Approved: February 13, 2001
Date

MINUTES OF THE HOUSE COMMITTEE ON INSURANCE.

The meeting was called to order by Chairperson Rep. Robert Tomlinson at 3:35 p.m. on January 16, 2000 in Room 526-S of the Capitol.

All members were present except:	Rep Carlos Mayans Rep. Eber Phelps
Committee staff present:	Bill Wolff, Research Ken Wilke, Revisor Mary Best, Secretary
Conferees appearing before the committee:	Ms. Larrie Ann Lower, Kansas Association of Health Plans Ms. Sarah Adams, Keys for Networking Mrs. Kathy Byrnes, Consumer, parent Ms. Amy Campbell, Kansas Mental Health Association Mr. Paul Klotz, Association of Community Health Centers of Kansas, Inc. Mrs. Elizabeth Adams, Kansas Alliance for the Mentally Ill Dr. Ty Porter, Menninger Foundation Mrs. Audrey Auernheimer, Consumer, parent Mrs. Barbara Bohm, Consumer, parent Ms. Mary Jo Bergkamp, Consumer, parent Ms. Ann Christman, Consumer, parent Mr. Brad Smoot, BC/BS & BC/BS of Kansas Mrs. Linda DeCoursey, Kansas Insurance Department Mr. Michael Larkin, Kansas Employer Coalition on Health Mr. Jeff Bottenberg, Western Surety Company
Others attending:	See Attached Guest List

HB 2033 - Insurance; report to the legislature concerning certain mental illnesses.

Please note the room change for this meeting. Chairman Tomlinson, upon calling the meeting to order, called the committee's attention to an error in the bill being presented. The date had overtly been eliminated from the bill and a balloon was going to be presented at a later date to re-insert the date. With that business aside, the Chair introduced Ms. Larry Ann Lower as the first conferee to address the bill.

Ms. Lower, Kansas Association of Health Plans, presented Proponent Testimony to the committee. A copy of the written testimony, (Attachment #1) is attached hereto and incorporated into the Minutes by reference. Ms. Lower gave an overview of the bill to the committee. Ms. Lower reminded the committee that the Senate passed this bill last session under SB 547 (36-4), requiring the testing of mental health parity on the state employees health insurance plan. She also reminded the committee that the House did not have time to run the bill and thus it was before them this session. However, this bill is not mandating he state employees to cover this benefit, since that decision had already been made by the health care commission and they were already providing mental health parity to all of the states employees. She continued to explain that this bill does require a report be submitted to the Legislature in regard to the cost and to do so by the date entered the bill. Ms. Lower stood for questions. Rep. Kirk requested information regarding which HMO's were providing this coverage now, their experience with the coverage and the costs.

Ms. Sarah Adams, Keys for Networking, gave Proponent Testimony to the committee. A copy of the testimony, (Attachment #2) is attached hereto and incorporated into the Minutes by reference.

Mrs. Kathy Byrnes, Consumer and parent, gave Proponent Testimony to the committee. A copy of the testimony is (Attachment #3), is attached hereto and incorporated into the Minutes by reference.

Ms. Amy Campbell, Kansas Mental Health Coalition, gave Proponent Testimony to the committee. Copies of her testimony and other materials are (Attachments # 4,5,6,7), are attached hereto and incorporated into the Minutes by reference. Ms. Campbell added to the previous testimony given by distributing a map showing 32 states which have already passed parity legislation as well as a handout from NAMI from studies dating from 1996 to 1999. Ms. Campbell also offered a suggested amendment to the bill which is numbered as Attachment #7. Ms. Campbell stood for questions from the committee. Questions were posed by Rep. Vickery regarding the federal plans and how they are effected by this plan? He also inquired into whether or not the federal plan included parity. Rep. Huff inquired as to whether this type of treatment ever came to an end or continued endlessly. Responses for the questions came from Dr. Ty Porter, Menninger Foundation. Chairman Tomlinson requested data from other states and requested the information include how may people were forced out of coverage in these states. He spoke of cost vs. affordability vs. people losing help. Rep. Boston inquired into number of claims being paid out and the cost of these claims.

Mr. Paul Klotz, Association of Community Health Centers of Kansas, Inc., was the next conferee to come before the committee. Mr. Klotz gave Proponent Testimony and a copy of the testimony is (Attachment #8), is attached hereto and incorporated into the Minutes by reference. There were no questions from the committee.

Mrs. Elizabeth Adams, National Alliance of Mental Illness, Kansas, was the next conferee to come before the committee. Mrs. Adams gave Proponent Testimony and included hand outs to the committee. A copy of the testimony and handouts are (Attachments #9,10,11), attached hereto and incorporated into the Minutes by reference. Mrs. Adams told the committee that the bill was very valuable to NAMI and the people it served. She explained, this is a step forward "with proof of the cost effectiveness of insuring treatment for disorders of the brain that manifest as mental illness." Mrs. Adams informed the committee that the U.S. Federal Government "gave 9.5 million employees mental health parity on January 1, 2001." She also informed the committee that, "data from the 32 other states and Kansas's own State health benefits plan only an increase of insurance costs up to 1 or 1 ½ percent with managed care." Mrs. Adams stood for questions. There were none.

Dr. Ty Porter, Menninger Foundation, came before the committee to present Proponent Testimony. Dr. Porter had no written testimony and spoke generally about the plan, summarizing what the previous speakers had reported. He also touched on biological illnesses such as ADD. Rep. Ostmeyer asked questions on genetic patterns.

Mrs. Audrey Auernheimer, Barbara Bohm, Mary Jo Bergkamp and Ann Christman, Consumers and parents, were recognized next by the Chairman and each gave her personal experience with a family member or themselves in regard to mental illnesses. Copies of their testimonies are, (Attachment #'s 12,13,14,15) attached hereto and incorporated into the Minutes by reference. Rep. Huff requested an explanation about bi-polarism, and was told it is the new name for manic depression.

Mr. Brad Smoot, BC/BS & BC/BS of Kansas, was the last Proponent Conferee to come before the committee. A copy of his testimony and chart is, (Attachment #'s 16,17), attached hereto and incorporated into the Minutes by reference. Mr. Smoot spoke of the support behind this bill, and reminded people this is not a "tracking bill" but a data presentation bill, "requiring the state health care benefits program to report on the costs of mental health coverage to the 2002 Legislature so that it may evaluate proposals to impose a mental health parity mandate on the private sector." Mr. Sneed related to the committee that Kansas all ready mandates mental health coverage (first dollar). Mr. Sneed reminded the committee of insurance mandates and raising premiums and their falling on the working men and women of Kansas, who must pay the cost of each mandate or elect to either reduce their coverages or do away with coverage altogether. Mr. Sneed stood for questions. There were none.

More written Proponent Testimony (Attachment #18) was presented for Col. Lynn Rolf, Consumer, parent.
Ms. Chris Collins, Kansas Medical Society, gave written Proponent Testimony (Attachment #19) only.
Mr. Whitney Damron, Kansas Psychological Association, submitted written Proponent Testimony (Attachment #20) only. Copies of these testimonies are attached hereto and incorporated into the Minutes by reference.

Ms. Linda DeCoursey, Kansas Insurance Department, gave Neutral Testimony, to the committee. A copy of her written testimony (Attachment #21) attached hereto and incorporated into the Minutes by reference.

Mr. Mike Larkin, Kansas Employer Coalition on Health, offered Opponent Testimony to the committee. A copy of the testimony (Attachment #22) is attached hereto and incorporated into the Minutes by reference. Mr. Larkin stated that they are not anti-parity, but are anti-mandates in the laws. Especially those laws that place higher premiums on small business and discouraging them from providing any coverage al all. This testimony concluded the public discussion on this bill. The bill will be worked on Thursday, the 18th of January.

The next order of business was bill presentation. The Chairman recognized Mr. Jeffery Bottenberg, Western Surety Company. The bill being offered would amend K.S.A. 8-2401 and K.S.A. 8-2404 and limit the coverage on motor vehicle dealer surety bonds to consumers. A copy of the proposed amendment (Attachment #23) is attached hereto and incorporated into the Minutes by reference. The proposed bill (amendment) was placed before the committee. Rep. Boston made the motion to hear the proposed bill. Rep. Huff seconded the motion and the motion carried.

Request was made for further bills or business, and with none coming forth the meeting was adjourned. The time was 5:45 p.m.

The next meeting will be held January 18th in the regular meeting room at 3:30 p.m.

HOUSE INSURANCE COMMITTEE GUEST LIST

DATE: Jan 16, 2001

HB 2033

NAME	REPRESENTING
Anne Christman	Consumer Kansas Association for the Medically Underserved Kansas Alliance for the Mentally Ill
Elizabeth Adams	Kansas Alliance for the Mentally Ill
Bud Smoot	BCBS
Pamela Ann Rovner	KAHP
~~Mike~~ Leslie "Les" Higgins	SRS C.A.C.
BARBARA Tobin	MHC of EASTERN KANSAS
Bryce Miller	NAMI Kansas
Laurie Haun	AARP
Ernest C. Poage	AARP
Joanne Yoder-Wentz	KDOA
Kevin Davis	Am Family Ins.
Whitney Damron	KS Psychological Assn.
Linda McCoursey	KS Ins Dept
Bill Sneed	KHA
Dr Ty Porter	Menninger Clinic
Jeremy Anderson	KS Ins Dept
Mary Jo Berghaus	~~NAMI~~ Parent
Kathy Byrnes	Parent/consumer-Keys
Sarah Adams	Consumer-Keys

HOUSE INSURANCE COMMITTEE GUEST LIST

DATE: Jan 16, 2008

NAME	REPRESENTING
Mike Parkin	KEC H (KS EMPLOYER COALITION ON HEALTH)
John Federico	Humana, Inc.
Terry Leatherman	KCCI
Paul M. Klotz	Assoc of CMHCs of KS, Inc.
Jeff Botterberg	Western Surety Co.
Amy Campbell	Kansas Mental Health Coalition
Danielle Noe	DOA
LARRY MAGILL	KS. ASSN OF INS AGENTS
Amy Kelley	Reps for Networking Inc
Steve Montgomery	United HealthCare
Katrina Hull	AP
Sam Sellers	KS. Assoc. of Ins. Agents
Amy Bennetts	Dept Administration
Eric Bohm	Citizen
Sky Westerlund	KS Chapter National Assoc of Soc. Workers
Michael White	Kearney Law Office
Chris Collins	Kansas Medical Society
Mary Ellen Conlee	Hosp. Psychiatric Services Coalition
Ted Burke	AIFA-KAM

HOUSE INSURANCE COMMITTEE GUEST LIST

DATE: ~~Jan 2016~~, 2021

NAME	REPRESENTING
Tucker Poling	rep. David Huff
Charles Quinn	rep. Dennis McKinney
Anne Spiess	KAIFA

Kansas Association of Health Plans

Testimony before the
House Insurance Committee
Hearings on HB 2033
January 16, 2001

Chairman Tomlinson 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. KAHP members serve all of the Kansans enrolled in a Kansas licensed HMO. KAHP members also serve the Kansans enrolled in HealthWave and medicaid HMO's and also many of the Kansans enrolled in PPO's and self insured plans. We appreciate the opportunity to provide comment on and appear in support of HB 2033.

The issue of health insurance mandates has been around for many years. Whether you are talking about durable medical equipment, mental health parity, prostate cancer screening, etc. The proponents of each of these issues feel these should all be covered benefits. The opponents generally emphasize the potential costs of these benefits. When costs increase, the potential reaction is employers choosing to discontinue health insurance benefits for possibly dependents or even all employees, therefore leading to an increase in the number of uninsured.

Two sessions ago the Kansas Legislature passed a law, K.S.A. 1999 Supp. 40-2249a, requiring all new health insurance mandates to be tested for costs on the largest employer in Kansas, the State of Kansas. This law enables the Legislature to evaluate the costs of mandating a particular benefit and then responsibly consider whether to enact the mandate on the rest of the private sector enrolled in a health insurance plan.

Late last session the Senate passed SB 547 (36-4) which would have required the testing of mental health parity on the state employees health insurance plan, however, the House did not have time to act on the bill. HB 2033 in essence is the same bill, however, you are not mandating the state employees to cover this benefit, due to the recent decision by the health care commission to provide mental health parity to all state employees. This bill also follows the 1999 law requiring a report to be made to the Legislature regarding the cost of this benefit. We support this responsible position.

I'll be happy to try to answer any questions you may have.

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ATTACHMENT #1

January 16, 2001

I am Sarah Adams, Director of Information Systems for Keys for Networking, Inc. I am here today to talk about the gross inequity between insurance coverage for mental health services and physical health services.

I am 29 years old. I am surviving major depression. I have suffered from this for as long as I can recall – from when I was a teenager. In February of 2000, I came to a point in my life I could see no future. I was taken to my regular doctor who referred me to a psychiatrist who immediately prescribed medication and further suggested a therapist. I began my medication and started to see the therapist. I did this for 5 months. I was prescribed six different anti-depressants as well as two different sleeping medications. During this 5 month period, I continued to see my therapist two times a week and my psychiatrist once a month. Blue Cross paid a portion of my claims with the therapist. I paid him 78 dollars a visit out of my own pocket.

