Approved: March 3, 1999
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE .

The meeting was called to order by Chairperson Senator Don Steffes at 12:30 p.m. on February 24, 1999 in Room 519 S of the Capitol.

All members were present except: Senator Paul Feleciano, Excused

Committee staff present: Dr. Bill Wolff, Research
Ken Wilke, Office of Revisor
Nikki Feuerborn, Committee Secretary

Conferees appearing before the committee: Brad Smoot, Blue Cross Blue Shield
Bill Sneed, HIAA
Terry Leatherman, KCCI
Frank Meyer, Custom Metal Fabricators, Herrington
Jim Schwartz, KECH
Bruce Wittt, Preferred health Systems
Larrie Ann Brown, KAHP

Others attending: See Attached

Chairman Steffes appointed a subcommittee for **SB 301** - Consumer credit; consumer credit code and **SB 272** - Deferred compensation (pay day) loans with Senator David Corbin serving as Chair; Senator Rich Becker, Senator Paul Feleciano, Senator Donald Biggs, and Senator Karin Brownlee.

Continued Hearing on SB 160 - Requiring mental health coverage to be the same as physical health coverage

Written testimony was received from Sharon Huffman, Legislative Liaison for the Commission on Disability Concerns, Department of Human Resources (Attachment 1).

Brad Smoot, Legislative Counsel for Blue Cross Blue Shield of Kansas and Blue Cross Blue Shield of Kansas City, presented testimony in opposition which would remove first dollar coverage for the five diseases listed in the bill (Attachment 2). He reminded the Committee that pharmacy benefits are not mandated by state law yet they are a very important part of many health care plans, i.e., psychiatry coverage and are currently provided by his company without discrimination between medical and psychological diagnosis. This benefit could become an expensive negotiable option for small group plans and individual plans. Mr. Smoot opposed the bill because of the adverse impact it would have on insurance premiums and affordability of health insurance for Kansans. The state health plan covers mental health only in their HMO's and the Blue Preferred package, therefore, they are not assuming responsibility for mental health parity in their self-insured plans. If this bill is implemented, the cost would be $10 million the first year and require adding $523,000 to the state health plan. Mr. Smoot referred to the testimony presented by Jim Cain at the hearing on Monday, February 22, as an example of one individual's mental illness coverage wrecking a small group plan by driving the cost to unaffordable levels.

Senator Barone asked for Blue Cross Blue Shield to provide the precise expenses of the five listed brain disorders or illnesses their company has paid based on the history today.

Bill Sneed, HIAA, spoke in opposition to the bill which would affect small groups and the individual market adversely (Attachment 3). Individuals should be allowed to make their own choices in insurance coverage and not be forced to pay for a benefit for which they do not wish coverage or cannot afford. Mr. Sneed said there were policies available in Kansas which do have the mental illness coverage offered in this bill. If there was a demand for this type of coverage, the insurance companies would provide the product.

Terry Leatherman, KCCI, supplied testimony objecting to the proposed legislation because mandates negatively impact the "endangered species" in today's insurance delivery mechanism...the small employer (Attachment 4).

Frank Meyer, President of Custom Metal Fabricators, Inc., requested that the Legislature not mandate

anything that would force small businesses to pay for something they do not want (Attachment 5). We compared what the company could afford to do for growth, expansion, and its employees if health insurance and other taxes were not required. If health insurance coverages keep increasing, mandates will become very unimportant to the average working person because they won't be able to afford any health insurance.

Jim Schwartz, Kansas Employer Coalition on Health, Inc., explained how mental health care does not share parity with the medical/surgical world for the following reasons (Attachment 6):

- The demand for mental care is practically unlimited.
- Mental care is subject to over-utilization to a degree unmatched in the medical arena.
- It is difficult in mental hospitals to identify when "treatment" is occurring.
- The recovery rate for mental illness is: 1/3 get better, 1/3 get worse, 1/3 do not change.
- Extremely difficult to nail down diagnoses as they appear to change with every generation.
- Providers find ways to classify patients as having one of the "paying conditions."
- Only way insurers can afford parity is through managed care.

Bruce Witt, Director of Regulatory Compliance of Preferred Health Systems, reported that having to discontinue first dollar coverage for only the five listed brain diseases would cause an increase in their administrative costs which may mitigate any cost savings from applying deductibles, co payments and coinsurance at the first dollar level (Attachment 7). He recommended utilizing the state employees' health plan as a test case to determine the actual cost impact of expanding coverage for mental illnesses beyond the level currently mandated.

Senator Barone requested a report on specific loss revenues from the mental and psychiatric wards of Via Christi institutions in terms of dollars being billed vs. dollars collected. He also requested information on the percentage of bills not collected for mental health treatment vs. those not collected for physical health.

Larrie Ann Brown, Kansas Association of Health Plans, said this bill had the potential to drive more employers into the self-insured plans, drop all coverage, or reduce other benefits offered (Attachment 8).

Written testimony in opposition to the bill was received from:

Kristin Van Voorst, Humana, Inc. (Attachment 9).
Gerard J Grimaldi, Kaiser Permanente (Attachment 10).

The hearing was closed.

The meeting was adjourned at 2:00 p.m. The next meeting is scheduled for Wednesday, March 3, 1999.

SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE GUEST LIST

DATE: 2/24/99

NAME	REPRESENTING
Terry Leatherman	KCCI
Frank Meyer	Custom Metal Fab
Karen L. Beckwith	Social Work -
Bill Sneed	HIAA
Kevin Davis	Am. Family Ins.
Jim Schwartz	KSCH
Tonya R. Dorf	Interhab
Wesley Marshall	InterHAB
B. Adams	NAMI Kansas
JANICE L. BARR	KS Assoc. Life Underwriters
Maggie Keating	KS Ins. Dept.
Paul Davis	Kansas Insurance Dept.
Grant Denny	KID
Chip Wheelen	KS Psychiatric Society
Cheryl Dillard	HealthNet
John Frederick	Boeing
Rich Guthrie	Health Midwest
Virginia Starr	Federico Consulting
Sheila Pearman	personal interest

SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE GUEST LIST

DATE: 24 Feb 99

NAME	REPRESENTING
Danielle Noe	Governor's Office
Amy A. Campbell	KMHC
Larrie Ann Brown	KAHP

STATE OF KANSAS
DEPARTMENT OF HUMAN RESOURCES

SB160

Bill Graves, Governor

Wayne L. Franklin, Secretary

COMMISSION ON DISABILITY CONCERNS
1430 S.W. Topeka Boulevard, Topeka, Kansas 66612-1877
Voice: (785) 296-1722 • TTY: (785) 296-5044 • Fax: (785) 296-0466
Toll Free: (Outside Topeka) 1-800-295-5232

February 24, 1999

TO: Senate Committee on Financial Institutions and Insurance

FROM: Sharon Huffman
Legislative Liaison

SUBJECT: Senate Bill 160

Thank you very much for introducing this bill and allowing me the opportunity to speak before you today.

