Approved: _____
Date March 20, 2000

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by Chairperson Senator Don Steffes at 9:00 a.m. on March 15, 2000 in Room 234-N of the Capitol.

All members were present except:

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

Conferees appearing before the committee: Amy Campbell, Kansas Mental Health Coalition
Kathleen Sebelius, Insurance Commissioner
Pat Ireland, Psychotherapist, Overland Park
Bryce Miller, NAMI Topeka
Sharon Huffman, Kansas Commission on Disability Concerns
Dean Collins, M.D., Topeka
Elizabeth Adams, NAMI Kansas
Eloise Reeves, NAMI-CAN
Cindy Ames, Topeka
Paul Klotz, Association of Community Mental Health Centers of Kansas

Others attending: (See Attached)

Hearing on SB 547–Insurance, providing coverage for certain mental health conditions
Continued discussion on SB 160–Requiring mental health coverage to be the same as physical

Dr. Bill Wolff, Legislative Research, gave a comparison review of the two bills (Attachment 1). The definition of mental illness, differences in implementation dates, and the requirement for test tracking in state health benefits program are the major area of difference.

Amy Campbell, Kansas Mental Health Coalition, explained that their highest public policy priority is the elimination of discrimination in health insurance coverage (Attachment 2). The Coalition requested an amendment which would define specific mental illnesses for equal treatment in health plans. They were in agreement with losing first dollar coverage and being subject to the usual health insurance deductibles, 80/20 co-pay and higher lifetime maximum limits. Ms. Campbell also expressed their support for test tracking in the state employees health care program. She pointed out that 75% of Kansans who have insurance are under Medicare, Medicaid, and ERISA plans thereby having better mental health benefits than those offered by commercial health insurance policies.

Kathleen Sebelius, Insurance Commissioner, referred to this bill as "a fairness issue" (Attachment 3). Unlike other illnesses, there are no additional insurances or riders available for mental illness. Mental illness is a disease or condition that is the cause of the greatest loss in productivity in the workforce. Commissioner Sebelius pointed out that 29 states have some form of parity legislation. Statistics now show there has been a drop in the length of inpatient psychiatric hospital stays, overall decline of health costs, and has not raised the cost per managed care enrollee by more than one dollar per month. Commissioner Sebelius asked for the passage of this legislation which would grant parity to Kansas families whose members have mental disorders.

Pat Ireland, Psychotherapist from Overland Park, expressed concern that **SB 547** might actually reduce outpatient benefits for some patients by requiring the same coverage for them as for any health problem (parity) (Attachment 4). The deductible of the insurance policy would apply to outpatient psychotherapy for those mental conditions specified in the bill. This would be a decrease from the current benefit. With many people having large deductibles up to $1500, this would mean they would have no psychotherapy paid for by insurance if they had 12 sessions at $80 per hour. The old mandate insurance would have paid for these sessions with their first dollar coverage. Ms. Ireland also stressed the need for patients to be allowed to choose their provider, especially in the psychotherapy area. She suggested an amendment to the bill that would require that the current mandate still apply to those mental conditions specified in the bill.

Bryce Miller, NAMI Topeka, related his personal history of bi-polar illness and the success of dealing with his disease due to early intervention and ongoing treatment (Attachment 5). He has been very active in mental health associations at both the state and local level. He requested the passage of parity legislation which would put Kansas in sync with its surrounding states. Mr. Miller could see no reason to again test track the mental health parity on the state employees health plan as it has already proven there is only a cost increase of $.72 per month.

Sharon Huffman, Legislation Liaison for the Kansas Commission on Disability Concerns, described the Town Hall Meetings conducted throughout the state by Kansas Rehabilitation Services (Attachment 6). One of the issues usually addressed at the meetings is the inadequate coverage for mental illness that individuals receive in their health insurance benefits. She explained that at least one-third of all homeless people have severe mental illness. Most of them would not be in the situation of having lost their homes, families, and jobs if adequate treatment had been provided through insurance. The direct and indirect costs incurred by our state and local governments for treating severe mental illness are very high.

Dean Collins, M.D., psychiatrist at Menningers and the VA, urged the Committee to include in **SB 547** the definition of mental illness found in **SB 160**. He expressed concern regarding the exact meaning of the listed mental illnesses described in **SB 547,** especially the term "specific" in determining obsession compulsive disorder. He stated that OBC is commonly referred to as a specific disease on its own, not requiring a definitive label before OBC.

Elizabeth Adams, Executive Director of NAMI Kansas, spoke on the recently published report of U.S. Surgeon General David Satcher's in which he states there is compelling evidence that mental illnesses are validly treatable physical disorders (Attachment 7). The fear and/or stigma of seeking treatment for brain disorders have also been addressed by the White House Conference on Mental Health of 1999 when President Clinton enacted mental health parity for more than 9.5 million federal employees.

Eloise Reeves, NAMI-CAN, related her personal story of rearing two children suffering from schizophrenia and the horrors and expenses which accompany such a disease (Attachment 8). She asked that Attention Deficit Disorder (ADD), Attention Deficit Hyperactive Disorder (ADHD), Autism, Asperger Syndrome, and other neurobiological brain disorders be included in those conditions covered in the proposed legislation.

Cindy Ames spoke on behalf of the many parents of mentally ill children who were unable to appear due to being out of vacation and sick leave time, children out of school due to problems, trying to meet doctor or therapy appointments, and the plethora of other problems facing such parents. She told of the constant financial drain on such families and their desire to keep their children at home rather than making them wards of the state. Most of these families have second mortgages or have lost their homes due to the lack of insurance coverage available to them for mental illness. Another problem is that the children are often the victims because the families cannot afford consistent medication or therapy for such children due to the cost. Mental health parity would address and alleviate many of these problems.

Paul Klotz, Executive Director of the Association of Community Mental Health Centers of Kansas, Inc., said that due to the closing of mental health hospitals, the Mental Health Centers have doubled their care for patients in the past 12 years, 100,000 (Attachment 9). Private insurance comprises only 7% of the funding stream to SMCH's. This is lower than it should be because in the majority of health insurance plans, only the required mandated limits for outpatient and inpatient mental health services are allowed. Mr. Klotz urged the Committee to carefully consider the comprehensive report from the National Institute of Mental Health, a division of the US Department of Health and Human Services. It states that nondiscriminatory mental health care in combination with managed care results in lowered costs and lower premiums (or at most very modest increases) within the first year of parity implementation.

The following presented written testimony supporting passage of the bill:

Col. Lynn W. Rolf, President, NE Kansas/ Leavenworth NAMI Family Support Group (Attachment 10).
Amy Donohoo, Case Manager, Wichita Community Health Center (Attachment 11).
Steve Kearney, Executive Director of the Kansas Psychiatric Society (Attachment 12).

Chairman Steffes continued the Hearing until March 21, 2000.

SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE
GUEST LIST
DATE: March 15, 2000

NAME	REPRESENTING
Joan Campbell	KS Mental Health Coalition
PAUL M. KLOTZ	~~Assn. of Cmty Mtl Hlth Ctrs of KS. Inc.~~
Sharon Huffman	KCDC-J KDHR
Kevin Davis	Am. Family Ins
Tim Wood	VCHS
Pat Ireland	self
STEVE KEARNEY	KS. PSYCHIATRIC SOCIETY
Chip Wheeler	Osteopathic Association
Linda DeCoursey	KS Insurance Dept.
Dean T. Collins, MD	Menninger Clinic
Elizabeth Adams	NAMI Kansas
Eloise Reeves	NAMI-CAN
Whitney Damron	KS Psychological Assn.
Jeff Bloom	DofA
[illegible]	DofA
[illegible]	KDHE
Chris Allin	KMS
Cindy Allison	Kansas Health Institute
[illegible]	Health Midwest
Larrie Ann Lower	KAHP
Bill Sneed	HIAA
Bill Howgill	Governor's Office
Cindy Hughes	Keep for Networking
Ken Bone	Member Cmtee.

