Approved: 2-19-01
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by Chairperson Sandy Praeger at 9:30 a.m. on February 14, 2001 in Room 234-N of the Capitol.

All members were present except:

Committee staff present: Dr. Bill Wolff, Kansas Legislative Research Department
Ken Wilke, Office of the Revisor of Statutes
JoAnn Bunten, Committee Secretary

Conferees appearing before the committee:

Kansas State Senator Jim Barone
Kansas State Senator Jim Barnett
Kathleen Sebelius, Kansas Insurance Commissioner
Steve Feinstein, Chairman, Kansas Mental Health Coalition
Paul Klotz, Association of Community Mental Health Centers
Jan Clay, CEO-Mental Health Consortium
Rochelle Chronister, former Secretary of SRS

Others attending: See attached list.

Reconsider action on SB 142 - Authorization of special orders of bank commissioner

The Chair called the Committee's attention to **SB 142** which passed out of Committee on February 13, 2001, and asked the Committee to reconsider action on the bill since there were questions raised about the amendments. Having voted on the prevailing side, Senator Feleciano made a motion that the Committee reconsider action on **SB 142 as amended** by the Committee, seconded by Senator Corbin. The motion carried.

Hearing on SB 274 - Insurance, providing coverage for certain mental health conditions

Kansas State Senator Jim Barone, testified before the Committee in support of **SB 274** which would mandate coverage for diagnosis and treatment of certain mental health conditions as defined in the *Diagnostic and Statistical Manuel of Mental Disorders of the American Psychiatric Association*. This bill would apply to the State Employees Health Care Benefits Program, municipal funded pools, and HMOs. Senator Barone pointed out that mental illness ranks second in the burden of disease established in market economies such as the U.S., and is second only to cardiovascular conditions. (Attachment 1)

Kansas State Senator Jim Barnett, M.D., expressed his support for the bill and noted that in his practice in Emporia, many of his office visits revolve as much around mental and emotional issues as physical ones. He pointed out that to be unable to obtain psychiatric referral for a mental health diagnosis results in inadequate treatment that costs everyone in the long run...as well as being unfair. (Attachment 2)

Kathleen Sebelius, Kansas Insurance Commissioner, expressed her support for the bill, and noted that while Kansas has been deliberating on the issue of adding a form of mental health parity to the statutes for years, 32 states currently have some form of mental health parity legislation. The Commissioner noted that new information from the Surgeon General's report suggests that implementing parity laws is not as expensive as once suggested. Case studies of five states that had a parity law for at least a year revealed a small effect on premiums plus or minus a few percent as outlined in her written testimony. (Attachment 3)

The Chair provided the Committee with information relating to the effect on insurer claim costs of a mental health parity mandate compiled by the Kansas Department of Health and Environment on data from 1999 claims as recorded on the state data base. (Attachment 4)

Steve Feinstein, Chairman, Kansas Mental Health Coalition, Paul Klotz, Association of Community Mental Health Centers, and Jan Clay, CEO-Mental Health Consortium, testified before the Committee in support of the bill providing information, statistics, and charts relative to mental health parity issues. (Attachments 5, 6 and 7)

Rochelle Chronister, former Secretary of SRS and chairman of the Kansas Advisory Group on Juvenile Justice provided strong support for **SB 274**. She noted that when she was Secretary of SRS, she was appalled to discover how little help the state was able to provide children who had serious mental illnesses. Many parts of the state only had professionals available at state hospitals and later on at Community Mental Health Centers. Parents would sometimes have to travel long distances to access any kind of treatment for their child. Ms. Chronister noted that the annual report on the Coalition for Juvenile Justice provides anecdotal evidence that 50% of youth who are involved with the juvenile system have some type of mental illness. She pointed out that one of the ways society could pay for parity would be by the potential reduction in juvenile crime through the treatment of some of these mental illnesses. She felt that if we can identify and begin treatment of children who have mental illnesses when they are young, we can in many cases reduce the long term effects on families and society that those untreated illnesses cause. (Attachment 8)

An interim report to Congress by the National Advisory Mental Health Council on the state-wide experiences following passage of mental health parity in Texas, Maryland, Rhode Island and Minnesota was distributed to the Committee by the Chair. (Attachment 9)

Adjournment

The meeting was adjourned at 10:30 a.m. The next meeting of the Committee is scheduled for February 15, 2001.

SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: 2-14-01

NAME	REPRESENTING
J. TED WALTERS	AARP-KS
Nancy Shaughnessy	Freelance
Todd Henderson	KS Pharmacists Assoc.
Harry Booze	Dept of Admin
MIKE LARKIN	KS EMPLOYER COALITION ON HEALTH
Kevin Davis	Am. Family Ins
Colleen Mello	Kathy Damron + Assoc.
Chris Collins	KMS
Mary Moore	KPA
Rudy G. Johnson	SRS - MH/SATR
Jan Clay	The Consortium Inc
Kathleen Selzler	ICID
Sonya All	Office of State Bank Comm
Judi Stork	OSBC
Anna Spiess	KAIFA
Amy Campbell	KMHC
Mary Jennings	NAMI
Wayne Lee Jennings	NAMI
Sarah Henderson	Horizon MHC, Hutchinson

SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: 2-14-01

NAME	REPRESENTING
[illegible]	Iroquois Center, Greensburg KS
Lou Ann Pruss	Iroquois Center, Greensburg KS
Dub Lakestraw	Family Service & Guidance Center Topeka, KS.
Dr. Wes Jones	Mental Health Center of East Central Kansas Emporia, KS
Marvin Rowe	KAHP
Brad Smoot	BCBS

Testimony of Sen. Jim Barone, District 13

before Financial Institutions and Insurance Committee

Wednesday, February 14, 2001, 9:30 a.m.

SB 274

Mental Health is critical to all Kansans.

During the last ten years, declared "The Decade of the Brain," neuroscience has exploded with new technology and effective medical treatments for disorders of the brain.

The U. S. Surgeon General's Report on Mental Health issued in 2000 after two years of extensive research concluded:

–one in every five Americans (Kansans) will need mental health treatment in any given year.
–mental illnesses are real conditions that have immense impact on individuals and families;
–the effectiveness of treatment is well-documented; and
–unwarranted stigma and discrimination have deprived people of their dignity and full participation in society for too long.

The Washington Business Group on Health, a large member group of employers known to be some of the most innovative public and private purchasers of health care, including AT&T, IBM, American Airlines, General Motors and Eastman Kodak, participated with the United States Office of Personnel Management in a mental health parity evaluation project. (Released March 2000). Key important findings were:

–Mental health benefits were essential to the "bottom line;"

–The costs of providing appropriate treatment for mental disorders must be measured in a larger context that also considers disability costs, employee absenteeism and lost productivity. Taking these into consideration, traditional benefit limitations were not cost effective;

–Increasingly, employers have focused on health system performance based on employee health and functioning–they have moved "beyond parity" to focus on functional outcomes–improving employee and family member wellness and productivity.