The Kansas Commission on Disability Concerns (KCDC) was established by Kansas law nearly 50 years ago to carry on a continuing program to promote a higher quality of life for people with disabilities. One of our responsibilities is to submit recommendations to the legislature believed necessary to promote the independence of people with disabilities.

Throughout the past five years KCDC has cooperatively conducted Town Hall Meetings throughout the state with Kansas Rehabilitation Services (KRS). During these meetings the public is invited to present their opinions regarding services offered by Kansas Commission on Disability Concerns and KRS, voice their concern about issues concerning them, or just speak about something happening on the state or federal level that they think should be handled by KCDC or KRS. Most of the people who attend the Town Hall Meetings are either individuals with disabilities or friends and family of individuals with disabilities.

One of the many issues that we continue to hear about at these meetings is the inadequate coverage for mental illness that individuals receive in their health insurance benefits. Adequate health insurance benefits are something that many of us take for granted. Unless we suffer from some sort of catastrophic accident or illness our benefits usually cover a large percentage of the medical expenses. Unfortunately, there has been a huge gap left in health insurance benefits for people who have a disease of the brain, most commonly referred to as mental illness. Although this disease is medically treatable, for many individuals it is left untreated or undertreated when the health insurance benefits run out.

Senate Financial Institutions & Insurance

Date 2/24

Attachment # 1

The costs to society of untreated severe mental illness are significant. For example, at least one-third of all homeless people have severe mental illness. Most of these people would not be homeless if they received appropriate treatment and supports. Similarly, the burden on our local jails when they are used as "surrogate treatment facilities" could be significantly reduced if adequate treatment and services were available for persons with severe mental illness. The direct and indirect costs incurred by our state and local governments for treating severe mental illness are very high. These costs to our taxpayers could be reduced if insurance policies would provide adequate coverage for severe mental illness.

Some opponents would have you believe that the reason severe mental illnesses are not covered equally in most insurance contracts is that there is limited data demonstrating the effectiveness of treatment for these disorders. This assumption is not true. According to a 1993 report issued by the National Advisory Mental Health Council, clinical studies demonstrate that diagnosis and treatment for severe mental illness is today as precise and effective as diagnosis and treatment for other disorders. For example, the efficacy rate in reducing symptoms for persons with schizophrenia who receive timely treatment is 60 percent, which compares with just a 41 percent efficacy rate for treatment of cardiovascular disease through angioplasty. The efficacy rate for reducing symptoms through timely treatment of persons with bipolar disorders is 80 percent.

The Kansas Commission on Disability Concerns urges this committee's support of SB 160 and asks you to recommend it favorably for passage.

BRAD SMOOT

ATTORNEY AT LAW

MERCANTILE BANK BUILDING
800 SW JACKSON, SUITE 808
TOPEKA, KANSAS 66612
(785) 233-0016
(785) 234-3687 (fax)

10200 STATE LINE ROAD
SUITE 230
LEAWOOD, KANSAS 66206
(913) 649-6836

Statement of Brad Smoot, Legislative Counsel
Blue Cross Blue Shield of Kansas
Blue Cross Blue Shield of
Kansas City
To
Senate Financial Institutions & Insurance Committee
Regarding 1999 Senate Bill 160
February 24, 1999

Blue Cross Blue Shield of Kansas is a not-for-profit mutual insurance company providing health insurance to 700,000 Kansans in 103 counties. Blue Cross Blue Shield of Kansas City is a non-profit hospital and medical service corporation serving 200,000 Kansans in Johnson and Wyandotte Counties. Both plans generally oppose mandated benefits because they tend to increase the costs of health insurance and thereby decrease the number of Kansas businesses and individuals who can afford coverage. On behalf of our customers, we must respectfully oppose Senate Bill 160.

SB 160 would expand coverage for five mental diseases of the brain listed in Section 2(d) to equal coverage provided physical illnesses. We understand the desire of the bill's supporters to increase the amount of insurance reimbursement to mental health providers and thereby decrease out-of-pocket expenses for individual patients. For several reasons, however, we cannot agree that SB 160 should be adopted.

To begin with, Kansas current nervous and mental mandate, K.S.A. 1998 Supp. 40-2,105 already mandates first dollar coverage for mental health services as well as drug and alcohol treatment. Except for childhood immunizations, physical ailments are not entitled to first dollar coverage. This is no small benefit and adds millions of dollars to the health insurance premiums paid by Kansans. Attached to my testimony is a chart we have developed to show a comparison between current coverages for mental health and a typical medical benefits plan. We have used a standard $500 deductible with an 80%-20% copay. The charts would vary some if the policy provided for larger ($1000) or smaller ($250) deductibles.

As you can see, out patient nervous and mental benefits (including drug and alcohol treatments) receive first dollar coverage for the first $500 while medical services are entirely out-of-pocket. Out patient benefits continue thereafter at 50% up to $1860 per year for individuals and small groups. Large groups are subject to the Insurance Department's interpretation that groups of 50 or more must continue to pay at 50% until the annual or lifetime cap (equivalent to medical) has been reached.

In addition, you will want to note that inpatient nervous and mental benefits are equal (in parity with) medical benefits for the first 30 days of treatment. Whether the hospital charge is $1000, $2000 or more per day, at least for 30 days per year (this benefit renews annually) insurers provide the same coverage for both mental and medical care.

Senate Financial Institutions & Insurance

Date 2/24/99

Attachment # 2

Also note the purple key bar indicating that pharmacy benefits are the same regardless of whether the condition is medical or mental. As most committee members know, mental health treatment today is increasingly reliant upon modern pharmacy. A recent review of one of our pharmacy benefit programs indicates that 13.43% of our claims costs are paid for antidepressant and antipsychotic medications. Pharmacy benefits are not mandated by state law yet they are a very important part of many health care plans and are provided without discrimination between medical and psychological diagnosis.