Initial Comparison of Senate Bills 160 and 547

	Senate Bill 160	Senate Bill 547
1.	Section 1 amends K.S.A. 1998 Supp. 40-2,103.	Section 4 amends K.S.A. 1999 Supp. 40-2,103.
2.	Section 2 restates K.S.A. 1998 Supp. 40-2,105 in full and amends such statute to define affected policies.	Does not include K.S.A. 40-2,105 language, but specifies that "mental illnesses" are no longer to be subject to K.S.A. 40-2,105 after January 1, 2002.
3.	Defines "mental illnesses" in section 2 (d) to include: (1) Schizophrenia, schizoaffective disorder, schizophreniform disorder, brief reactive psychosis, paranoid or delusional disorder, atypical psychosis; (2) major affective disorder (bipolar and major depression), cyclothymic and dysthymic disorders; (3) obsessive compulsive disorder; (4) panic disorder; and (5) pervasive developmental disorder, including autism.	Defines "mental illnesses" in Section 2 (b) to include: (1) Schizophrenia, schizoaffective disorder; (2) bipolar disorder and major depressive disorder; (3) *specific* obsessive compulsive disorder; (4) panic disorder.
4.	Implements equal coverage statewide on publication in the statute book.	Implements equal coverage in the state health benefits program January 1, 2001. Implements equal coverage statewide January 1, 2002.
5.	Does not address K.S.A. 1999 Supp. 40-2249a.	New Section 3 implements the act subject to K.S.A. 1999 Supp. 40-2249a which would require that the equal coverage provisions of this act be implemented in the state health benefits program and that the health care commission report to the Legislature March 1, 2002 regarding utilization data and providing a recommendation for or against expanding the coverage of this act statewide.

Mike Horan, Chair

KANSAS MENTAL HEALTH COALITION

Amy A. Campbell, Lobbyist
P.O. Box 4103, Topeka, KS 66604-6103
Telephone: 785-234-9702 Fax: 785-234-9719
Joining together in one voice to meet critical needs of persons with mental illness.

Testimony presented to the
Senate Financial Institutions and Insurance Committee
regarding Senate Bill 547
March 15, 2000
Amy A. Campbell, Lobbyist

The Kansas Mental Health Coalition is comprised principally of statewide organizations representing consumers, families, community service providers, and dedicated individuals as well as community mental health centers, hospitals, nurses, physicians, psychologists, and advocates. The Coalition is a roundtable where differences are discussed and common goals are developed. All share a common interest; we are dedicated to improving the lives of Kansans with mental illnesses.

Our highest public policy priority is the elimination of discrimination in health insurance coverage. We believe that because mental illnesses are diagnosable, treatable medical conditions, health insurance coverage should be the same as it is for other illnesses or diseases.

Mental Illnesses
This Committee heard testimony in 1999 regarding Senate Bill 160, which would establish equal coverage for mental illnesses statewide. Senate Bill 547 includes several elements of that proposal, including defining specific mental illnesses for equal treatment in health care plans. The Coalition would respectfully request amending New Section 1 (b) and New Section 2 (b) to state:

> *For the purposes of this act, "mental illness" means the following: Schizophrenia, schizoaffective disorder, schizophreniform disorder, brief reactive psychosis, paranoid or delusional disorder, atypical psychosis, bipolar disorder, major depressive disorder, cyclothymic and dysthymic disorders, obsessive compulsive disorder, panic disorder, and pervasive developmental disorder as such terms are specified in the diagnostic and statistical manual of mental disorders, fourth edition, (DSM-IV,1994) of the American psychiatric association but shall not include conditions not attributable to a mental disorder that are a focus of attention or treatment (DSM-IV, 1994).*

The limited definitions above do not constitute a comprehensive list of biologically based mental illnesses as recognized by the Kansas State Employees Health Care Commission and the majority of national provider and advocacy organizations. However, the Coalition believes that it is imperative that severe mental illnesses should be categorized as medical conditions with the same health insurance coverage as other medical diagnoses. It is much more cost effective to diagnose and treat mental illnesses, and we hope employers will choose to further implement parity for their employees based on the minimal costs involved.

First Dollar Coverage
It has been suggested that both proposed bills would cause insureds to lose "first dollar coverage" for outpatient mental health services. The provisions of current law at K.S.A. 40-2,105 sub. (a) stipulate that if a patient can be treated for alcoholism, drug addiction, or a mental disorder on an outpatient basis, the insurer is required to pay for the treatment according to a formula: 100% of the f[illegible]

Senate Financial Institutions & Insurance
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Attachment 2

$100, and only 50% of the next $1,640 per year. In other words, the maximum amount that an insurer is required to pay for outpatient treatment in any one year is $1,000; while the patient must pay up to $840; a net 45.65% copayment. If the total cost of treatment exceeds $1,840 per year, the insured must pay 100% of the balance. **Equal coverage for the mental illnesses specified in the act would be subject to the usual health insurance deductibles, 80/20 co-pay, and much higher lifetime maximum limits and would no longer be subject to the discriminatory annual limitations.**

It is our understanding that mental illnesses and conditions not listed in the bill will remain subject to K.S.A. 40-2,105. Current Kansas law requiring minimum mental health coverage for alcoholism, drug additions, or mental disorders is extremely important and must be preserved in order to assure necessary treatment.

Test Tracking

The Coalition is willing to promote a full year of implementation in the State Employees Health Care program as specified in SB 547, to meet the requirements of K.S.A. 1999 Supp. 40-2249a, and specifically requests that the Committee not delay statewide implementation any later than the January 1, 2002 date currently in SB 547. If possible, we would ask that the bill be applied to the indemnity plans offered by the State, in order to avoid penalizing the participants in the managed care and PPO plans, who have greater benefits than those specified in this bill.

A year ago, Insurance Commissioner Kathleen Sebelius and SRS Secretary Rochelle Chronister testified to this Committee and provided statistical data from numerous studies, including a Rand Corporation Study and a study performed for the U.S. Dept. of Health and Human Services stating that the potential premium increase for implementing equal coverage ranges from .3% to 3.4%. To date, 29 states have implemented some form of equal coverage, and their experiences show us that costs of premiums are not increasing rapidly and employers are not trying to evade the new laws by becoming self-insured, nor do they tend to shift increased costs to employees.

At that time, the Kansas State Employees Health Care Commission had begun its first year of incorporating equal coverage for state employees covered by managed care and PPO plans. Statistics provided by the Commission indicate that the increased cost for what was provided in 1999 for biological based mental health parity benefits, compared to what was provided under the previous benefit schedule is approximately $8.68 per participating beneficiary for the year. Additional data was reported by Terry Bernatis, plan administrator, including an estimated total cost increase for the managed care plans of $106,076. There are 26,832 HMO participants and 1,459 PPO participants. There are 85,836 participants in the entire plan.

Impact to Kansans

In previous testimony, the Insurance Commissioner explained that approximately 75% of Kansans who have health insurance are under federal jurisdiction (Medicare, Medicaid, and self-insured plans under ERISA). This was a general statement regarding the authority of the Commissioner to regulate health insurance policies. In the context of coverage for mental illnesses, the benefits available under Medicare and Medicaid are significantly better than most commercial health insurance policies. Furthermore, those plans that are exempt from state jurisdiction under the federal Employees Retirement Income Security Act are subject to the federal mental health parity law requiring equal coverage limits. In other words, one out of four Kansans with health insurance have substandard mental health benefits compared to the other 75% who are under federal jurisdiction. Passage of state legislation would equalize coverage for the other 25% of insured Kansans.

There is abundant research which consistently concludes that accurate diagnosis and appropriate treatment of mental illnesses results in social and economic benefits which far exceed the cost of providing treatment. But that is a secondary reason you should take favorable action on this issue. The principal reason you should recommend passage of equal coverage for mental illnesses is because it would eliminate discrimination and restore fairness in health insurance coverage.

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

TO: Senate Committee on Financial Institutions and Insurance

FROM: Kathleen Sebelius, Insurance Commissioner

RE: SB 160 – Eliminating discrimination in coverage of specific mental illnesses
SB 547 – Providing coverage for certain mental health conditions

DATE: March 15, 2000

Mr. Chairman and members of the Committee:

Thank you for the opportunity to discuss with you the very important topic. In preparing for this testimony, I dusted off copies of my comments made before legislative committees during for the last five years. And, while some things remain the same, new light can be shed on the topic of mental health parity.

