHETISTS										84
PHYSICAL THERAPISTS										
OCCUPATIONAL THERAPISTS										
SPEECH/HEARING THERAPISTS										
PROFESSIONAL COUNSELORS										
PSYCHOLOGISTS	84		X	85		74		75	75	73
PSYCHIATRIC NURSES									83	83
SOCIAL WORKER						82/89			83	77
DENTISTS	74			74	88	73		74/89	75	73
ORAL SURGEONS			X							
OPTOMETRISTS			80	74	83	73			82	73
PODIATRISTS			81	74		73				73
CHIROPRACTORS			X	74	86	73		80/86	75	86/89	73
OSTEOPATHS			X							73
NATUROPATHS										
ALCOHOLISM	88		82	86		86	78	80	74	80/88
DRUG ABUSE	88					78/86		80	83	78/88
MENTAL HEALTH	88		74/77			78/86	86	75	79/83	73/89
MAMMOGRAPHY SCREENING			89		89	88				86
BREAST RECONSTRUCTION			80							
MATERNITY	74								75	75
PRESCRIPTION DRUGS									83	
ORTHOTIC AND/OR PROSTHETIC DEVICES										78
CLEFT PALATE		85		85						82
TEMPOROMANDIBULAR JOINT DISSORDER										
DIABETIC EDUCATION					84					
DIABETIC OUTPATIENT										85
SECOND OPINION							82		77	
HOME HEALTH										82
HOSPICE							86			
LONG TERM CARE										85/89
INVITRO FERTILIZATION	87									
AMBULATORY SURGERY	74						78			
ANTI-ABORTION		85					78			
PUBLIC INSTITUTIONS										69/82
AMBULANCE/TRANSPORT FOR NEWBORNS								80		
PREVENTIVE CARE FOR CHILDREN/INFANTS	88								79	76
OTHER HEALTH CENTERS				85				78		79
DEPENDENT STUDENTS										79
ADOPTED CHILDREN			81	89						
NEWBORNS	74	74	75	76	74	74	76	73	76	77
MENTALLY/PHYSICALLY HANDICAPPED	68	72	67	69/86				72		77
NON-CUSTODIAL CHILDREN									89	
CONVERSION PRIVILEGE			83		86	78/80	74		82	79
CONTINUATION FOR DEPENDENTS			76/85		86	78/84	80			77
CONTINUATION FOR EMPLOYEES	74	75	84		86	84	80	83	83/86	79
CATASTROPHIC COVERAGE										78
MANDATE EVALUATION	87								89	

X = Year unknown
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Bold Print = Mandated offerings

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2-11

MANDATED COVERAGES

	MA	MI	MN	MS	MO	MT	NE	NV	NH	NJ
ALL LICENSED HEALTH PROFESSIONALS								85		84
NURSES	85		83	80		87	84			82
NURSE MIDWIVES			88	80		87			85	
NURSE PRACTITIONERS			83	80		87				
NURSE ANESTHETISTS										75
PHYSICAL THERAPISTS					84					
OCCUPATIONAL THERAPISTS						85/87			83	
SPEECH/HEARING THERAPISTS										
PROFESSIONAL COUNSELORS	75	68*	75/89	74	83	81	74	80	75	73
PSYCHOLOGISTS	86								83	
PSYCHIATRIC NURSES	82					85				
SOCIAL WORKER	75		73	74	78	83	75	75		77/79
DENTISTS		85							75	
ORAL SURGEONS	*		73	66	78		69	75		67
OPTOMETRISTS	*		73		78		69	75		
PODIATRISTS	87	79	73	80	78		67	82		80
CHIROPRACTORS							67	75		
OSTEOPATHS										
NATUROPATHS	73	74/82	73/82	74	77/85	79	80	83		77
ALCOHOLISM		74/82	73/82		80	81		83		
DRUG ABUSE	73/82		75/87		80	81			75/83	
MENTAL HEALTH	87	89	88					89	88	
MAMMOGRAPHY SCREENING		85	80					83		83
BREAST RECONSTRUCTION	85		73		73			77		
MATERNITY										
PRESCRIPTION DRUGS		85								
ORTHOTIC AND/OR PROSTHETIC DEVICES			88							
CLEFT PALATE			87					89		
TEMPOROMANDIBULAR JOINT DISORDER										
DIABETIC EDUCATION										
DIABETIC OUTPATIENT										
SECOND OPINION						81				
HOME HEALTH	86							75		
HOSPICE		84						83/89		
LONG TERM CARE										
INVITRO FERTILIZATION	87									
AMBULATORY SURGERY		84/85	76		75/81					
ANTI-ABORTION					83					
PUBLIC INSTITUTIONS			73			73	84			
AMBULANCE/TRANSPORT FOR NEWBORNS				79						
PREVENTIVE CARE FOR CHILDREN/INFANTS	88				89					
OTHER HEALTH CENTERS										
DEPENDENT STUDENTS								76		
ADOPTED CHILDREN	75		83							
NEWBORNS	74		73	74	74	73	75	76	75	75
MENTALLY/PHYSICALLY HANDICAPPED	56	66	69	72		71		76	69	66
NON-CUSTODIAL CHILDREN						89				
CONVERSION PRIVILEGE	76		77		81	81	78	80		
CONTINUATION FOR DEPENDENTS			73/77		69		80	80	81	
CONTINUATION FOR EMPLOYEES			73		85	81	79		85	
CATASTROPHIC COVERAGE			76							
MANDATE EVALUATION								86	89	

X = Year unknown
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Bold Print = Mandated offerings

08/89

MANDATED COVERAGES

	NH	NY	NC	ND	OH	OK	OR	PA	RI	S.
ALL LICENSED HEALTH PROFESSIONALS								86		
NURSES		84		85				82/		
NURSE MIDWIVES	85	82		85	84	71		82/		
NURSE PRACTITIONERS				85			80	86		
NURSE ANESTHETISTS				85				86		
PHYSICAL THERAPISTS		73						78/81		
OCCUPATIONAL THERAPISTS										
SPEECH/HEARING THERAPISTS										
PROFESSIONAL COUNSELORS										
PSYCHOLOGISTS	77	71	77	87	74	71	76	78/88		
PSYCHIATRIC NURSES				89						
SOCIAL WORKER		85		89			79/89			
DENTISTS	77	75			73	71/89		71		
ORAL SURGEONS										
OPTOMETRISTS	77	X			80	71	76	78		85
PODIATRISTS	77	X			80	71/89		71		72
CHIROPRACTORS	84	X	73	79/89	80	71/89		71/81	87	80
OSTEOPATHS	77				80	71/89				
NATUROPATHS										
ALCOHOLISM	83	82/83	84	75/89	78			75/87	86	80
DRUG ABUSE		87	84	75/89						87
MENTAL HEALTH		77		75/89	83			73/87		
MAMMOGRAPHY SCREENING		88/89		89		88/89		89	88/89	
BREAST RECONSTRUCTION		75								
MATERNITY		76		89	79			73		
PRESCRIPTION DRUGS				79						
ORTHOTIC AND/OR PROSTHETIC DEVICES										
CLEFT PALATE			82							
TEMPOROMANDIBULAR JOINT DISORDER	89			89						
DIABETIC EDUCATION								87		
DIABETIC OUTPATIENT									83*	
SECOND OPINION		76							84*	
HOME HEALTH	77	~~77~~/75								
HOSPICE		85						87		
LONG TERM CARE										
INVITRO FERTILIZATION										
AMBULATORY SURGERY		X				76				
ANTI-ABORTION				79				82		
PUBLIC INSTITUTIONS			75		76					
AMBULANCE/TRANSPORT FOR NEWBORNS	75					84				88
PREVENTIVE CARE FOR CHILDREN/INFANTS		82								
OTHER HEALTH CENTERS		X								
DEPENDENT STUDENTS				81						
ADOPTED CHILDREN	88	X		87		86				
NEWBORNS	75	89	73	79	74	75	75	76		74
MENTALLY/PHYSICALLY HANDICAPPED	69	65/89	69/73	83	71			68*		70
NON-CUSTODIAL CHILDREN				87			85/89			
CONVERSION PRIVILEGE	83	71/81	82	83	75/84		81	76*	78	78
CONTINUATION FOR DEPENDENTS	83	85	83	87			81		83	78
CONTINUATION FOR EMPLOYEES		85		81			81			
CATASTROPHIC COVERAGE								85	86	88/89
MANDATE EVALUATION										

X = Year unknown
* = Commercials only
Bold Print = Mandated offerings

08/89

STATE OF KANSAS

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TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
MEMBER: EDUCATION
ELECTIONS
FEDERAL AND STATE AFFAIRS
LEGISLATIVE, JUDICIAL AND CONGRESSIONAL
APPORTIONMENT

House Insurance Committee February 28, 1990

HB 2889

As one of the key authors of the 1986 mental health/alcohol treatment mandate, I wanted to take this opportunity to share with the committee a few thoughts regarding what motivated the legislature to impose this mandate and others in recent years.