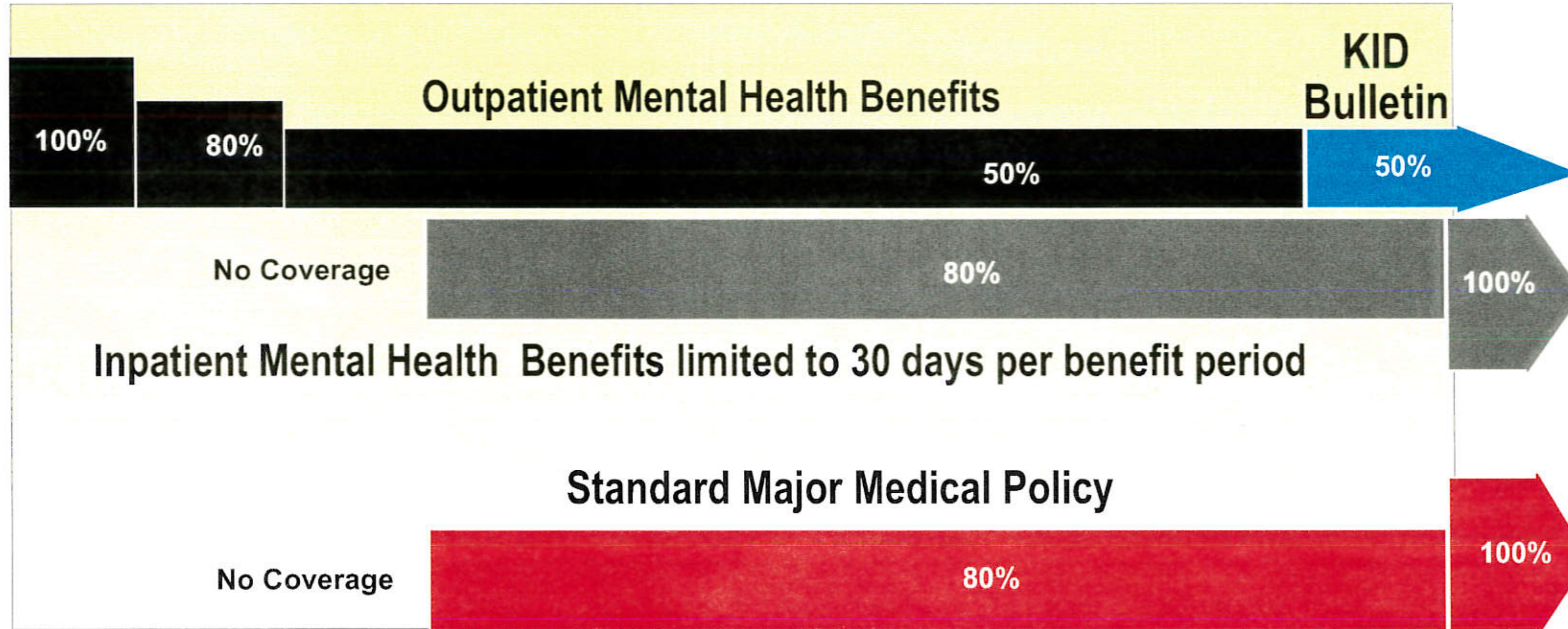
During the summer interim, Miller and Newberg, Inc., retained by the Department of Health & Environment, estimated the costs of a parity bill at 1% to 2.5% depending on whether the bill would cover long term custodial care. SB 160 does cover long term stays. Operating from a 2% premise ($22 million), we have adjusted downward for the reduction in diseases subject to the mandate (7 to 5), corrected for the KID bulletin effecting groups of 50 and above and made slight modification for the impact of the state employees health care plan mental health parity provision for employees choosing HMO plans. I am advised by the bill sponsor that the intent of SB 160 is to eliminate first dollar coverage for the five diseases listed and mandate true parity for those conditions. If the sponsor's intent is adopted, the fiscal impact on the private (insured) sector would be more than $10 million in the first year. The impact on the state employees health care plan would be an additional $523,000. If first dollar coverage is not eliminated for these diseases, the impact of SB 160 increases to more than $15 million per year.

We view these estimates as very conservative for several reasons: First, even proponents of SB 160 rely on higher estimates (H&HS study -- 3.6%; KID cites -- 2 to 5% and the KU study paid for by NAMI Kansas says at least 3%). SRS relies on the National Center for Mental Health Services conclusion that mental health "parity" increases premiums 3.4% -- a hefty 70% higher than the starting point for our estimates. Secondly, the NCMHS and SRS acknowledge that increases are lowest (1%) in "tightly managed" health care settings and higher (5%) in traditional fee-for-service and PPO settings. As you know, Kansas has low HMO penetration. Finally, all this assumes that provider diagnosis, referral and treatment practices will remain constant. Such an assumption is contrary to our experience and even sound business practices.

In summary, we cannot support SB 160 because of the adverse impact it has on insurance premiums and the affordability of health insurance for Kansans. However, if you plan to act on the bill, we hope you will strengthen the language on page 2, line 5 to more clearly state the author's intent to eliminate first dollar coverage where parity coverage is provided for the five named mental diseases. One might replace the phrase "Notwithstanding the foregoing" with "in lieu of the forgoing schedule of benefits." Without clarification, we think SB 160 is more than mental health parity. It is parity plus.

Thank you for consideration of our views.

Annual Major Medical & Mental Health Coverage: A Comparison of Current Law



After annual outpatient Mental Health maximum (company has paid out $1,000) has been met for small groups (2 - 50 in size) and individuals, outpatient benefits end until benefit period renews.

Inpatient Mental Health benefits are paid at the same level as non-mental health benefits for up to 30 days per benefit period.

Benefits are paid at 100% until benefit period renews or lifetime maximum is met.

- Out-patient Mental Health Mandate KSA 40- 2,105
- Typical Major Medical Benefit using Deductible of $500 (single). Then 80/20% Coinsurance until individual pays $1000 out-of-pocket. Then 100%.
- Pharmacy benefit not based on diagnosis. No distinction between physical and mental conditions.
- In-patient Mental Health Mandate KSA 40- 2,105
- Mental Health Benefit Requirement applicable to groups 51+ in size pursuant to KID Bulletin. First KSA 40- 2,105 must be met, then continuing benefits are paid at minimum of 50% until benefit period renews or lifetime maximum is met.

MEMORANDUM

TO: The Honorable Don Steffes, Chairman
Senate Financial Institutions & Insurance Committee

FROM: Bill Sneed, Legislative Counsel
Health Insurance Association

DATE: February 22, 1999

RE: S.B. 160

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I am here today representing the Health Insurance Association of America ("HIAA"). HIAA is the nation's leading advocate for the private, market-based health care system. Our 255+ members provide health insurance to approximately 110 million Americans. We appreciate this opportunity to provide comments on S.B. 160. After reviewing the bill, we appear today in opposition to its passage.

BACKGROUND

Over the past two years, a number of states have considered legislation requiring coverage for mental health benefits beyond what is required under federal law. To date, 13 states have enacted a mental health parity mandate exceeding federal requirements. However, with only one exception (Vermont), these states have avoided enacting an open-ended mental health benefit mandate by placing significant restraints on parity requirements--for example, by exempting individual and small employer health plans; limiting the mandate to serious, biologically-based mental illnesses; or permitting employers who experience more than a minimal cost increase as a result of the mandate to opt out (see attached table, "Characteristics of State Mental Health Parity Mandates").