In September 2000, I started seeing a new psychiatrist. My new psychiatrist prescribed a medication that has helped my thoughts. He has also worked extensively with me every week to get perspective and help me clear my head. He really listens to what I have to say and doesn't just offer, "Well, why do you think you feel like that, Sarah?" We actually dialogue. This doctor saved my life.

However, I cannot pay the doctor's fees. When December 2000 came about, my insurance bills started not only doubling, but also tripling in figures. I thought it was a mistake. I called Menninger's and they assured me it was correct. On October 3rd, 2000, I maxed out my yearly outpatient benefits. Now I am solely responsible for charges of over 200 dollars a visit - which is over 1000 dollars a month. My benefit year renews in March of 2001 where I will again have coverage to continue my doctor visits. I will then have approximately 10 weeks of psychiatry covered by Blue Cross. I will then again have to stop and wait to begin again in March of 2002.

I cannot afford to continue to work with my doctor. My psychiatrist and I decided to cut our visits down. I plan to visit him only once a month. He and I both agreed this was not the best solution, but yet the only solution. I was just beginning to make progress.

On another note, I also suffer from Rheumatoid Arthritis. I see my regular doctor almost as frequently as my psychiatrist. It doesn't matter how many times I need to see the doctor. After

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Attachment #2

meeting my 100 dollar deductible my insurance always takes care of this. I receive no bills. I receive a statement from my insurance company on what has already been paid. I pay almost nothing to treat this debilitating disease. I don't even have to worry about treating this disease. My insurance plan has a two million dollar physical illness lifetime benefit.

My depression is just as debilitating, but I cannot afford the treatment. I am worried that I may lose the ground that I have gained because without help from my insurance company, I can no longer address this disease. My insurance plan has a 7500 dollar lifetime benefit for mental health illnesses. I cannot afford to be well.

I ask you today for your help to make insurance coverage for mental health services equal to that of the coverage for physical illnesses. I also ask you on behalf of Keys for Networking, Inc., the state organization which represents families who have children with emotional and behavioral problems to provide Kansas parity for mental health. I want to introduce Kathy Byrnes from Olathe, Kansas. She has a similar story. We need your help.

Sarah Adams
Keys for Networking, Inc.
1301 SW Topeka Blvd.
Topeka, Kansas 66612
785-233-8732

January 16, 2001

My name is Kathy Byrnes. I have resided in Johnson County for the past 13 years. I currently live in Olathe. I am here today to speak about the significant difficulties I have faced in managing my son's mental illness, and helping him become a contributing member of our community, because of poor mental health benefits we have had through our health insurance providers over the years.

Psychiatric symptoms first became most pronounced with my son in first grade. We managed to "tread water" over the years, seeking evaluations and treatments, oftentimes having to pay out of pocket when insurance benefits were exhausted or forego a treatment because it just was unaffordable. My husband and I had to give up our dream of living in Overland Park, where the rest of my family resides, because our debts were too high to afford that lifestyle.

However, by ninth grade, even those efforts weren't enough. Things quickly deteriorated. My son started high school with a psychiatric hospitalization. By now, my husband and I were considering every option available to get financial help for our son. We both maintained full-time employment so we could transfer family health insurance benefits from one employer to another just to maintain some mental health benefit for Mike each calendar year. When even that plan wasn't enough, we borrowed money from family until that resource was exhausted. We incurred significant debts. At the worst point, we considered asking for Mike to be determined a CINC (child in need of care) just to get a payment source for his treatment. This would have meant losing him to state custody. It would have meant having SRS involved with my family, and making decisions I wouldn't necessarily agree with. It meant losing my license to practice social work in Kansas because I would have had a substantiated case against me such as medical neglect. That move alone would have added one entire family to the child welfare system in terms of expenses and removed from the community my ability to contribute. I would stop giving and instead need to start receiving. All to get help for my son.

We chose not to go that route. My husband and I are proud people. We don't want handouts when we are able-bodied and can contribute. So, we continued to incur more and more debt, trying to get enough help for our son, taking on additional employment whenever possible to put a dent in the bills.

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Just as we were facing bankruptcy, the State of Kansas started the SED waiver. My son was one of the first recipients of that waiver. I am happy to report that Mike and my family benefitted well from those services. Mike met his goals in nine months, and the costs for the entire treatment period were less than 2 weeks of hospitalization. The treatment he received was in large part not even considered a covered service by our private insurance companies, so we never would have gotten them otherwise except to pay out-of-pocket at a cost of at least $450 per month.

Mike is now finishing high school, is employed, and plans to attend college in the Fall. He is majoring in telecommunications. He is a contributing member of our community.

Mike does need to continue mental health treatment, as his problems will never completely "go away." There is no cure for significant mental illness. We continue to struggle with health insurance benefits being inadequate for mental health treatment. Much of the expense continues out-of-pocket. Fortunately, Mike's needs are less so we struggle but can pay for them. Unfortunately, we continue to hit cutbacks in getting him the help he needs. For example, one month after re-enrolling for our health insurance coverage, I was notified that our insurance won't pay for any prescriptions not written by our primary care provider. Our PCP doesn't feel comfortable managing his psychotropic medications, which is why we go to a psychiatrist. So, we are unsure how we will get this newest problem resolved. I worry, what will be next?

Kathy Byrnes
4405 Lane
Olathe, Kansas 66061
(913) 254-9153

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
House Committee on Insurance
by Amy A. Campbell
January 16, 2001

History
The Kansas Mental Health Coalition is an organization developed as a roundtable for consumers and providers of mental health services where all stakeholders are invited to come together to discuss and debate issues of concern. The Coalition meets to identify issues of common concern and develop priorities which all of the members can support. The members of the Coalition have identified specific areas of concern regarding the successful advancement of mental health reform priorities.

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, psychiatrists, 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. Last year, 200 individuals from across the state came to Topeka to join the Coalition, Keys for Networking, NAMI, and the Association of Community Mental Health Centers to advocate mental health legislation, including the Senate passed version of Sub SB 547.

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. This is one step toward reducing the stigma associated with mental illnesses. Removing stigma and discrimination will encourage appropriate and effective treatment for consumers who often seek inappropriate care.

Last year, the Senate passed Sub. for SB 547 which would have instituted test tracking in the State Benefits Plan for equal coverage of biologically based mental illnesses. The definition of mental illnesses in the bill was the same as the definition recognized by the Kansas State Employees Health Care Commission in HMO and PPO plans at the time, and would have extended coverage to the indemnity portions of the plan.

On August 9, 2000, the Kansas State Employees Health Care Commission adopted managed mental health parity in Blue Select and Blue Traditional plans. The Commission was not ordered to take this action, but proceeded on the basis of the past year's experience in the managed care portions of the plan. The motion to implement parity for all state employees passed unanimously. Members of the commission and the plan administrator interviewed health care professionals and reviewed state plan implementation from other states before choosing the coverage which now benefits approximately 90,000 covered lives.

House Bill 2033
House Bill 2033 is a directive to the Kansas State Employees Health Care Commission to provide additional

information to the Legislature regarding the plan experience for 2000. It is not, as written, a mental health parity bill. The Kansas Mental Health Coalition is thrilled to have the opportunity to come forward to talk about parity with this committee and to support each step toward increased parity, but would strongly suggest additional amendments to the legislation in order to act now on the mental health parity issue. Kansas has historically been an innovative state in the area of mental health treatment and has fallen behind when it comes to parity.

In 1999, the Kansas State Employees Health Care Commission began its first year of incorporating equal coverage for state employees in HMO and PPO plans. Statistics provided by the Commission indicated that the increased cost for what was provided in 1999 for biological based mental health parity benefits, compared to what was provided under the 1998 benefit schedule was approximately 73 cents per participating beneficiary per month. Additional data reported by Terry Bernatis, plan administrator, including an estimated total cost increase for the managed care plans of $106,076. There were 26,832 HMO participants and 1,459 PPO participants.

Although the benefits defined for mental health parity in the 2001 year are slightly different than those offered previously, the resulting costs should be very similar. Additionally, study after study has shown that for mental health care, the cost consequences of improved coverage as many states have currently implemented, are relatively minor, and in fact, can result in fewer dollars being spent overall.

First Dollar Coverage

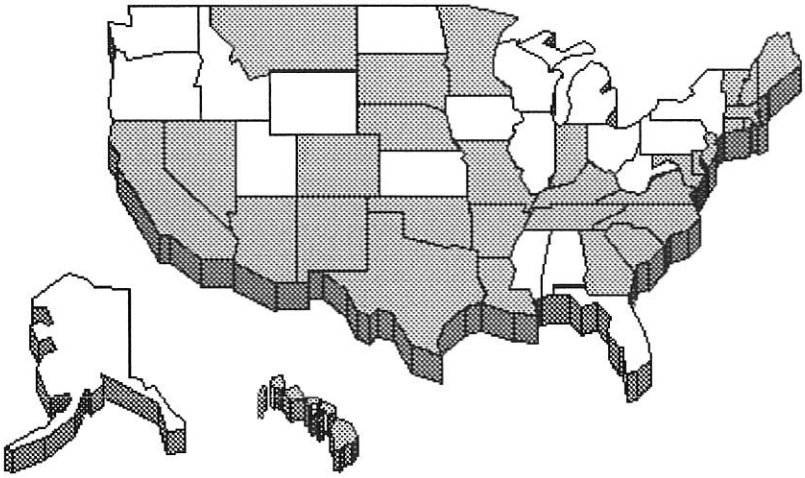
It has been suggested that equal coverage might cause insureds to lose "first dollar coverage" for outpatient mental health services. The provisions of current law at K.S.A. 40-2,105 sub. (a) stipulate that if a patient can be treated for alcoholism, drug addiction, or a mental disorder on an outpatient basis, the insurer is required to pay for the treatment according to a formula: 100% of the first $100, 80% of the next $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 discriminatory annual limitations.** The bill offers true parity for defined mental illnesses by replacing the "first dollar coverage" with coverage equal to physical disorders. Mental disorders and conditions not listed in the bill will remain subject to K.S.A. 40-2,105, which provides for the "first dollar coverage".

Cost

According to the Surgeon General, states and employers could logically experience cost savings over time. To date, 32 states have implemented some form of equal coverage, and their experiences show that 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.

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 take another step towards eliminating discrimination and instituting fairness in health insurance coverage.

STATES WITH MENTAL ILLNESS PARITY LAWS



32 states that have passed parity legislation

Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Hawaii, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, 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.

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The Cost Of Mental Illness Insurance Parity

The cost of paying for health insurance parity for mental illness has been one the most hotly debated issues at the national and state levels. Despite vehement opposition by special interests who have claimed that parity would break the back of business, multiple studies show minimal cost impact and that businesses are going ahead with plans to provide parity to their employees.

1. **Background Report: Effects of the Mental Health Parity Act 0f 1996** *(March 30, 1999)*

- Issued by the Substance Abuse and Mental Health Services Administration (SAMHSA), results of this national survey showed that 86 percent of employers who made changes in health plans to comply with the 1996 Federal law did not make any compensatory reductions in other benefits because the cost of compliance was minimal or nonexistent.

2. **Parity in Financing Mental Health Services: Managed Care Effects on Cost, Access & Quality** [i] *(July 15, 1998)*

- The second in a series of reports to Congress issued by the National Advisory Mental Health Council found that full parity costs less than one percent of annual healthcare costs. When implemented in conjunction with managed care, parity can reduce costs by 30 to 50 percent.

3. **Rand Corporation Study** [ii] *(November 12, 1997)*

- Equalizing annual limits (typically $25,000) - a key provision of the Mental Health Parity Act of 1996 - will increase costs by only about $1 per employee per year under managed care.
- An even more comprehensive change required by some state laws (i.e., removing limits on inpatient days and outpatient visits) will increase costs by less then $7 per enrollee per year.
- The main beneficiaries of parity will be families with children who, under current conditions, are more likely than adult users to exceed their annual benefit limits and go uninsured for the remainder of the year.

4. **Mercer Study** [iii] *(October 23, 1997)*

- 85 percent of American companies are either in compliance or plan to make changes to comply with the Mental Health Parity Act of 1996 by January 1, 1998.

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- Seven out of ten of those same employers agree that mental health parity is a reasonable national policy goal and that parity is important to their employees.

5. **National Advisory Mental Health Council's Interim Report on Parity Costs** [i] *(April 29, 1997)*

- The introduction of parity in combination with managed care results in, at worst, very modest cost increases. In fact, lowered costs and lower premiums were reported within the first year of parity.
- Maryland reported a 0.2 percent decrease after the implementation of full parity at the state level; Rhode Island reported a less than 1 percent (0.33 percent) increase of total plan costs under state parity; Texas experienced a 47.9 percent decrease in costs for state employees enrolled in its managed care plan under parity.