I certainly appreciate the committee's interest in looking at the significant issue of availability and affordability of health care, however I feel that it is very important that as the committee examines this important issue, that the committee not allow interest groups to turn back the clock on improvements made within recent years regarding fairness in health care accessibility. Needless to say, I am specifically referring to the 1986 mental health mandate. In recent days, insurance providers have questioned the wisdom of mandates in general, thus I wish to review for the committee, what I believe were the motivating factors behind the enactment of these mandates.

Attachment 3

First and foremost, I believe that the Kansas legislature sought to end acts of discrimination towards a particular patient class with the mental health mandate. There are few individuals who would ever argue with you in this day and age, as to whether or not mental illness "is really an illness". However, that clearly was the position taken by the insurance industry in its practice prior to 1986, by only offering mental health insurance coverage as an option. Was this a fair practice? I would strongly suggest that it was not. What other illnesses do we separate out and offer as an option for coverage? To do so, suggests that mental illness is not really an illness, therefore you need not worry about its coverage. Do we take that approach with heart disease? If I never smoke, exercise regularly, and have no history of heart disease within my family, should I be offered a medical insurance policy that lists heart disease as an optional area for coverage? Or a step further, if there is no incidence in the last 100 years of cancer within my family, should I be able to opt out of having any coverage for any illness associated with cancer? Certainly both of these suggestions sound absurd, and I believe that the Kansas House and Senate took that same position in 1986, when through the passage of the mental health/chemical dependency mandate, we finally put to rest discriminatory insurance practices and recognized that mental illness was in fact a disease in need of treatment.

I also believe that the Legislature sought to acknowledge in 1986 that a disproportionate amount of mental health services were being paid for by state and local tax dollars, and an underproportionate amount paid by the private sector. Specifically the taxpayer, through larger and larger subsidization of community mental health centers and state hospitals, was providing the bulk of mental health services, and the taxpayer was in fact picking up a significant share of the bill. If a repeal of the mandate is enacted, the committee might wish to consider the fiscal impact to the state general fund, as more and more people would turn to the public sector for mental health services.

I also believe that the Kansas Legislature was ahead of many others throughout the United States in trying to address what many refer to as the number one problem facing the United States in the late 80's and the 90's: the scourge of drugs. I found it particularly interesting to note when Senator Bond convened the joint hearing earlier this month of the House Insurance Committee and the Senate Commercial & Financial Institutions Committee, he identified a number of critical issues facing our nation and state, including both the availability and affordability of health insurance and the problem of drugs. This particular mandate has been quite effective in assisting many individuals to beat the scourge of drugs. Therefore it would certainly be ironic at a time in which the public focus on fighting drug abuse is at an all

time high, to allow the repeal of the mandate law.

HB 2889 would modify current state mandate laws to require that mandated areas revert back to a mandatory offer, rather than an automatic inclusion in all health policies. Insurance providers have tried to assure members of this committee that the mandatory optional offer would still insure coverage to all Kansans. I would submit to the committee that this is far from the truth. The mandatory offer, or optional offer, is what we had in effect prior to the passage of the 1986 mental health mandate, and it failed to provide mental health services to most Kansans. Prior to the passage of the mandate, over 76% of all policies within Kansas failed to include coverage for mental health or chemical dependency treatment. It sounds very fair to simply allow the mandates to become available options, however in practice this will only result in most health insurance providers dropping to the bare coverage required and eliminating many areas of coverage. Because of the stigma attached to seeking mental health or chemical dependency treatment many members of a group are reluctant to admit mental illness within themselves or their families, and thus it becomes very difficult to advocate within a group for inclusion of such services within a group insurance policy. The mandatory group option failed in the past and I believe it would fail again if this bill is approved by this committee.

While I strongly oppose all efforts to weaken mandates previously enacted by the Legislature, I do commend Chairman Sprague and the committee for your desire to address the affordability and accessibility issues regarding health insurance. I would submit that this is a critical national issue and needs to be looked at in a slow and deliberate manner to insure that wise decisions are made. The Kansas Legislature needs to assure itself that it has the sufficient materials and data to make informed and wise decisions regarding health care matters. As a former member of this committee, I have grave concerns regarding the ability of the Legislature to access sufficient information about the insurance market and the rate setting decision process.

Thank you for allowing me to testify today.

K A N S A S H M O A S S O C I A T I O N

Testimony on HBs 2888, 2889 and 3015 presented 28 Feb 1990

by

MEYER L. GOLDMAN, PRESIDENT, KANSAS HMO ASSOCIATION

Mr. Chairman and members of the Committee. I am Meyer L. Goldman of Kansas City, president of the Kansas HMO Association. The members of our association provide comprehensive health care services to more than 250,000 Kansas on a prepaid contractual basis.

I have already testified before this committee about the Association's concern over mandating of benefits, based on the influence of mandates on cost, and the resulting reduction in availability of health care cost protection to workers and their dependents. I will not take your time to repeat these statements.

HBs 2889 and 3015 would eliminate mandates to provide certain services and require only that these services be offered on an optional basis. HB 2888 would establish guidelines to be followed before mandates are considered for adoption.

We believe that elimination of any mandates will be beneficial to the people of Kansas. We support the thrust of HBs 2888 and 3015. We also support HB 2888, which would give you important information with which to assess the value and the effect of the service being required, before adoption of a proposal.

Attachment 4

It is not likely that passage of the bills will cause any major immediate change in the services offered by HMOs in Kansas. Most of the services mandated by Kansas law were already provided by HMOs and will continue. This is because the basic concept of a health maintenance organization requires more comprehensive benefits than those of traditional indemnity insurance.

I am affiliated with Prime Health, a staff model HMO in the Kansas City area now serving more than 70,000 subscribers. In our 14 years of operation we have always provided for coverage of newly born children, mammography and mental health services. We also provide a substantial number of preventive services which we believe substantially benefits our subscribers by avoiding illnesses and improving their general health.

We do see complications in the mandate to offer specific services, levels of services or specific providers because of the multiplicity of contracts we would be required to develop. Since HMOs provide services rather than pay of claims, we must be ready to render the service if it is chosen by the contracting employer. This, in our case, means including on our staff the health care providers, whether they are used or not. This would make compliance awkward and lessen the cost-effectiveness of the bills.

Our experience has shown that mandates greatly increase utilization even when services were previously offered. Prime Health statistics indicate how much this could be. By allowing flexibility in the nature of the delivery of the service, or price structure, costs can be controlled better.

I understand that there is thought of deferral of action on these bills for an interim study of all their implications, particularly those pertaining to costs and savings. The Kansas HMO Association agrees with this suggestion and is ready to help where it can by developing and providing statistics and other information.

The Association is planning a survey of its members to determine the effect of existing mandates on cost structure and utilization of services. The issue is complex but we hope to be able to have some information within a few months.

I will be glad to try to answer any questions.