Senate Financial Institutions & Insurance

Date 2/24/99

Attachment # 3

POLSINELLI, WHITE, VARDEMAN & SHALTON
555 South Kansas Avenue, Suite 301
Topeka, Kansas 66603-3443
(785) 233-1446
(785) 233-1939 (FAX)

Significantly, most employers and many individuals already purchase insurance for mental illness, often with reasonable limits on inpatient and outpatient treatment. According to the Employee Benefits Research Institute, 98% of employees in medium and large firms have coverage for inpatient mental health care and 97% have coverage for outpatient care. Although many purchaser of insurance opt for less than full "parity" between benefits for physical and mental illness, existing levels of coverage represent a significant commitment to providing benefits for mental illness.

DISCUSSION

HIAA opposes health benefit mandates, including mental health "parity" mandates, because they constrain the ability of insurance purchasers and consumers to choose for themselves what is best allocation of their available health insurance dollars and the appropriate level of coverage for their needs based on the best available information about medical technologies and treatments. Mandates unwisely lock into law what should be a flexible and evidence-based decision about appropriate levels of coverage made in the context of rapidly advancing medical knowledge and evolving medical technologies. In our view, choices about the distribution of health insurance dollars among different types of benefits should remain in the hands of purchasers and consumers, who are in the best position to judge what is the most efficient and appropriate allocation of their resources.

There are a number of additional reasons why we believe that mandating mental health "parity" is poor public policy:

Forcing the purchase of benefits that consumer may not want or can't afford only ensures that many more individuals will be unable to afford any insurance at all.

Independent research consistently shows that increasing the cost of health insurance results in fewer individuals being covered, though estimates of the precise impact vary from study to study. One study of the small employer health insurance market estimated that for every 1% increase in premiums, the number of covered employees drops by 0.9%.[1] While some studies estimate a somewhat smaller impact, others indicate a significantly larger impact, such as a 2-2.6% reduction in the number of small employers offering health coverage for every 1% increase in cost.[2] Clearly, while there is some uncertainty regarding how many individuals would lose coverage due to an increase in the cost of coverage, the number is significant, and could potentially be quite large.

Moreover, while estimates of the added cost of mandating full mental health parity also have varied, a number of credible studies estimate the cost increase to be quite large (see attached fact sheet, "The Cost of State Mental Health Mandates"). A 1998 study by the Department of Health and Human Services (HHS), for example, estimated that full mental health parity would increase insurance premiums by 3.6% on average, with cost increases varying significantly depending on the type of health plan involved. The HHS study showed that mandating full mental health parity would increase the cost of PPO coverage by 5.1%.

A number of studies commissioned by mental health providers and mental health advocates have predicted just a small increase in the cost of insurance due to mental health parity mandates. These studies share an important flaw: They wrongly assume that benefits will be provided in a tightly-controlled managed care setting. Yet most consumers prefer less restrictive

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[1] Morrisey, *et al.*, "Small Employers and the Health Insurance Market," *Health Affairs* (Winter 1994).

[2] *See id.*, p. 155, n. 16.

preferred provider organization (PPO) and point of-service (POS) plans, which will experience significant premium increases if open-ended mental health "parity" is mandated. In addition, many consumers, especially rural Kansas residents, lack access to more controlled managed care plans. Other flaws common to these studies include the use of overly optimistic cost assumptions and a willingness to overlook the disproportionate effect of mandates on small businesses and persons who purchase their coverage individually.

Some of these studies also assume that benefits for physical illnesses will be reduced to compensate for additional mandated mental health benefits. For example, several studies conducted by Coopers & Lybrand place too much emphasis on **cost offsets** that may not materialize, and ignore the true cost increases that will be borne by employees and consumers. It is also important to note that the final cost estimates developed by Coopers and Lybrand only reflect the financial impact on employers. The analysis assumes that employers will find various ways to offset the cost increases, such as passing the cost on to employees. This does not mean that those costs do not exist or are unimportant; it simply means that *someone else is paying the bill*, namely, the employee or individual health insurance purchaser. To understand the full impact of any proposal, the full cost should be considered rather than just the employer contribution portion.

Small employers are singled out to bear the cost. Large employers, who can afford to self-insure, are unaffected by state mental health mandates. Under ERISA, they are exempt from such mandates and retain the ability to purchase coverage with reasonable limits on mental health benefits. Small employers don't have this option. They typically can't afford to establish a self-insured health plan governed by ERISA.

OTHER ALTERNATIVES

We would like to remind the Committee that just recently the State of Kansas began a program to provide for additional mental health coverages. That program is in its infancy, and as such we believe that S.B. 160 is premature in its introduction, and that the State should wait until enough sound data is gathered from this employment of coverage before enacting any additional mandates. Further, if the Committee believes some action should be taken, we would recommend the following issues be addressed in the bill.

1. The new mandate should apply only to large (51 or more) groups. As stated earlier, to impose the mandate on individual policies (which individuals can decide on their own to purchase) or on small group business (which requires guaranteed issue and renewability) would have a devastating effect on current business.

2. The law should provide an exception for those plans complying with the federal mental health mandate law and not require dual mandates.

3. On page two, line 21, the new term "mental illnesses" should be reworded to "biological based mental illnesses."

CONCLUSION

For all of these reasons, HIAA bleieves that mandating mental health "parity" is an unwise public policy option. Determining appropriate levels of coverage for health benefits, whether they are mental or physical health benefits, should not be politicized. Rather, it is a decision that we believe should remain in the hands of the purchasers and consumers of health benefits, who are in the best position to judge what constitutes an appropriate allocation of their resources. We urge the Committee not to endorse S.B. 160.

Thank you again for this opportunity to comment. Please contact me of you have any questions about these comments or would like additional information.

Respectfully submitted,

William W. Sneed

Attachments: 2

Health Insurance Association of America

The Cost of State Mental Health Mandates

December 1, 1998

How much do mental health mandates cost?

Numerous studies have shown that mandates requiring "parity" between insurance benefits for mental health and benefits for physical illness, even those that are limited, add significantly to the cost of health coverage.

- In 1996, the Blue Cross and Blue Shield Association found that in five states with laws requiring limited mental health "parity", the mandate had caused the cost of health coverage to increase by 4-10%:

  Blue Cross/Blue Shield of **Georgia**: Average monthly claims paid increased by 5%
  Blue Cross/Blue Shield of **Maine**: Average monthly premiums increased by 4-7%
  Blue Cross/Blue Shield of **Maryland**: Average monthly premium increased by 4%
  Blue Cross/Blue Shield of **Massachusetts**: Average monthly premium increased by 10%
  Blue Cross/Blue Shield of **New Hampshire**: Average monthly premium increased by 8%

- According to a 1998 study by the U.S. Department of Health and Human Services, full mental health parity would increase health insurance premiums on average by 3.6%, with cost increases varying significantly depending on the type of health plan involved. The study estimated a 5.1% increase for PPO plans, which are the most popular and rapidly growing type of coverage in the U.S.