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 bipolar rates 80%. The U. S. Government began covering its 9.5 million employees with mental health parity on January 1, 2001. As you well know, Kansas State

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Government now covers its 90,000 state plan participants with better coverage than we are proposing. Medicaid provides mental health benefits better than private pay coverage. No state has moved backwards. Twenty-six other states are moving ahead with parity this year; half are expanding existing law.

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 physical organ, like the others, and must have medical attention when a disorder occurs.

It is time to cover the working men and women of Kansas to the fullest extent possible.

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Internal Medicine
ASSOCIATES, LLC

INTERNAL MEDICINE

James M. Geitz, M.D.

James A. Barnett, M.D., F.A.C.P.

W. Brock Kretsinger, D.O.

W. Timothy Duncan, M.D.

Rachel A. Duncan, M.D.

CARDIOLOGY

M. Usman Sheriff, M.D.

EMERITUS

Phillip W. Morgan, M.D. (1928-1966)

Edward J. Ryan, M.D. (1947-1979)

John L. Morgan, M.D. (1949-1984)

Gould C. Garcia, M.D. (1964-1999)

SERVICES

Bone Densitometry

Ultrasonography

Mammography

In-Office Laboratory

Nuclear Cardiology

Echocardiography

Cardiac Catheterization

Diagnostic

Interventional

Holter Monitor

Exercise Testing

Pacemaker Clinic

Testimony – Mental Health Parity

Madam Chairman, fellow Senators of the Financial Institutions and Insurance committee, thank you for the opportunity to testify in support of mental health parity.

I would like to tell you briefly about my practice. I practice internal medicine and take care of adults over the age of 16. Much of my work revolves around preventive health care. Fortunately, most of my patients are healthy. Some are not. Those who are ill or who have chronic health problems do not suffer from physical ailments, alone.

From over 18 ½ years of practice and a decade of training before, I know that mental and physical health cannot be separated. I cannot and do not adequately treat the patient without consideration of both. If one aspect is ignored, the diagnosis just isn't complete, and the treatment inadequate. Resources are wasted and outcomes are suboptimal.

Many of my office visits revolve as much around mental and emotional issues as physical ones. I manage both. If either are beyond my capabilities, I obtain consultation and appropriate referrals. To be unable to obtain psychiatric referral for a mental health diagnosis results in inadequate treatment that costs everyone in the long run. It is also unfair.

Through the years, I have taken care of many patients with chronic disease and those with very poor prognoses. These diagnoses include congestive heart failure, chronic obstructive pulmonary disease, and malignancy. Many are repeatedly hospitalized and on multiple medications. Even though their outlook may be poor and their functional capacity limited, I treat them to the best of my ability and to the fullest of their desire. We should do nothing less with mental illness.

I ask for your support of mental health parity for the citizens of the state of Kansas.

James A. Barnett

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Attachment No. 2

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

TO: Senate Committee on Financial Institutions and Insurance

FROM: Kathleen Sebelius, Insurance Commissioner

RE: SB 274 – Providing coverage for certain mental health conditions

DATE: February 14, 2001

Madam Chairwoman and members of the Committee:

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

What has changed....

While Kansas has been deliberating on the issue of adding a form of mental health parity to the law books for years and years, more and more states added a mental health parity law to their state statutes. Currently, 32 states have some form of parity legislation: Alabama, Arkansas, Arizona, 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 (Guam and Puerto Rico).

Statistics are now available from states with mental health parity laws. In Maryland, for example, statistics showed a seven percent drop in the length of inpatient psychiatric hospital

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stays one year after passage of a mental health benefit parity law (National Underwriter). A 1997 Rand Corporation study found that raising the typical average dollar limit on the mental health coverage would increase costs by about $1 per managed care enrollee.

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

Let's bring statistics closer to home. In 1998, the Kansas Health Care Commission asked insurers to submit bids, with and without mental health parity. The ranges on the bids came in from zero percent to approximately six percent, with most at 1.5 to 2%. Final cost to implement biological based mental health parity for Kansas state employees health plan was 1.5%. 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. Analysis of the 1999 claims paid and attributable to eligible mental health services indicated the factor of paid claims per contract was a mere 73c/member/month.

At their August 8, 2000 meeting, the Kansas Health Commission agreed to extend for health plan year 2001, parity for mental health benefits for Kansas state employees having indemnity

coverage or fee for service type coverage, i.e., Kansas Choice Blue Select and Kansas Choice Senior (traditional programs). Once again with the bids that companies submitted, the final cost to implement biological based mental health parity for Kansas state employees traditional health programs was 1.5%. However, under these programs, mental health services will be reviewed and managed by Health Management Strategies (HMS). HMS is responsible for monitoring claims and determining whether "parity" benefits will apply. Even though these plans are considered indemnity or fee for service types of coverage, HMS monitors or provides a "gatekeeper" concept. It is well documented that if a "gatekeeper" is used, then additional claim costs are in the 1-2% area.

What hasn't changed…..

What hasn't changed is that I still strongly believe insurance coverage for mental illness diseases is a fairness issue. While coverage for mental health disorders has for existed for some time in Kansas history, it exists differently than coverage for other illnesses, and would lead one has to ask why the difference exists? There is little question that those individuals with "mental disorders" are treated differently from their neighbors who have "physical disorders." It is difficult, if not impossible to obtain insurance coverage for brain diseases, with the same levels of coverage that individuals can obtain for any physical condition. It is difficult to understand why an illness of the body, such as diabetes, is covered while an illness of the mind, such as schizophrenia, is not. Both conditions can be treated and often brought under control by drug therapy and other medical interventions, but the brain disorders are not adequately covered by health insurance. To isolate mental illness for minimal protection, while fully covering physical diseases in a major medical policy, seems to be discrimination of the worse kind.

What hasn't changed…..

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

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

With more than five million Americans suffering from mental illnesses, 21 percent of all hospital beds are filled by people with severe mental illnesses such as major depression, bipolar disorder or schizophrenia (NAMI). NAMI also stated that the total price tag is over $120 billion, which includes direct costs (hospitalization, medication) and indirect costs (lost wages and

productivity, absenteeism, family caregiving, and suicides). At the same time, with proper medical care and support services, the treatment success rate for schizophrenia is 60 percent, 65 percent for major depression, and 80 percent for bipolar disorder, compared to rates of only 40 to 50 percent for heart disease (NAMI).

What hasn't changed....

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

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

In summary, this issue is the same---it is a fairness issue. While coverage for mental health disorders has for existed for some time in Kansas history, it exists differently than coverage for other illnesses, and would lead one has to ask why the difference exists? Thirty-two states now

have parity laws. Studies show that implementing parity laws is not as expensive as once suggested. Further, employers did not attempt to avoid the laws by becoming self-insured or by passing on costs to employees. Research is bringing forth ways to identify, treat and even prevent disorders in some cases, and outpacing the capacities of the health service system to deliver mental health services to those who would benefit from it in a fair and equitable way. In your considerations of mental illnesses parity, please bring fairness to those Kansas families with mental disorders.