6. **Lewin Study** [iv] *(April 8, 1997)*

- In a survey of New Hampshire insurance providers, no cost increases were reported as a result of a state law requiring health insurance parity for severe mental illnesses.

7. **Congressional Budget Office** *(June 4, 1996)* - federal cost estimate projected a 0.4 percent increase in premiums and a 0.16 percent increase in employer contributions for parity in annual and lifetime limits.

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[i] NAMHC was requested by the Senate Appropriations Committee, in its report accompanying the 1997 appropriations bill (Sen. Report No. 104-368) to report on what is known about the costs of providing equitable coverage for people with mental illness-particularly those that are "severe and clearly identifiable, diagonsable, and treatable."

[ii] Conducted by the UCLA/RAND Center for Research on Managed Care for Psychiatric Disorders and funded by the National Institute of Mental Health for and the Healthcare Communities Project of the Robert Wood Johnson Foundation.

[iii] More than 300 businesses polled by William M. Mercer, Inc., one the nation's leading human resources consulting organizations, for the National Alliance for the Mentally Ill (NAMI).

[iv] Mercer surveyed for NAMI 11 of the 18 insurance carriers and health plans in New Hampshire representing the majority of covered lives in the state.

Suggested amendments to HB 2033

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

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

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

(e) 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 K.S.A. 40-2249a, and amendments thereto, shall not apply to this act.

New Sec. 4. This act shall take effect and be in force from and after its publication in the statute book.

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Association of Community Mental
Health Centers of Kansas, Inc.
700 SW Harrison, Suite 1420, Topeka, KS 66603-3755
Telephone (785) 234-4773 Fax (785) 234-3189
Web Site: www.acmhck.org

Association of Community Mental Health Centers of Kansas, Inc.
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House Committee on Insurance
Testimony on Equal Coverage Insurance
Paul Klotz, Executive Director
January 16, 2001

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.

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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.

At the National Council for State Legislatures session some years ago, 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 this 1998 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.

Testimony on House Bill 2033
Submitted by: Elizabeth Adams

You are elected Representatives of thousands of voters that I also represent as the Executive Director of NAMI Kansas, the Alliance on Mental Illness. On their behalf, may I tell you that House Bill 2033 is valuable to us. Thank you Chairman Tomlinson for moving forward with proof of the cost effectiveness of insuring treatment for disorders of the brain that manifest as mental illness.

Mental Health is critical to all Kansans.

Saving Kansans' jobs, homes, and even lives is a greater claim on Kansan leadership than the potential cost for mental health parity. However, data from the 32 other states and Kansas's own State health benefits plan show only an increase of insurance costs up to 1 or 1 ½ percent with managed care.

The U.S. Surgeon General David Satcher, Ph.D. has declared mental health fundamental to health, saying mental illness and mental health are two points on the same continuum for each of us. A Report from his two-year commission to study extensively America's mental health needs and systems, according to Dr. Satcher, has proven one in five Americans (Kansans) will need mental health treatment in any given year.

The burden of mental illness on health and productivity in the U.S. and throughout the world has long been profoundly underestimated, according to his findings. 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 U.S. It is second only to cardiovascular conditions. Did you know the recovery rate from heart disease is 45%? Treatment success rates from schizophrenia are at 60%; for major depression, 65% and bi-polar rates 80%.

The U.S. Federal government gave 9.5 million employees mental health parity on January 1, 2001. The trend is clear - Treatment works: if you can get it.

Discrimination is wrong. No Kansan should be denied the right to medical care for a treatable biological illness. Treatment for the kidneys, the heart, the lungs, would never be excluded from insurance coverage. The brain is a fallible physical organ, like the others, and must have medical attention when a disorder occurs. Neuroscience has exploded with effective research and treatment for the brain. Hope burgeons for people previously misunderstood, outcast, shamed and discriminated against due to mental illness. Don't let their hope die in your hands. The time is now to give equal insurance coverage to the thousands of Kansans who deserve it.

Thank you for your concern.

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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.

NAMI
KANSAS
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."**

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

NAMI KANSAS

THE ALLIANCE ON MENTAL ILLNESS

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Kansas' Voice on Mental Illness

Mental Health Parity

Contextual National Background – Currently, 33 states have mental health insurance parity. Parity was first successful in the early 90s with state employees in Texas, Maine, New Hampshire, Rhode Island and Maryland.

By 1996, The Mental Health Parity Act (Domenici/Wellstone) was passed and six additional states had enacted parity. In 1997, Arizona, Arkansas, Colorado, Connecticut, Indiana, Missouri, S. Carolina and Vermont added parity and expansion was made in Texas. In 1998, Delaware, Georgia, S. Dakota and Tennessee added parity. In 1999, California, Hawaii, Indiana, Louisiana, Montana, Nebraska, Nevada, New Jersey, Oklahoma, Utah, Virginia, Missouri (expansion from managed care only) and the territories of Guam and Puerto Rico joined the national trend. Last year Alabama, Massachusetts, Kentucky and New Mexico gained parity. National action shows that where parity began in a state employees' program or managed care scenario only, further legislation **always** expands it to the greater public.

January 1st, 2001, the Federal Employees Health Benefits Program, *the largest health insurance program in the nation,* implemented parity for **9.5 million** federal employees, retirees and their families.

Evaluating financial benefit—Parity legislation eliminates or reduces discriminatory provisions affecting persons with brain disorders. It shifts some financial responsibility for serious mental illness from the public safety net back to private plans. Parity allows individuals to access treatment. Treatment works. Employees may remain on the job, providing for the financial welfare of themselves and their families—productive taxpayers.

From a report to the U.S. Office of Personnel Management: Large Employer Experiences and Best Practices in Design…prepared by the Washington Business Group on Health (March 2000), to "assess how workplace benefits and programs can enhance employment health and production" these recommendations were made:

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- Employers could move to expand parity or near parity benefits, improve the quality of care and contain or reduce costs.
- Improved employee wellness that resulted from expanded health care coverage resulted in reduced disability costs, decreased absenteeism and improved productivity.
- Failure to identify and treat mental illness and addictions imposes great costs and emotional burdens on individuals and their families and results in lost productivity.
- Stigma remains a significant barrier to care for employees because many fear that their illness will become known to their employer or fellow employees.
- One employer reported at full parity, inpatient costs dropped by 46% and outpatient costs decreased by 21%, yet there was no increase in readmission rates. The average number of visits also decreased.

The **Milbank Report** sites studies from states that have parity laws, a federal SAMHSA study and the RAND study, evaluating 24 managed behavioral health care plans in states with parity. The studies showed minimal increases in cost. New, more sophisticated actuarial models of costs of parity show that, in general, as the overall proportion of the population in managed care increases, the projected cost of parity declines.

In summary, parity legislation has proven to be less costly than initially predicted by concerned insurance interests. The financial burden on both public and private insurance providers has not been excessive. Cost increases have not increased numbers of uninsured people. The utilization of MH services has been reduced over the past five years.

Investments Required—The Surgeon General has stated, " 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 to confront the attitudes, fear, and misunderstanding that remain as barriers before us.

"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 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," Dr. Satcher said.

Pertinent educational excerpts from *Mental Health: A Report of the Surgeon General,* published by the Department of Health and Human Services are included in the following to supplement the common understanding in Kansas of the need for mental health parity.

The Fundamentals of Mental Health and Mental Illness—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.

The brain has emerged as the central focus for studies of mental health and mental illness. New scientific disciplines, technologies, and insights have begun to weave a seamless picture of the way in which the brain mediates the influence of biological, psychological, and social factors on human thought, behavior, and emotion in health and in illness. Molecular and cellular biology and molecular genetics, which are complemented by sophisticated cognitive and behavioral science, are preeminent research disciplines in the contemporary neuroscience of mental health. These disciplines are affording unprecedented opportunities for "bottom-up" studies of the brain. This term refers to research that is examining the workings of the brain at the most fundamental levels. Studies focus, for example, on the complex neurochemical activity that occurs within individual nerve cells, or neurons, to process information; on the properties and roles of proteins that are expressed, or produced, by a person's genes; and on the interaction of genes with diverse environmental influences. All of these activities now are understood, with increasing clarity, to underlie learning, memory, the experience of emotion, and, when these processed go awry, the occurrence of mental illness or a mental health problem.

Equally important to the mental health field is "top-down" research; here, as the term suggests, the aim is to understand the broader behavioral context of the brain's cellular and molecular activity and to learn how individual neurons work together in well-delineated neural circuits to perform mental functions.

Effective Treatments—As information accumulates about the basic workings of the brain, it is the task of translational research to transfer new knowledge into clinically relevant questions and targets of research opportunity- to deliver, for example, what specific properties of a neural circuit might make it receptive to safer, more effective medications. To elaborate on this example, theories derived from knowledge about basic brain mechanisms are being wedded more closely to brain imaging tools such as functional Magnetic Resonance Imaging (MRI) that can observe actual brain activity. Such a collaboration would permit investigators to monitor the specific protein molecules intended as the "targets" of a new medication to treat a mental illness or, indeed, to determine how to optimize the effect on the brain of the learning achieved through psychotherapy.

In its entirety, the new "integrative neuroscience" of mental health offers a way to circumvent the antiquated split between the mind and the body that historically has

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hampered mental health research. It also makes it possible to examine scientifically many of the important psychological and behavioral theories regarding normal development and mental illness that have been developed in years past. The unswerving goal of mental health research is to develop and refine clinical treatments as well as preventive interventions that are based on an understanding of specific mechanisms that can contribute to or lead to illness but also can protect and enhance mental health.

Organization of Mental Health Care— Another of the defining trends has been the transformation of the mental illness treatment and mental health services landscapes, including increased reliance on primary health care and other human service providers. Today, the U.S. mental health system is multifaceted and complex, comprising the public and private sectors, general health and specialty mental health providers, and social services, housing, criminal justice, and educational agencies. These agencies do not always function in a coordinated manner. The configuration of the system reflects necessary responses to a broad array of factors including reform movements, financial incentives based on who pays for what kind of services, and advances in care and treatment technology. Although the hybrid system that exists today serves diverse functions well for many people, individuals with the most complex needs and the fewest financial resources often find the system fragmented and difficult to use. A challenge for the Nation in the near-term future is to speed the transfer of new evidence-based treatments and prevention interventions into diverse service delivery settings and systems, while ensuring greater coordination among these settings and systems.

A Mental Health Primer— seemed necessary for persons outside the mental health field to better understand the discussions in this report. The information follows:

- The multifaceted complexity of the brain is fully consistent with the fact that it supports all behavior and mental life. Proceeding from an acknowledgment that all psychological experiences are recorded ultimately in the brain and that all psychological phenomena reflect biological processes, and modern neuroscience of mental health offers an enriched understanding of the inseparability of human experience, brain and mind.
- Mental functions, which are disturbed in mental disorders, are mediated by the brain. In the process of transforming human experience into physical events, the brain undergoes changes in its cellular structure and function.
- Diagnoses of mental disorders made using specific criteria are as reliable as those of general medical disorders.
- A range of treatments of well-documented efficacy exits for most mental disorders. Two broad types of intervention include psychosocial treatments - for example, psychotherapy or counseling - and psychopharmacologic treatments; these often are most effective when combined.
- About 10 percent of the U.S. adult population use mental health services in the health sector in any year, with another 5 percent seeking such services from social service agencies, schools, or religious or self-help groups.

Yet critical gaps exist between those who need service and those who receive service.

- Gaps also exist between optimally effective treatment and what many individuals receive in actual practice settings.
- Mental illness and less severe mental health problems must be understood in a social and cultural context, and mental health services must be designed and delivered in a manner that is sensitive to the perspectives and needs of racial and ethnic minorities.
- The notion of recovery reflects renewed optimism about the outcomes of mental illness, including that achieved through an individual's own self-care effects, and the opportunities open to persons with mental illness to participate to the full extent of their interests in the community of their choice
- The consumer movement has increased the involvement of individuals with mental disorders and their families in mutual support services, consumer-run services, and advocacy. They are powerful agents for changes in service programs and policy.

Consumer and Family Movement— The emergence of vital consumer and family movements promises to shape the direction and complexion of mental health programs for many years to come. Although divergent in their historical origins and philosophy, organizations representing consumers and family members have promoted important, often overlapping, goals and have invigorated the fields of research as well as treatment and service delivery design. Among the principal goals shared by much of the consumer movement are to overcome stigma and prevent discrimination in policies affecting persons with mental illness; to encourage self-help and a focus on recovery from mental illness; and to draw attention to the special needs associated with a particular disorder or disability as well as with age or gender or by the racial and cultural identity of those who have mental illness.

Mental Health and Mental Illness Across the Lifespan—
The Surgeon General's report takes a lifespan approach to its consideration of mental health and mental illness. Three chapters that address, respectively, the periods of childhood and adolescence, adulthood, and later adult life beginning somewhere between ages 55 and 65, capture the contributions of research to the breadth, depth, and vibrancy that characterize all facets of the contemporary mental health field.