- A 1998 study conducted by Price Waterhouse for the Association of Private Pension and Welfare Plans found that a mental health parity mandate would increase health insurance premiums, depending on type of health plan, as follows: 9.9% for fee-for-service; 10% for PPO and Point-of-Service plans; and 2.9% for HMOs.

- A 1997 study by Milliman & Robertson prepared for the National Center for Policy Analysis estimated that mandating mental health parity would increase insurance premiums by 5-10%.

What about studies showing just a small increase in cost?

A number of studies commissioned by mental health providers and advocates predict just a small increase in the cost of insurance due to mental health parity mandates. These studies share an important flaw: They wrongly assume that benefits will be provided in a tightly-controlled managed care setting. Yet most consumers prefer less restrictive preferred provider organization (PPO) and point-of-service (POS) plans, which will experience significant premium increases if open-ended mental health "parity" is mandated. Other flaws common to these studies include the use of overly optimistic cost assumptions and a willingness to overlook the disproportionate effect of mandates on individuals and small businesses. Some of these studies also assume that benefits for physical illnesses will be reduced to compensate for additional mandated mental health benefits.

555 13th Street, NW - Suite 600 East, Washington, D.C. 20004-1109 202/824-1600

Health Insurance Association of America

CHARACTERISTICS OF STATE MENTAL HEALTH "PARITY" MANDATES[1]

State	Individual health plans exempt	Small employer health plans exempt	Limited to serious or biologically-based illnesses	Does not cover substance abuse/ chemical dependency	Applies only if employer elects to offer mental health coverage	Cost increase exemption
Arkansas	✓	✓		✓		1.5%
Colorado	✓		✓	✓		
Connecticut			✓	✓		
Delaware			✓	✓		
Indiana	✓			✓	✓	1%
Maine	✓	✓	✓	✓		
Maryland		✓				
Minnesota	✓	✓				
New Hampshire	✓		✓	✓		
Rhode Island			✓			
South Dakota			✓			
Texas[2]	✓	✓	✓			
Vermont[3]						

[1] This table does not list states that have enacted parity mandates that conform to federal requirements under the Mental Health Parity Act of 1996. In addition, a number of states not listed here require certain minimum benefit levels for mental health benefits (*e.g.*, minimum annual inpatient and outpatient treatment days) when they are offered by a health plan. Such mandates, though problematic, do not seek to create "parity" as that term is commonly understood.

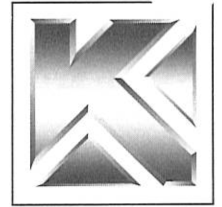
[2] The Texas law requires health plans to provide at least 45 days of inpatient and 60 days of outpatient treatment annually for serious mental illnesses. A health plan may not include lifetime limits on inpatient or outpatient treatment days. Amount limits, deductibles and coinsurance factors for serious mental illnesses must be the same as those for physical illness.

[3] The Vermont law is broad in scope and contains none of the limitations included in this table.

555 13th Street, NW - Suite 600 East, Washington, D.C. 20004-1109 202/824-1600

LEGISLATIVE TESTIMONY

Kansas Chamber of Commerce and Industry



web: www.kansaschamber.org

835 SW Topeka Blvd. Topeka, KS 66612-1671 (785) 357-6321 FAX (785) 357-4732 e-mail: kcci@kansaschamber.org

SB 160 February 24, 1999

KANSAS CHAMBER OF COMMERCE AND INDUSTRY

Testimony Before the

Senate Committee on Financial Institutions and 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 comment on SB 160, and to again express the fundamental reasons why the Kansas Chamber opposes the principle behind state mandated insurance coverage.

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 47% of KCCI's members having less than 25 employees, and 77% 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.

1) MANDATES NEGATIVELY IMPACT THE "ENDANGERED SPECIES" IN TODAY'S INSURANCE DELIVERY MECHANISM...THE SMALL EMPLOYER

Senate Financial Institutions & Insurance

Date 2/24/99

Attachment # 4

Mandates do not affect Kansans who are insured through state or federal insurance progr… or by employer self insurance plans. As a result, mandates are imposed on only roughly one/third of the insured in the state. That one/third is also the segment of the population most challenged to find and retain affordable insurance, the individual policyholder and those insured through small employer plans.

2) MANDATES DEMONSTRATE THE LEGISLATURE'S LACK OF FAITH IN THE FREE ENTERPRISE SYSTEM

A mandate, at its heart, is a government statement that private sector insurance will fail unless the government compels action. Please remember private insurance was born to meet a consumer need.

3) MANDATES REMOVE OPPORTUNITY TO DEVELOP MARKET RESPONSIVE INSURANCE PRODUCTS

If today's insurance product does not properly compensate for mental health treatment, please consider that a reason for this deficiency might be previous government mandates concerning nervous and mental disorders. After prescribing a coverage regimen in this area, the Legislature is now considering further changes to what should be in an insurance policy in this area, in SB 160. Thank you for the opportunity to comment on SB 160. I would be happy to answer any questions.

February 24,1999

TESTIMONY ON SB 160

By Frank Meyer President Custom Metal Fabricators Inc.

Mr. Chairman and Committee Members, I thank you for the opportunity to be here today to share my thoughts on the need to control health care insurance cost.

First allow me to introduce Custom Metal Fabricators. We are a small family owned corporation in Herington Kansas with 45 employees. We provide Health Care coverage for all our employees and pay half the cost of their family plan.

Last year, as in past years over 35% of our sales were exported, going to Sweden, Argentina, Romania and other countries. over the years we have shipped equipment to over 30 countries around the world.

As a business person and former school board member I have had the privilege of visiting with a number of Kansas Legislators over the years. At times we agree and at times we disagree, which is ok and normal, but the one thing I have found almost all of you agree on. unfunded federal mandates really get you hot.

Now when you think about it most health insurance in Kansas is paid for by employers -- we say to you, like you say to the feds, if you pass it fine but don't ask us to pay for it.

Enough of that, lets talk about some of things we could do with the money we spend on health care so you know it's real cost.

We could give all employees a $1,600 raise.

In 10 years we could replace all our equipment with new state of the art machinery.

We could Pay the interest on a $800,000 loan to expand our facility and put 20 more people to work. (which would bring $1,500,000 new money to Herington each year)

One year's health insurance cost would pay 5 years property tax.

We could Lower our prices and become more competitive on the world market

The above is the corporate side of health care costs, and I am sure some of you don't really care about me because as everyone knows Corporations have unlimited funds to work with.

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He is on the local School Board and the volunteer fire department.