Mental Health Parity Costs

This is discussion of the effect on insurer claim costs of a mental health parity mandate.

Data presented here is from 1999 claims as recorded on the Kansas state database. Claims include all reported, in- and out-patient, and all providers paid by insurers. The data reviewed are diagnoses proposed for coverage, specifically ICD-9 codes 295, 296, 297, 299, 300, 301, and 314. Some subcodes under code 300 were estimated based on HCFA data because they were not all originally captured.

We estimate about 1.3% of Kansas health claim payments in 1999 were for these diagnoses. In 1998 a study of 1997 claims showed a comparative figure of about .8% then. Most of the increase appears to be from a higher proportion of allowed charges being paid by insurers. However, the database is now much more comprehensive than in 1997 and some of the increase is just due to better reporting.

Mental health diagnoses were paid at 72% of allowed charges in 1999. This compares to an average of 86% over all conditions. The differences from 100% are the various deductibles, coinsurances and copays, maximums, etc., present in insurance plans. All things being equal, mental health parity would increase mental health claim costs by 20%, which is the increase from the 72% to the 86% above. This would increase overall costs or premiums by .26%. This is probably simplistic. Individual insurance plans have not been examined in detail and there are probably large variations by company and by plan. Additionally, as was pointed out in 1998, it is not clear that some unintended coverages for long or custodial care stays may not be included. Those would increase costs considerably, perhaps 2% or more.

Most recent studies have given about a one percent increase in cost for mental health parity. Estimates of increases are generally lower now than in the past, perhaps from better information but also due to already increasing coverage by insurers raising the base. Some studies have given much higher increases, some by including substance abuse costs and the effect of increased utilization due to insurance, neither considered here, although increased utilization will probably occur to some degree.

Stephen Fernstein, M.D.

Mental Health Insurance Parity: It's right and it's time

Imagine that your child has a serious health problem that will require a lifetime of treatment. You open your health insurance benefits manual. You find for this particular disorder you are entitled to 30 days of hospitalization per year. Moreover, any treatments will be covered at 100% of the first $100, 80% of the next $100, and 50% of the next $1640 in any year up to a total of $7,500 in your child's lifetime. You read on and find that for all other disorders the insurance company will pay 80% of the cost of treatment after a deductible of $300 is satisfied. Moreover, your maximum out of pocket expense will be $2,000 per year and the overall lifetime limit will be $2,000,000. Does that seem fair or reasonable to you? I would not be surprised if you were shocked, outraged, and finally devastated at the unfairness of this arbitrary treatment.

These are exactly the insurance inequities that people who have a mental illness have been forced to accept. The result of this unfair and unequal treatment is that individuals and families affected by serious mental illnesses who have jobs and health insurance, either have had to bankrupt themselves to pay for treatment, are forced to depend on public agencies for care and treatment, and/or struggle to survive without adequate or effective treatment.

There was a time when mental illnesses were poorly understood and the effectiveness of medications and other treatments was far from optimum. People with these disorders were the butt of jokes and their suffering was somehow conceived to be of their own making. In spite of the dramatic advances in our understanding of the origins of mental illness in the brain and the major advances in effective treatment over the past 20 year, the inertia of decades of stigma continues to be reflected in the way Kansas health insurance is structured today.

The publication of the first Surgeon General's Report on Mental Health in 1999 heralded a new era in the acceptance and treatment of mental illness. The following are some of the observations in this report that are relevant to the parity issue:

- One in five Americans has a mental disorder in any one year;
- Mental illness is the second leading cause of disability and premature mortality in the United States;
- Mental health is fundamental to health;
- Mental disorders are real health conditions;
- The efficacy of mental health treatments is well documented; and
- A range of treatments exists for most mental disorders.

While parity is moot for the 44 million Americans who have no health insurance, there should no longer be any question about the need for or timeliness of legislation in Kansas that will ensure equal treatment for those who have insurance and need treatment for mental disorders.

Nonetheless, the health insurance industry continues to vigorously lobby against parity for Kansans. They make two arguments. The first is that government should not be in the business of mandating business practices and the second is that the cost of parity

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could make health insurance so expensive it will reduce either the number of people presently insured or the quality of their existing coverage.

The mandate argument is a "straw man". Kansas's statutes already regulate the insurance industry and these statutes specifically address coverage for mental illnesses. Proponents of Mental Health Parity are not asking for a new mandate. We are asking that the current mandate be revised to reflect the present state of scientific and medical knowledge about the treatment of mental illnesses. We propose that in light of this new knowledge it is neither reasonable nor fair to treat mental illness differently than other illness.

The health insurance industry says that requiring the same coverage for all illnesses might cause large increases in the cost of health insurance and, as a result, many employers would drop this benefit or their employees would not be able to afford it. They would like our legislators to believe that more data needs to be obtained before they should correct the inequities in the system. But they choose to ignore The Report On Mental Health Parity to the Congress by the National Advisory Mental Health Council and the report to the Office of Personnel Management (OPM) entitled A Look At Parity in Employer-sponsored Health Benefit Programs, both published last year. These reports examined the cost issues based on parity experiences in 31 states as well as a large number of major corporations that provide generous mental health and substance abuse benefits to their employees.

Parity level benefits were given to the 8.7 million beneficiaries of the Federal Employees Health Benefit Program this year. That decision was based upon the hard data cited above. A very sophisticated statistical simulation model estimated that there would be a total increase in health insurance premium costs of 1.4 percent when parity is implemented. A key finding in the OPM report was that, "The costs of providing appropriate treatment for mental and addictive disorders must be measured in a larger context that also considers disability costs, employee absenteeism and lost productivity. Taking these into consideration, employers found that traditional benefit limitations were not cost effective. Further, increasingly, employers have focused on health system performance based on employee health and functioning."

Parity has already been tested in Kansas. The state offered 25 percent of its employee's mental health parity through existing managed care plans for three years and now has extended that coverage to all 90,000 state employees. The decision to include all state employees was based, in part, on the finding that parity caused less than a 1.5- percent increase. This finding is exactly the same as the national datum on cost. Further data gathering on this issue is simply redundant. To cite reports that say that for every 1 percent of mental health cost increase there will be 300,000 people nationally who will lose their insurance coverage is to go far beyond the limits of the data. Specifically, those numbers are projections based on untested assumptions. They are not measures based on actual experience. In fact, the Surgeon General's report tells us that making mental health treatment more readily available produces a reduction in total health care costs. If that is the case then one could expect little or no change in the number of people covered.