What hasn't changed…..

What hasn't changed is that I still strongly believe insurance coverage for mental illness diseases is a fairness issue. While coverage for mental health disorders has for existed for some time in Kansas history, it exists differently than coverage for other illnesses, and would lead one has to ask why the difference exists? There is little question that those individuals with "mental disorders" are treated differently from their neighbors who have "physical disorders." It is difficult, if not impossible to obtain insurance coverage for brain diseases, with the same levels of coverage that individuals can obtain for any physical condition. It is difficult to understand why an illness of the body, such as diabetes, is covered while an illness of the mind, such as

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schizophrenia, is not. Both conditions can be treated and often brought under control by drug therapy and other medical interventions, but the brain disorders are not adequately covered by health insurance. To isolate mental illness for minimal protection, while fully covering physical diseases in a major medical policy, seems to be discrimination of the worse kind.

What hasn't changed…..

What hasn't changed are the compelling statistics indicating a clear reason to take action. According to the landmark "Global Burden of Disease" study, commissioned by the World Health Organization and the World Bank, four of the 10 leading causes of disability for persons age five and older are mental disorders. Among developed nations, including the United States, major depression is the leading cause of disability. Also near the top of these rankings are manic-depressive illness, schizophrenia, and obsessive-compulsive disorder. However, in this past decade, research has initiated effective treatments and service delivery strategies for many mental disorders. An array of safe and potent medications and psychosocial interventions, typically used in combination, allow effective treatment of most mental disorders.

The National Association for the Mentally Ill (NAMI) states that mental illness today is more common than cancer, diabetes or heart disease. According to the National Advisory Mental Health Council, a group of experts advising both the National Institute of Mental Health and the Congress, mental disorders affect about 22 percent of the adult population in any year. Serious mental disorders affect over five million adults in any year in two to three percent of the adult population. In addition, about 3.2 percent of children and adolescents between the ages of nine to seventeen have a severe mental disorder in any six-month period. Schizophrenia affects 1.5 percent of the adult population; major depression about 1.1 percent; manic depressive illness or bipolar disorder about 1 percent.

With more than five million Americans suffering from mental illnesses, 21 percent of all hospital beds are filled by people with severe mental illnesses such as major depression, bipolar disorder or schizophrenia (NAMI). NAMI also stated that the total price tag is over $120 billion, which includes direct costs (hospitalization, medication) and indirect costs (lost wages and productivity, absenteeism, family caregiving, and suicides). At the same time, with proper medical care and support services, the treatment success rate for schizophrenia is 60 percent, 65 percent for major depression, and 80 percent for bipolar disorder, compared to rates of only 40 to 50 percent for heart disease (NAMI).

What hasn't changed....

Mandating full health insurance coverage for mental illnesses was "unthinkable" in the past because of the fear of increased costs. The Bureau of Labor Statistics reported that in 1981, 58 percent of the men and women who had some sort of employer-provided health coverage had inpatient coverage for mental illness comparable to that for physical illness, and 10 percent had comparable outpatient coverage. By 1993, those percentages were down to 16 percent and 4 percent, respectively.

When considering the impact of cost and concerns about the economics of these benefits, one must also look at the question of what the cost is of untreated mental health conditions in terms of employee days-off and overall loss of productivity. Studies started showing that workers with severe depression or other mental illnesses were costing large employers heavily in absenteeism, poor productivity, disability benefits, even at-work violence. Companies then began seeking more extensive treatment of these problems because it might actually save the employers money in the long run. It is quite likely that the cost increases in health plans will be offset by a reduction in more serious and costly illnesses. We need to balance the issue.

What has changed....

Since my last testimony on mental health parity, (February, 1999) and while Kansas has been deliberating on the issue of adding a form of mental health parity to the law books, 11 more states and two territories have passed parity legislation. Currently 29 states have some form of parity legislation: Arkansas, Arizona, California, Colorado, Connecticut, Delaware, Georgia, Hawaii, Indiana, Louisiana, Maine, Maryland, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont and Virginia (Guam and Puerto Rico).

Statistics are now available from states with mental health parity laws. In Maryland, for example, statistics showed a seven percent drop in the length of inpatient psychiatric hospital stays one year after passage of a mental health benefit parity law (National Underwriter). A 1997 Rand Corporation study found that raising the typical average dollar limit on the mental health coverage would increase costs by about $1 per managed care enrollee.

Early studies of state imposed mental health mandates show that costs have risen by an average of 2-5%. But, new information from the Surgeon General's report suggests that implementing parity laws is not as expensive as once suggested. Case studies of five states that had a parity law for at least a year revealed a small effect on premiums (plus or minus a few percent). Further, this study indicated that employers did not attempt to avoid the laws by becoming self-insured or by passing on costs to employees. Separate studies of laws in Texas, Maryland, and North Carolina have shown that costs actually declined after parity was introduced where legislation coincided with the introduction of managed care. The study also

mentioned that in general, the number of users increased, with lower average expenditures per user.

Bringing those statistics closer to home, the Kansas State Employees Health Care Commission asked insurers to submit bids, with and without mental health parity. The benefits were seen to far outweigh the insignificant cost increases with those plans. As of January 1, 1999, Kansas State employees had the option for parity for mental health benefits in the managed care plans.

In summary, this issue is the same---it is a fairness issue. While coverage for mental health disorders has for existed for some time in Kansas history, it exists differently than coverage for other illnesses, and would lead one has to ask why the difference exists? Twenty-nine states now have parity laws. Studies show that implementing parity laws is not as expensive as once suggested. Further, employers did not attempt to avoid the laws by becoming self-insured or by passing on costs to employees. Research is bringing forth ways to identify, treat and even prevent disorders in some cases, and outpacing the capacities of the health service system to deliver mental health services to those who would benefit from it in a fair and equitable way. In your considerations of mental illnesses parity, please bring fairness to those Kansas families with mental disorders.

PATRICIA S. IRELAND, M.S.W., L.S.C.S.W.
PSYCHOTHERAPIST
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3-15-2000

February 18, 2000

State Capitol
300 S.W. 10th Ave.
Topeka, Kansas 66612-1504

Re: S.B. 547 and H.B. 2765:
Mandated Mental Health
Insurance Benefits

Dear Senator

I appreciate your continued work to improve mental health care in Kansas.

I am concerned that S.B. 547 and H.B. 2765 may actually reduce outpatient benefits for some people although they are intended to increase benefits for certain mental conditions by requiring the same coverage for them as for any health problem (parity). I am aware that in 1997 the federal mandate which requires parity for groups of 51 or more was enacted in K.S.A. 40-2258, and that S.B. 547 and H.B. 2765 are voluntary efforts to extend parity to smaller group and individual policies.

Under the current insurance mental health mandate, K.S.A. 40-2-105, 100% of the first $100, 80% of the second $100, and 50% of the next $1640 is required as minimum annual coverage for outpatient psychotherapy. This is before any deductible. The lifetime maximum of $7500 actually starts over anytime a person changes insurance. According to Kansas Insurance Commissioner's Bulletin 1991-16, "In addition, the required levels of outpatient coverage under K.S.A. 40-2-105 are minimum levels of coverage. For example, the minimum benefit levels would apply for outpatient treatment whether or not such treatment was received through any required preferred provider network." (6-01-91, pg. 6).

I. S.B. 547 states specifically that the requirements of K.S.A. 40-2-105, the current mandate, will no longer apply to the mental conditions specified in S.B. 547, (new section 2, (g), lines 18-20).

II. H.B. 2765 starts with the current mandate, but then states "notwithstanding the foregoing" (the current mandate), coverage for the specified mental conditions "will be no less extensive than coverage for any type of health care." Mary Torrence of the Revisor of Statutes Office believes that this means "ignore the preceding" or that the current mandate under K.S.A. 40-2-105 would not apply to the mental conditions specified in H.B. 2765.