What you have before you is a copy of his pay check stub dated 12-18-98. As you can see I have blocked out his name and clock #

Employee 43, 3 children 1 in college
1 " high school
1 " middle school

CUSTOM METAL FABRICATORS, INC. 09536

EMPLOYEE NO.	EMPLOYEE NAME	DEPT.
[redacted]	[redacted]	1

CHECK DATE	CHECK NO.
12/18/98	9536

Earnings...		State Tax	31.75	Year to Date...	
Over Time	44.26	Local Tax		Gross	34,019.24
Regular Pay	1018.63	Medicare Tax	15.94	Fica	1,973.07
Vacation	106.40	Subtotal	478.14	Medicare	461.45
Subtotal	1,169.29	Net Pay	691.15	Federal	3,768.87
Deductions & Taxes...		Total Hours	74.60	State	943.96
Emp Payable 2	100.00 — to pay his deductibles on health costs				
Ins Before Tax	69.91				
Savings 3	50.00				
Uniforms	14.68				
Fica Tax	68.16				
Federal Tax	127.70				

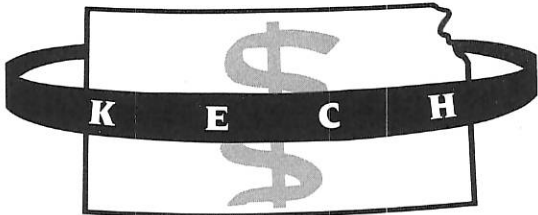
Please Detach Before Depositing Check

Total pay	$34,019	— his plan + 1/2 of family plan provided by employer.
Fed. & State ducks	-$ 7,145	
Medical expenses paid by him	-$ 2,417	(he still hast to pay
disposable income	$24,457	sales and property tax)

Now lets look at just his health care cost, remember we pay 100% of his individual plan plus 50% of his family plan.

His 50% of family plan (one year)	$1,817.66
Deductible	$ 400.00
80-20 on next $1,000	$ 200.00
His Total Cost	$2,417.00
Insurance cost paid by CMF	$3,449.00
Total cost for medical care	$5,866.00

I think you get the point. We are spending a lot of money on health care. If you raise the price you will drive people out of the system and all your mandated coverage won't help those who are "running bare" because they can't afford what you say they should have.



Kansas Employer Coalition on Health, Inc.

214 ½ S.W. 7th Street, Suite A • Topeka, Kansas 66603
(785) 233-0351 • FAX (785) 233-0384

Testimony to Senate Committee on Financial Institutions and Insurance
on Senate Bill 160
(Mental Health Parity)

by James P. Schwartz, Jr.
Consulting Director
February 24, 1999

I have to admit I'm ambivalent about this bill.

All of us past a certain age remember when mental illness was considered a personal character flaw. People who sought treatment were thought of as caving into their weaknesses and requesting expensive indulgences that a good kick in the pants or a visit to church ought to take care of. No doubt that kind of thinking persists to some degree and diminishes mental health benefits unfairly.

A friend of mine had a major depressive episode that left him suicidal and hospitalized. After 30 days the insurance company wanted him to leave, even though he still had thoughts of suicide. The insurance company essentially said it was willing to take a chance that he wouldn't do it. Very scary for the man and his family. Such stories invite legislative remedies.

Having said that, I still have to acknowledge a troubling side to mental health care, especially when we try to make a rich entitlement to it through the voluntary insurance market. Mental health care does not share parity with the medical/surgical world in several important ways.

I know a little about this subject because a close family member was an inpatient at Menninger for almost a year. Looking back, I'm grateful for that kind of access; it worked. I have to recognize, though, that the amount of resources consumed by that patient was a luxury. There's no way that society, through the mechanism of a standard insurance policy, can make that much care available to everybody who might benefit from it. Here's why.

First, the demand for mental care is practically unlimited. Dr. Karl Menninger was once asked what he considered to be the incidence of mental illness. His answer was "100%". If

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that's true, we're looking at an insatiable market, limited only by the availability of insurance to pay for it.

Second, mental care is subject to overutilization to a degree unmatched in the medical arena. In my association with Menninger, there were any number of patients who had not the least interest in their treatment. Some planned to leave as soon as spring arrived; some spent their psychotherapy hours playing cards with their therapists; others were reluctantly enduring hospitalization because the alternative was jail.

Another parity discrepancy is what happens during hospitalization. In acute-care hospitals, people are undergoing pretty serious interventions for the most part. But in mental hospitals you'd be hard put to identify when "treatment" was occurring. My family member spent months at Menninger before being assigned to a therapist, even though more than ready to begin. Throughout the year that patient became quite good at making pottery, a real asset to the hospital's city-league volleyball team, a challenge at bridge, and a killer at scrabble. These activities were, of course, billed to Mutual of New York, as "activity therapy." No medication was ever dispensed and psychotherapy visits occurred only weekly. The cost, though, as you might guess, was astronomical.

Another disparity between mental and physical medicine is the recovery rate. When my patient was hospitalized, the rule of thumb was that a third got better, a third got worse, and a third didn't change. I doubt the odds are much better now. Those are hardly encouraging odds on which to stake generous coverage limits.

Senate Bill 160 tries to build in some protections against overutilization by targeting only the most serious conditions. But I have to tell you that those diagnoses are slippery. My family member got three different diagnoses from three different psychiatrists, and one of those diagnoses is on the list in SB 160. I would hope that reliability of diagnosis is improving, but I'm not encouraged by the experience of a little girl here in town who seems to get a new diagnosis every year. Indeed, the history of psychology is a litany of new diagnostic terms every generation. So I'm little comforted by the enumeration of certain diagnoses in SB 160.

Mental and physical diagnoses are disparate in another way. You either have a fractured arm or you don't. But everybody has a touch of obsessive/compulsive disorder; it's just a matter of degree that sets individuals apart.

Tying parity to diagnosis, while well intended, carries a risk that providers will find ways to classify patients as having one of the "paying" conditions. We've seen that

problem in the med/surg world with the advent of Medicare's diagnosis-related-groups for pay purposes. But in the mental world, where diagnoses are much harder to establish reliably, the possibility of manipulation is greater.

What all this adds up to is this: sure there's a sad legacy of stigmatizing mental illness and according it a lesser standard of coverage for unjust reasons. But not all the difference in coverage can be explained on that basis. Simply put, as one physician explained to me, mental care is about 50 years behind the med/surg world in terms of scientific rigor. Because of this disparity in rigor, the granting coverage parity is an overreaction.

Finally, there's an obscure downside to requiring full parity. The only way insurers will be able to defend against runaway costs, in the absence of blunt restrictions like dollar limits, will be to use sharper ones. That's called managed care. If we really want to accelerate the movement to managed care, this legislation will do it. But I'll bet we'd all be more comfortable with managed care being fuelled by the healthcare environment, rather than by the unintended consequences of our actions here.