There are no longer questions about the positive impact on individuals, businesses and communities when inequalities in insurance are eliminated. In the final analysis Mental Health Parity is not about insurance. It is not about costs. It ought to be all about doing what is right and fair. We hope that the 2001 Legislature will act now to end the discrimination in health insurance and offer relief to working individuals and families crushed by the financial burden of mental illness.

Stephen H. Feinstein, Ph.D.
Kansas Mental Health Coalition, Chair
NAMI Kansas, President

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Committee on Financial Institutions and Insurance
Testimony on Equal Coverage Insurance
Paul M. Klotz, CEO
FEBRUARY 14, 2001

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

This is a fiscal issue.

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

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

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

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

The public supports it.

In June a nationwide poll conducted by Opinion Research Corporation for the National Mental

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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.

We attended a session on mental health parity while at the NCSL conference a couple years ago. Information was presented that mental health parity is an issue that is receiving a lot attention from state legislatures -- during the 1997-98 legislative sessions 88 bills were introduced in 32 states. Thirty-two states now have parity.

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

I ask you to review the NIMH study. It is particularly significant because for the first time, a nonpartisan and objective agency (unconnected to mental health advocates or insurance

companies) has examined all available data and concluded that parity will not break the bank!

It will help reduce the stigma of mental illness.

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

The Consortium Inc.
Community-Based Mental Health & Substance Abuse Services

TESTIMONY TO THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE CONCERNING SENATE BILL 274

2/14/01
Presented by Jan Clay, President/CEO
The Consortium Inc.

Good Morning Senator Praeger and distinguished committee members. My name is Jan Clay. I am the President and CEO of a locally based, non-profit behavioral health care provider sponsored organization. The name of my organization is The Consortium Inc. My organization provides management services to a variety of public and private purchasers in the delivery of mental health and substance abuse services both regionally and statewide. My organization manages a provider network made up of all 29 licensed community mental health centers, hospitals that provide psychiatric and substance abuse care, and some substance abuse agencies.

I am here to voice my support of Senate Bill 274, commonly referred to as the Mental Health Parity Bill. I believe that individuals and families should have the same access to mental health services that they have for medical care. The argument of mental illness and substance abuse issues having just as much of a devastating impact on lives and communities as physical illnesses has been well documented. The fact that mental illnesses and substance abuse illnesses have a biological basis has also been extensively research and validated. The social and economic negative impacts of mental illness and substance abuse have been written and verbally articulated for the past 40 years

Needless to stay the arguments reference are enough to justify Senate Bill 274. However, let me add that the "science" of mental health treatment has progress and continues to progress in developing effective best practices that have been documented to improve the condition of individuals and families with a variety of psychiatric diagnoses.
No longer is mental health treatment seen as "more art than science". There continues to be a growing body of science-based knowledge about the assessment and treatment of mental illness.

I would like to present to the committee several charts that display our current experience in identifying the top ten diagnostic categories in some of the contracts we manage. I would like to explain to you that this data comes from two of our databases. Our Automated Information Management System (AIMS) and our Health Wave database. This information is a very small sample and is not representative of the total number of Kansas's residents that are seen. The numbers of Medicaid eligible and indigent residents that are seen in our system far out number the residents that have commercial

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who have commercial insurance and the associated percentages indicate the most frequent diagnoses in this pool.

Go through Charts:

The data that we have identified would suggest that the primary diagnostic groups that our providers are treating for adults are Major Depression, Dysthymic Disorders, Adjustment Disorders, Personality Disorders and Alcohol Abuse. For children the most frequent diagnostic groups treated were ADHD, Oppositional Defiant, Adjustment Disorders, Dysthymic Disorders, Depressive Disorders, Conduct Disorders, Major Depression, and Disruptive Behavior.

The good news is that the majority of these diagnostic groups have empirically base best practice guidelines that can be used to manage the care in the most efficient and effective ways possible. The number of diagnostic groups that were identified in SB 274 is so small that it did not make it into our material. These diagnoses also have in most cases, empirically based practice guidelines that assist clinicians in managing care.

I am somewhat concerned on the lifetime coverage of $7,500. This amount will severely restrict the amount of medically necessary services that may be required for individuals who suffer from those diagnosis that have been identified in SB 274 as well as some of the diagnosis present in our data. Given the nature of commercial populations, in that they may tend to reflect other diagnostic groups that are not included in SB 274, but also may be of a severe nature, I believe that a review of the lifetime benefit limitation of $7,500.00 is necessary. At a minimum, I have seen many commercial plans include an annual 20-visit outpatient and a 30-45 day annual inpatient stay. In addition, some benefit plans allow the "flexing" of services in which for example one day of inpatient can be substituted for 2 days of partial hospitalization.

One final comment I would like to make is that there has been significant progress in the research of what is called a "Medical Cost Offset". This is a result of decreasing the need for some medical services when an associated mental illness is being treated. This result also translates into fewer dollars for total care of the individual.

I applaud the committee in introducing a bill that will move toward providing mental health benefits, hopefully on an equal footing with medical benefits, to Kansas's residents. If the committee has any questions, please free to ask know or at a later date.

Thank you.

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The Consortium Inc.
Community-Based Mental Health & Substance Abuse Services

TABLES

1. Diagnosis by BC/BS (Adults) AIMS Data Base Outpatient Services
2. Diagnosis by Other Private Insurance (Adults) AIMS Data Base Outpatient Services
3. Diagnosis by BC/BS (Youth) AIMS Data Base Outpatient Services
4. Diagnosis by Other Private Insurance (Youth) AIMS Outpatient Services
5. Diagnosis by Number of Inpatient Days (Youth) Health Wave Data Base Inpatient Services
6. Diagnosis by Number of Outpatient Service Hours (Youth) Health Wave Data Base Outpatient Services