LEGISLATIVE TESTIMONY

Kansas Chamber of Commerce and Industry

500 Bank IV Tower One Townsite Plaza Topeka, KS 66603-3460 (913) 357-6321

A consolidation of the
Kansas State Chamber
of Commerce,
Associated Industries
of Kansas,
Kansas Retail Council

HB 2889 & HB 3015

February 28, 1990

KANSAS CHAMBER OF COMMERCE AND INDUSTRY

Testimony Before the

House Committee on Insurance

by

Terry Leatherman
Executive Director
Kansas Industrial Council

Mr. Chairman and members of the committee:

I am Terry Leatherman, with the Kansas Chamber of Commerce and Industry. Thank you for the opportunity to express KCCI's support for HB 2889 and HB 3015, which embrace the concept of eliminating mandated coverages from health care insurance programs.

The Kansas Chamber of Commerce and Industry (KCCI) is a statewide organization dedicated to the promotion of economic growth and job creation within Kansas, and to the protection and support of the private competitive enterprise system.

KCCI is comprised of more than 3,000 businesses which includes 200 local and regional chambers of commerce and trade organizations which represent over 161,000 business men and women. The organization represents both large and small employers in Kansas, with 55% of KCCI's members having less than 25 employees, and 86% having less than 100 employees. KCCI receives no government funding.

The KCCI Board of Directors establishes policies through the work of hundreds of the organization's members who make up its various committees. These policies are the guiding principles of the organization and translate into views such as those expressed here.

Attachment 5

If price were no object, all the mandated benefits affected by these bills would be included in all insurance programs, regardless of government requirements. However, price is a significant problem for many Kansas employers.

When I appeared before this Committee earlier this month on this subject, I presented preliminary results from a KCCI survey of its membership on this subject. With final results now tabulated, here are some conclusions from the survey.

1. Health care insurance costs are soaring.

* 82% indicate premium increases of over 10% in the past year.

* 53% indicate premium increases of over 20% in the past year.

* Only 2 of 423 survey respondents indicate premium decreases in the past year.

* Premium increases were consistently high for all business categories.

2. While all employers face spiraling costs, it is the small employer who cannot afford to offer health care insurance programs for workers.

* Overall, 92% of employers responding offered health insurance to workers. However, smaller businesses were less likely to offer insurance programs.

* 76% of businesses with less than 10 employees offered insurance.

* 92% of businesses with 10 to 25 employees offered insurance.

* 96% of businesses with 25 to 100 employees offered insurance.

* 100% of businesses with more than 100 employees offered insurance.

3. If the current mandated benefits were repealed, they would be included in many employer-sponsored insurance plans. In fact, the larger the employer, the more likely the benefit would be provided.

* The survey asked employers if they would offer mandated coverages in a voluntary marketplace. None of the four benefits received 50% support from the smallest employer group. All four of the options received over 50% support from the largest employer group.

* One of the four mandated benefits listed on the survey was providing mammograms and pap smears laboratory testing. Here is the percentage of employers who would offer this benefit, in a voluntary marketplace, per employer group.

Less than 10 employees - 48%

10 to 25 employees - 63%

25 to 100 employees - 73%

over 100 employees - 78%

In summary, all employers are being affected by spiraling health insurance costs, but it is the small employer who is being driven from the marketplace. If it is this Committee's goal to encourage more employers to offer health care insurance to employees, steps must be taken to make insurance more affordable. It is for that reason that the repeal of mandated benefits is a viable option.

The encouraging news from the survey is how the marketplace would respond to the repeal of mandated benefits. In general, the small employer would opt for a very basic health care plan for their workers. However, the larger employers will be much more likely to offer a comprehensive health care package to their employees, complete with the current mandated benefits.

The final results of KCCI's Health Care Insurance Survey are attached to my testimony. Please note the first page lists the overall survey results. The pages which follow break down the results in categories, based on the size of the employer.

Thank you for the opportunity to present KCCI's views on this issue. I would be happy to answer any questions.

KCCI HEALTH CARE INSURANCE SURVEY

Business size: total results Businesses surveyed: 423 (100

1. Does your business offer a health care insurance program to employees and dependents?

YES		NO	
388	92 %	35	8 %

2. Have individual premiums increased/decreased in the past year?

increased 1% to 10%	44	11 %
increased 10% to 20%	113	28 %
increased 20% or more	215	54 %
decreased	2	.5 %
stayed the same	26	7 %

3. In the past two years, has your health insurance plan adopted any of the following?

increase in deductible	218	52 %
employee contributions	168	40 %
eligibility period	30	7 %
changed insurance co.	107	25 %

4. The Kansas Legislature may consider repeal of mandated insurance benefit programs in 1990. The repeal would mean insurance policies written by Kansas companies would no longer be required to provide several mandated coverages. Would you support the repeal of health care insurance mandates?

YES		NO	
241	57 %	109	26 %

5. Would you voluntarily provide to your workers the following insurance coverages; with additional premium charges?

Services by an optometrist, chiropractor or podiatrist	175	41 %
Services by a duly licensed psychologist	196	46 %
Treatment for alcoholism, drug abuse, nervous or mental conditions, social worker services	241	57 %
Mammograms or pap smears laboratory testing	278	66 %

If so, on what payment basis?

Employer/employee share	227	71 %
Employer pays	39	12 %
Employee pays	52	16 %

KCCI HEALTH CARE INSURANCE SURVEY

Business size: 10 or less employees Businesses surveyed: 88 (21%)

1. Does your business offer a health care insurance program to employees and dependents?

YES		NO	
67	76 %	21	24 %

2. Have individual premiums increased/decreased in the past year?

increased 1% to 10%	7	10 %
increased 10% to 20%	22	30 %
increased 20% or more	36	49 %
decreased	0	0 %
stayed the same	8	11 %

3. In the past two years, has your health insurance plan adopted any of the following?

increase in deductible	32	36 %
employee contributions	7	8 %
eligibility period	1	1 %
changed insurance co.	16	18 %

4. The Kansas Legislature may consider repeal of mandated insurance benefit programs in 1990. The repeal would mean insurance policies written by Kansas companies would no longer be required to provide several mandated coverages. Would you support the repeal of health care insurance mandates?

YES		NO	
43	49 %	27	31 %

5. Would you voluntarily provide to your workers the following insurance coverages; with additional premium charges?

Services by an optometrist, chiropractor or podiatrist	32	36 %
Services by a duly licensed psychologist	28	32 %
Treatment for alcoholism, drug abuse, nervous or mental conditions, social worker services	37	42 %
Mammograms or pap smears laboratory testing	42	48 %

If so, on what payment basis?

Employer/employee share	35	62 %
Employer pays	10	18 %
Employee pays	11	20 %

KCCI HEALTH CARE INSURANCE SURVEY

Business size: 10 to 25 employees Businesses surveyed: 107 (25%)

1. Does your business offer a health care insurance program to employees and dependents?

YES		NO	
98	92 %	9	8 %

2. Have individual premiums increased/decreased in the past year?

increased 1% to 10%	8	8 %
increased 10% to 20%	26	26 %
increased 20% or more	62	61 %
decreased	0	0 %
stayed the same	5	5 %

3. In the past two years, has your health insurance plan adopted any of the following?

increase in deductible	56	52 %
employee contributions	37	35 %
eligibility period	6	6 %
changed insurance co.	23	21 %

4. The Kansas Legislature may consider repeal of mandated insurance benefit programs in 1990. The repeal would mean insurance policies written by Kansas companies would no longer be required to provide several mandated coverages. Would you support the repeal of health care insurance mandates?

YES		NO	
60	56 %	30	28 %

5. Would you voluntarily provide to your workers the following insurance coverages; with additional premium charges?

Services by an optometrist, chiropractor or podiatrist	39	36 %
Services by a duly licensed psychologist	42	39 %
Treatment for alcoholism, drug abuse, nervous or mental conditions, social worker services	56	52 %
Mammograms or pap smears laboratory testing	67	63 %

If so, on what payment basis?