III. Possible Unintended Consequences of S.B. 547 and H.B. 2765:

A. Deductible and Number of Sessions

Under S.B. 547 and H.B. 2765, the deductible of the insurance policy would apply to outpatient psychotherapy for those mental conditions specified in the bills. This would be a decrease from the current benefit. With many people having large deductibles of $1000 to $1500 on individual policies, it would mean that they would have no psychotherapy paid for by insurance if they had 12 sessions at $80 per hour, whereas, under the old mandate insurance would have paid on all these sessions. A good number of people with Major Depressive Episode, Dysthymic Disorder, or Panic Disorder only require ten to twelve sessions, although many others need longer term psychotherapy.

For those needing longer term psychotherapy, at $80 per session, the current mandate would require insurance to pay at least half on 43 sessions per year. Parity with other health problems may or may not provide this amount of coverage depending on the policy and insurance company practices. There is an incentive under the current mandate not to use more sessions than you really need through having to pay for half after the first three sessions.

B. Preserving the ability to choose providers

It could be important to be aware of any future proposed amendments that could limit the ability to choose providers. In Missouri, when the federal mandate for parity for groups of 51 or more was incorporated into state law in 1999, it was specifically worded to allow all the psychotherapy services for all mental conditions to be provided through preferred provider arrangements. As a result, as of 01-01-00, Blue Cross of Kansas City no longer pays for out-of-network psychotherapists even though businesses or

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individuals would have purchased preferred provider policies with the assumption they could choose their provider. **

IV. Suggested Amendments to H.B. 2765 and S.B. 547:

A. H.B. 2765: Substituting "In addition to the foregoing" for "Notwithstanding the foregoing" would clarify that K.S.A. 40-2-105, the current mandate, still applies to the specified mental conditions.

B. S.B. 547: An amendment could state that K.S.A. 40-2-105, the current mandate, still applies to those mental conditions specified in S.B. 547.

C. Or, making parity in both bills apply only to inpatient treatment and outpatient day treatment programs such as those at hospitals and mental health centers.

D. These amendments would accomplish the following:
1. Preserve coverage before any deductible for outpatient psychotherapy.
2. Preserve as a minimum psychotherapy benefit the current mandate of 100% of the first $100, 80% of the next $100, and 50% of the next $1640. This would safeguard against parity with other health conditions actually resulting in a reduction of benefits over the current mandate under some policies or circumstances.

Insurance Commissioner's Bulletin No. 1998-4 concerns K.S.A. 40-2258, which enacted in Kansas the federal mandate for parity for groups of 51 or more. It states on page 3, no. 9, "the conference report on the federal legislation stipulates that the federal act should not hinder the application of any state law that provides more favorable treatment for mental health benefits. There is nothing in the minimum outpatient dollar coverage requirements on K.S.A. 1997 Supp 40-2-105 (the current mandate) which prevents the application of the mental health coverage provisions in the federal law."

Therefore, it is also possible to add parity for specified mental conditions to the existing mandate for smaller groups and individual policies. This would avoid the unintended consequences of actually decreasing the benefit in some cases. Thank you again for your work to improve health care for Kansans.

Sincerely,

Pat Ireland

Pat Ireland, LSCSW

** The negative consequences of not having the freedom to choose psychotherapy providers are:
1. Psychotherapy is in one of the most personal health services available. Many people feel much more willing to seek out therapy if someone they know and trust has already seen and been satisfied with a certain therapist. In addition, a therapist can do a better job if he or she has already seen the client's husband, wife, or parent.
2. Businesses frequently change insurance carriers. If a client is limited to only preferred providers, he or she would have to change therapists in midstream when their employer changes insurance. Furthermore, many people return to psychotherapy a year or several years later. With freedom to choose providers, one can go back to the original psychotherapist with confidence and save unneeded time on background information and building trust.
3. In Lawrence and Kansas City, the vast majority of psychotherapists can not, fox example, get into the two largest local insurance companies' provider panels, Blue Cross and Health Net. They have been closed for years. So it is not a matter of psychotherapists being unwilling to join networks. Most insurance companies simply do not accept more providers. There is also the principal of freedom to compete fairly for business which is further violated if only preferred providers are paid through insurance. Not many people would choose to pay 100% cash if insurance benefits are available. If insurance only pays providers who are in networks, there would be good psychotherapists who would be put out of business simply because they could not get into the closed provider networks. Clients will ultimately suffer because they will have longer waits to get in therapy, and some experienced and talented therapists would no longer be available to those needing psychotherapy.

Note that people who receive Social Security or SSI due to their mental condition, have Medicare or Medicaid.

See pgs 2+3, nos. 6+9 as related to S-B 547

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

BULLETIN 1998-4

TO: All Companies Authorized To Transact Accident and Health Insurance In The State Of Kansas

FROM: Kathleen Sebelius
Commissioner of Insurance

SUBJECT: Mental Health Issues

DATE: February 12, 1998

The Kansas Insurance Department has received a number of questions regarding the requirements for coverage of mental health benefits as set out in the Mental Health Parity Act of 1996 ("MHPA") and 1997 Kansas Senate Bill 204 (K.S.A. 1997 Supp. 40-2258). The federal act and the corresponding state statute applies to groups of 51 or more employees and is effective January 1, 1998. This bulletin is intended to respond to some of the issues raised by insurance carriers.

Initially, it should be recognized that the federal law must be read in conjunction with the existing requirements for mental health coverage contained in K.S.A. 1997 Supp. 40-2,105. Both K.S.A. 1997 Supp. 40-2,105 and K.S.A. 1997 Supp. 40-2258 deal with mental health benefits provided under group health insurance policies.

The mental health "mandate" (K.S.A. 1997 Supp. 40-2,105) provides that health insurers must provide at least 30 days of inpatient treatment and the following outpatient benefits:

> "...limited to not less than 100% of the first $100, 80% of the next 100 and 50% of the next $1,640 in any year and limited to not less than $7,500 in any such person's lifetime...."

K.S.A. 1997 Supp. 40-2,105 (emphasis added).

These requirements apply to "....every insurer which issues any individual or group policy of accident and sickness insurance providing medical, surgical or hospital expense coverage for other than specific diseases or accidents only..."

Questions:

(1). **May carriers use different annual or lifetime dollar limits for outpatient mental health coverage than they use for hospital, medical and surgical coverage?**

No. K.S.A. 1997 Supp. 40-2258 provides for the following with regard to annual and lifetime dollar limitations on benefits:

(a) If there is no aggregate limit on substantially all hospital, medical and surgical expense benefits, there can not be any aggregate limit on mental health benefits.

(b) If there is an aggregate lifetime limit on substantially all hospital, medical and surgical expense benefits the policy must either (1) apply the same limit to hospital, medical and

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surgical benefits as it does to mental health benefits or (2) not include any aggregate limit on mental health benefits.

(2) **Do the provisions of K.S.A. 1997 Supp. 40-2258 apply to the inpatient mental health coverage requirements specified in K.S.A. 1997 Supp. 40-2,105?**

No. Because the inpatient benefits in K.S.A. 1997 Supp. 40-2,105 are stated in the statute as limitations on the number of days which will be covered, the provisions of K.S.A. 1997 Supp. 40-2258 do not apply since they only address dollar limits on mental health coverage.

(3) **May carriers substitute "per visit" limitations on outpatient mental health coverage for the outpatient dollar limits set out in K.S.A. 1997 Supp. 40-2,105?**

Yes. The Department has in the past permitted carriers to pay for outpatient mental health coverage on a per visit basis provided that such coverage was actuarially equivalent to the minimum dollar limits on outpatient coverage.

(4) **If a carrier pays for outpatient mental health benefits on a per visit basis, are they exempt from K.S.A. 1997 Supp. 40-2258 since that statute only applies to annual or lifetime "dollar" benefit caps?**

No. The Department will permit carriers to substitute mental health outpatient "per visit" coverage for the minimum dollar amounts required in K.S.A. 1997 Supp. 40-2,105. However, it is the position of the Department that the "per visit" limits are directly based on and tied to the dollar amounts set out in that statute. The provisions of K.S.A. 1997 Supp. 40-2258 specifically refer to annual or lifetime dollar limits for mental health coverage and requires insurance carriers to parallel those limitations for hospital, medical and surgical expense benefits. However, it is permissible to increase the per visit copayment amounts to reflect any additional costs of providing coverage beyond your current benefit structure. For example, you currently limit the number of visits per year to 20 with a $25 copayment per visit. In the future, it would be acceptable to increase the per visit copayment amount with the 21st and subsequent visits.