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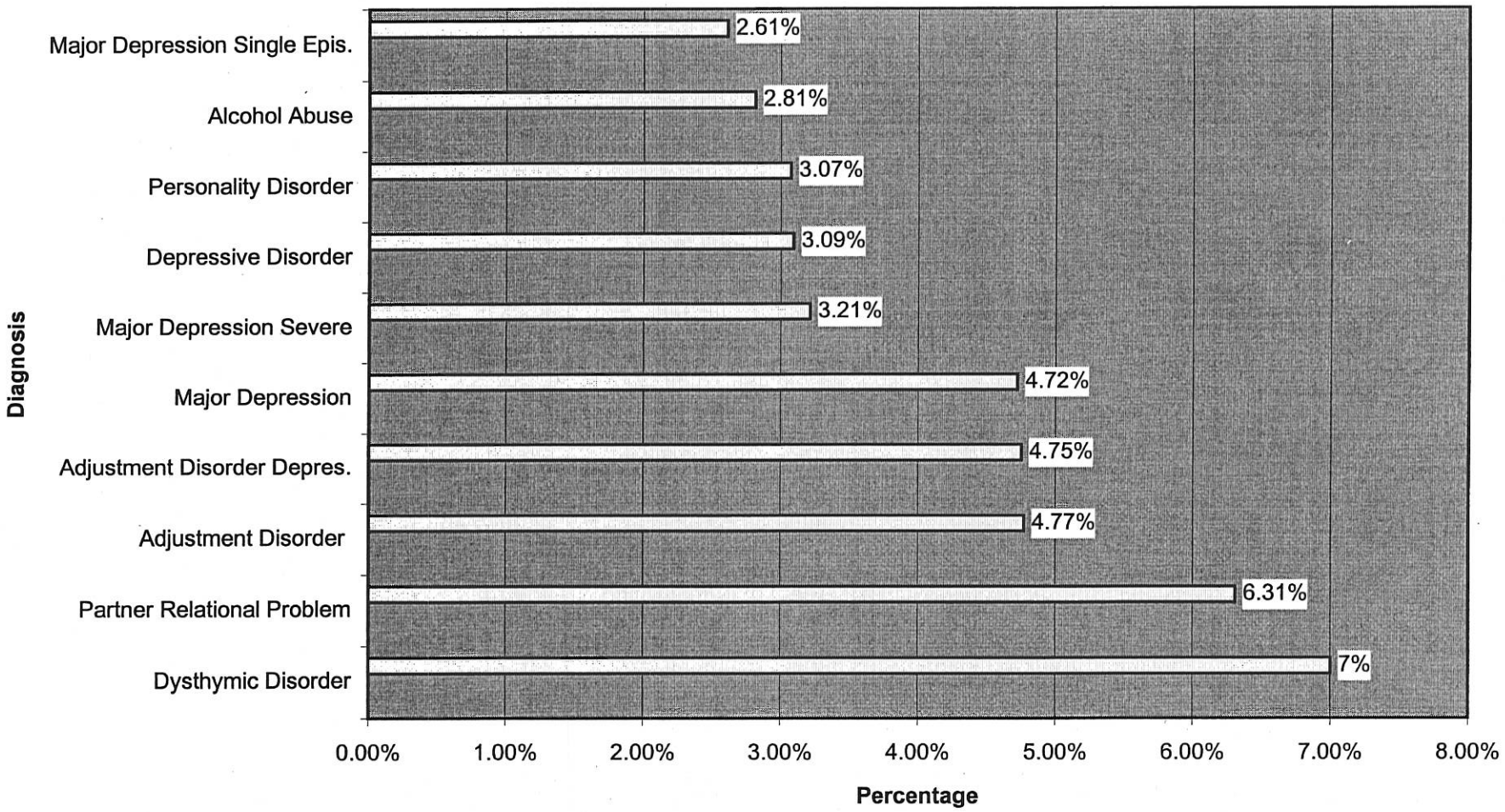
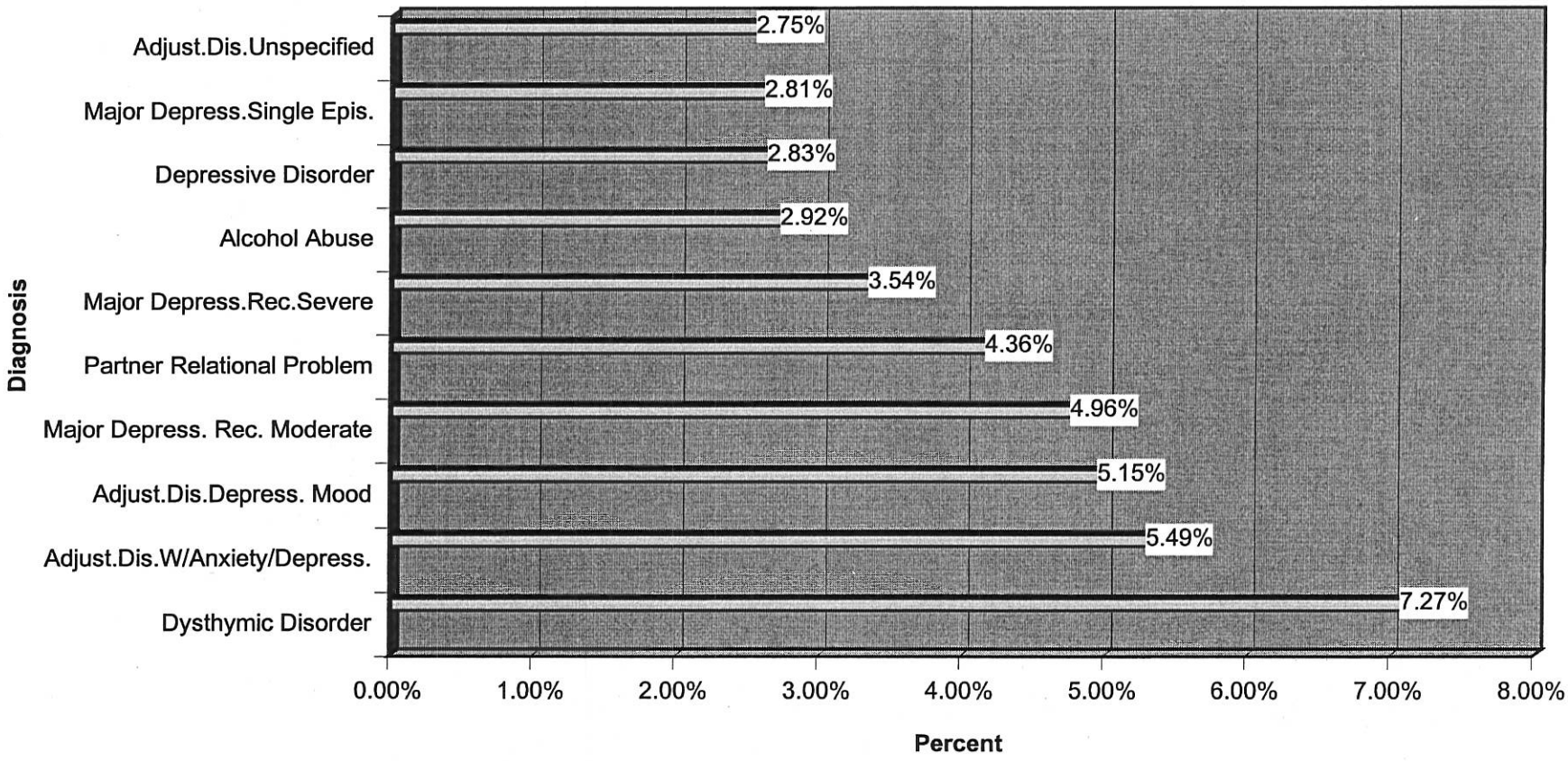
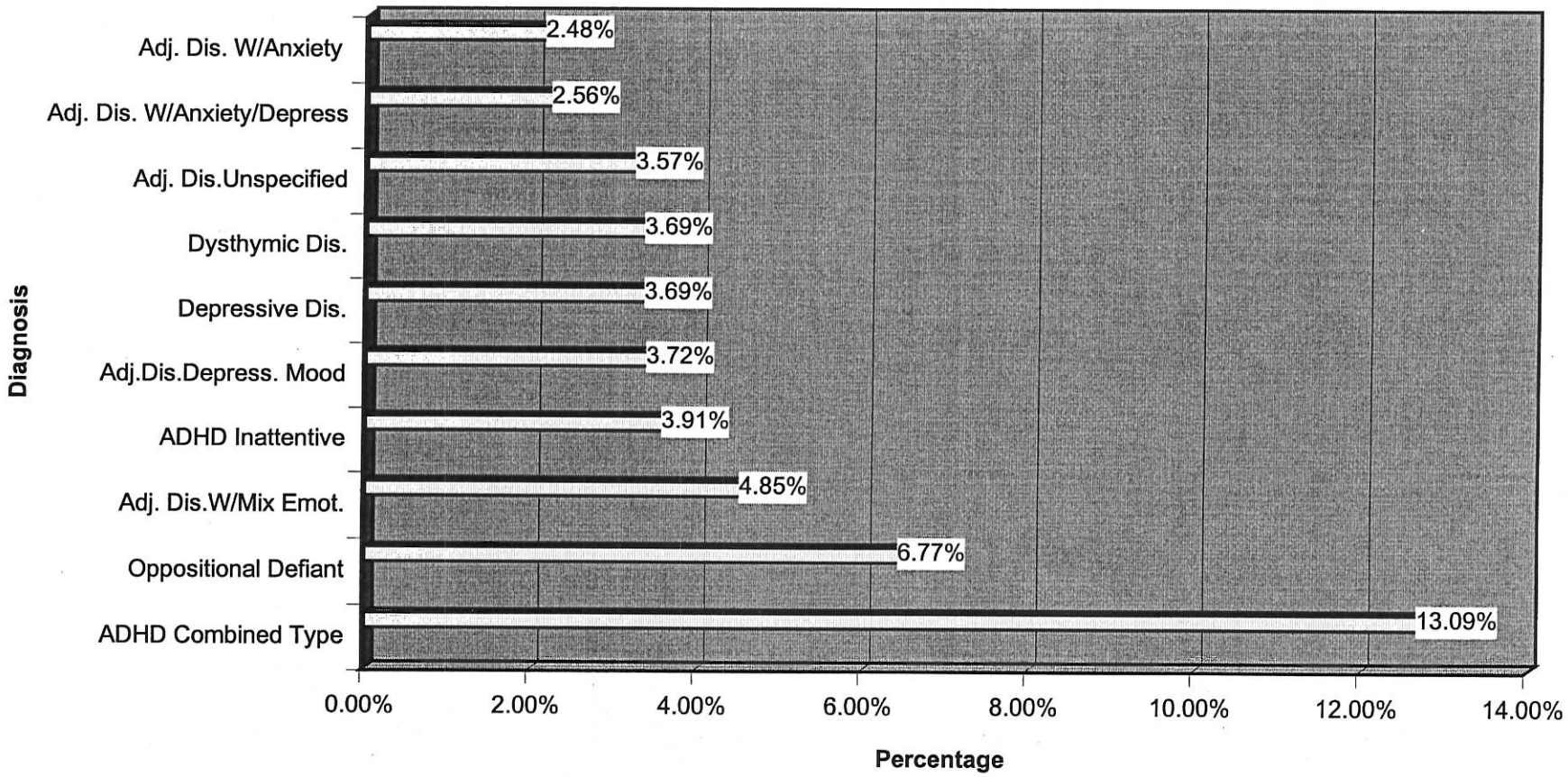
Diagnosis by BC/BS (Adults)
AIMS Data Base
Outpatient Services
July Thru Dec 2000