The disorders featured in depth in Chapters 3, 4, and 5 were selected on the basis of the frequency with which they occur in our society, and the clinical, societal, and economic burden associated with each. To the extent that data permit, the report takes note of how gender and culture, in addition to age, influence the diagnosis, course, and treatment of mental illness. The chapters also note the changing role of consumers and families, with attention to informal support services (i.e., unpaid services), with which many consumers are comfortable and upon which they depend for information. Persons with mental illness and, often, their families welcome a proliferating array of support services - such as self-help programs, family self-help, crisis services, and advocacy -that help them cope with the isolation, family disruption, and possible loss of employment and housing that

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may accompany mental disorders. Support services can help to dissipate stigma and to guide patients into formal care as well.

Mental health and mental illness are dynamic, ever-changing phenomena. At any given moment, a person's mental status reflects the sum total of that individual's genetic inheritance and life experiences. The brain interacts with and responds - both in its function and in its very structure - to multiple influences continuously, across every stage of life. At different stages, variability in expression of mental health and mental illness can be very subtle or very pronounced. As an example, the symptoms of separation anxiety are normal in early childhood but are signs of distress in later childhood and beyond. It is all too common for people to appreciate the impact of developmental processes in children, yet not to extend that conceptual understanding to older people. In fact, people continue to develop and change throughout life. Different stages of life are associated with vulnerability to distinct forms of mental and behavioral disorders but also with distinctive capacities for mental health.

Even more than is true for adults, children must be seen in the context of their social environments - that is, family and peer group, as well as that of their larger physical and cultural surroundings. Childhood mental health is expressed in this context, as children proceed along the arc of development. A great deal of contemporary research focuses on developmental processes, with the aim of understanding and predicting the forces that will keep children and adolescents mentally healthy and maintain them on course to become mentally healthy adults. Research also focuses on identifying what factors place some at risk for mental illness and, yet again, what protects some children but not others despite exposure to the *same* risk factors. In addition to studies of normal development and of risk factors, much research focuses on mental disorders in childhood and adolescence and what can be done to prevent or treat these conditions and on the design and operation of service settings best suited to the needs of children.

For about one in five Americans, adulthood - a time for achieving productive vocations and for sustaining close relationships at home and in the community - is interrupted by mental illness. Understanding why and how mental disorders occur in adulthood, often with no apparent portents of illness in earlier years, draws heavily on the full panoply of research conducted under the aegis of the mental health field. In years past, the onset, or occurrence, of mental illness in the adult years was attributed principally to observable phenomena--for example, the burden of stresses associated with career or family, or the inheritance of a disease viewed to run in a particular family. Such explanations now may appear naive at best. Contemporary studies of the brain and behavior are racing to fill in the picture by elucidating specific neurobiological and genetic mechanisms that are the platform upon which a person's life experiences can either strengthen mental health or lead to mental illness. It now is recognized that factors that influence brain development prenatally may set the stage for a vulnerability to illness that may lie dormant throughout childhood and adolescence.
Schizophrenia, mood disorders such as major depression and bipolar illness, and anxiety often are devastating conditions. Yet relatively few mental illnesses have an unremitting course marked by the most acute manifestations of illness; rather, for reasons that are not

yet understood, the symptoms associated with mental illness tend to wax and wane. These patterns pose special challenges to the implementation of treatment plans and the design of service systems that are optimally responsive to an individual's needs during every phase of illness. As this report concludes, enormous strides are being made in diagnosis, treatment, and service delivery, placing the productive and creative possibilities of adulthood within the reach of person who are encumbered by mental disorders.

The promise of research on mental health promotion notwithstanding, a substantial minority of older people are disabled, often severely, by mental disorders including Alzheimer's disease, major depression, substance abuse, anxiety, and other conditions. In the United States today, the highest rate of suicide - an all-too-common consequence of unrecognized or inappropriately treated depression - is found in older males. This fact underscores the urgency of ensuring that health care provider training properly emphasizes skills required to differentiate accurately the causes of cognitive, emotional, and behavioral symptoms that may, in some instances, rise to the level of mental disorders, and in other instances be expressions of unmet general medical needs.

As the life expectancy of Americans continues to extend, the sheer number - although not necessarily the proportion - of persons experiencing mental disorders of late life will expand, confronting our society with unprecedented challenges in organizing, financing, and delivering effective mental health services for this population. An essential part of the needed societal response will include recognizing and devising innovative ways of supporting the increasingly more prominent role that families are assuming in caring for older, mentally impaired and mentally ill family members.

Children and Mental Health—

- Childhood is characterized by periods of transition and reorganization, making it critical to assess the mental health of children and adolescents in the context of familial, social, and cultural expectations and about age-appropriate thoughts, emotions, and behavior.
- The range of what is considered "normal" is wide; still, children and adolescents can and do develop mental disorders that are more severe than the "ups and downs" in the usual course of development.
- Approximately one in five children and adolescents experiences the signs and symptoms of a DSM-IV disorder during the course of a year, but only about 5 percent of all children experience what professionals term "extreme functional impairment."
- Mental disorders and mental health problems appear in families of all social classes and of all backgrounds. No one is immune. Yet there are children who are at greatest risk by virtue of a broad array of factors. These include physical problems; intellectual disabilities (retardation); low birth weight; family history of mental and addictive disorders; multigenerational poverty; and caregiver separation or abuse and neglect.
- Preventive interventions have been shown to be effective in reducing the impact of risk factors for mental disorders and improving social and

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emotional development by providing, for example, educational programs for young children, parent-education programs, and nurse home visits.

- A range of efficacious psychosocial and pharmacological treatments exists for many mental disorders in children, including attention-deficit/hyperactivity disorder, depression, and the disruptive disorders.
- Research is under way to demonstrate the effectiveness of most treatments for children in actual practice settings (as opposed to evidence of "efficacy" in controlled research settings), and significant barriers exist to receipt of treatment.
- Primary care and the schools are major settings for the potential recognition of mental disorders in children and adolescents, yet trained staff are limited, as are options for referral to specialty care.
- The multiple problems associated with "serious emotional disturbance" in children and adolescents are best addressed with a "systems" approach in which multiple service sectors work in an organized, collaborative way. Research on the effectiveness of systems of care shows positive results for system outcomes and functional outcomes for children; however, the relationship between changes at the system level and clinical outcomes is still unclear.
- Families have become essential partners in the delivery of mental health services for children and adolescents.
- Cultural differences exacerbate the general problems of access to appropriate mental health services. Culturally appropriate services have been designed but are not widely available.

Adults and Mental Health—

- As individuals move into adulthood, developmental goals focus on productivity and intimacy including pursuit of education, work, leisure, creativity, and personal relationships. Good mental health enables individuals to cope with adversity while pursuing these goals.
- Untreated, mental disorders can lead to lost productivity, unsuccessful relationships, and significant distress and dysfunction. Mental illness in adults can have a significant and continuing effect on children in their care.
- Stressful life events or the manifestation of mental illness can disrupt the balance adults seek in life and result in distress and dysfunction. Severe or life-threatening trauma experienced either in childhood or adulthood can further provoke emotional and behavioral reactions that jeopardize mental health.
- Research has improved our understanding of mental disorders in the adult stage of the life cycle. Anxiety, depression, and schizophrenia, particularly, present special problems in this age group. Anxiety and depression contribute to the high rates of suicide in this population. Schizophrenia is the most persistently disabling condition, especially for young adults, in spite of recovery of function by some individuals in mid to late life.
- Research has contributed to our ability to recognize, diagnose, and treat each of these conditions effectively in terms of symptom control and behavior

management. Medication and other therapies can be independent, combined, or sequenced depending on the individual's diagnosis and personal preference.

- A new recovery perspective is supported by evidence on rehabilitation and treatment as well as by the personal experiences of consumers.
- Certain common events of midlife (e.g., divorce or other stressful life events) create mental health problems (not necessarily disorders) that may be addressed through a range of interventions.
- Care and treatment in the real world of practice do not conform to what research determine is best. For many reasons, at times care is inadequate, but there are models for improving treatment.
- Sensitivity to culture, race, gender, disability, poverty, and the need for consumer involvement are important considerations for care and treatment.
- Barriers of access exist in the organization and financing of services for adults. There are specific problems with Medicare, Medicaid, income supports, housing, and managed care.

Older Adults and Mental Health

- Important life tasks remain for individuals as they age. Older individuals continue to learn and contribute to the society, in spite of physiologic changes due to aging and increasing health problems.
- Continued intellectual, social, and physical activity throughout the life cycle are important for the maintenance of mental health in late life.
- Stressful life events, such as declining health and/or the loss of mates, family members, or friends often increase with age. However, persistent bereavement or serious depression is not "normal" and should be treated.
- Normal aging is not characterized by mental or cognitive disorders. Mental or substance use disorders that present alone or co-occur should be recognized and treated as illnesses.
- Disability due to mental illness in individuals over 65 years old will become a major public health problem in the near future because of demographic changes. In particular, dementia, depression, and schizophrenia, among other conditions, will all present special problems in this age group:
    - Dementia produces significant dependency and is a leading contributor to the need for costly long-term care in the last years of life;
    - Depression contributes to the high rates of suicide among males in this population; and
    - Schizophrenia continues to be disabling in spite of recovery of function by some individuals in mid to late life.
- There are effective interventions for most mental disorders experienced by older persons (for example, depression and anxiety), and many mental health problems, such as bereavement.
- Treating older adults with mental disorders accrues other benefits to overall health by improving the interest and ability of individuals to care for themselves and follow their primary care provider's directions and advice, particularly about taking medications.

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- Primary care practitioners are a critical link in identifying and addressing mental disorders in older adults. Opportunities are missed to improve mental health and general medical outcomes when mental illness is under recognized and under treated in primary care settings.
- Barriers to access exist in the organization and financing of services for aging citizens. There are specific problems with Medicare, Medicaid, nursing homes, and managed care.

Capabilities Outpacing Capacities of Mental Health Services—
In the United States in the late 20th century, research-based capabilities to identify, treat, and, in some instances, prevent mental disorders are outpacing the capacities of the existing service system to deliver mental health care to all who would benefit from it. Approximately 10 percent of children and adults receive mental health services from specialists or general medical providers in a given year. Approximately one in six adults, and one in five children, obtain mental health services either from health care providers, the clergy, social service agencies, or schools in a given year.

An overview of the current system of mental health services, describing where people get care and how they use services is helpful in understanding trends in spending and costs of care. Only within recent decades, in the face of concerns about discriminatory policies in mental health financing, have the dynamics of insurance financing become a significant issue in the mental health field. In particular, policies that have emphasized cost containment have ushered in managed care. Intensive research currently is addressing both positive and adverse effects of managed care on access and quality, generating information that will guard against untoward consequences of aggressive cost-containment polices.

Inequities in insurance coverage for mental health and general medical care - the product of decades of stigma and discrimination - have prompted efforts to correct them through legislation designed to produce financing changes and create parity.

- Historically, financial barriers to mental health services have been attributable to a variety of economic forces and concerns (e.g., market failure, adverse selection, moral hazard and public provision). This has accounted for differential resource allocation rules for financing mental health services.
  - "Parity" legislation has been a partial solution on this set of problems.
  - Implementing parity has resulted in negligible cost increases where the care has been managed.
- In recent years, managed care has begun to introduce dramatic changes into the organization and financing of health and mental health services.
- There is little direct evidence of problems with quality in well-implemented managed care programs. The risk for more impaired populations and children remains a serious concern.
- There is increasing concern about consumer satisfaction and consumers' rights

A Vision for the Future: Actions for Mental Health in the New Millennium—

- ***Overcome Stigma***: Powerful and pervasive, stigma prevents people from acknowledging their own mental health problems, much less disclosing them to others. For our Nation to reduce the burden of mental illness, to improve access to care, and to achieve urgently needs knowledge about the brain, mind, and behavior, stigma must no longer be tolerated. Research on brain and behavior that continues to generate ever more effective treatments for mental illnesses is a potent antidote to stigma. The issuance of this Surgeon General's Report on Mental Health seeks to help reduce stigma by dispelling myths about mental illness, by providing accurate knowledge to ensure more informed consumers, and by encouraging help seeking by individuals experiencing mental health problems.
- ***Improve Public Awareness of Effective Treatment***: Americans are often unaware of the choices they have for effective mental health treatments. In fact, there exists a constellation of several treatments of documented efficacy for most mental disorders. Treatments fall mainly under several broad categories - counseling, psychotherapy, medication therapy, rehabilitation - yet within each category are many more choices. All human services professionals, not just health professionals, have an obligation to be better informed about mental health treatment resources in their communities and should encourage individuals to seek help from any source in which they have confidence.
- ***Ensure the Supply of Mental Health Services and Providers***: The fundamental components of effective service delivery, which include integrated community-based services, continuity of providers and treatments, family support services (including psychoeducation), and culturally sensitive services, are broadly agreed upon, yet certain of these and other mental health services are in consistently short supply, both regionally and, in some instances, nationally. Because the service system as a whole, as opposed to treatment services considered in isolation, dictates the outcome of recovery-oriented mental health care, it is imperative to expand the supply of effective, evidence-based services throughout the Nation. Key personnel shortages include mental health professionals serving children/adolescents and older people with serious mental disorders and specialists with expertise in cognitive-behavioral therapy and interpersonal therapy, two forms of psychotherapy that research has shown to be effective for severe mental disorders. For adults and children with less severs conditions, primary health care, the schools, and other human services must be prepared to assess and, at times, to treat individuals who come seeking help.
- ***Ensure Delivery of State-of-the-Art Treatment***: A wide variety of effective, community-based services, carefully refined through years of research, exist for even the most severe mental illnesses, yet are not being translated into community settings. Numerous explanations for the gap between what is known from research and what is practiced beg for innovative strategies to bridge it.
- ***Tailor Treatment to Age, Gender, Race, and Culture***: Mental illness, no less than mental health, is influenced by age, gender, race, and culture as well as additional facets of diversity that can be found within all of these population groups - for example, physical disability or a person' s sexual orientation. To be effective, the diagnosis and treatment of mental illness must be tailored to all characteristics that shape a person's image and identity. The consequences of not understanding these influences can be profoundly deleterious.

