Approved: March 22, 2000
Date

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 21, 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: Larrie Ann Lower, Kansas Association of Health Plans
Brad Smoot, Blue Cross/Blue Shield
Bill Sneed, HIAA
Terry Bernatis, State Employees Health Plan

Others attending: (See Attached)

Continued Hearing on SB 547–Insurance, providing coverage for certain mental health conditions

Larrie Ann Lower, Executive Director of Kansas Association of Health Plans, stated their opposition to the bill because any mandate increases premiums which causes more individuals to be added to the uninsured population (Attachment 1). This means that for every 1% increase in health insurance costs in Kansas, an estimated 2,000 Kansans become uninsured. Full parity for mental health would only affect those Kansans with health insurance who are not part of a self-insured plan. Such a mandate has the potential to drive more employers into self-insured plans or reduce or drop other benefits offered. Ms. Lower pointed out the bill could drive up health insurance costs for the state employees health plan because the bill lacks any language requiring the Legislature to take action based upon the cost impact report presented by the state employees health benefits coordinator.

Ms. Lower presented two sets of amendments. The first set would require that the mandate be tested on the state employees health insurance plan and that the HMO portion of the plan be restructured to match the mandated benefits in the bill. At the end of the testing period, the Legislature would decide, based upon cost impact studies, whether to pass legislation mandating the benefit on the rest of the state. The second set of amendments would require the Legislature to pass a resolution to implement the mandate on the rest of the state after the cost impact is reported.

Brad Smoot, BlueCross/Blue Shield, stated his opposition to the bill because the cost of moving to full parity has been substantially diminished because the system has already incurred much of the expense for mental health coverage (Attachment 2). The impact of mental health mandates will fall most heavily on the individual and small group markets who can least afford additional costs for coverage. This is due to ERISA, out-patient pharmacy benefits which are frequently optional, and because federal requirements do not apply to small groups (2-50). If the Committee was intent on acting on a mental health mandate, he urged them to comply with the test track requirement enacted last year as it removes first dollar coverage for mental illnesses as defined in the bill. **SB 160** could not be considered as parity as first dollar coverage would still be required and deductibles would not apply.

The Committee discussed the increased difference in the amount of non-payment of costs by private pay clients for mental health care (90%) vs. non-payment for physical care (50%). This really is just a cost-shifting because the costs are increased in other areas. The Committee requested actual figures from Mr. Smoot on cost shifting in the mental health area. The fact that this proposed mandate would be spread out over only 30% of the insured population was discussed. It was pointed out that persons in need of durable medical equipment could receive grants from the State General Fund which means that all tax payers share in the cost rather than just a few. How could this concept be used in spreading the cost of mental health parity?

Bill Sneed, HIAA, said his clients are opposed to all mandates as they eventually cause a rise in health

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

insurance costs (Attachment 3). He pointed out that if a bill was designed which included all the mandates which have been put into effect since 1984 the increase would be substantial. These mandates have led to the expense and lack of availability of affordable health insurance for many citizens. The entity that always ends up paying for the increase in premiums is the people individually of through taxes. Mr. Sneed agreed with the proposed amendment which would require test tracking parity with termination and a "yes or no" decision after the results are in. Insurance is not available on the open market for total mental health care only. Mr. Sneed does not know of any study regarding the estimated loss of work productivity due to mental illness.

Terry Bernatis, Administrator of the State Employees Health Plan, gave a brief review of the fiscal note for mental health parity on the state plan. She was requested to present by the end of the day a very clear and concise response to the following questions:

- The exact cost to each member of the plan
- The exact cost to direct bill enrollees (retirees)
- Who would be covered
- A breakdown on the cost to the state, the employees and the federal government

Senator Becker moved that the minutes of March 20 be approved as presented. Motion seconded by Senator Corbin. Motion carried.

SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE
GUEST LIST
DATE: 3-21-00

NAME	REPRESENTING
Amy A. Campbell	Ks Mental Health Coalition
Bill Sneed	HIAA
Larrie Ann Lower	KAHD
Greg Beards	DofA
Sam Sellers	KAIA
M.L. McTiney	SRS
Kevin Davis	Am Family Ins.
Tim Woop	VCHS
Tom Knox	Pharmacia & Upjohn
Whitney Damron	KS Psychological Assn.
Susan Lunn	Ks Psychological Assn.
Chip Wheelen	Osteopathic Assn
Amy Schieferecke	Sen. Stephens
Steve Montgomery	United Health Care
Lee Wright	Farmers
Linda DeCoursey	KID
Paul M. Klotz	Assoc. of CMHCs KS., Inc.
Stacy Kramer	WR. Inc.
John Peterson	Ks Government Consulting
Wesley Marshall	Indian Tribes MHLC
Susan Bechard	KPS
Karen Barone	Heinlein Chrtd
Jennifer Crow	Federico Consulting
David Hanson	Ks Insur Assn

Kansas Association of Health Plans

Testimony before the
Senate Financial Institutions and Insurance Committee
The Honorable Don Steffes, Chairman
Hearings on SB 547
March 21, 2000

Good morning Chairman Steffes and members of the committee. Thank you for allowing me to appear before you today. I am Larrie Ann Lower, 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 most of the Kansans who are insured by an HMO.

For several reasons, the KAHP must respectfully oppose SB 547. This bill if enacted in its current form has the potential of creating 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.

In previous hearings on this issue, you have heard that full parity for mental health is estimated to increase premiums by either 3.4% on average or some have said 3.6% or 2-5%. Regardless of the percent increase, the fact is that insurance premiums most likely 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.

SB 547 has the potential to drive more employers into the self insured plans, drop coverage altogether or reduce other benefits offered. Previously you have also heard testimony on this issue citing a study that states employers will not attempt to avoid parity laws by becoming self-insured. That same study states that employers do not tend to pass on the costs of

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parity to employees. However, the authors of the study presented to you in previous hearings on this issue, 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.

Although this bill appears to require that mental health parity first be tested on the state employee's health insurance we would like to point out that this bill does have the potential to drive up health insurance costs for the state. You should also note that the benefits this bill mandates are not exactly the same benefits provided to the state employees who choose to participate in the HMO portion of the state health plan. This bill also lacks any language requiring that the legislature take action based upon the cost impact report presented by the state employees health benefits coordinator, March 1, 2002. The current bill would allow the mandate to automatically be in effect January 1, 2002 on the rest of the policies subject to state imposed mandates, before the legislature even receives the March 1, 2002 cost impact report. Therefore the mandate would be in effect throughout the rest of the state regardless of what the report on the cost impact to the state employees health plan indicates.

In conclusion, this mandate if enacted could increase the cost of the state employees health plan and if then automatically enacted on the rest of the policies in this state subject to state imposed mandates will most likely increase the cost of employers health insurance therefore running the real risk of increasing the number of uninsured in Kansas. The KAHP would request that you not pass this legislation for the reasons stated above.

However, if you feel this is a necessary mandate then we would strongly suggest that this legislation indeed first be subject to the provisions of K.S.A. 1999 Supp. 40-2249a, which you passed last year to determine its potential cost impact and then allow the legislature to determine if the mandate should then be expanded to include the rest of those policies subject to Kansas legislation. I would like to offer two versions of amendments that would accomplish the intent of K.S.A. 1999 Supp. 40-2249a, which was to determine the cost impact of an insurance mandate by testing the mandate first on the largest employer of the state, the state of Kansas, before subjecting the employers of this state to potentially cost rising mandates, that may lead to an increase in the number of uninsured in Kansas.

The first set of amendments would simply require that the mandate be tested on the state employees health insurance plans. The amendments would require that the HMO portion of the state employees health plan be restructured to match the mandated benefits in this bill. At the

end of the testing period, after the cost impact report is presented, the legislature would then decide, based on the cost impact report, whether to pass legislation mandating the benefit on the rest of the state.

The second set of attached amendments creates a second option. This set of amendments requires that the legislature pass a resolution to implement the mandate on the rest of the state after the cost impact is reported. This language is similar to previously enacted legislation: K.S.A. 39-7,117(c).

I will be happy to answer any questions the committee may have.