(5) **What is the practical effect of applying the provisions of K.S.A. 1997 Supp. 40-2258 to the mental health mandate in K.S.A. 1997 Supp. 40-2,105?**

If a carrier does not have any annual or lifetime dollar limits on their hospital, medical and surgical expense benefits, they may not have annual or lifetime dollar limits on outpatient mental health coverage. If a carrier has an annual or lifetime dollar limit on their hospital, medical and surgical expense benefits, the same annual or lifetime dollar limits on outpatient mental health benefits must apply, whether such benefits are provided on an indemnity (dollar) basis or on a per visit basis.

(6) **What are the minimum outpatient mental health benefits that can be provided for compliance with K.S.A. 1997 Supp. 40-2258 and K.S.A. 1997 Supp. 40-2,105?**

The minimum outpatient mental health benefits that can be provided are 100% of the first $100, 80% of the next $100 and thereafter, a reasonable coinsurance no less favorable than that required by state law.

(7) **Can a health carrier use different copayment or coinsurance amounts in mental health benefits and for medical and surgical coverage?**

Yes. Insurance carriers may vary the amount of copayments or coinsurance required for mental health benefits and for hospital, medical and surgical expense benefits.

(8) **Are Health Maintenance Organizations subject to K.S.A. 1997 Supp. 40-2258?**

Yes. K.S.A. 1997 Supp. 40-2258 provides that its provisions apply to "an accident and sickness insurer which offers coverage through a group policy providing hospital, medical, or surgical expense benefits pursuant to K.S.A. 1997 Supp. 40-2209 and amendments thereto...." K.S.A. 1997 Supp. 40-2209 applies to any contract issued by a health maintenance organization.

(9) **Are the mental health coverage provisions in K.S.A. 1997 Supp. 40-2,105 preempted by the federal Health Insurance Portability and Accountability Act of 1996?**

No. The Health Insurance Portability and Accountability Act of 1996 and the conference report on the legislation stipulates that the federal act should not hinder the application of any state law which provides more favorable treatment for mental health benefits. There is nothing in the minimum outpatient dollar coverage requirements in K.S.A. 1997 Supp. 40-2,105 which prevents the application of the mental health coverage provisions in the federal law.

(10) **How will insurance carriers which want to opt out of K.S.A. 1997 Supp. 40-2258 prove the 1% rate impact to the Insurance Department?**

Companies will be required to follow the requirements set out in the Interim Rules for Mental Health Parity issued by the Department of Health and Human Services (Federal Register, Volume 62, No. 245, December 22, 1997). Any notices of exemptions by a health carrier should be provided to the Department of Health and Human Services. In addition, each insurer shall maintain at its home or principal office a complete file containing notices of exemption along with all supporting information. Such file shall be subject to regular and periodical inspection by this Department.

Any questions regarding this Bulletin may be directed to the Kansas Insurance Department, Accident and Health Division, 420 SW 9th Street, Topeka, Kansas 66612, (785)296-7850.

Kathleen Sebelius

Kathleen Sebelius
Commissioner of Insurance

NAMI Topeka

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Testimony on Parity presented to the
Senate Financial Institutions and Insurance Committee
Submitted by Bryce Miller
March 15, 2000

Insurance, providing coverage for certain mental health conditions. I am Bryce Miller, mental health advocate. Chairman Steppes and members of the Senate Financial Institutions and Insurance, it is a privalage to discuss mental health insurance parity.

However, before delving into that I would like to tell you about myself. I graduated from McPherson College in 1953 and Kansas State University in 1955. In 1974 I was diagnosed with bi-polar illness; also known as manic-depression illness. With proper medication and good treatment, I have been able to continue working. I worded 19 years for the State of Kansas; all in the Kansas Dept of Human Resources.

During my active state service I also was a volunteer President Mental Health Association in Kansas, 1985-86; Board Member of the National Alliance for the Mentally Ill, 1990-1996 and at present a member of the Board of Directors, National Alliance for the Mentally Ill, 1990- 1998 (located in Arlington, VA).

I served on the original Governor's Mental Health Services Planning Council, 1990-1998. You will remember the Planning Council helped trigger off the mental health reform era. Recently, I was appointed by Governor Graves to serve on the Kansas State Employees Health Care Commission representing the retired employees.

As I travel around the country to attend various mental health conferences, I often am asked the question "How is insurance parity coming in Kansas?" It really is embarassing to find an answer, when the surrounding states of Nebraska, Colorado, Oklahoma and Missouri have parity laws on the books. In fact 29 states have passed mental health insurance laws with New Mexico being the most recent and was the 29th state to establish mental health insurance parity. Why can't Kansas be the 30th state to provide parity? I see no reason why not.

As a member of the Kansas State Employees Health Commission I have watched with interest the one year parity trial for state employees and their families. 26,832 HMO participants and 1,469 PPO participants were involved.

The increased cost for what was provided in 1999 for biological based mental health parity benefits, compared to what was provided under the previous benefit schedule is $8.68 per contract annually or $0.72 per month. 75% of the EAC for the HCC has voted to support parity.

I see no reason to have another year trial for more state employees. Now is the time to get mental health insurance parity and become #30. Also, I will be able to go to convention without getting embarassed.

Parity is really a bipartisan project. Mental illness can strike Republicans, Democrats and Independents. Now is the time to move forward and pass a parity law.

Senate Financial Institutions & Insurance
Date 3/15/00
Attachment 5

KANSAS

Bill Graves
Governor

DEPARTMENT OF HUMAN RESOURCES
Kansas Commission on Disability Concerns

Richard E. Beyer
Secretary

March 14, 2000

TO: Senate Committee on Financial Institutions and Insurance

FROM: Sharon Huffman
Legislative Liaison

SUBJECT: Senate Bill 547

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.

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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 547 and asks you to recommend it favorably for passage.

NAMI KANSAS

THE ALLIANCE ON MENTAL ILLNESS

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Kansas' Voice on Mental Illness

Testimony for the Senate Financial Institutions and Insurance Committee - March 15, 2000

It's an honor to speak with you. Thank you for the years of hard work—learning, reasoning, studying and taking responsibility for my welfare as a Kansan. I am indebted to you. My name is Elizabeth Adams. I am the executive director of NAMI Kansas—the Alliance on Mental Illness. I need to speak briefly on two points.

The war against ignorance about mental illness, or biologically based brain disorders, has won a pivotal victory. With U.S. Surgeon General David Satcher's report on the nation's mental health, compelling scientific evidences prove that mental illnesses are validly treatable physical disorders. The organ of the mind merits equal treatment with every other organ in the human body. Measurable outcomes of recovery prove treatment works; if you can get it.

Fear is the last uneducated voice against treating brain disorders. Fear of being shamed for an illness so misunderstood. Fear of being stigmatized for seeking treatment. Fear of the cost. National government has spoken clearly in the enforced parity bill of 1996 and the White House Conference on Mental Health of 1999, where President Clinton enacted mental health parity for over 9.5 million federal employees. Twenty-nine other states have passed parity legislation. Your courage to support Kansans' personal dignity and provide them with necessary health services is commended. Thank you for parity.

Thank you for disregarding the myths that defend inequitable insurance coverage. Severe mental illnesses can be reliably and accurately diagnosed and treated.

Thank you for learning the facts. One in every five Americans IS affected by mental illness. Nearly half of all Americans have a psychiatric disorder at least once in a lifetime.

Thank you for reasoning with us today to bring parity quickly to Kansans. At its most extreme estimate from the state employee's market test, 72 cents a month is affordable.

In taking responsibility for my welfare, you have promised me your best. Don't let citizens in your care lose their homes this year, declare bankruptcy, or worse because they could not afford the medical services they deserve. Act now, with parity. Thank you.