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- ***Reduce Financial Barriers to Treatment***: Concerns about the cost of care – concerns made worse by the disparity in insurance coverage for mental disorders in contrast to other illnesses – are among the foremost reasons why people do not seek needed mental health care. While both access to and use of mental health services increase when benefits for those services are enhanced, preliminary data show that the effectiveness – and, thus the value – of mental health care also has increased in recent years, while expenditures for services, under managed care, have fallen. Equality between mental health coverage and other health coverage – **a concept known as parity** – is an affordable and effective objective.

Mental Health: A Report of the Surgeon General
Department of Health and Human Services/U.S. Public Health Service

Thank you Mr. Thomlinson for giving me the opportunity to speak today for bill # 2033.

This topic is such an important issue to be brought to the attention of you, our lawmakers in Kansas, as well as the good people of our state who are concerned for mental health issues.

I truly hope we will continue to focus our attention on the issues of mental health and particularly issues related to mental health parity.

The reason I feel so passionately on this topic is because of my own personal experience with lack of funds and services available for the two out of four of my children unfortunate enough to be diagnosed with mental illness in the past few years.

In January of 1994, after repeated suicide attempts, my daughter was hospitalized by her doctor to Prairie View. In spite of the fact

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that the attending psychiatrist believed my daughter to be a good candidate for long term care, she was released after 30 days. Our insurance coverage was maxed out. My 12-year-old daughter was released. She continued to be suicidal throughout her teen years. Only after her molester was court ordered to pay my daughter's mental health bills in 1996 were we able to get for her the kind of psychiatric care she badly needed. Clinical depression such as my daughter was diagnosed with is a biological brain disorder. In the same way that diabetes or heart disease is a biological disorder.

My beautiful, talented, and gifted daughter deserves the kind of medical care and attention given to any other biological disease.

I truly thought that having a daughter diagnosed with clinical depression at 12 years old was the

worst possible thing that could happen to me as a mother.

Two years after my daughter was diagnosed with mental illness, my son was diagnosed — in July of 1996 of paranoid schizophrenia.

As devastating as this diagnosis was, it was a relief to finally have a name for the very strange behaviour we had observed for 2 years.

He was only 22 years old when finally diagnosed — in Arkansas.

My son lived with us for a four month period in 1995 during which he beat his sister, tried to ingest rat poisoning, and spent endless hours staring at his face in a mirror.

During my son's four month stay, we tried desparately to get help for him through the courts, the mental health center, and the local hospital. Basically we were told at the local hospital that there appeared to be "Schizophrenic" symptoms

displayed by my son, but there was nothing they could do, because my son had no income, and no insurance for hospitalization.

It took my son becoming more and more violent for him to finally get the treatment he needed. A judge ordered him to the Arkansas State Hospital for crimes committed.

Sirs, I beg you to take the issues of mental health parity seriously.

My son, if he is released, with no medication will quickly become a danger to society. He is only one sufferer of mental illness. The burden to society of leaving these illnesses untreated is an atrocity. These devastating illnesses being left untreated create sometimes insurmountable problems in our family members as well as on society. For the sake of our loved ones, and for the sake of the innocent victims who are sometimes hurt by the actions of those who suffer mental

illness, please let's make some positive changes in the discriminatory practice which keeps sufferers of brain disorders from getting treatment in exactly the same fashion as those who suffer diabetes & heart disease.
Thank you. -

Audrey Auernheimer
Salina, KS

BARBARA BOHM'S TESTIMONY ON HB 2033

I am bipolar and, therefore, by current definitions, one of the severe and persistently mentally ill. If I am ever in the position to have private insurance in Kansas again, I would personally be affected by this bill.

This is a bill to help NEWLY diagnosed individuals with biologically based illness and the children of Kansas who are currently carried on their parent's private insurance policies. After the individual's illness has reached such a stage due to lack of insurance coverage of treatment, the individual usually loses their job, ALL insurance coverage, and all too soon winds up on the public dole. At this point, they are sick, discouraged, unemployed, bankrupt, with their careers in ruins.

So it is not really case of this bill causing NEW costs to the working taxpayer. By the very definition of disabled, those of us with biologically based mental illness who qualify for disability ARE NOT WORKING. So who currently are paying part, and in most cases, essentially ALL of these medical bills? Every single taxpayer in Kansas through supporting medicaid and medicare via their taxes.

This is merely a matter of sifting costs to those who can most afford it. An individual might well think they have responsibly paid for good insurance coverage to help keep their personal medical bills off the public dole. In BIG print the policy might read $1 Million Dollar catastrophic medical coverage for things like a bad heart. In smaller print, it will say it offers mental illness coverage as well. In itsey-bitsey print at the bottom of the page in a footnote, it will then say $10,000 LIFETIME coverage for mental illness costs.

My FIRST hospital stay when I was originally diagnosed lasted 4 months, because they did not know what medicines worked for me. It is common for it to take 10 YEARS, with multiple hospital stays, before a bipolar individual is stabilized enough to break out of the hospitalization cycle. It certainly took 10 years in my case.

So this bill is not really a matter of generating NEW costs for the taxpayers of Kansas. They are not heartless. They are ALREADY bearing these costs, as the unemployed disabled cannot. It is simply a matter of shifting costs out of SRS's pocketbook to the private sector, where the costs can most affordably be borne.

BARBARA BOHM
P.O. BOX 373
AMERICUS, KS 66835
316-443-5758

Barbara Bohm

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1/13/01
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To: Members of Kansas House of Representatives Insurance Committee
Rep. Robert Tomlinson, Chairman

From: Mary Jo Bergkamp

Re: Role of insurance in treatment of daughter's bi-polar illness.

Ladies and Gentlemen:

Ten years ago our daughter received the diagnosis of bi-polar disorder, formerly known as manic-depressive illness. She was a freshman in college when this beastly depressive illness reared its ugly head. Fortunately, Ellen was covered by our family's insurance policy because she was a student under the age of 23.

Although not perfect, our limited coverage of one-month inpatient per year did allow her two weeks at Stormont Vail hospital at the time of her first manic-psychotic episode. Her doctor recommended longer term care; and we were fortunate that Prairie View hospital in Newton, Kansas accepted her remaining two weeks of coverage and wrote off much of the three additional weeks needed for medication adjustment and therapy.

As grateful as I am, I shudder to think what would have happened if we had not had at least the one month of coverage and a hospital's willingness to work with our means. Just as a heart or cancer patient can incur astronomical costs, so can a patient with a disease like our daughter's. With limited coverage and no recourse, we may have lost Ellen before she stabilized enough to fight for her life.

During the past ten years, Ellen has had at least 15 hospitalizations. 80% of people with depressive disorders have efficacious results with medical treatment as opposed to 60% of heart and 40% of cancer patients. Our daughter falls into the 20% of the mentally ill who are bi-polar. She is also a rapid-cycler, which means she has four or more episodes a year. Actually, Ellen is an ultra rapid-cycler who at times cycled up and down four times in a half hour. It is hard to imagine the insanity we would feel if our moods soared and sank to this extreme. Six to 11% of bi-polar individuals are rapid cyclers and are the most difficult to treat successfully. Ellen also requires four medications daily and on-going weekly therapy at this time.

Currently our policy allows 20 outpatient visits per year. However, even a 15 minute medication check counts as a full visit. One can easily see this is not adequate coverage for our daughter, but she now has secondary coverage from Medicare and Medicaid. Without parity for mental health many individuals will not receive the help that would be offered for other illnesses that require therapy.

Today at the age of 29, Ellen has enjoyed an apartment of her own for four years. She has worked for Stormont Vail hospital as a transporter for over 2 years. With cognitive therapy and now state-of-the-art neurocognitive therapy, she has regained her ability to

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concentrate. Whether or not she returns to honors courses at KU, she can now enjoy magazines, newspapers and even an occasional novel.

Today we know that with proper treatment and support, even those with the most severe and persistent forms of mental illness can lead happy, healthy and productive lives.

On behalf of my entire family including my husband Bob and Ellen's sister Catie and brother Mike - a big thank you to all of you for your efforts that have helped us in the past and will continue in the future.

Good afternoon. My name is Anne Christman. I am 30 years old. A native of Mobile, Alabama, I came to Topeka in 1988 for psychiatric hospitalization at the Menninger Clinic where I remained as an inpatient for approximately 2 years. I have worked for the past 10 years in Topeka in the private sector and have also attended Washburn University on a part-time basis, financing my education on academic scholarships, in pursuit of a degree in Business Management. I have been on the Dean's List several times and maintain a GPA of 3.8.

Since leaving the Menninger Foundation I have been followed by a resident psychiatrist at the Shawnee Community Mental Health for medications that treat my condition, which is BiPolar Illness. I am currently on three different medications, medications that I have been on for the last 12 years. Although I have not been hospitalized since, I have been told that I am uninsurable in the private market because of my history and because of the medication that I need in order to manage my condition. I am currently an Office Manager for the Kansas Association for the Medically Underserved. I have been denied any health care coverage by Blue Cross/Blue Shield of Kansas and by Prudential. Both insurance companies cited the medications that I was on as their justification for denying coverage. KAMU, like many small private companies cannot offer an affordable group health plan, yet they do reimburse the premium for a private health plan.

Because I cannot obtain insurance at my current place of employment, it has been suggested to me that I search for employment within the public sector or with a large private company so that I can qualify for a group health plan. I believe that this discriminates against persons like myself because I clearly do not have the same number or quality of choices that other people without my condition or circumstances have, even though I have been a productive member of society for the past 10 years. I either have to make career decisions based on an illness that I have so that I can get adequate and fair health care; or choose to seek employment with a company for which my skills or talents are not adequately utilized.

Both insurance companies told me that I was considered a "high risk" and *because* I was high risk, and that the Kansas High Risk Pool had been created, they would not going to cover me. A premium for someone with my history, single, 30 years old and a non-smoker, would be roughly $350.00 a month with a deductible of $500.00 and medications would be covered only 50%. (My medications are roughly $400.00 a month).

In the case of my condition, BiPolar Illness, insurance companies are allowed to set up arbitrary conditions, which exclude responsible people like myself and instead place them in the role of victim. . BiPolar illness is a chronic disease, just as Diabetes, Hypertension, Coronary Artery Disease and Congestive Heart Failure, Asthma and any other number of diseases. In each of these instances, staying under strict medical supervision, making lifestyle adjustments and continuing to follow a supervised health treatment plan including medication is generally necessary. Those individuals may have difficulty finding health insurance, but once they do get it, it is complete and comprehensive. Whereas, as in the case of my illness, I am not only discriminated against in getting health insurance, but also in getting adequate coverage for my condition. Yet, I am *not* at risk. Medication and medical support has allowed for my personal success. However, by allowing insurance companies to discriminate against me, you are placing me at risk. This is unacceptable, this is discrimination. Why is it that because my illness is classified as mental, I do not have the same choices as other people with chronic illness do? Is that not the definition of **discrimination**?

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BRAD SMOOT

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STATEMENT of BRAD SMOOT
LEGISLATIVE COUNSEL
BLUE CROSS BLUE SHIELD OF KANSAS
and
BLUE CROSS BLUE SHIELD OF KANSAS CITY

THE HOUSE INSURANCE COMMITTEE
2001 HOUSE BILL 2033

JANUARY 16, 2001

Mr. Chairman and Members,

Blue Cross Blue Shield of Kansas is a non profit Topeka-based health insurer serving 103 Kansas counties and Blue Cross Blue Shield of Kansas City, also a non profit insurer, serves Johnson and Wyandotte Counties. Together, they provide insurance coverage for 1 million of your fellow Kansans. We support 2001 House Bill 2033, requiring the state health care benefits program to report on the costs of mental health coverage to the 2002 Kansas Legislature so that it may evaluate proposals to impose a mental health parity mandate on the private sector.