Session of 2000

SENATE BILL No. 547

By Committee on Financial Institutions and Insurance

2-2

AN ACT concerning insurance; providing coverage for certain mental health conditions; amending K.S.A. 1999 Supp. 40-2,103 and repealing the existing section.

Be it enacted by the Legislature of the State of Kansas:

New Section 1. (a) From and after January 1, 2001, the state health benefits program established by K.S.A. 75-6101 *et seq.*, and amendments thereto, shall provide a program of insurance which provides coverage for diagnosis and treatment of mental illnesses under terms and conditions no less extensive than coverage for any other type of health care.

(b) For the purposes of this act, "mental illness" means the following: Schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, specific obsessive compulsive disorder and panic disorder as such terms are defined 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.

~~New Sec. 2. (a) Any individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization which provides coverage for mental health benefits and which is delivered, issued for delivery, amended or renewed on or after January 1, 2002, shall include coverage for diagnosis and treatment of mental illnesses under terms and conditions no less extensive than coverage for any other type of health care.~~

~~(b) For the purposes of this act, "mental illness" means the following:~~ Schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, specific obsessive compulsive disorder and panic disorder ~~as such terms are defined 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.~~

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

contracting with the state to provide health care benefits

~~(d) The provisions of this section shall not apply to any medicare supplement policy of insurance, as defined by the commissioner of insurance by rule and regulation.~~

~~(e) The provisions of this section shall be applicable to the Kansas state employees health care benefits program and municipal funded pools.~~

~~(f) The provisions of this section shall not apply to any policy or certificate which provides coverage for any specified disease, specified accident or accident only coverage, credit, dental, disability income, hospital indemnity, long term care insurance as defined by K.S.A. 1999 Supp. 40-2227 and amendments thereto, vision care or any other limited supplemental benefit nor to any medicare supplement policy of insurance as defined by the commissioner of insurance by rule and regulation, any coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, automobile medical payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group, blanket or individual basis.~~

~~(g)~~ From and after January 1, ~~2002~~, the provisions of K.S.A. 40-2,105, and amendments thereto, shall not apply to mental illnesses as defined in this act.

New Sec. ~~3.~~ The provisions of this act shall be implemented as required by K.S.A. 1999 Supp. 40-2249a.

Sec. ~~4.~~ K.S.A. 1999 Supp. 40-2,103 is hereby amended to read as follows: 40-2,103. The requirements of K.S.A. 40-2,100, 40-2,101, 40-2,102, 40-2,104, 40-2,105, 40-2,114 and 40-2250, and amendments thereto and K.S.A. 1999 Supp. 40-2,160 and 40-2,165 through 40-2,170 ~~and section~~ 2, and amendments thereto, shall apply to all insurance policies, subscriber contracts or certificates of insurance delivered, renewed or issued for delivery within or outside of this state or used within this state by or for an individual who resides or is employed in this state.

Sec. ~~5.~~ K.S.A. 1999 Supp. 40-2,103 is hereby repealed.

Sec. ~~6.~~ This act shall take effect and be in force from and after its publication in the statute book.

(d)

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Session of 2000

SENATE BILL No. 547

By Committee on Financial Institutions and Insurance

2-2

AN ACT concerning insurance; providing coverage for certain mental health conditions; amending K.S.A. 1999 Supp. 40-2,103 and repealing the existing section.

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New Section 1. (a) From and after January 1, 2001, the state health benefits program established by K.S.A. 75-6101 *et seq.*, and amendments thereto, shall provide a program of insurance which provides coverage for diagnosis and treatment of mental illnesses under terms and conditions no less extensive than coverage for any other type of health care.

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New Sec. 2. (a) Any individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization which provides coverage for mental health benefits and which is delivered, issued for delivery, amended or renewed on or after ~~January~~ July 1, 2002, shall include coverage for diagnosis and treatment of mental illnesses under terms and conditions no less extensive than coverage for any other type of health care.

(b) For the purposes of this act, "mental illness" means the following: Schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, specific obsessive compulsive disorder and panic disorder as such terms are defined 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.

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

1-6

(d) The provisions of this section shall not apply to any medicare supplement policy of insurance, as defined by the commissioner of insurance by rule and regulation.