March 14, 2000

To: Senate Financial Institutions and Insurance Committee

From: Eloise Reeves, NAMI-CAM

Re: Insurance Parity

Before you stands a mother who is proud to be a Kansan. I am proud because you and legislators like you have made Kansas a wonderful place to live and raise children. Your efforts to help children and adolescence with programs such as the Home and Community Based Services, Healthwave, and Special Education programs are very much appreciated.

I applaud you for all of these endeavors and your hard work on the parity senate bills that include individuals with biologically based brain disorders to be covered under health insurance plans. My plea is for you to include the diagnosis of Attention Deficit Disorder (ADD), Attention Deficit Hyperactive Disorder (ADHD), Autism, Asperger Syndrome, and other neurobiological brain disorders. I cannot thank you enough for giving hope to parents like myself and enabling us to access treatment for our catastrophically ill children.

Now I will relate to you my personal story. I am the mother of two children who are tormented by the demons and the hauntings of schizophrenia. They are both diagnosed with Schizoaffective Disorder, Bi-polar type. My first-born son saw his first psychiatrist at age three. Our hopes and dreams for him were stolen from us at that moment. He was

in and out of psychiatric units and the state hospital until he was placed in Indian Trails nursing facility for the mentally ill nearly five years ago. He is now thirty-five years old. Because of a recent relapse he is now a patient Osawatomie State Hospital. My other ill child is my adopted granddaughter. Chrissy is nine years old. I have had her from birth. My ill son is her birth father. Her birth mother also suffers from mental illness. I cannot begin to tell you how many thousands of dollars we have spent to care for both of them. For my son we were fortunate to have the assets to fund his care. Most parents do not have the means to fund their child's care. In some instances, they must give up custody of their child to the state so that their ill child can receive appropriate treatment. My son's lifetime insurance cap was at $25,000. That ran out shortly after he became suicidal and was hospitalized several times. When he was sixteen years old I was told by a mental health facility, where our insurance had run out, to have him admitted to Topeka State Hospital. We were told that he would need at least a full year of treatment at Topeka State. I made one of the hardest decisions of my life. I became his twenty-four hour caregiver and kept him in our own home. He had three very serious suicide attempts that put him in ICU. I could not step out my front door without worrying what I would find when I came back in. All of this because we had already exhausted are lifetime mental health coverage on our health insurance policy.

My son is a survivor and I guess God has a reason for him to still be alive. With mental health parity a statute in Kansas other mothers would not have to suffer the pain I endured trying to keep my child alive. Please pass a parity bill that insures humane, responsible, and appropriate treatment to our loved ones who suffer from brain disorders.

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Testimony on Equal Coverage Insurance
Paul M. Klotz, Executive Director
March 15, 2000

Thank-you for this opportunity to speak in favor of equal health insurance coverage for serious brain disorders.

This is a fiscal issue.

Community Mental Health Centers (CMHC's) provide care to over 100,000 citizens per year. Patient loads have generally doubled over the past ten to twelve years largely as a result of deinstitutionalization. During the period from 1970 to 1997, the State Hospital average daily census declined by more than eighty percent. Many of these former hospital patients now rely on CMHC's for mental health services to maintain their ability to live in their own community.

In Kansas, 97 percent of all citizens seeking public mental health care are seen at community mental health centers.

Of the CMHC clientele, 22,000 are serious, at risk patients that require ongoing care and treatment. An estimated 10,000 are seriously emotionally disturbed children that are being served in the community, and over 12,000 are severe and persistently mentally ill adults. Growth of these types of services in the community has been dramatic. Without CMHC's, these seriously mentally ill adults and children would be confined to a hospital.

Private insurance comprises only 7 percent of the funding stream to CMHC's. This is lower than it should be because in the majority of health insurance plans, only the required mandated limits for outpatient and inpatient mental health services are allowed. The lack of parity in mental health and the lack of the recognition on the part of private insurance companies as to the value of "non-traditional" mental health services have necessitated the development of a largely publicly funded mental health system throughout the nation. County, state and federal governments are funding necessary services that private insurance does not cover. According to data from the National Comorbidity Survey, 64 percent of individuals with severe mental disorders have private insurance.

The public supports it.

In June a nationwide poll conducted by Opinion Research Corporation for the National Mental Health Association (NMHA) revealed a major discrepancy between what Americans want in their health insurance and what they actually have.

While, the survey shows the vast majority of Americans -- 93 percent -- think mental illnesses should be treated the same as physical illnesses, the reality is that 96 percent of insurance plans provide inferior coverage for mental illnesses compared to other illnesses.

According to the National Institute of Mental Health (NIMH), one in four Americans will experience a mental illness in a given year.

NMHA's survey of more than 1,000 adults found:

- 61 percent strongly agreed and 32 percent agreed that health care insurance should provide the same coverage for mental health problems as it does for physical health problems.
- Support for mental health parity does not depend on an individual's belief that a family member might need mental health care: 61 percent of respondents strongly supported parity while 28 percent had a strong expectation of a family member's need for mental health treatments.
- Support for mental health parity may relate to an individual's awareness of insurance discrimination against people with mental illnesses. Of those polled, 61 percent (the same percentage that strongly favored mental health parity legislation) had some knowledge of the limits of their health insurance coverage for mental health treatments.
- 30 percent of respondents did not know the extent to which their insurance would cover mental health treatments. In fact, the Bureau of Labor Statistics said last year that 96 percent of insurance plans impose limits on mental health care that they do not place on physical health care.

Since 1994 nearly every state legislature has considered parity for mental health.

I attended a session on mental health parity while I was at the NCSL conference last week. Information was presented that mental health parity is an issue that is receiving a lot attention from state legislatures -- during the 1997-98 legislative sessions 88 bills were introduced in 32 states.

At the NCSL session, we received a comprehensive report from the National Institute of Mental Health, a division of the U.S. Department of Health and Human Services. The reports states that nondiscriminatory mental health care in combination with managed care "results in lowered costs and lower premiums (or at most very modest increases) within the first year of parity implementation." Moreover, NIMH specifically found that its research does not support assertions - made by some -- that "high financial costs" will result from parity because they are using outdated assumptions.

I ask you to review the NIMH study. It is particularly significant because for the first time, a nonpartisan and objective agency (unconnected to mental health advocates or insurance companies) has examined all available data and concluded that parity will not break the bank!

It will help reduce the stigma of mental illness.

Contrary, to persistent myth, mental illnesses are both real and definable. Thanks to research advances, the diagnosis and treatment of mental disorders have undergone dramatic improvements in recent years, enabling millions of people to be treated successfully lead productive lives. Furthermore, the great majority of people can now be treated on an outpatient basis. Even those who once would have spent much of their lives disabled and hospitalized can now live successfully in the community if they have access to treatment.

The Surgeon General Has Issued a Call to Action

Every year, one out of every five Americans — adults and children alike — experience a mental disorder. These illnesses of the brain ruin lives and destroy families. We know that effective treatment works, but the fact is, too many Americans are denied access and too many Americans are afraid to cross over the barrier of stigma.

The US Surgeon General is calling on all Americans to help fix a mental illness treatment system burdened with critical gaps and hurtful stereotypes.

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Kansas' Voice on Mental Illness

Surgeon General reports on mental health issues: Brings nation's focus to facts about mental illness

"Stigmatization of people with mental disorders has persisted throughout history. It is manifested by bias, distrust, stereotyping, fear, embarrassment, anger and/or avoidance. Stigma leads others to avoid living, socializing or working with, renting to, or employing people with mental disorders such as schizophrenia.

"It reduces patients' access to resources and opportunities and leads to low self-esteem and hopelessness. It deters the public from seeking, and wanting to pay for care.

"In its most overt and egregious form, stigma results in outright discrimination and abuse. More tragically, it deprives people of their dignity and interferes with their full participation in society. **Stigma must be overcome."**

Surgeon General's report calls for educated response—Parity

Surgeon General David Satcher, M.D., Ph.D., on completion of a two-year commission, has published the first Surgeon General's Report on Mental Health in which he establishes without argument that mental disorders are real and treatable health conditions. His research stipulates that the efficacy of mental health treatments is well documented and a range of treatment exists for most mental disorders.