After consideration of dozens of health insurance mandate proposals, numerous committee hearings and interim recommendations, the 1999 Kansas Legislature enacted Senate Bill 3 including the "test track" procedure to be utilized here in H 2033. In an era of rapidly rising health care costs and health insurance premiums, it seemed wise to the Legislature and the public that government impose any new health insurance burdens on itself first and evaluate those burdens before imposing them on individuals, families and employers in the private sector. The "test track" bill passed the legislature with strong bi-partisan support in both houses.

Last year the Senate passed S 547, imposing a mental health parity pilot project on the state health benefits plan and requiring a report to the 2002 Kansas Legislature of the state's experience with the expanded coverage. House Bill 2033 would impose a similar obligation and, with a technical amendment (identifying a report date), could enable the Legislature to consider a mental health mandate for the private sector next year, just as if it had passed the Senate bill last session. This is because the state employees health care commission voluntarily expanded its benefits to include parity coverage for those biologically-based mental illnesses identified in H 2033. The state will have the experience and the data required by the "test track" legislation to give lawmakers a realistic view of the benefits and burdens to be imposed on working men and women of Kansas.

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Testimony of Brad Smoot
2001 House Bill 2033

Frankly, we at BCBS view insurance mandates as primarily an issue for our customers since mandate costs are generally passed on as premium increases. However, since our customers from the largest Kansas employers to the individual insureds are deeply concerned with the cost of health insurance, we would like to clarify a few points of interest about the current state of mental health coverage for your deliberations. (A benefits chart has been distributed to help illustrate and compare coverages under mental health and major medical policies.)

First, Kansas already mandates mental health coverage. Known as "first dollar" coverage, this mandate was adopted in the 1970's to encourage persons to seek early treatment for mental disorders. If the Legislature decides to impose a "parity" mandate on the private sector, it will need to decide whether to retain the "first dollar" mandate (thus creating greater insurance benefits for mental illnesses than other medical conditions -- a sort of "super parity") or whether to eliminate it (true "parity").

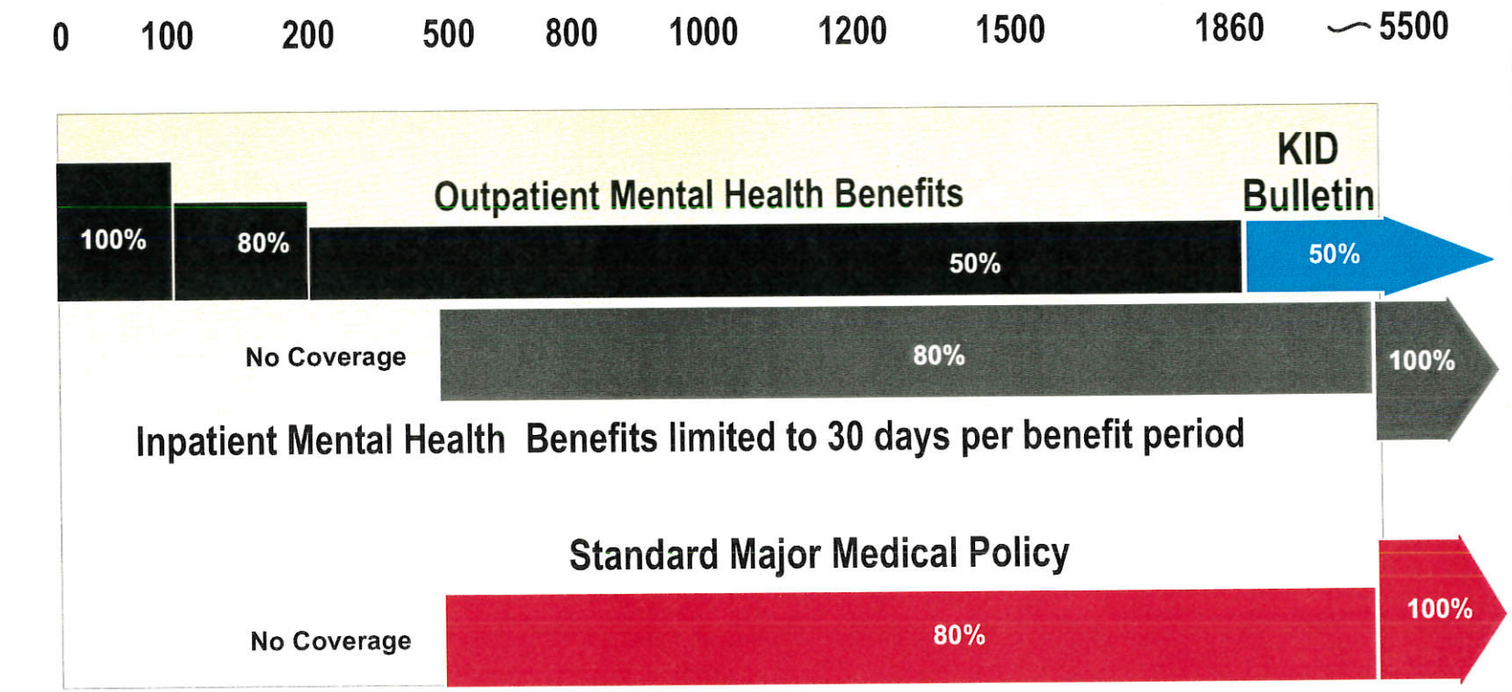
Second, biologically-based mental illnesses of the type listed in H 2033 and now covered by the state employees health plan, are increasingly treated with modern pharmacology. Typically, insurers do not distinguish between drugs for treatment of mental illness and other medical conditions. BCBS of Kansas, for example, spent 13.25% of its prescription drug expenditures on drugs for the treatment of mental illnesses. In other words, for the most common treatment of biologically-based mental illnesses, namely psychotherapeutic drugs, "parity" already exists and consumes a substantial portion of prescription drug expenditures by Kansas insurers.

Third, some have suggested that private sector insurance, and the premium payers they insure, do not pay their fair share of mental health costs. BCBS of Kansas, the state's largest insurer, paid nearly $20 million to mental health providers and another $10 million for mental health prescriptions last year. The totals for all carriers may be three times this amount.

Finally, insurance mandates and the premium increases they cause fall most heavily on individuals, their dependents and small businesses. The uninsured, self-insured groups, Medicare, Medicaid and federal employees are unaffected by state insurance mandates. Large groups are more likely to absorb premium increases while the individual and small group markets are extremely price sensitive. In the end, the working men and women of Kansas must pay the cost of each new mandate or elect to reduce other benefits or drop coverage for themselves or their dependents.

We support an orderly cost-conscious review of the mental health parity issue. House Bill 2033 begins that process. Thank you for consideration of our views.

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



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

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

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

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

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1-7-1

BLBS

Testimony on House Bill 2033
Submitted by Col. Lynn Rolf, Leavenworth
16 January 2001

It is an honor and privilege to submit this testimony to you as a Kansan, a NAMI affiliate president of a family support group, a professional soldier with 31 year's of service to our Nation, and a father of a 24-year-old son with paranoid schizophrenia. As an adult, my son 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?

As of today, over 29 states have enacted laws to provide greater parity in health insurance benefits for people with mental illnesses. With California, at least 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. Parity bills should require health plans to cover adults and children with the most severe mental illnesses, including schizophrenia, schizoaffective disorder, brief reactive psychosis, paranoid or delusional disorder, atypical psychosis, bipolar disorder, major depression, 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.

Today we have federal laws requiring parity for federal employees, we now have a years experience with parity for our state employees with very little increased cost, And now I ask the simple question, since my son is employed by neither but a Kansan nonetheless: Why can't Nick 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,

COL Lynn Rolf

President, NE Kansas/Leavenworth NAMI Family Support Group

Leavenworth, Ks 66027

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1-16-01
ATTACHMENT #18

KMS
KANSAS MEDICAL SOCIETY

TO: House Committee on Insurance

FROM: Chris Collins Chris Collins
Director of Government Affairs

DATE: January 16, 2001

RE: HB 2033: Insurance Coverage for Mental Illness

The Kansas Medical Society appreciates the opportunity to provide written comments this afternoon in support of HB 2033.

In 1997 the KMS adopted a policy which endorsed the principle of mental health parity by requiring third party payors to provide mental illness benefits which are equivalent in scope and duration to those benefits provided for other illnesses. We believe HB 2033, which "test-tracks" mental health coverage, is a significant step in that direction, and we support its enactment.

KMS urges this Committee to recommend HB 2033 as favorable for passage. Thank you for your time and consideration.

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1-16-01
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SUBMITTED TESTIMONY

TO: **The Honorable Bob Tomlinson**
And Members Of The
House Insurance Committee

FROM: **Whitney Damron**
On Behalf Of The
Kansas Psychological Association

RE: **HB 2033 – Mental Health Parity Study**

DATE: **January 16, 2001**

Good afternoon Chairman Tomlinson and Members of the House Insurance Committee. My name is Whitney Damron and I respectfully submit testimony to you this afternoon on behalf of my client, the Kansas Psychological Association.

With the issue of Mental Health Parity currently undergoing a test track cost analysis with the state health care system, the Kansas Psychological Association is somewhat confused with the need for additional study. The KPA would respectfully suggest the current debate should be framed in terms of what mental health disorders should be covered by such legislation and not whether any such disorders should be covered at all.

The Kansas Psychological Association stands ready to work together with all parties affected for the adoption of reasonable and responsible mental health parity legislation that is in the best interests of all parties concerned, including the insurance companies, but most of all, the insureds and particularly the children of our state.

Thank you for your consideration of this information.

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ATTACHMENT # 20

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

January 16, 2001

TO: House Committee on Insurance

FROM: Linda De Coursey, Director of Government Affairs
Kansas Insurance Department

RE: HB 2033 – report to legislature regarding providing for certain mental illnesses

Mr. Chairman and members of the Committee:

Thank you for the opportunity to discuss with you this very important topic on behalf of Insurance Commissioner Sebelius. In preparing for this testimony, I dusted off copies of her comments made before legislative committees during the last ~~five~~ SIX years on the topic of mental health parity.

What hasn't changed in those ~~five~~ SIX years is that Insurance Commissioner Sebelius still strongly believes 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 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 rarely covered, but if so, coverage is not adequate. To

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21-1

420 SW 9th Street
Topeka, Kansas 66612-1678

785 296-3071
Fax 785 296-2283

Consumer Assistance Hotline
1 800 432-2484 (Toll Free)

isolate mental illness for minimal protection, while fully covering physical diseases in a major medical policy, seems to be discrimination of the worse kind.

Over half the states now have parity laws. The Surgeon General's report, along with many other studies, 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).

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.

Bringing statistics a little closer to home is the fact that the Kansas State Employees Health Care Commission, in 1998, 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. Information already exists for a two-year period on those plans should you request it from the Health Care Commission.

Just last year, the Kansas State Employee Health Commission agreed to extend for health plan year 2001, parity for mental health benefits for Kansas state employees having fee for service type coverage.

While the intent of HB 2033 is to appease the "test tracking" requirement, for all practical purposes, mental health parity for all types of health plans exists in Kansas for state employees. Passing a law asking for a report seems merely to put off bringing fairness to those Kansas families with mental disorders, whom are not state employees. Thank you for your kind attention to our comments.

Testimony to the House Committee on Insurance
House Bill 2033
Mental Health Parity

Michael F. Larkin
Kansas Employer Coalition on Health
January 16, 2001

Good Afternoon. My name is Mike Larkin, and I am the Executive Director for the Kansas Employer Coalition on Health. The Kansas Employer Coalition on Health, known also as KECH, is a consortium of nearly 50 employers throughout Kansas devoted to providing high quality, cost-effective healthcare to their employees and their families. Its members include large corporations in Kansas such as Sprint and Western Resources as well as smaller employers such as and Midwest Grain Products in Atchison. In order for member employers to continue to provide quality healthcare benefits to all their employees, we believe healthcare costs must remain affordable.

I am sure you are already aware that employers pay for the preponderance of individual health insurance premiums in this country. This health benefit, while costly, is an expense employers are willing to shoulder as a means of attracting and retaining employees. Many employers also offer optional family coverage for their employees' families. The health insurance coverage an employer offers his or her employees is in many cases a mutually agreed upon package that employees want and employers are willing to provide.

KECH is not opposed to mental health parity in particular. We are however, opposed to mandates in general. We believe that mandating any benefit comes at a cost. That cost may come in many forms, such as increased costs of insurance coverage, encouraging firms to self insure and thus be exempt from mandates, and discouraging small businesses from providing any coverage at all.

In 1999 the Health Insurance Association of America (HIAA) commissioned a study on mandated benefit laws and employer-sponsored health insurance. This study found the following:

- One in five to one in four uninsured Americans lacks coverage because of benefit mandates.
- Workers pay for mandated benefits in the form of reduced wages or fewer benefits, as well as higher insurance premiums.
- Smaller firms are disproportionately affected by mandates in part because they are less likely than larger firms to be able to avoid the costs of mandates by self-insuring.
- Given that ERISA preempts self-insured firms from state mandates, the passage of such mandates will not lead to substantially more people with a given benefit.
- Smaller firms are disproportionately affected by mandates in part because they are less likely than larger firms to be able to avoid the costs of mandates by self-insuring.