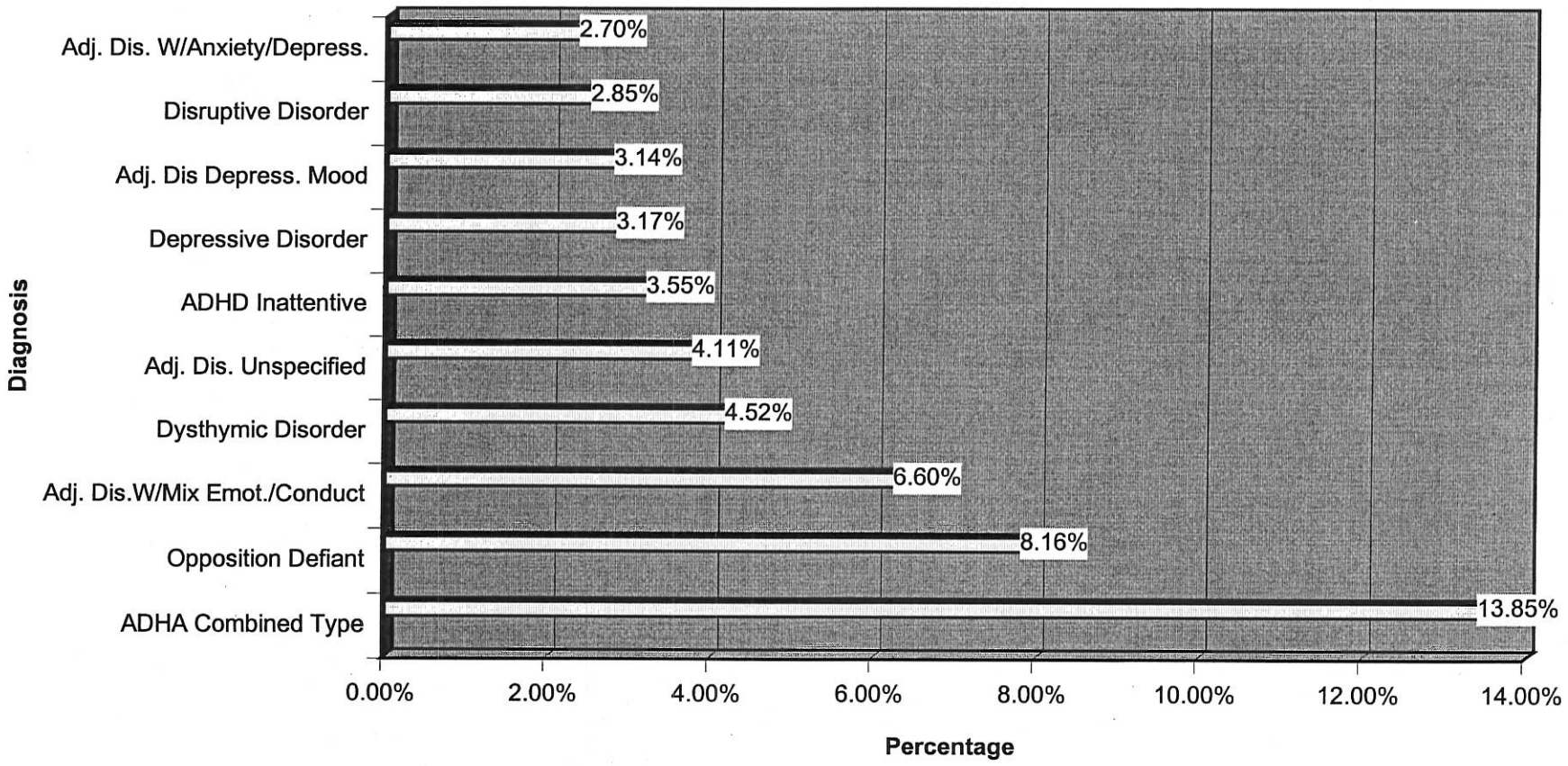
Diagnosis by Other Private Insurance (Adults) AIMS Data Base
Outpatient Services
July Thru Dec 2000