Employer/employee share	44	58 %
Employer pays	16	21 %
Employee pays	16	21 %

KCCI HEALTH CARE INSURANCE SURVEY

Business size: 25 to 100 employees Businesses surveyed: 134 (32%)

1. Does your business offer a health care insurance program to employees and dependents?

YES		NO	
129	96 %	5	4 %

2. Have individual premiums increased/decreased in the past year?

increased 1% to 10%	13	10 %
increased 10% to 20%	37	28 %
increased 20% or more	76	58 %
decreased	2	1 %
stayed the same	4	3 %

3. In the past two years, has your health insurance plan adopted any of the following?

increase in deductible	77	57 %
employee contributions	65	49 %
eligibility period	10	7 %
changed insurance co.	41	31 %

4. The Kansas Legislature may consider repeal of mandated insurance benefit programs in 1990. The repeal would mean insurance policies written by Kansas companies would no longer be required to provide several mandated coverages. Would you support the repeal of health care insurance mandates?

YES		NO	
78	58 %	37	28 %

5. Would you voluntarily provide to your workers the following insurance coverages; with additional premium charges?

Services by an optometrist, chiropractor or podiatrist	57	43 %
Services by a duly licensed psychologist	66	49 %
Treatment for alcoholism, drug abuse, nervous or mental conditions, social worker services	80	60 %
Mammograms or pap smears laboratory testing	98	73 %

If so, on what payment basis?

Employer/employee share	81	76 %
Employer pays	9	8 %
Employee pays	17	16 %

5-7

K[illegible] HEALTH CARE INSURANCE SURVEY

Business size: more than 100 employees Businesses surveyed: 94 (22%)

1. Does your business offer a health care insurance program to employees and dependents?

YES		NO	
94	100 %	0	0 %

2. Have individual premiums increased/decreased in the past year?

increased 1% to 10%	16	17 %
increased 10% to 20%	28	30 %
increased 20% or more	41	44 %
decreased	0	0 %
stayed the same	9	9 %

3. In the past two years, has your health insurance plan adopted any of the following?

increase in deductible	53	56 %
employee contributions	59	63 %
eligibility period	13	14 %
changed insurance co.	27	29 %

4. The Kansas Legislature may consider repeal of mandated insurance benefit programs in 1990. The repeal would mean insurance policies written by Kansas companies would no longer be required to provide several mandated coverages. Would you support the repeal of health care insurance mandates?

YES		NO	
60	64 %	15	16 %

5. Would you voluntarily provide to your workers the following insurance coverages; with additional premium charges?

Services by an optometrist, chiropractor or podiatrist	47	50 %
Services by a duly licensed psychologist	60	64 %
Treatment for alcoholism, drug abuse, nervous or mental conditions, social worker services	68	72 %
Mammograms or pap smears laboratory testing	71	76 %

If so, on what payment basis?

Employer/employee share	67	85 %
Employer pays	4	5 %
Employee pays	8	10 %

KPL GAS SERVICE

TESTIMONY

TO

HOUSE INSURANCE COMMITTEE

HB 2889

FEBRUARY 28, 1990

BY COLLIER CASE, KPL GAS SERVICE

Mr. Chairman and Members of the Committee:

My name is Collier Case, I am Manager of Employee Benefits for The Kansas Power and Light Company and a member of the Board of Directors of The Kansas Employer Coalition on Health. I am here today on behalf of KPL to support House Bill 2889.

Over 70% of KPL Gas Service's (4600) employees work in the state of Kansas. These 3,300 plus individuals are covered by the company's health care programs. Our plans are self funded as well as insured. The company's overall health care costs have risen dramatically over the last 5 years at an average annual rate of 13.75%. During that same period the CPI has increased at an average annual rate of 3.69%. In 1989 we spent over 15.5 million dollars for healthcare for our employees and retirees, compared to 9.2 million dollars in 1985.

Attachment 6

818 KANSAS AVENUE ★ P.O. BOX 889 ★ TOPEKA, KANSAS 66601 ★ (913) 296-6300

KPL is fortunate to be able to self fund a good portion of its healthcare program which generally precludes mandated benefits. However, we also offer Health Maintenance Organizations as alternatives to our basic program. In 1989 we spent over 1.9 million dollars in HMO premiums. HMO costs have risen 30% in each of the last 2 years. Some of that increase is attributable to mandated benefits for such coverages as outpatient treatment of alcoholism, drug abuse, nervous and mental conditions; pap smear and mammogram services.

We view the rising cost of healthcare as a major component of our total compensation package. Increases in our insured healthcare alternatives to the extent we have seen will not be tolerated and we will have to discontinue offering these alternatives. For KPL employees they do have another plan to go to - other businesses do not have that flexibility. Those employers may drop their health benefits which, in the viscous cycle of healthcare, means more uninsured - more bad debt - and therefore higher costs from the providers of services to cover the bad debt, which results in higher costs to KPL employees and our healthcare plan.

Healthcare benefits are part of the compensation agreement between the employer and the employee. It becomes increasingly difficult to customize that arrangement to a form which is beneficial to both parties when the employer or insurance carrier is forced to make the benefit at least so big because of mandates.

I appreciate the opportunity to speak before you and reiterate KPL Gas Services support for HB 2889 which would make current mandated benefits options to be considered by plan sponsors.

Kansas Employer Coalition on Health, Inc.
1271 S.W. Harrison • Topeka, Kansas 66612 • (913) 233-0351

Kansas Employer Coalition on Health
Testimony to the House Insurance Committee
re: H-2888, 2889 and 3015
(restricting mandated benefits)
February 28, 1990

by Jim Schwartz, Consulting Director

I am Jim Schwartz, consulting director for the Kansas Employer Coalition on Health. The coalition is over 100 companies across the state who share a concern about the soaring cost of health care provided to employees.

Although the Coalition is mostly composed of larger, self-insured companies who are exempt from state mandates, we do have quite a few fully insured members, and, besides, we feel a duty to say a few words on behalf of small employers who haven't the time or expertise become involved in these complexities.

In practically every state, including Kansas, the American system of employment-based health insurance is voluntary. A number of laws create incentives for employers to offer health insurance, but for any number of reasons, mostly economic, a substantial number of employers elect not to. It's perfectly legal for them to decide *not* to offer coverage for physician and hospital care, mental health benefits, chiropractic care, optometrists' services, treatment for substance abuse, and so on.

Isn't it a bit peculiar, then, for the law to say, "but if you do offer health insurance at all, it has to be nine yards long and nine yards wide"? Isn't this situation something like saying, "you don't have to give money to the poor, but if you do, it has to be at least $50"? Clearly

the problem with such a requirement is that many people who might otherwise give *something* to the poor, find that they cannot go the whole nine yards, and so give nothing.

Indeed, a recent study by the Health Insurance Association of America estimates that 16% of small firms that do not offer coverage *would* in an essentially mandate-free world.

So how should the mix of benefits be determined in a voluntary system? Since not even the richest plan can afford every possible health benefit, an evaluation must be made of the options. Employers try to match the needs of the employee group with an attractive and cost-effective selection of benefits.

When government intervenes and elevates some services to the status of mandates, the process of having the benefits compete on their merits gets distorted. So does the process of negotiating compensation levels between labor and management.

We believe that in a voluntary system, the choices are best left to the volunteers. Employers and labor groups, who are best attuned to the needs of individual workforces, are in the best position to choose the mix of benefits.

H-2888 is a step in the right direction. If there must be mandates, then they ought to be able to pass inspection for social and economic impact. H-2889 and 3015 give mandates the status they should have had all along in a voluntary system: optional.

We vigorously support the principles contained in these bills and urge their passage.

Testimony on HB 2888
Before the House Insurance Committee
By: Larry W. Magill, Jr., Executive Vice President
Independent Insurance Agents of Kansas
February 28, 1990

Thank you, Mr. Chairman, and members of the committee for the opportunity to appear in support of HB 2888 requiring impact reports on all proposed new mandated health care benefits.

We feel it would be an important step towards providing consistent and complete information for the legislature when considering future mandates.

Plus, it would provide a consistent record of the justification for a mandate that could be referenced years after the fact to determine if projections were accurate.