If you're ambivalent about this bill, as I am, I hope your impulse is to wait this one out.

Testimony on Senate Bill No. 160 before the
Senate Financial Institutions and Insurance Committee
The Honorable Don Steffes, Chairman
By
Bruce Witt
Director of Regulatory Compliance
Preferred Health Systems
February 24, 1999

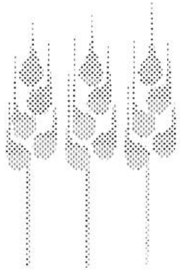
Thank you for the opportunity to testify on Senate Bill No. 160. I would like to begin by providing you some background information on Preferred Health Systems. We are a provider owned managed care organization based in Wichita, Kansas, and the parent corporation of Preferred Plus of Kansas, Inc., a health maintenance organization (HMO), Preferred Health Systems Insurance Company, a life and health insurance company, and Preferred Health Care, a statewide preferred provider organization. Preferred Health Systems has experienced significant growth since its inception. When you combine the covered lives of our HMO and PPO plans, we now have a total insured population of approximately 84,000. Via Christi Regional Medical Center owns the largest percentage of stock in Preferred Health Systems.

I have just a couple of comments relating to Senate Bill No. 160. First, Section 2. (a) of the bill states that individual or group accident and sickness policies providing medical, surgical or hospital expense coverage must provide coverage for the diagnosis and treatment of mental illnesses under the same terms and conditions as any other physical illnesses. Section 2. (d) then defines mental illnesses as those conditions falling under the five categories of diagnoses listed under subsection (d). Since this bill would amend the current Kansas statute mandating minimum levels of coverage for alcoholism, drug abuse or nervous and mental conditions, it is unclear whether the minimum levels of coverage, particularly the mandated first dollar coverage of outpatient treatment, is to apply to these five categories of illnesses initially, and then equal coverage after that; or does the bill intend to remove the five categories of diagnoses from the current mandate, and allow such illnesses to be subject to deductibles, copayments and coinsurance. If it is the intent to allow the cost sharing provisions required for any other physical illness to be applied to the five categories listed in Section 2. (d), it appears subsection (a) of the bill should be amended by stating the following or a similar phrase: "The minimum benefit levels for inpatient and outpatient treatment of alcoholism, drug abuse or nervous or mental conditions required under this subsection shall not apply to the coverage for diagnosis and treatment of mental illnesses as defined in subsection (d)." However, if it is not the intent to apply the minimum mandated levels of coverage to the five defined categories, this may create administrative difficulties for health insurance companies. Speaking for our company, our claim system is programmed to map any mental health diagnosis listed under the statistical manual of mental disorders, fourth edition (DSM-IV, 1994) of the American psychiatric association to the mandated levels of coverage for such conditions. Since the five categories of illnesses listed under subsection (d) are in the DSM-IV manual, we would have to re-map our system to pay claims for such conditions differently than other mental health diagnoses listed in the DSM-IV. In essence, it would likely increase our administrative costs, which may mitigate any cost savings from applying deductibles, copayments and coinsurance at the first dollar level.

The second comment I have is this concept is currently being implemented under some of the plans offered under the state of Kansas Employee Health Benefits Program. More specifically, the fully insured HMO and PPO plans offered by the state. Beginning January 1, 1999, the fully

insured plan options were required to cover seven defined "biologically based" mental illnesses at the same level as any other physical illnesses. Our recommendation to the committee is to utilize the state employee health plan as a test case to determine the actual cost impact of expanding coverage for mental illnesses beyond the level currently mandated. The fully insured plans offered under the state health plan currently represent only 20% of the total covered lives under the plan. Although it is still a credible population and would yield valid data, it is a population where the costs are more effectively controlled through managed care. The cost impact figures we are currently seeing with respect to the recent mental health parity legislation indicate an increase in costs between .5 to 1% under our managed care plans. We understand the cost impact data under fee-for-service plans to be ranging between 3 to 5%. To obtain the most accurate data on the cost impact on for all types health insurance plans, including fee-for-service arrangements, we believe this mandate should be tested on all plans (including the self-funded plan covering approximately 80% of the covered lives) offered under the state health plan.

Thank you for your consideration of the comments presented in this testimony. I would be happy to answer any questions.



Kansas Association of Health Plans

Testimony before the
Senate Financial Institutions and Insurance Committee
The Honorable Don Steffes, Chairman
<u>Hearings on SB 160</u>
February 24, 1999

Good afternoon Chairman Steffes and members of the committee. Thank you for allowing me to appear before you today. I am Larrie Ann Brown, Executive Director of the Kansas Association of Health Plans (KAHP).

The KAHP is a nonprofit association dedicated to providing the public information on managed care health plans. Members of the KAHP are Kansas licensed health maintenance organizations, preferred provider organizations and others who support managed care. Members of the KAHP serve many of the Kansans who are insured by an HMO.

The KAHP appears today in opposition to SB 160. This bill creates an unlevel playing field because as you know, self insured plans are exempt from state laws because they are governed by the Federal ERISA law. We also know that a state imposed health insurance mandate affects only a limited amount of Kansans who have health insurance. As Insurance Commissioner, Kathleen Sebelius stated in her testimony presented to the interim committee "only approximately 25% of Kansans with health insurance would be affected."

SB 160 has the potential to drive more employers into the self insured plans, drop coverage altogether or reduce other benefits offered. I spent some time tracking down some of the various statistics given to you on Monday. One of the studies presented to you was conducted by Mathematic Policy Research. This study stated that employers will not attempt to avoid parity laws by becoming self-insured. The study also stated that employers do not tend to pass on the costs of parity to employees. However, the authors of the study noted that their estimates do not account for the possibility that employers may respond to parity mandates by - among other things- dropping coverage or reducing other benefits offered to their employees.

You also heard testimony on Monday stating that full parity for mental health is estimated to increase premiums by either 3.4% on average or some said 3.6% or 2-5%. Regardless of the percent increase you choose, the fact is that premiums will increase. According to a Congressional Budget Office report, the CBO estimated that nationwide, for every 1% increase in health insurance costs, 200,000 more individuals are added to the uninsured population. The State of Kansas is generally estimated to be 1% of the population of the United States. This means that for every 1% increase in health insurance costs in Kansas, an estimated 2,000 Kansans become uninsured.

We are submitting the written testimony of Kaiser Permanente and Humana and with the permission of the Chairman, I would now like to turn the podium over to Bruce Witt from Preferred Health Systems in Wichita.