NSE Ins. Comm
1-16-01
ATTACHMENT # 22

The study concluded that mandates have increased the cost of health insurance, disproportionately hurting employees who work for small businesses. The cumulative effect has had a measurably detrimental impact on the ability of Americans to afford health insurance coverage. Mandates are attractive. Their proponents argue that they guarantee access to particular coverage, expand benefits, and enhance quality. More than that, they are off-budget. The costs don't appear as explicit items in state or federal budgets. However, mandates are not free. They are paid for by workers and their dependents, who receive lower wages or lose coverage altogether.

On behalf of KECH, I hope this information assists you in refining and crafting a bill beneficial to all Kansans. Mr. Chairman, this concludes my prepared statement. I would be happy to answer questions you or other members of the committee may have.

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Polsinelli | Shalton | Welte

A Professional Corporation

Memorandum

TO: THE HONORABLE BOB TOMLINSON, CHAIRMAN
HOUSE INSURANCE COMMITTEE

FROM: JEFFERY S. BOTTENBERG

RE: PROPOSED AMENDMENT TO K.S.A. 8-2401 AND K.S.A. 8-2404

DATE: JANUARY 15, 2001

Mr. Chairman, Members of the Committee: My name is Jeff Bottenberg and I represent Western Surety Company, an insurance company that specializes in providing commercial surety bonds. Western Surety Company is an affiliate of CNA Surety Company, which is the nation's largest provider of commercial surety bonds and one of the largest U.S. insurance groups. Western Surety Company is an active participant in the Kansas surety market.

This proposal would amend K.S.A. 8-2401 and K.S.A. 8-2404 to limit the coverage on motor vehicle dealer surety bonds to consumers. By way of background, in 1989 the Kansas Legislature required every new and used vehicle dealer to maintain a surety bond in the amount of $15,000. The intent of the Legislature was that such bond would help cover the expenses incurred by consumers as a result of the fraudulent sales practices of vehicle dealers. Such intent is clear from the plain reading of the statute as well as the legislative testimony provided at the committee hearings.

House Ins. 1-16-2001
Attachment # 23
23-1

One AmVestors Place
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Unfortunately the Kansas Supreme Court has disregarded the wisdom and intent of the Legislature, as it has recently held that the bond must cover any potentially aggrieved party. Such decision was rendered in the case Hartford Casualty Insurance Company v. Credit Union 1 of Kansas.

Such decision is not only contrary to the intent of the Legislature when it first passed the bonding requirement, but unnecessarily increases the liability of our company, to the detriment of our policyholders and stockholders.

At the time of the full hearing, I will provide the Committee a full analysis of the proposal and why we believe such proposal is deserving of your committee's favorable consideration.

Thus, on behalf of my client, I respectfully request that the attached proposal be introduced by the House Insurance Committee. If you have any questions, please feel free to contact me.

Respectfully Submitted,

Jeff Bottenberg

JSB
Attachment

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____.B._____

AN ACT concerning the vehicle dealers and manufacturers licensing act; relating to vehicle dealer bonds; amending K.S.A. 1999 Supp. 8-2401 and 8-2404 and repealing the entire sections.

Be it enacted by the Legislature of the State of Kansas

Section 1. K.S.A. 8-2401 is hereby amended to read as follows:

8-2401. Definitions. As used in this act, the following words and phrases shall have the meanings:
(a) "Vehicle dealer" means any person who: (1) For commission, money or other thing of value is engaged in the business of buying, selling or offering or attempting to negotiate a sale of an interest in vehicles; or (2) for commission, money or other thing of value is engaged in the business of buying, selling or offering or attempting to negotiate a sale of an interest in motor vehicles as an auction motor vehicle dealer as defined in (bb); but does not include: (A) Receivers, trustees, administrators, executors, guardians, or other persons appointed by or acting under the judgment or order of any court, or any bank, trustee or lending company or institution which is subject to state or federal regulations as such, with regard to its disposition of repossessed vehicles; (B) public officers while performing their official duties; (C) employees of persons enumerated in provisions (A) and (B), when engaged in the specific performance of their duties as such employees; (D) auctioneers conducting auctions for persons enumerated in provisions (A), (B) or (C); or (E) auctioneers who, while engaged in conducting an auction of tangible personal property for others, offer for sale: (i) Vehicles which have been used primarily in a farm or business operation by the owner offering the vehicle for sale, including all vehicles which qualified for a farm vehicle tag at the time of sale except vehicles owned by a business engaged primarily in the business of leasing or renting passenger cars; (ii) vehicles which meet the statutory definition of antique vehicles; or (iii) vehicles for no more than four principals or households per auction. All sales of vehicles exempted pursuant to provision (E), except truck, truck tractors, pole trailers, trailers and semitrailers as defined by K.S.A. 8-126, and amendments thereto, shall be registered in Kansas prior to the sale.
(b) "New vehicle dealer" means any vehicle dealer who is a party to an agreement, with a first or second stage manufacturer or distributor, which agreement authorizes the vehicle dealer to sell, exchange or transfer new motor vehicles, trucks, motorcycles, or trailers or parts and accessories made or sold by such first or second stage manufacturer or distributor and obligates the vehicle dealer to fulfill the warranty commitments of such first or second stage manufacturer or distributor.
(c) "Used vehicle dealer" means any person actively engaged in the business of buying, selling or exchanging used vehicles.

(d) "Vehicle salesperson" means any person who is employed as a salesperson by a vehicle dealer to sell vehicles.
(e) "Board" means the vehicle dealer review board created by this act.
(f) "Director" means the director of vehicles, or a designee of the director.
(g) "Division" means the division of vehicles of the department of revenue.
(h) "Vehicle" means every device in, upon or by which any person or property is or may be transported or drawn upon a public highway, and is required to be registered under the provisions of article 1 of chapter 8 of Kansas Statutes Annotated except that such term shall not include motorized bicycles, and such term shall not include manufactured homes or mobile homes. As used herein, the terms "manufactured home" and "mobile home" shall have the meanings ascribed to them by K.S.A. 58-4202, and amendments thereto.
(i) "Motor vehicle" means any vehicle other than a motorized bicycle, which is self-propelled and is required to be registered under the provisions of article 1 of chapter 8 of Kansas Statutes Annotated.
(j) "Licensor" means the director or division or both.
(k) "First stage manufacturer" means any person who manufactures, assembles and sells new vehicles to new vehicle dealers for resale in this state.
(l) "Second stage manufacturer" means any person who assembles, installs or permanently affixes body, cab or special unit equipment to a chassis supplied by a first stage manufacturer, distributor or other supplier and sells the resulting new vehicles to new vehicle dealers for resale in this state.
(m) "First stage converter" means any person who is engaged in the business of affixing to a chassis supplied by a first stage manufacturer, distributor or other supplier, specially constructed body units to result in motor vehicles used as, but not limited to, buses, wreckers, cement trucks and trash compactors.
(n) "Second stage converter" means any person who is engaged in the business of adding to, subtracting from or modifying previously assembled or manufactured vehicles and sells the resulting converted vehicles at retail or wholesale.
(o) "Distributor" means any person who sells or distributes for resale new vehicles to new vehicle dealers in this state or who maintains distributor representatives in this state.
(p) "Wholesaler" means any person who purchases vehicles for the purpose of resale to a vehicle dealer.
(q) "Factory branch" means any branch office maintained in this state by a first or second stage manufacturer for the sale of new vehicles to distributors, or for the sale of new vehicles to new vehicle dealers, or for directing or supervising, in whole or in part, its representatives in this state.
(r) "Distributor branch" means any branch office similar to subsection (q) maintained by a distributor for the same purposes as a factory branch.
(s) "Factory representative" means a representative employed by a first or second stage manufacturer or factory branch for the purpose of making or promoting the sale of its new vehicles to new vehicle dealers, or for supervising or contacting its new vehicle dealers or prospective new vehicle dealers with respect to the promotion and sale of such vehicles and parts or accessories for the same.
(t) "Distributor representative" means any representative similar to subsection (s) employed by a distributor or distributor branch for the same purpose as a factory representative.
(u) "Person" means any natural person, partnership, firm, corporation or association.

(v) "New motor vehicle" means any motor vehicle which has never been titled or registered and has not been substantially driven or operated.
(w) "Franchise agreement" means any contract or franchise or any other terminology used to describe the contractual relationship between first or second stage manufacturers, distributors and vehicle dealers, by which:
(1) A right is granted one party to engage in the business of offering, selling or otherwise distributing goods or services under a marketing plan or system prescribed in substantial part by the other party, and in which there is a community of interest in the marketing of goods or services at wholesale or retail, by lease, agreement or otherwise; and
(2) the operation of the grantee's business pursuant to such agreement is substantially associated with the grantor's trademark, service mark, trade name, logotype, advertising or other commercial symbol designating the grantor or an affiliate of the grantor.
(x) "Broker" means any person who, for a fee, commission, money, other thing of value, valuable consideration or benefit, either directly or indirectly, arranges or offers to arrange a transaction involving the sale of a vehicle, or is engaged in the business of: (1) Selling or buying vehicles for other persons as an agent, middleman or negotiator; or (2) bringing buyers and sellers of vehicles together, but such term shall not include any person registered as a salvage vehicle pool or any person engaged in a business in which the acts described in this subsection are only incidentally performed or which are performed or authorized within the requirements or scope of any other category of license, or not prohibited, in the manner authorized by the vehicle dealers' and manufacturers' licensing act.
(y) "Salvage vehicle dealer" means any person engaged in the business of buying[,] selling or exchanging used vehicles and primarily engaged in the business of the distribution at wholesale or retail of used motor vehicle parts and includes establishments primarily engaged in dismantling motor vehicles for the purpose of selling parts.
(z) "Lending agency" means any person, desiring to be licensed under this act and engaged in the business of financing or lending money to any person to be used in the purchase or financing of a vehicle.
(aa) "Established place of business" means a building or structure, other than a building or structure all or part of which is occupied or used as a residence, owned either in fee or leased and designated as an office or place to receive mail and keep records and conduct the routine of business. To qualify as an established place of business, there shall be located therein an operable telephone which shall be listed with the telephone company under the name of the licensed business, except that a vehicle dealer who derives at least 50% of such person's income from operating a farm as a resident thereof, the established place of business may be the farm residence of such vehicle dealer and the operable telephone may be located in such residence when such dealer engages only in vehicles and equipment not required to have vehicle registration to travel on a highway.
(bb) "Auction motor vehicle dealer" means any person who for commission, money or other thing of value is engaged in an auction of motor vehicles except that the sales of such motor vehicles shall involve only motor vehicles owned by licensed motor vehicle dealers and sold to licensed motor vehicle dealers, except that any auction motor vehicle dealer, registered as such and lawfully operating prior to June 30, 1980, shall be deemed to be and have been properly licensed under this act from and after July 1, 1980. For the purposes of this subsection, an auction is a private sale of motor vehicles where any and all licensed motor vehicle dealers who

choose to do so are permitted to attend and offer bids and the private sale of such motor vehicles is to the highest bidder.
(cc) "Licensee" means any person issued a valid license pursuant to this act.
(dd) "Dealer" means a vehicle dealer as defined by this act, unless the context otherwise requires.
(ee) "Insurance company" means any person desiring to be licensed under this act and engaged in the business of writing or servicing insurance related to vehicles.
(ff) "Supplemental place of business" means a business location other than that of the established place of business of the dealer which may be operated by the dealer on a continuous year-round basis and, for new vehicle dealers, is within the defined area of responsibility in their franchise agreement, and for all other dealers is within the same city or county where the established place of business of the dealer is operated.
(gg) "Salvage yard" means the place owned or leased and regularly occupied by a person, firm or corporation licensed under the provisions of this act for the principal purpose of engaging in the business of a salvage vehicle dealer. Salvage yard shall include the location where the:
(1) Products for sale are displayed and offered for sale;
(2) books and records required for the conduct of the business are maintained;
(3) records are kept in the normal daily business activity; and
(4) records are made available for inspection.
(hh) "Salvage vehicle pool" means any person who as an agent for a third party is primarily engaged in the business of storing, displaying and offering for sale salvage vehicles.
(ii) "Major component part" means any vehicle part including the front clip, rear clip, doors, frame, chassis, engine, transmission, transaxle, cab, bed and box bearing the public vehicle identification number or engine number, if manufactured prior to 1981; or any vehicle part bearing a derivative of such number.
(jj) "Recreational motor vehicle" means a recreational vehicle as defined by subsection (f) of K.S.A. 75-1212, and amendments thereto.
(kk) "Consumer" means a natural person who is a retail buyer of a motor vehicle.