We do not anticipate that present concerns over the cost of health insurance will diminish at all in the future. In fact, we anticipate they will only increase. Nor do we expect that the legislature has seen all the potential mandated providers and coverages. Every time a new group of providers is licensed, they will seek a mandate for direct reimbursement. By passing HB 2888, the legislature will simply shape the debate in the future in a logical and complete fashion.

We urge the committee to act favorably on HB 2888.

Attachment 8

Testimony on HB 2889 and HB 3015
Before the House Insurance Committee
By: Larry W. Magill, Jr., Executive Vice President
Independent Insurance Agents of Kansas
February 28, 1990

Thank you Mr. Chairman, and members of the committee, for the opportunity to appear in support of House Bills 2889 and 3015. Both measures would make mandates optional, but HB 3015 would simply require that they be available if requested by the policyholder, where HB 2889 would require a formal offer, and presumably, a formal signed rejection by the insured of the offer.

For this reason, we support the concept in HB 3015 over the mandatory offer in HB 2889. We are concerned about the administrative burden on agents and companies of being forced to quote every individual option, price each option separately and obtain a signed rejection on each separate mandate that is rejected.

Perhaps even more significant than the administrative burden and costs on our members is the potential legal liability from insureds who later allege that they gave an uninformed rejection. This has been a problem in those states where a formal offer of uninsured or underinsured motorists coverage is required.

Our association has and continues to be philosophically opposed to mandating insurance. That includes mandating that if you purchase insurance it must contain certain coverages as is the case with the health insurance coverage mandated in Kansas.

To our knowledge, this is the first time we have appeared on the mandate issue. There are a number of reasons for this:

1. Group insurance is an increasingly important part of our

members' agencies and therefore we're not as content to sit back and let others carry the debate on an issue this important.

2. It is difficult to deal with mandates one at a time compared to all at once. There is a tendency for the legislature to view each new mandate as a small impact, yet when they are all taken together, they represent a significant increase in cost. Plus, it is politically important to be consistent. Once the legislature gives one group a mandate, it is hard to deny the next group that comes in.

   For all of these reasons, we feel the only way the legislature can deal with the mandate issue is to deal with all of them at once.

3. We share the increasing concern for the cost and availability of group health insurance - particularly for small employers. This is based on the realization that a large number of the 37 million uninsured Americans are working uninsured.

4. To the extent that mandates are driving more firms to self-insure, they are exposing more employers and their employees to the risks of an inadequately funded self-insurance program. In addition, it is putting insurance at a competitive disadvantage with self-insurance that is not equitable. If an employer is large enough to self-insure, they should make that decision on a basis other than escaping mandates. We also would like to point out that if the present public entity group self-insurance act is expanded to include authority for group health, disability and life, there will potentially be a huge number of additional employees and public entity employers escaping the present mandates.

We commend the committee for tackling this large an issue during this session. It is obvious from watching that everyone has learned a great deal and that the problems and potential solutions are much better understood.

Clearly eliminating mandates is one of the more significant cost saving steps the committee can take. Other conferees are in a better position to address the cost savings and you have already heard some of that testimony.

However, it would not surprise us to see many of the mandates continue to be included in small employer groups. Making them optional simply adds

flexibility where none has existed before in benefit design and choices.

Another reason we support HB 3015 is that it eliminates the mandates on individual policies. In individual insurance, the consumer is paying the entire cost and that cost can be a significant impediment to carrying the coverage. Anything the legislature can do to moderate the cost of individual coverage will help address the uninsured problem.

In the case of individual insurance an "offer" will not work because of adverse selection. Only those who need a particular mandate will choose to purchase it and companies will not be able to price it on that basis.

In addition, eliminating mandates on individual insurance without also doing so for small groups, could create an unfair competitive advantage for individual health insurers and cause a shift from small group to individual policies that may not be intended or desirable.

We urge the committee to act favorably on HB 3015 and make mandatory coverage available but not required.

Kansas Insurance Department
Testimony Before the
House Insurance Committee
on House Bill No. 3015
Presented by Dick Brock

House Bill No. 3015 was introduced as a vehicle to convert the current statutes relating to mandated benefits and services from a mandate for inclusion in accident and sickness insurance contracts to a mandate for availability of such policy provisions. House Bill No. 2889 is a proposal that would make a similar change but would require insurers to continue to offer the coverage and when we see a requirement to "offer" something we assume the legislative intent is for an affirmative offer of some kind. The difference between a mandated offer and mandated availability is not of tremendous significance although the mandated offer does obviously do more toward acquainting potential insurance purchasers that such benefits and services can be obtained. The value of this distinction between House Bill No. 2889 is one of the factors you will need to weigh when considering the respective merits of the two bills.

The difference in treatment of individual policies of accident and sickness insurance is, however, a very important consideration. House Bill No. 2889 would require the benefits and services now mandated to be offered on both individual and group policies. There is nothing inherently wrong with this approach but applying the mandatory offer to individual policies will almost certainly result in adverse selection against the insurance company. That is individuals who have, expect to have or think they might have a condition covered by one of the benefits or services which must be offered will tend to purchase the coverage to a much greater degree than others. As a result, the necessary spread of risk and the fortuitous and unexpected nature of an event which results in claims under the policy is not left to normal elements of chance but rather is skewed toward those who are more likely to need the benefit or use the service to a greater degree than a more random insured population would produce. Needless to say, this will drive the costs of the

coverage up through a greater frequency of claims because it is likely that more people accepting the offer will have or find a need for the coverage.

House Bill No. 3015 avoids this problem but it does so at the expense of simply eliminating any required opportunity for persons to purchase coverage for the benefits and services now mandated. This doesn't mean no such coverage will be available because it can be reasonably anticipated that many insurers will build some of these coverages or some version of these coverages into their contracts anyway. Nevertheless, this is a substantive difference and one you will want to keep in mind when and if action is taken on either of these proposals.

MENTAL HEALTH COVERAGE
H.B. 2889 & H.B. 3015

Association of CMHCs of Kansas, Inc.
February 28, 1990

Contact: Paul M. Klotz 913-234-4773

This Association strongly opposes both **H.B. 2889 and H.B. 3015** in that these bills could eliminate a whole population from mental health care and treatment. Also, the Bills could have the affect of transferring much of these costs from the private sector to the taxpayer. Already government pays a disproportionate share of mental health costs. Prior to passage of mandated mental health coverage only 23 percent of the insured were covered for mental and nervous conditions.

The only purpose of seeking a mandate for nervous and mental coverage was to avoid discrimination toward people with mental illness. Even with the state mandate, coverage for mental illness is nowhere near equal to physical illness. This fact is alarming when you realize that more than 60 percent of visits to general medical doctors are made by patients who have an emotional rather than an organic basis for their physical symptoms.

We don't believe psychiatric coverage has:

- Unduly increased premiums,
- Caused employers to move to self insurance,
- Caused termination of policies,
- Interfered with actions of insurance companies to cost contain; such as DRG's, MAP's, CAP's, Co-pays, deductibles and managed health care.

Attachment 10

We believe that psychiatric coverages have:

- Made current health insurance benefits more equitable for those who by chance suffer from a mental illness as opposed to a physical illness.
- Provided an offsetting cost savings against surgical and medical costs.
- Lessened the burden on taxpayers who finance a disproportionate share of the costs for psychiatric care.
- Improved worker productivity.
- Encouraged patients to use less costly outpatient treatment.
- Allowed the risk of mental illness to be shared by all insured as is physical illness.
- Directed clients to proper treatment professionals.
- Better defined what mental illness is and what it is not.
- Provided a cap on some benefits.

We believe that the mandate can be strengthened by:

- Allowing for trade-offs between inpatient and outpatient benefits for certain subscribers.
- Provide for extraterritoriality as outlined in **H.B. 2768.**
- Encourage the use of outpatient services rather than inpatient services.
- Encourage day treatment/partial hospitalization versus full inpatient treatment.
- Greater use of utilization review and quality assurance procedures.