(e) The provisions of this section shall be applicable to the Kansas state employees health care benefits program and municipal funded pools.

(f) The provisions of this section shall not apply to any policy or certificate which provides coverage for any specified disease, specified accident or accident only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance as defined by K.S.A. 1999 Supp. 40-2227 and amendments thereto, vision care or any other limited supplemental benefit nor to any medicare supplement policy of insurance as defined by the commissioner of insurance by rule and regulation, any coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group, blanket or individual basis.

(g) From and after ~~January~~ July 1, 2002, the provisions of K.S.A. 40-2,105, and amendments thereto, shall not apply to mental illnesses as defined in this act.

New Sec. 3. The provisions of this act shall be implemented as required by K.S.A. 1999 Supp. 40-2249a.

Sec. 4. K.S.A. 1999 Supp. 40-2,103 is hereby amended to read as follows: 40-2,103. The requirements of K.S.A. 40-2,100, 40-2,101, 40-2,102, 40-2,104, 40-2,105, 40-2,114 and 40-2250, and amendments thereto and K.S.A. 1999 Supp. 40-2,160 and 40-2,165 through 40-2,170 *and section 2*, and amendments thereto, shall apply to all insurance policies, subscriber contracts or certificates of insurance delivered, renewed or issued for delivery within or outside of this state or used within this state by or for an individual who resides or is employed in this state.

Sec. 5. K.S.A. 1999 Supp. 40-2,103 is hereby repealed.

Sec. 6. This act shall take effect and be in force from and after its publication in the statute book.

(h) The provisions of this section shall be effective on and after July 1, 2002, by further authorization by a concurrent resolution approved by a majority of all members elected (or appointed) and qualified of each house of the legislature and shall not be effective prior to that date.

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
Senate Financial Institutions & Insurance Committee
Senate Bills 160 and 547
March 21, 2000

Mr. Chairman and Members:

Thank you for this opportunity to comment on the above-referenced legislation mandating health coverage for specified mental illnesses. Combined, the Kansas Blues and Kansas City Blues serve one million Kansans. On behalf of those who must pay the premiums -- those individuals and employers, large and small -- we must respectfully oppose both measures.

Our opposition to mental health parity is nothing new and it has been tempered by recent changes. There are several reasons for this: 1) As you know, current law requires first dollar out patient mental health coverage and thirty days inpatient; 2) health plans attempt to manage care and often cover more than traditional indemnity carriers; 3) today's medical practice relies more heavily on drug therapies which are commonly paid under prescription drug benefits and 4) federal legislation (under the KID interpretation for large groups) already requires 50% outpatient coverage. Thus, the cost of moving to full parity has been substantially diminished. Stated differently, we have come a long way toward parity already. Therefore, the changes proposed by S 160 and S 547 have less cost impact because the system has already incurred much of the expense for mental health coverage.

However, because HMO's are an option mostly for groups; because out patient pharmacy benefits are frequently optional; because individuals and small groups cannot escape mandates under ERISA and because the current federal requirements do not apply to small groups (2-50), the impact of these mental health mandates will fall most heavily on the individual and small group markets -- the two most volatile and fragile markets there are.

Finally, if the Committee intends to act on a mental health mandate, we encourage you to work from S 547. This bill includes the test track requirement enacted last year and represents real parity since it removes the first dollar coverage for mental illnesses as defined in the bill. We endorse the technical change of date to July 1, 2002 (page 1, line 31 and page 2, line 18) or the complete removal of the mandate on the private sector until testing on the state plan has been completed, as proposed by the Kansas Association of Health Plans.

For these reasons, we must encourage you once again to reject yet another health insurance mandate. Thank you.

Senate Financial Institutions & Insurance
Date 3/21/00
Attachment
2

MEMORANDUM

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

FROM: Bill Sneed, Legislative Counsel
Health Insurance Association of America

DATE: March 15, 2000

RE: S.B. 547

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. 547. After reviewing the bill, we appear today in opposition to its passage.

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.

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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 <u>any</u> 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.

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. 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,

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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.

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.

S.B. 547

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.

CONCLUSION

For all of these reasons, HIAA believes 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. 547.

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