"The past 25 years have been marked by several discrete, defining trends in the mental health field. These have included:

⇒ The extraordinary pace and productivity of scientific research on the brain and behavior;
⇒ The introduction of a range of effective treatments for most mental disorders;
⇒ A dramatic transformation of our society's approaches to the organization and financing of mental health care; and
⇒ The emergence of powerful consumer and family movements."

Dr. Satcher writes, "The burden of mental illness on health and productivity in the U.S. and throughout the world has long been profoundly underestimated. Data developed by the massive Global Burden of Disease study, conducted by the World Health Organization, the World Bank and Harvard University, reveal that mental illness including suicide, r*anks second in the burden of disease* established in market economies such as the U.S." *(See addendum)*

Federal leadership, educated about mental illness, passed the Mental Health Parity Act of 1996, the Federal Employees Health Benefits Program, 1999, mandating parity for more than 9.5 million federal workers and family members and the Mental Health Equitable Treatment Act of 1999 is poised for enactment (see addendum).

A total of **28 states, Kansas excluded,** now have some degree of mental health parity:

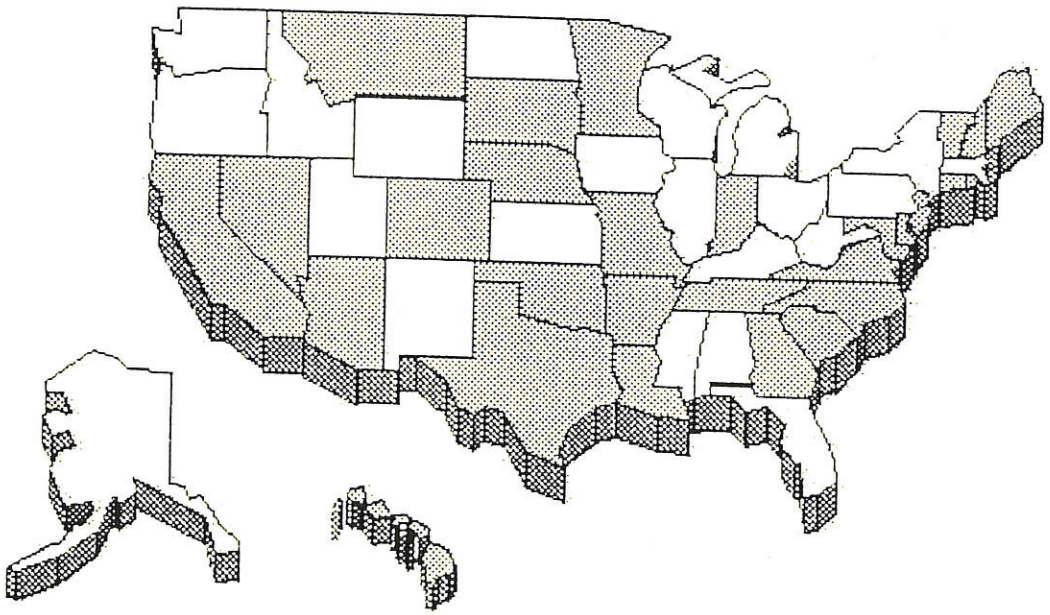
In 1999: 10 states and two territories passed parity legislation (California, Guam, Hawaii, Indiana, Louisiana, Missouri, Montana, Nebraska, Nevada, New Jersey, Oklahoma, Puerto Rico, Virginia).

In 1998: 4 states passed parity legislation (Delaware, Georgia, South Dakota, Tennessee).

During 1997: 9 states passed mental illness parity legislation (Arizona, Arkansas, Colorado, Connecticut, Indiana, Missouri {managed care only}, South Carolina, Texas, Vermont).

Between 1991-1996: 7 states implemented mental illness parity measures (Maine, Maryland, Minnesota, New Hampshire, North Carolina{state employees only}, Rhode Island, Texas{state employees only}).

The map below shows the states with parity by shaded areas. Kansas stands out in the heartland without it.



US Surgeon General delivers landmark MH report

Following are direct excerpts from the Mental Health Report by Surgeon General David Satcher, M.D., Ph.D. It is the first report ever issued on mental health issues by that high ranking office.

"Tragic and devastating disorders such as schizophrenia, depression and bipolar disorder, Alzheimer's disease, the mental and behavioral disorders suffered by children, and a range of other mental disorders affect nearly one in five Americans in any year, yet continue too frequently to be spoken of in whispers and shame. Fortunately, leaders in the mental health field--fiercely dedicated advocates, scientists, government officials and consumers--have been insistent that mental health flow in the mainstream of health. I agree and issue this report in that spirit.

"...The mental health field is plagued by disparities in the availability of and access to its services... A key disparity often hinges on a person's financial status; formidable financial barriers block off needed mental health care from too many people regardless of whether one has health insurance with adequate mental health benefits, or is one of 44 million Americans who lack any insurance. *We have allowed stigma and a now unwarranted sense of hopelessness about the opportunities for recovery from mental illness to erect these barriers. It is time to take them down.*

The science-based report conveys several messages. One is that mental health is fundamental to health. A second message is that mental disorders are real health conditions that have an immense impact on individuals and families throughout this Nation and the world.

"The review of research supports two main findings: **(1) The efficacy of mental health treatments is well documented** and **(2) A range of treatments exists for most mental disorders.** On the strength of these findings, the single, explicit recommendation of the report is to *seek help* if you have a mental health problem or think you have symptoms of a mental disorder.

"Promoting mental health for all Americans will require scientific know-how but, even more importantly, a societal resolve that we will make the needed investment. The investment does not call for massive budgets; rather, it calls for the willingness of each of us to educate ourselves and others about mental health and mental illness, and thus to confront the attitudes, fears and misunderstanding that remain as barriers before us. It is my intent that this report will usher in a healthy era of mind and body for the Nation.

"The past 25 years have been marked by several discrete, defining trends in the mental health field. These have included:

- The extraordinary pace & productivity of scientific research on the brain and behavior;
- The introduction of a range of effective treatments for most mental disorders;
- A dramatic transformation of our society's approaches to the organization and financing of mental health care; and
- The emergence of powerful consumer and family movements.

Additional "overarching themes" of the report include (1) Mental health and mental illness are points on a continuum; (2) Public Health perspective, the need and development of a broader population-based public health model; and (3) Mental disorders are disabling.

Satcher writes, " **The burden of mental illness on health and productivity in the US and throughout the world has long been profoundly underestimated.** Data developed by the massive Global Burden of Disease study, conducted by the World Health Organization, the World Bank and Harvard University, reveal *that mental illness, including suicide, ranks **second** in the burden of disease* established in market economies, such as the US." *See Table 1 below.*

Table 1. Disease burden by selected illness categories in established market economies, 1990

	Percent of Total DALYs
All cardiovascular conditions	18.6
All mental illness**	15.4
All malignant disease (cancer)	15.0
All respiratory conditions	4.8
All alcohol use	4.7
All infectious and parasitic disease	2.8
All drug use	1.5

Mental Health Equitable Treatment Act of 1999

Mr. Domenici:
(Greetings to the President and thanks to co-sponsor, Mr. Wellstone)

Synoptic comment: "This *bill* will say to the insurance companies and the businesses of America, unless they have 25 or fewer employees, their insurance coverage of their employees and their employees' families, if there is going to be mental illness or mental disease coverage, they will have to, as to severe illnesses, have coverage with full parity.... I believe that we have made great strides in providing parity for the coverage of mental illness. I would submit the Mental Health Parity Act of 1996 is a good first start, but the act is also not working...ways are being found around the law by placing limits on the number of hospital days covered and outpatient visits.

Call to action: That is why I believe it is time for a change. Essentially, we are going to take a piece of America that is currently discriminated against in health care because those Americans do not have a disease of the heart but have a disease of the brain. We now can define it sufficiently that there is no reason to cover one and not the other, and in the process we will stop discriminating against about 10 million American families. Medical science is in an era where we can accurately diagnose mental illnesses and treat those afflicted so they can be productive. I would ask then, why with this evidence would we not cover these individuals and treat their illnesses like any other disease? We should not. So, I would submit there should not be a difference in the coverage provided by insurance companies for mental health benefits and medical benefits.