Kansas Psychiatric Society

1259 Pembroke Lane
Topeka, KS 66604
Telephone: (913) 232-5985
or (913) 235-3619

February 28, 1990

TO: House Insurance Committee

FROM: Kansas Psychiatric Society Chip Wheelen

SUBJECT: House Bills 2889 and 3015; Repeal of Mandated Benefits Under Policies of Accident and Health Insurance

Thank you for this opportunity to express our opposition to both HB 2889 and HB 3015. The Kansas Psychiatric Society is generally opposed to any legislation which would repeal mandated mental health benefits.

For many, many years, victims of mental illness have suffered the consequences of societal thinking which discriminated between what most of us call physical illness versus mental illness. The fact of the matter is, medical science has determined conclusively that most forms of mental illness are indeed physical. It has been scientifically determined that most diagnosable mental illnesses are attributable to organic causes. Environmental factors, which many people believe cause mental illness, simply contribute to the difficulties experienced by those who suffer from mental illness. Unfortunately, the proponents of legislation to repeal mandated mental health benefits have apparently digressed in thinking that mental health is somehow distinct from physical health. This would constitute a return to prejudicial discrimination against those who suffer from mental illness.

Perhaps the most important point to be made is that if health and accident insurance policies do not include mental health benefits, many who would benefit from early medical intervention will not receive the much needed treatment. As a result, they will become less productive in their work, or perhaps lose their employment altogether. This means that those interests who are promoting the repeal of mandated benefits would stand to lose significant production at their work sites. This cost would far exceed the cost of including mental health benefits under contracts for insurance. In the other example, mentally ill persons who might lose their jobs would likely become wards of the State and perhaps become patients at one of our very expensive institutions. Attached to this statement is a copy of an article from the November 10, 1989 "American Medical News," which describes the costs to industry in those states where mental health benefits are not provided under accident and health insurance.

Another very important point is that of the numerous conferees who appeared to testify on the general subject of health insurance, not one of them could produce valid statistics indicating that mandated benefits have significantly contributed to the rising cost of insurance coverage. If anything, the conferees indicated that the estimated premium dollars attributable to all mandated benefits under health insurance are modest at most. In this context, it is extremely important to keep in mind that the cost for mandated benefits in the short-term is far less than the cost of remedial health care in the long-term. We respectfully suggest to you that until such time that the Kansas Insurance Department can obtain the information necessary to conclusively identify the true cost components of health and accident insurance coverage, that all discussions pertaining to the repeal of mandated benefits should be curtailed.

We respectfully urge you to report HB 2889 and HB 3015 not recommended for passage. Thank you for considering our comments.

Attachment 11

Gallup finds pervasive absenteeism

Stress treatment costing billions

By Janice Somerville
AMN STAFF

Bill explodes at his boss, Paul can't focus on any project long enough to finish it, and Barb is home sick with the flu.

All are suffering from stress, which causes American workers to miss an average of 16 days on the job each year, indicates a recent survey by the Gallup Organization Inc.

And the problem is widespread, reports the poll, conducted by the Princeton, N.J.-based public opinion research firm and released at a symposium sponsored by the New York Business Group on Health. Nearly three-fourths of the corporate medical directors and human resources managers surveyed called it "very pervasive" or "fairly pervasive."

Stress, anxiety, and depression cost American businesses billions of dollars each year in lost wages and for treatment of related disorders, said one of the symposium's speakers, Robert M.A. Hirschfeld, MD, chief of the Mood, Anxiety and Personality Disorders Research Branch of the National Institute of Mental Health.

The cost of occupational disability related to mental problems averages $8,000 per case, he said.

"The good news is that depression is one of the most treatable illnesses," Dr. Hirschfeld said. "That means businesses needn't experience this enormous drain on their resources."

Business can alter this by including mental health coverage in group insurance policies and by educating employees and managers. "Mental health, in general, and depression, in particular," he said, "are discriminated against by most group health insurance policies, which provide no mental health coverage or considerably less than they do for other medical problems."

Introducing the results of the Gallup survey, NYBGH Executive Director Leon Warshaw, MD, predicted that, if current trends continued, the problem would dominate the field of occupational disease in the 1990s.

The survey suggests that workers affected by stress, anxiety, and depression also harm businesses when they are on the job — not just when they stay home. Forty-seven percent of survey respondents said the problem contributes to decreased production, 40% said it lowers employee morale, and 30% said it contributes to alcohol and substance abuse.

The managers reported that 13% of their employees suffer from symptoms of depression, including difficulty in concentrating (36%), sleep problems (35%), loss of energy (27%), and loss of interest in work (18%).

In helping their workers cope with such problems, directors at large companies said their first step is referral to a physician or psychiatrist or to their in-house employee assistance program. Nine out of 10 directors surveyed said their firms have such a program.

To help employees seek early medical treatment of mental illness, one company, Tenneco Inc., redesigned its health insurance benefit package and decreased inpatient mental health care expenses by 41%, said Edward J. Bernacki, MD, the firm's vice president for corporate health. Dr. Bernacki said the plan emphasized outpatient treatment and increased the employee's share of costs. Outpatient charges increased 17%, he said.

Common symptoms, consequences for employees who suffer from stress, depression

Managers report that an average of 13% of their employees suffer from depression. They show these symptoms:

- 36% have difficulty concentrating.
- 35% experience sleep problems.
- 27% report loss of energy.
- 18% have a loss of interest in work.

Consequences of stress, anxiety, and depression, according to managers:

- 47% said it contributes to decreased production.
- 40% report a negative impact on morale and increased absenteeism.
- 30% said it results in drug and alcohol abuse.

Source: Gallup Poll

STATE OF KANSAS

MIKE HAYDEN, *Governor*

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

ALCOHOL AND DRUG ABUSE SERVICES

300 SW Oakley, Topeka, Kansas 66606-1861

☎ (913) 296-3925

TO: The House Committee on Insurance

FROM: Andrew O'Donovan, Commissioner, SRS/Alcohol and Drug Abuse Services

RE: House Bills 2889 and 3015

DATE: February 28, 1990

I am strongly opposed to the language as proposed in both House Bill 2889 and House Bill 3015. Both these bills remove the mandate of insurance coverage for alcoholism, drug abuse and nervous and mental conditions as now required by Kansas Statute for individual and group insurance policies.

The passage of these bills would lead to an increased burden on the State of Kansas to fund treatment for alcoholism and drug addiction. Without the ability of insurance to pay for treatment, many persons would seek help from state funded programs. All the state funded residential treatment programs now have waiting lists to enter treatment and the passage of either or both these bills would increase this problem.

My other concern is that insurance will continue to pay to treat the symptoms of these diseases. By this I mean that insurance will continue to pay for by-products of the diseases of alcoholism and drug addiction, such as: gastritis, pancreatitis, ulcers, cirrhosis, DUI related injuries, heart disease, and the many other physical ailments that need medical attention as a result of these addictions.

Utilizing the option of the "offer" or "request" as stated in these bills would be akin to eliminating coverage. Employers would think that their employees do not have alcohol or addiction problems and would not choose the coverage. Parents would be in denial (a product of the addiction disease) towards themselves or their children and would not choose this option either.

The passage of either or both of these bills removes the insurance coverage for the treatment of the number one problem facing our country today: alcoholism and drug addiction. The annual cost to Kansas is estimated to be 1 billion dollars a year in such areas as lost productivity, accidents, welfare costs, early death, accidents, etc. This serious a problem needs to continue to be covered by health insurance policies so that we can find solutions to the problem.

If a person is alcoholic or drug addicted, only one solution remains to them: They must be treated or they will die! And before they die, they will cost the health care system many dollars in related illnesses and cause much suffering for their family and friends. Without mandated insurance coverage, this system will become worse.

If you need any additional information, please contact me at 296-3925.

Thank you for this opportunity to present my views on this matter.