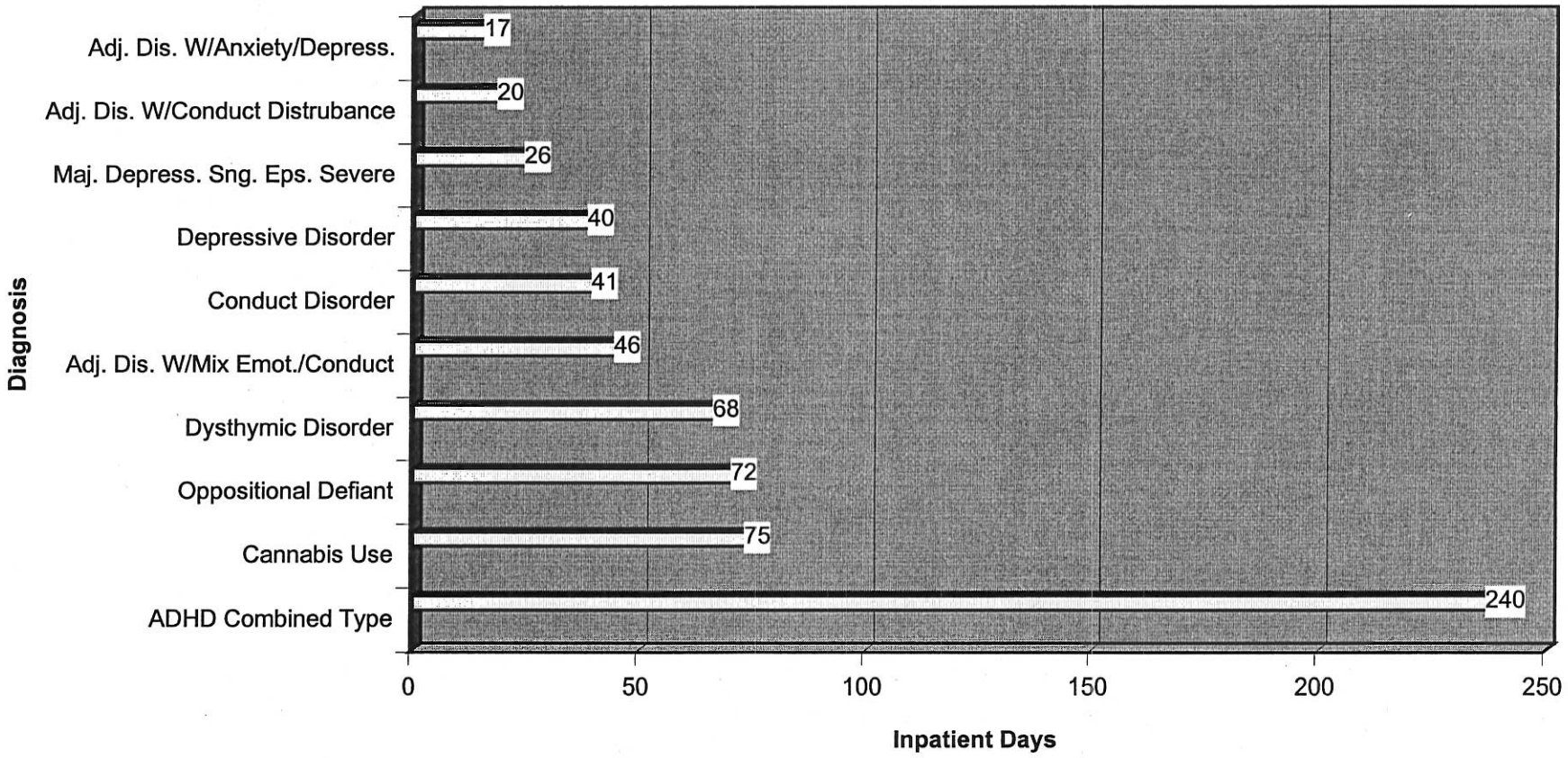
Diagnosis by BC/BS (Youth) AIMS Data Base
Outpatient Services
July Thru Dec 2000