Rebuttal: Some will immediately say we cannot afford it or that inclusion of this treatment will cost too much. But, I would first direct them to the results of the Mental Health Parity Act of 1996. That law contains a provision allowing companies to no longer comply if their costs increase by more then 1 percent. Do you know how many companies have opted out because their costs have increased by more than one percent? Only four companies out of all the companies throughout the country.

Statistical comment: Within the developed world, including the United States, 4 of the 10 leading causes of disability for individuals over the age of 5 are mental disorders. In the order of prevalence the disorders are major depression, schizophrenia, bipolar disorder and obsessive compulsive disorders.

Quoted from statements on introduced bills and joint resolutions (Senate--April 14, 1999

Rolf, Lynn W. COL ROLFL

From: Rolf, Lynn W. COL ROLFL
Sent: Tuesday, March 14, 2000 11:55 AM
To: 'eadams@nami.org'
Subject: Congressional Testimony

It is an honor and privilege to submit this testimony to you as a Kansan, a professional soldier with 30 year's of service to our Nation, and a father of a 24 year old son with paranoid schizophrenia. As an adult, Nick cannot get health insurance like his brothers who do not suffer from a mental illness. What's wrong with this picture?

Many states have placed themselves at the forefront of national leadership in ensuring treatment for people with mental illnesses by passing a state Mental Illness Parity Law.

My question to you is why has not Kansas passed a similar law?

Bill 547 can be a law with far-reaching importance! As of today, 29 states have enacted laws to provide greater parity in health insurance benefits for people with mental illnesses.

With California, 54 percent of the American people can now say that they live in states with parity laws. Out of 226 million Americans with health insurance coverage, 120 million - 53 percent-now will be covered by parity. In Kansas, millions of people could be protected.

A parity law in Kansas will help put an end to discrimination and stigma and provide greater health insurance coverage for biological brain disorders. Medical science has proven that treatment works for mental illnesses, but only if a person can get it. The need to ensure treatment is especially urgent for children and adolescents. Approximately 12 percent of youth under the age 18 have mental, behavioral or developmental disorders, but only 20 percent of these kids get the help they need.

Your leadership can assure that lives will be saved. Bill 547 should require health plans to cover adults and children with the most severe mental illnesses, including schizophrenia, bipolar disorder, major depression, schizoaffective disorder, panic disorder, obsessive-compulsive disorder, autism, anorexia nervosa, and bulimia nervosa. Our plan should insist that HMO's and insurers must provide equitable co-payments, deductibles and maximum lifetime benefits as well as providing for partial hospital stays and outpatient services.

While this law is good news for states that have recently passed them and the nation, I hope we Kansan's can expect to see our administration and legislature rise to the occasion and add momentum to the national parity movement.

Senate Financial Institutions & Insurance
Date 3/15/00
Attachment
10

I will close by saying again that something is wrong if my son Nick can't get insured because he has a mental illness, one that has been treatable with expensive new atypical medicine, and his 3 brothers who may suffer from diabetes are assured they can be treated with fairness and dignity from insurance providers.

Thanks for your time and hopefully your support.

Sincerely,

COL Lynn Rolf

President, NE Kansas/Leavenworth

NAMI Family Support Group

610 Scott Avenue

Ft Leavenworth, Ks 66027

10-2

My name is Amy Donohoo and I am a case manager at a Wichita community health center. I have been employed there for 6 1/2 years. I also have a severe and persistent mental illness - namely schizoaffective disorder. My condition warrants frequent trips to my psychiatrist to adjust my medications. I also see a therapist twice a month. Although I was formerly on Social Security Disability for 8 years, I was able to obtain my Bachelors degree in Social Work and return to work. However, I find that I cannot maintain my job without a level of supports from my psychiatrist and therapist.

My insurance with my job pays 100% of the costs for medical treatment. However, if I must see my psychiatrist or therapist, it only pays 70%. This leaves me to have to pay the additional costs of the treatment. It is a big stressor on me to have to pay these additional fees. I am faced with a dilemma - do I go ahead and see the doctor when I

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am ill, or do I try to get by without it and become symptomatic again, thus jeopardizing my ability to keep my job? I am also a single mother, and the money that I must pay towards my mental health expenses is an extreme hardship on me. My question is - why I am I being penalized for having a brain disorder when in fact my condition is a neurochemical malfunction in my brain - a physical illness? Medical science has long since found that mental illness is not caused by the child's upbringing or environment, but is an excess or lack of neurotransmitters in the brain. If this is so, why does my insurance not pay 100% of the costs associated with the disease? Mental illness has been likened to diabetes, in that medicine is needed to maintain the stability of the person - yet people with diabetes are able to obtain cheaper treatment based on the idea that it is a physical impairment. I feel that I have a right to treatment that is paid at the same

Dear as a physical disease. I also know of many others that are in the same predicament as myself. I would like to ask that you support the Senate Bill No. 160 to allow more mentally ill people to return to work and receive treatment in a fair and just way.

Amy M. Donohoo, LBSW
Field Casemanager

Kansas Psychiatric Society

Founded 1942

A District Branch of the American Psychiatric Association

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March 15, 2000

To: Chairman Steffes and members of Senate Financial Institutions & Insurance Committee
From: Kansas Psychiatric Society; Steve Kearney, Executive Director
RE: Senate Bill 547

Dear Chairman Steffes:

Thank you for the opportunity to express our support of Senate Bill 547, which would provide equal health insurance coverage for Kansans with mental illnesses. The goal of the Kansas Psychiatric Society is to ensure that all serious medical conditions are treated equally and fairly, and that mental illnesses are granted the same level of consideration as other serious physiological problems.

The existing Kansas statute (K.S.A. 40-2,105) governing health insurance coverage for substance abuse, nervous conditions and mental conditions is extremely valuable. However, the existing statute creates an inadvertent form of discrimination against Kansans who suffer from severe, disabling illnesses. Kansans requiring inpatient treatment at any facility are required to receive coverage for a minimum of thirty (30) days, with the intention of providing an adequate period of time for treatment. The thirty-day minimum has become the coverage limit in most health policies, and does not provide for any extended-care treatments.

Additionally, K.S.A. 40-2,105 stipulates that a Kansan treated on an outpatient basis shall be insured according to a formula: 100% of the first $100, 80% of the next $100, and only 50% of the next $1,640/year. The maximum amount that an insurer is required to pay for outpatient treatment in one year is $1,000, while the patient must pay up to $840. This is a 45.65% co-payment policy. This formula is entirely different from most health insurance policies, which require the insured to pay for the initial costs until a deductible is met, followed by a reasonable co-payment for additional costs.

Studies conducted within the medical community have shown that equal insurance coverage for mental health issues has benefited society in a number of ways:

- Reduced the number of medical/surgical outpatient visits;
- Reduced medical inpatient days;
- Reduced psychiatric inpatient days; and
- Reduced indirect expenses associated with diminished work productivity.

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Other benefits to society include improved work attendance, improved family functioning, less antisocial behavior and decreased crime-related costs. Among those for whom psychotherapy is most often indicated are victims of violence, trauma and abuse, those with anxiety and eating disorders, pregnant and nursing women, and those with serious physical illnesses. Many of the individuals within these groups are also most affected by coverage limits and co-payment requirements, and they are more likely to be minorities, women and children. Failure to promptly and adequately treat mental illness tends to cause functional disability, thus worsening the condition. Children in particular are the most vulnerable, yet they (and society) stand to benefit the most from their treatment.

We respectfully request that you impose a simple standard of fairness in health insurance. We urge you to recommend passage of Senate Bill 547, which would define mental illnesses as those diagnoses which are the most severe and disabling, and require that health insurance coverage for mental illnesses be equal to coverage for other medical conditions. This would restore the fundamental premise of insurance: to spread the risk among all who pay premiums so that the insured who becomes afflicted with a mental illness will receive adequate health insurance benefits.