TESTIMONY

HOUSE BILL NO. 2889

House Insurance Committee

February 28, 1990

Mr. Chairman and Members of the Insurance Committee of the House of Representatives:

I represent the Kansas Alcohol and Drug Addiction Counselors Association, the Kansas Association of Alcohol and Drug Program Directors and the Kansas Community Alcohol Safety Action Project Coodinators Association. We oppose House Bill No. 2889 in it's present form as it appears to make treatment for alcohol and drugs abusers an option which shall be offered by the insurance company at an adjusted premium rate.

One can only visualize what problems will occur if this legislation is enacted. Estimates indicate that 70% of our population in the State of Kansas will use or have used alcohol and other drugs. The remaining 30% can be considered those who abstain for various reasons from mind altering drugs or those who could be possibly recovering alcohol and drug abusers. Our organizations have serious doubt that the 30% of the citizens of the State of Kansas would, if offered, choose to pay additional premium for coverage for alcohol or drug abuse when they practice abstinence. Insurance companies must then spread the cost of those people who choose to take the option of alcohol and drug abuse treatment to not 100% of their policy holders, but only 70%. Common sense tells us that this additional coverage would cost those who wish to purchase it at least 30% more because of the spreading of the risk factor being limited to 70% of the population.

It is estimated that there are 170,000 practicing alcoholics and drug abusers in the State of Kansas at this time. Those people, in most part, are suffering from what we describe as the disease of denial. They deny that they have a problem. These 170,000 people probably would not accept the option of alcohol and drug abuse treatment because if they did they would be admitting that they had a problem with their alcohol and drug abuse. These 170,000 citizens of the State of Kansas can only look forward to either drinking or drugging theirselves to death or going on the public roles of welfare at the expense of the citizens of Kansas.

This brings up another interesting fact that by eliminating mandatory coverage for those people who purchase health insurance, we can expect a larger portion of those people who refuse to exercise the option to buy coverage for alcohol and drug abuse to seek treatment at public expense through the programs of alcohol and drug abuse services. At the present time, there are not enough community alcohol treatment centers in the State of Kansas to take care of the load that we are presently faced with. There is over a 30 day waiting period

throughout the State for those people who wish to get into treatment. Some of these people have been arrested for crimes and are being held in the jails throughout the State, at taxpayers expense, until a bed becomes available. These waiting periods are costly to all of us who are taxpayers in the State. Implementation of a proposed legislation such as House Bill No. 2889, would only make that problem more severe.

Our three organizations disagree in unison to the proposed optional coverage offered by the insurer to the State of Kansas. It must be made available to all insurees in the State of Kansas because alcoholism and drug abuse are the third leading killers of our citizens at this time.

Respectfully,

Gene Johnson

Gene Johnson
Lobbyist
Kansas Alcoholism and Drug Addiction Counselors Association
Kansas Association of Alcohol and Drug Program Directors
Kansas Community Alcohol Safety Action Project Coordinators Association

KANSAS NASW

National Association of Social Workers, Inc.
Chapter Office
817 West Sixth Street
Topeka, Kansas 66603

Telephone: 913-354-4804
Gigi Felix, LMSW
Executive Director

TESTIMONY TO THE HOUSE COMMITTEE

ON INSURANCE

WEDNESDAY, FEBRUARY 28, 1990

RE: HB 2889
HB 3015

Good afternoon, and thank you for again giving me the opportunity to speak to you on insurance issues. I am here today regarding two bills which effect the mandated coverages for Kansans. House Bills 2889 and 3015 both address this issue with emphasis on different syllables, HB3015 deals with group coverages with the emphasis on the policy holder requesting a certain type of coverage, and HB2889 with all carriers mandated to offer a menu of coverages to the policyholder. **K-NASW opposes both these bills.**

K-NASW opposes these bills most strongly because of the effect they will have on the client ("consumer"). If enacted, the choice of coverage will be totally taken out of the hands of any individual enrolled in a group policy. The decisions will be made for them by their employer. If the employer decides that his/her bottom line can sustain the costs, then the individual will have the coverage. If, however, the bottom line can not absorb the costs, the individual will not be covered. So, the smaller the business - usually associated with smaller wages and budgets - will probably opt not to include the coverages for mental health care, substance abuse, mammography, etc. The result is that the individual worker will not have these services available to him/her unless they can afford to pay 100% out of their own pockets. Given the choice of paying the rent, eating, or paying for a mammogram, what do you think most families would choose?

These bills will leave people without essential services, and that is unacceptable.

Furthermore, the enactment of either bill seems to be a regressive policy for the state. We now enable solid health care options, through mandated benefit packages, for our work force and their families. This legislation seems to be a step backward in the compassionate stance that current statute allows. Considering the people's reaction to the SRS cutbacks, I believe that Kansans would support keeping the mandated benefits, and this committee, and the legislature as a whole, to look for a different approach to solving the insurance costs.

Attachment 14

KANSAS NASW
National Association of Social Workers, Inc.
Chapter Office
817 West Sixth Street
Topeka, Kansas 66603
Telephone: 913-354-4804

A different approach? Good question! I wish I could offer you a reasonable and fair approach that would solve this apparent dilemma. (I say apparent, because no one has mentioned acceptance of the insurance industry's need to raise the rates, and look for how the people can afford to pay them.)

I have heard testimony with this committee on previous occasions stating that there are many factors related to insurance costs escalating as they have. Longer life spans, ill babies, the high cost of technology, the consumer's appetite for care, and more. Mandated services is a small portion of the cost, according to testimony, yet one which would be sorely missed by the average citizen.

The cost of coverage may be a barrier to insurance for some people and businesses ... this is practically a given. But it does not seem fair that the solution become a burden to those covered now. If the only answer is to deny coverage to the majority so the currently medically indigent MIGHT be able to afford minimal coverage, I suggest that there is something wrong, and another solution be sought.

We also oppose these bills as they deny the consumer the opportunity to choose a social worker for services if they are not covered by insurances. It is documented that the cost of social work services is less that of other licensed mental health care providers. I will be glad to track down the documentation if it would be helpful.

SPECIFICS:

We **OPPOSE HB 2889** because it leaves the benefit package up to the employer who will use the company's bottom line to determine the insurance package, and not allow the individual the freedom of choice, unless s/he is willing to pay for it directly which puts the burden on the family's budget.

We **OPPOSE HB3015** because of the same reasons, AND it does not even require that an employer be told what can be provided, but puts the burden on him/her to ASK for certain coverages.

I urge you to report these two bills negatively from this committee.

Thank you again for your time, I will be glad to try and answer any questions you have for me.

STATE OF KANSAS

MIKE HAYDEN, *Governor*

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

ALCOHOL AND DRUG ABUSE SERVICES

300 SW Oakley, Topeka, Kansas 66606-1861

☎ (913) 296-3925

February 28, 1990

Representative Rex Hoy
Kansas House Representatives
State Capital
Topeka, KS

Dear Representative Rex Hoy:

As per your request, I have listed below the number of licensed/certified program components since 1981 to present.

Year	Licensed/Certified Components	
1981	116	
1982	129 + 14	70 New
1983	141 + 12	
1984	157 + 16	
1985	185 + 28	
1986	245 + 60	135 New
1987	275 + 30	
1988	320 + 45	
1989	336 + 16	31
Present	351 + 15	

54YR

Next 3YRS. After Mandated

If I can be of any further assistance, please feel free to contact me.

Sincerely,

David Chapman, Administrator
Licensure/Certification Section

DC:kaf

cc: Allyn Lockner

Attachment 15

COMPARISON OF INPATIENT PSYCHIATRIC TRENDS

	1984	1986 (March 5 inforce)	1988
National Trends:			
Percent Of Total Health Care Costs	6% - 10%		15% - 25%
Blue Cross and Blue Shield of Kansas Trends:			
Percent Of Total Health Care Costs	5.2%		14.0%
Percent Of Inpatient Days Used	10.8%		31.0%
Percent Of Total Patients	3.8%		8.8%
Average Charge Per Patient	$3,060		$6,518
	Cost 2yr Before		Cost 2yrs After
State Employee Group:			
Percent Of Total Health Care Costs	6.2%		10.0%
Percent Of Inpatient Days Used	15.8%		23.0%
Percent Of Total Patients	8.6%		8.8%
Average Charge Per Patient	$2,547		$4,589

C.P.I.