Section 2. K.S.A. 8-2404 is hereby amended to read as follows:

8-2404. (a) No vehicle dealer shall engage in business in this state without obtaining a license as required by this act. Any vehicle dealer holding a valid license and acting as a vehicle salesperson shall not be required to secure a salesperson's license.
(b) No first stage manufacturer, second stage manufacturer, factory branch, factory representative, distributor branch or distributor representative shall engage in business in this state without a license as required by this act, regardless of whether or not an office or other place of business is maintained in this state for the purpose of conducting such business.
(c) An application for a license shall be made to the director and shall contain the information provided for by this section, together with such other information as may be deemed reasonable and pertinent, and shall be accompanied by the required fee. The director may require in the application, or otherwise, information relating to the applicant's solvency, financial standing, or other pertinent matter commensurate with the safeguarding of the public interest in the locality in which the applicant proposes to engage in business, all of which may be considered by the director in determining the fitness of the applicant to engage in business as set forth in this section. The director may require the applicant for licensing to appear at such time and place as may be designated by the director for examination to enable the director to determine the

accuracy of the facts contained in the written application, either for initial licensure or renewal thereof. Every application under this section shall be verified by the applicant.

(d) All licenses shall be granted or refused within 30 days after application is received by the director. All licenses, except licenses issued to salespersons, shall expire, unless previously suspended or revoked, on December 31 of the calendar year for which they are granted, except that where a complaint respecting the cancellation, termination or nonrenewal of a sales agreement is in the process of being heard, no replacement application shall be considered until a final order is issued by the director. Applications for renewals, except for renewals of licenses issued to salespersons, received by the director after February 15 shall be considered as new applications. All salespersons' licenses issued on or after January 1, 1987, shall expire on June 30, 1988, and thereafter shall expire, unless previously suspended or revoked, on June 30 of the calendar year for which they are granted. Applications for renewals of salespersons' licenses received by the director after July 15 shall be considered as new applications. All licenses for supplemental places of business existing or issued on or after January 1, 1994, shall expire on December 31, 1994, unless previously expired, suspended or revoked, and shall thereafter expire on December 31 of the calendar year for which they are granted, unless previously suspended or revoked.

(e) License fees for each calendar year, or any part thereof shall be as follows:

(1) For new vehicle dealers, $50;

(2) for distributors, $50;

(3) for wholesalers, $50;

(4) for distributor branches, $50;

(5) for used vehicle dealers, $50;

(6) for first and second stage manufacturers, $200 plus $50 for each factory branch in this state;

(7) for factory representatives, $25;

(8) for distributor representatives, $25;

(9) for brokers, $50;

(10) for lending agencies, $25;

(11) for first and second stage converters, $25;

(12) for salvage vehicle dealers, $50;

(13) for auction motor vehicle dealers, $50;

(14) for vehicle salesperson, $15; and

(15) for insurance companies, $50.

Any salvage vehicle dealer who is also licensed as a used vehicle dealer shall be required to pay only one $50 fee for both licenses. Any new vehicle dealer who is also licensed as a used vehicle dealer shall be required to pay only one $50 fee for both licenses.

(f) Dealers may establish approved supplemental places of business within the same county of their licensure or, with respect to new vehicle dealers, within their area of responsibility as defined in their franchise agreement. Those doing so shall be required to pay a supplemental license fee of $10. In addition to any other requirements, new vehicle dealers seeking to establish supplemental places of business shall also comply with the provisions of K.S.A. 8-2430 through 8-2432, and amendments thereto. A new vehicle dealer establishing a supplemental place of business in a county other than such dealer's county of licensure but within such dealer's area of responsibility as defined in such dealer's franchise agreement shall be licensed only to do business as a new motor vehicle dealer in new motor vehicles at such supplemental place of business. Original inspections by the division of a proposed established place of business shall be

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made at no charge except that a $5 fee shall be charged by the division for each additional inspection the division must make of such premises in order to approve the same.

(g) The license of all persons licensed under the provisions of this act shall state the address of the established place of business, office, branch or supplemental place of business and must be conspicuously displayed therein. The director shall endorse a change of address on a license without charge if: (1) The change of address of an established place of business, office, branch or supplemental place of business is within the same county; or (2) the change of address of a supplemental place of business, with respect to a new vehicle dealer, is within such dealer's area of responsibility as defined in their franchise agreement. A change of address of the established place of business, office or branch to a different county shall require a new license and payment of the required fees but such new license and fees shall not be required for a change of address of a supplemental place of business, with respect to a new vehicle dealer, to a different county but within the dealer's area of responsibility as defined in their franchise agreement.

(h) Every salesperson, factory representative or distributor representative shall carry on their person a certification that the person holds a valid state license. The certification shall name the person's employer and shall be displayed upon request. An original copy of the state license for a vehicle salesperson shall be mailed or otherwise delivered by the division to the employer of the salesperson for public display in the employer's established place of business. When a salesperson ceases to be employed as such, the former employer shall mail or otherwise return the original copy of the employee's state license to the division. A salesperson, factory representative or distributor representative who terminates employment with one employer may file an application with the director to transfer the person's state license in the name of another employer. The application shall be accompanied by a $2 transfer fee. A salesperson, factory representative or distributor representative who terminates employment, and does not transfer the state license, shall mail or otherwise return the certification that the person holds a valid state license to the division.

(i) If the director has reasonable cause to doubt the financial responsibility or the compliance by the applicant or licensee with the provisions of this act, the director may require the applicant or licensee to furnish and maintain a bond in such form, amount and with such sureties as the director approves, but such amount shall be not less than $5,000 nor more than $20,000, conditioned upon the applicant or licensee complying with the provisions of the statutes applicable to the licensee and as indemnity for any loss sustained by ~~any person~~ *a consumer* by reason of any act by the licensee constituting grounds for suspension or revocation of the license. Every applicant or licensee who is or applies to be a used vehicle dealer or a new vehicle dealer shall furnish and maintain a bond in such form, amount and with such sureties as the director approves, in the amount of $15,000, conditioned upon the applicant or licensee complying with the provisions of the statutes applicable to the licensee and as indemnity for any loss sustained by ~~any person~~ *a consumer* by reason of any act by the licensee in violation of any act which constitutes grounds for suspension or revocation of the license. To comply with this subsection, every bond shall be a corporate surety bond issued by a company authorized to do business in the state of Kansas and shall be executed in the name of the state of Kansas for the benefit of any aggrieved ~~party~~ *consumer*. The aggregate liability of the surety for all breaches of the conditions of the bond in no event shall exceed the amount of such bond. The surety on the bond shall have the right to cancel the bond by giving 30 days' notice to the director, and thereafter the surety shall be relieved of liability for any breach of condition occurring after the effective date of cancellation. Bonding requirements shall not apply to first or second stage manufacturers, factory

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branches, factory representatives or salespersons. Upon determination by the director that a judgment from a Kansas court of competent jurisdiction is a final judgment and that the judgment resulted from an act in violation of this act or would constitute grounds for suspension, revocation, refusal to renew a license or administrative fine pursuant to K.S.A. 8-2411, and amendments thereto, the proceeds of the bond on deposit or in lieu of bond provided by subsection (j), shall be paid. The determination by the director under this subsection is hereby specifically exempted from the Kansas administrative procedure act (K.S.A. 77-501 through 77-549, and amendments thereto,) and the act for judicial review and civil enforcement of agency actions (K.S.A. 77-601 through 77-627, and amendments thereto). Any proceeding to enforce payment against a surety following a determination by the director shall be prosecuted by the judgment creditor named in the final judgment sought to be enforced. Upon a finding by the court in such enforcement proceeding that a surety has wrongfully failed or refused to pay, the court shall award reasonable attorney fees to the judgment creditor.

(j) An applicant or licensee may elect to satisfy the bonding requirements of subsection (i) by depositing with the state treasurer cash, negotiable bonds of the United States or of the state of Kansas or negotiable certificates of deposit of any bank organized under the laws of the United States or of the state of Kansas. When negotiable bonds or negotiable certificates of deposit have been deposited with the state treasurer to satisfy the bonding requirements of subsection (i), such negotiable bonds or negotiable certificates of deposit shall remain on deposit with the state treasurer for a period of not less than two years after the date of delivery of the certificate of title to the motor vehicle which was the subject of the last motor vehicle sales transaction in which the licensee engaged prior to termination of the licensee's license. In the event a licensee elects to deposit a surety bond in lieu of the negotiable bonds or negotiable certificates of deposit previously deposited with the state treasurer, the state treasurer shall not release the negotiable bonds or negotiable certificates of deposits until at least two years after the date of delivery of the certificate of title to the motor vehicle which was the subject of the last motor vehicle sales transaction in which the licensee engaged prior to the date of the deposit of the surety bond. The cash deposit or market value of any such securities shall be equal to or greater than the amount of the bond required for the bonded area and any interest on those funds shall accrue to the benefit of the depositor.

(k) No license shall be issued by the director to any person to act as a new or used dealer, wholesaler, broker, salvage vehicle dealer, auction motor vehicle dealer, second stage manufacturer, first stage converter, second stage converter or distributor unless the applicant for the vehicle dealer's license maintains an established place of business which has been inspected and approved by the division. First stage manufacturers, factory branches, factory representatives, distributor branches, distributor representatives and lending agencies are not required to maintain an established place of business to be issued a license.

(l) Dealers required under the provisions of this act to maintain an established place of business shall own or have leased and use sufficient lot space to display vehicles at least equal in number to the number of dealer license plates the dealer has had assigned.

(m) A sign with durable lettering at least 10 inches in height and easily visible from the street identifying the established place of business shall be displayed by every vehicle dealer. Notwithstanding the other provisions of this subsection, the height of lettering of the required sign may be less than 10 inches as necessary to comply with local zoning regulations.

(n) If the established or supplemental place of business or lot is zoned, approval must be secured from the proper zoning authority and proof that the use complies with the applicable zoning law, ordinance or resolution must be furnished to the director by the applicant for licensing.
(o) An established or supplemental place of business, otherwise meeting the requirements of this act may be used by a dealer to conduct more than one business, provided that suitable space and facilities exist therein to properly conduct the business of a vehicle dealer.
(p) If a supplemental place of business is not operated on a continuous, year-round basis, the dealer shall give the department 15 days' notice as to the dates on which the dealer will be engaged in business at the supplemental place of business.
(q) Any vehicle dealer selling, exchanging or transferring or causing to be sold, exchanged or transferred new vehicles in this state must satisfactorily demonstrate to the director that such vehicle dealer has a bona fide franchise agreement with the first or second stage manufacturer or distributor of the vehicle, to sell, exchange or transfer the same or to cause to be sold, exchanged or transferred.
No person may engage in the business of buying, selling or exchanging new motor vehicles, either directly or indirectly, unless such person holds a license issued by the director for the make or makes of new motor vehicles being bought, sold or exchanged, or unless a person engaged in such activities is not required to be licensed or acts as an employee of a licensee and such acts are only incidentally performed. For the purposes of this section, engaged in the business of buying, selling or exchanging new motor vehicles, either directly or indirectly, includes: (1) Displaying new motor vehicles on a lot or showroom; (2) advertising new motor vehicles, unless the person's business primarily includes the business of broadcasting, printing, publishing or advertising for others in their own names; or (3) regularly or actively soliciting or referring buyers for new motor vehicles.
(r) No person may engage in the business of buying, selling or exchanging used motor vehicles, either directly or indirectly, unless such person holds a license issued by the director for used motor vehicles being bought, sold or exchanged, or unless a person engaged in such activities is not required to be licensed or acts as an employee of a licensee and such acts are only incidentally performed. For the purposes of this section, engaged in the business of buying, selling or exchanging used motor vehicles, either directly or indirectly, includes: (1) Displaying used motor vehicles on a lot or showroom; (2) advertising used motor vehicles, unless the person's business primarily includes the business of broadcasting, printing, publishing or advertising for others in their own names; or (3) regularly or actively soliciting buyers for used motor vehicles.
(s) The director of vehicles shall publish a suitable Kansas vehicle salesperson's manual. Before a vehicle salesperson's license is issued, the applicant for an original license or renewal thereof shall be required to pass a written examination based upon information in the manual.
(t) No new license shall be issued nor any license renewed to any person to act as a salvage vehicle dealer until the division has received evidence of compliance with the junkyard and salvage control act as set forth in K.S.A. 68-2201 *et seq.*, and amendments thereto.
(u) On and after the effective date of this act, no person shall act as a broker in the advertising, buying or selling of any new or used motor vehicle. Nothing herein shall be construed to prohibit a person duly licensed under the requirements of this act from acting as a broker in buying or selling a recreational vehicle as defined by subsection (f) of K.S.A. 75-1212, and amendments thereto, when the recreational vehicle subject to sale or purchase is a used recreational vehicle which has been previously titled and independently owned by another person for a period of 45

days or more, or is a new or used recreational vehicle repossessed by a creditor holding security in such vehicle.
(v) Nothing herein shall be construed to prohibit a person not otherwise required to be licensed under this act from selling such person's own vehicle as an isolated and occasional sale.

Section 2. K.S.A. 8-2401 and K.S.A. 8-2404 are hereby repealed.

Section 3. This act shall take effect and be in force from and after its publication in the statute book.