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Attachment # 8

Senate Financial Institutions & Insurance Committee
RE: SB 160 Mental Health Coverage
Date: February 24, 1999
Written comments of Kristin Van Voorst, Humana, Inc.
in opposition of SB 160

Humana Inc., headquartered in Louisville, Ky., is one of the nation's largest publicly traded managed health care companies with approximately 6.2 million medical members located primarily in 15 states and Puerto Rico. Humana offers coordinated health care through a variety of plans — health maintenance organizations, preferred provider organizations, point-of-service.

Humana would like to go on record in opposition of SB 160. It is the concern of Humana that this additional mandate will increase health insurance premiums. The question most at contention is how much will the premium costs increase. Numerous studies have projected these increases. The Employee Benefit Research Institute (EBRI) prepared a report examining the differences among the various companies cost analyses of mental health parity. They found a wide range of results including a Milliman & Robertson report which estimated an overall health insurance increase of 2.5 percent on typical PPO plans; a Watson Wyatt study which predicted an 8.3 to 11.4 percent increase; and a report from the Congressional Budget Office which estimated a 4 percent rise (National Underwriter; March 17, 1997).

The EBRI report findings, regardless of the varying ranges, points to one thing - premium increases for employers and ultimately consumers. During the proponents testimony earlier this week, it was pointed out how expensive mental health services can be for consumers, even those with good paying jobs. During the interim hearings this summer it was pointed out and agreed to by proponents that the cost analysis that reported lower premium increase were based on the fact that the mental health services would be delivered through a managed care setting. Additional testimony on Monday confirms this fact. In Secretary Chronister's testimony a study by HHS pointed out that "(c)ost increases have been **lowest** in systems with tightly managed care ...."

Based on these facts, health plans need to be able to manage mental health services in a managed care setting, if they choose. It is our suggestion that if the committee feels strongly about passing this bill that the following language be amended into the bill:

An insurer or health maintenance organization may require that the covered services required by this section be provided by an exclusive provider of health care, or a group of exclusive providers of health care, which has entered into a written agreement with the insurer or health maintenance organization to provide benefits under this section. The insurer or health maintenance organization may condition the payment of such benefits, in whole or in part, on the use of such exclusive providers.

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The insurer or health maintenance organization may directly or indirectly enter into a capitation contract with an exclusive provider of health care or a group of exclusive providers of health care to provide benefits under this section. In providing the benefits under this section, the insurer or health maintenance organization may impose other appropriate financial incentives, peer review, and utilization requirements to reduce service costs and utilization without compromising quality of care.

Without such an amendment, premium cost increases will no doubt mirror the higher increases reflected in studies such as the Watson Wyatt study of 8.3 to 11.4 percent. There is only one result of premium cost increase of this kind - more employers, especially small employers, will drop their health insurance for their employees totally. The result of any legislation should not be to cause more consumers to become uninsured. Employers should be able to determine the needs of their employees, if the employers are experiencing heavy absenteeism, poor productivity, or even at-work violence due to instances of mental illness, than employers will request better mental health coverage from health plans.

Although some of the cost increase projections of cost appear minimal, any mandate, regardless of increase, cannot be decided in a vacuum. Current increases in medical costs and any other additional mandates imposed on health plans that would increase premiums must be factored into any decisions regarding more mandates. In a recent study released by the Health Insurance Association of America, blaming the unintended consequences of well-intentioned mandates, estimated the number of uninsured Americans will rise to 53 million, more than one in five, by 2007 even if currently good economic conditions persist. That number could reach as high as 60 million if the country experiences an economic downturn, leaving nearly one in four under the age of 64 without any form of health care coverage

The study, conducted by William Custer of the Center for Risk Management and Insurance Research of Georgia State University, noted that two forms of state regulations, coverage mandates and small group reforms, have had the opposite of their intended effect by increasing insurance costs, leading to a reduction in the numbers of people who can afford insurance.

Humana urges the committee to oppose support of this bill which could have the unintended consequence of resulting in additional Kansans being uninsured.

Testimony of Kaiser Permanente
In Opposition to Kansas SB 160

Mr. Chairman, thank you for the opportunity to express the views of Kaiser Permanente in opposition to Kansas SB160. Kaiser Permanente is a federally qualified HMO that provides quality health care to more than 68,000 members in the Kansas City area. For many reasons, Kaiser Permanente believes that if mental health parity legislation is to be adopted, it would be best addressed by federal legislation so that a national mental health standard would apply to covered individuals of both insured and self-insured plans.

- Kaiser Permanente is a federally qualified HMO. As such, unlike most other carriers, we are required to provide comprehensive benefits with no deductibles, nominal copayments, and unlimited physician and inpatient benefits for physical illness. We may not impose preexisting condition limits or deductibles and may impose only reasonable copayments that are not barriers to care.

- Most insurers, on the other hand, are not subject to any of these requirements. In addition, they usually have limited inpatient benefits; they have monetary caps on the amount of coverage that may be provided each year and over the life of the policy; and they may impose preexisting limits, deductibles, and high copayments. Thus, federally qualified HMOs such as Kaiser Permanente would have to assume a higher cost (e.g. we have no lifetime limits for physical illness), and we would be at greater risk for adverse selection of high utilizers. This proposal would result in Kaiser Permanente having to increase premiums our policyholders pay, and we would be at a competitive disadvantage to indemnity carriers.

- Kaiser Permanente recognizes that mental health benefits can be an important aspect of an individual's well-being. That's why we already provide mental health coverage as part of our comprehensive health care. As part of their group package, the majority of our members are eligible for up to 30 days of hospital care per year with no copay and up to 20 outpatient visits per year for mental health care at nominal copay. Prescription drugs prescribed as part of a member's mental health treatment can be obtained for the same nominal copay as all other drugs available in the member's benefit package.

- Unlike many other carriers, we offer an individual plan, Personal Advantage, for individual or family subscribers, that provides health benefits coverage to consumers who may be self-employed, unemployed, or without coverage in the workplace. Behavioral health coverage is included in Personal Advantage. Passage of SB 160 is a direct invitation for adverse selection because only those individuals who are likely to want mental health coverage for themselves or their family are likely to opt for it.

- Because of ERISA and other exclusions, the majority of Kansans would derive no benefit from passage of SB 160. In fact, this proposal likely would drive more employers into the self-insured market, aggravating the unlevel playing field for some HMOs and creating an unfair competitive advantage for plans that provide self-insured coverage options exempt from state law. For example, if this proposal is adopted, exempt self-insured plans would benefit from adverse selection by keeping mental health benefits low or non-existent. But employees in self-insured companies who need mental health services for themselves or their family members would be encouraged to choose the offering of a federally qualified HMO providing these benefits, or would utilize the HMO coverage of a spouse for these benefits. Exempt self-insured plans would gain from reduced utilization and HMOs, which are subject to state law, would suffer from adverse selection.

Submitted by Gerard J. Grimaldi
Director, External Affairs and Member Services
February 24, 1999
913/967-4638

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Date 2/24/99
Attachment # 10