83	84	85	86	87	88	89
3.2%	4.3%	3.6%	1.9%	3.7%	4.2%	4.8%

HT:ca
02/90

February 28, 1990

TO: Jack Roberts
cc: John Knack

FROM: Dwight Wicker

SUBJECT: PSYCHOTHERAPY PAYMENT/CHARGE HISTORY

You asked me to gather information relating to payments/charges for psychiatrists, psychologists and social workers over the past ten years. Unfortunately, I do not have 1984-1989 data separated by each category of provider, but I do have information about allowed charges when each provider group was recognized for separate reimbursement.

In reviewing the chart below, remember that in 1979 few psychologists and social workers practiced independently and they relied on an M.D. to bill for their services. By 1981 psychologists could bill independently and by 1983 social workers could bill independently.

Mandate of 1986

	1979	1981	1983	1989
Psychiatrist, M.D.	$631,931	$589,798	$516,796	*
Psychologist	$323,321	$779,836	$725,239	*
Social Worker	$176,257	$398,728	$575,183	*
	$1,131,509	$1,768,362	$1,817,218	$11,850,000

7 yrs before 5 yr before 3 yr before 3 yrs later

NOTE: * Because of coding/system changes in 1984/85 data no longer available.

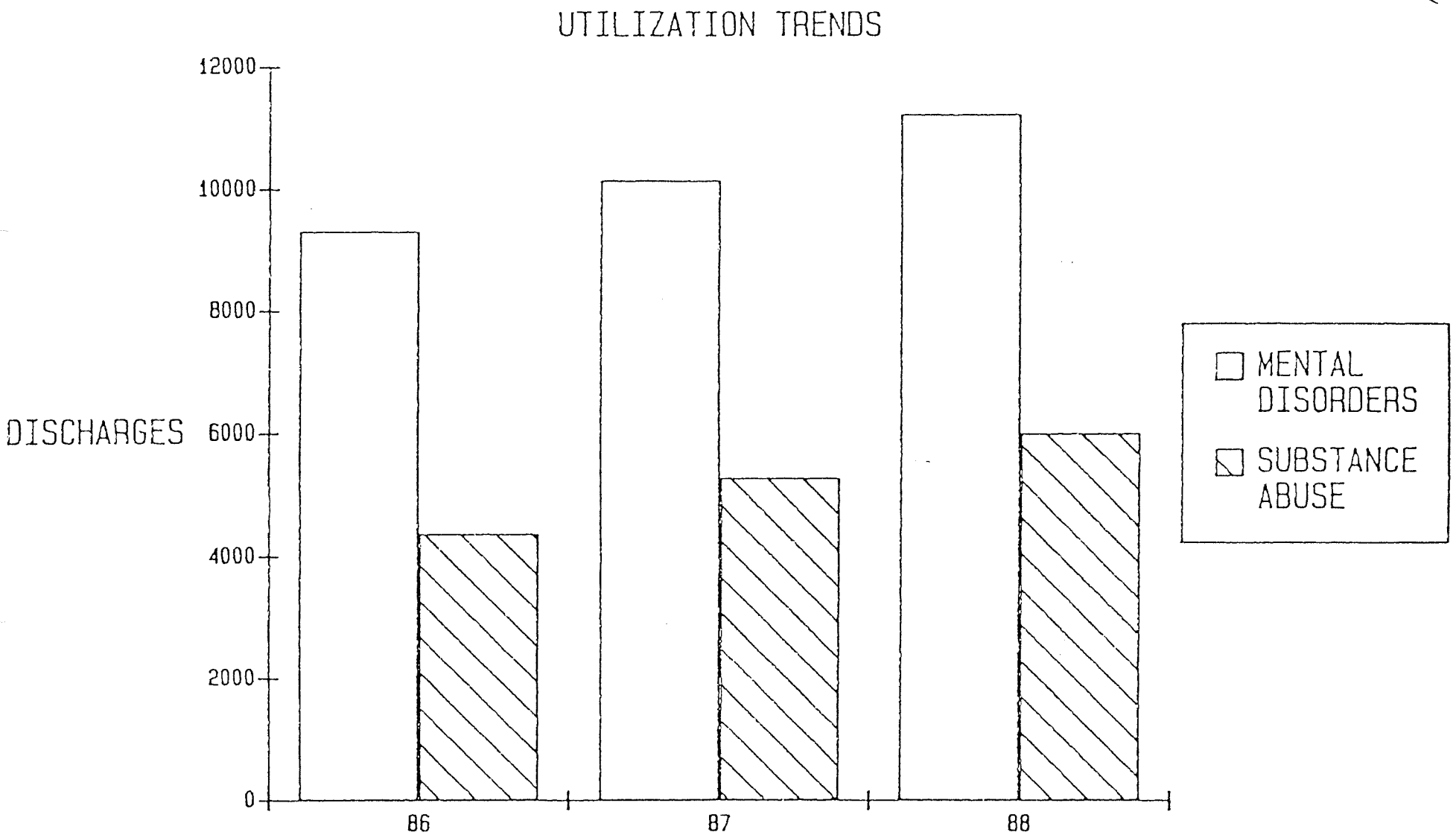
Average charge received from social worker in 1989 was $71.28 for 1 hour of psychotherapy.

Average charge received from psychiatrists/psychologists in 1989 was $75.66 for 1 hour of psychotherapy.

As you can see, we have seen dramatic increases in allowed charges and payments over the past ten years. Some of this increase is due to expanded coverage for outpatient services but some must be attributed to an increasing number of providers as well. The average charge we were billed in 1989 shows very little difference in charges between social workers and psychiatrists/psychologists. (Unfortunately, I cannot separate the data for the latter provider groups.)

DW/bab

15-3


UTILIZATION TRENDS
DISCHARGES
12000
10000
8000
6000
4000
2000
0
86
87
88
MENTAL DISORDERS
SUBSTANCE ABUSE

JAMES A. McHENRY, JR., PH.D.
1416 S. W. COLLINS
TOPEKA, KANSAS 66604

TESTIMONY OPPOSING HB 2889
February 28, 1990

I appreciate the opportunity to appear before the House Insurance Committee to voice my concerns about House Bill 2889. As a private citizen and a Kansas taxpayer, I believe this bill would produce some profoundly negative consequences if adopted.

I am particularly concerned about the impact of the amendments proposed in Section 4, which would remove the mandate regarding coverage for alcohol and drug abuse or nervous or mental conditions. Between 1983 and 1987, I served as the Commissioner of Alcohol and Drug Abuse Services in Kansas. In that capacity, I had the opportunity to study this issue carefully. I vividly recall two impressions which I would like to place before you.

1. With reference to alcoholism, drug abuse and mental illness, society has an enormous stake in promoting access to early intervention and treatment services. When people still have a "social margin" in place, the prospects for their recovery are quite good. The availability of insurance coverage acts as an additional incentive to the acceptance of treatment. In the face of the denial which so frequently accompanies alcoholism and drug abuse, this consideration can make a great deal of difference.

2. When alcohol and drug abusers and the mentally ill do not receive appropriate treatment, the bill society pays rapidly mounts. The costs we assume show up in our rising prison population, the terrible death toll on our highways, and the long term consequences of child abuse and neglect.

I realize that health insurance costs are continuing to rise. This year I had to agree to a significant increase in the deductible on my own policy in order to keep the monthly premium within my budget. As a matter of public policy, however, it is penny wise and pound foolish to decrease the coverage available in our state for the the treatment of alcoholism, drug abuse and nervous or mental conditions. If we must make a significant investment, let's at least make it at a point where the opportunities for a positive return are both evident and well-documented.

I would like to thank the Committee for considering these views, and I hope you will decide to pursue other strategies rather than those suggested in HB 2889.

Testimony submitted by James McHenry, Ph.D.