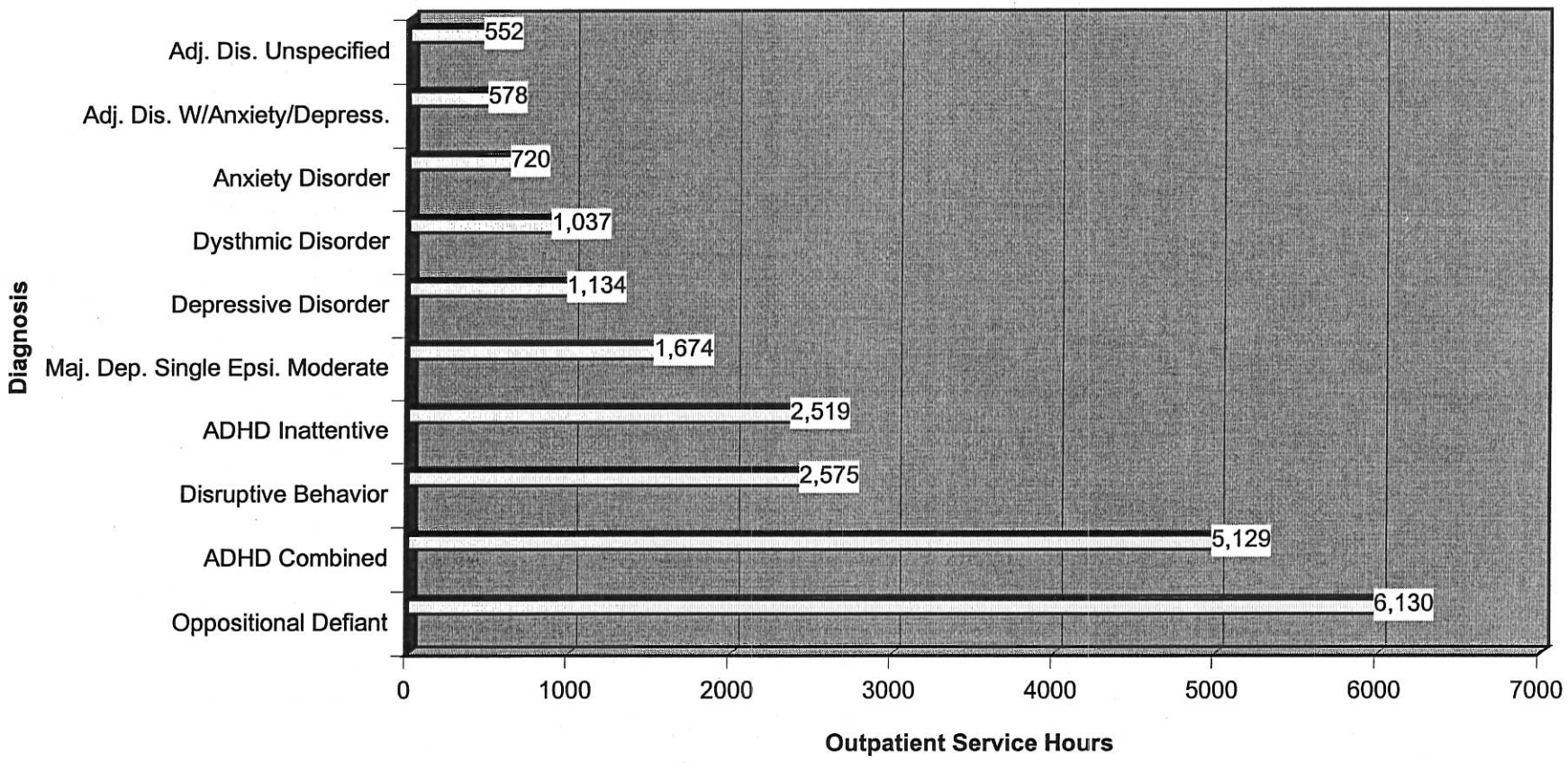
Diagnosis by Other Private Insurance (Youth) AIMS Data Base
Outpatient Services
July Thru Dec 2000



Diagnosis by Number of Inpatient Days (Youth) Health Wave Data Base
Inpatient Services
January Thru December 2000



Diagnosis by Number of Outpatient Service Hours (Youth) Health Wave Data Base
Outpatient Services
January Thru Decmber 2000



Practice Directorate

Medical Cost Offset

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I. Defining Medical Cost Offset: Policy Implications

A. Definition of Medical Cost Offset

For the purposes of this analysis, medical cost offset is defined as follows: an offset occurs if medical utilization decreases as a result of mental health intervention. A *Total Offset* occurs when general health care savings exceed the cost of the mental health treatment effectively resulting in the treatment paying for itself. *Fiedler, J.L., and Wight, J.B. (1989). The medical offset effect and public health policy: Mental health industry in transition. New York: Praeger.*

B. Mental Health Patients Typically Overutilize Medical Services

1. **Many visits to primary care physicians are actually mental health related**

   - Only 5% of those suffering from a mental disorder see a mental health professional; the other 95% receive treatment from a family physician. *Lechnyr, R. (1993). The cost savings of mental health services. EAP Digest, 22.*

   - 'Between 11-36% of all general care physician visits involved patients with diagnosable psychiatric disorders.' *Eisenberg, L. (1992). Treating depression and anxiety in primary care. New England Journal of Medicine, 326, 1080-1083.*

   - 'Many patients with mental health problems are treated in ordinary health care services. They are often multi-users of care.' *Borgquist, L., Hansson, L., Lindelow, G., Nettelbladt, P., & Nordstrom, G. (1993). Perceived health and high consumers of care: A study of mental health problems in a Swedish health care district. Psychological Medicine, 23, 763-70.*

   - 'Approximately 10 percent of adults have anxiety disorder, yet it is estimated that only one-fourth of affected persons receive treatment. Treatment is usually given in a general medical setting rather than through the mental health system. Most patients with anxiety disorders are treated by nonpsychiatrist physicians who are generally familiar with the pharmacological management of anxiety. However, nondrug treatment can be more

H 7-10

effective, and may be both time-efficient and less risky.' *Altrocchi, J., Antonuccio, D., Basta, R. & Danton, W.G. (1994). Nondrug treatment of anxiety. American Family Physician, 10, 161-6.*

- Researchers have estimated that between 50 and 70 percent of a physician's normal caseload consists of patients whose medical ailments are significantly related to psychological factors. *VandenBos, Gary R. & DeLeon, Patrick H. (1988). The use of psychotherapy to improve physical health. Psychotherapy, 25, 335-343.* If mental health care were available to these patients, it could reduce medical utilization and generate significant cost savings.

2. Patients with mental illness are heavy users of medical services

Patients diagnosed with mental illness are typically heavy users of medical services. If mental health services were made available to these patients, medical utilization would decrease resulting in potentially large savings to health care programs.

- Studies have shown that those persons not receiving mental health services visited a medical doctor twice as often for unnecessary care than persons who receive treatment. *Lechnyr, R. (1992). Cost savings and effectiveness of mental health services. Journal of the Oregon Psychological Association, 38, 8-12.*

- A recent six year analysis of the Hawaii Medicaid population, funded by a $5.5 million government grant, included 16,000 Medicaid recipients and nearly 30,000 federal employees. By tracking medical records, researchers were able to show that patients seeking mental health treatment during the study period were much higher utilizers of the medical system, with physical health care costs 200 to 250 percent higher than those not seeking mental health intervention. *Cummings, N.A., Dorken, H., Pallak, M.S. et al. (1990). The impact of psychological intervention on healthcare utilization and costs. Biodyne Institute, April 1990.*

- Concluding a systematic review of the scientific literature regarding mental health in primary care settings, one researcher calculated primary care utilization differences. He reported that patients with diagnosable mental disorders average twice as many visits to their primary care physicians as those without a mental disorder. *Borus, J.F. & Olendzki, M.C. (1985). The offset effect of mental health treatment on ambulatory medical care utilization and charges. Archives of General Psychiatry, 42, 573-580.*

- Research based at the Columbia Medical Plan, a prepaid Maryland group practice divided approximately 20,000 enrollees into three groups: mentally ill who received treatment, mentally ill who did not receive treatment, and a comparison group who had no diagnosable mental disorders. Statistics showed that in all three study years, the comparison group utilized less medical services than individuals with mental disorders. During a one year period, untreated mentally ill increased their medical utilization by 61%, while the comparison group averaged only a 9% increase. The treated group was similar to the comparison population, averaging only an 11% average increase. *Hankin, J.R., Kessler, L.G. & Goldberg, I.D. (1983). A longitudinal study of offset in the use of nonpsychiatric services following specialized mental health care. Medical Care, 21, 1099-1110.*

II. Medical Cost Offset

. Amount of Offset can Depend on the Severity of Illness

1. Those with less severe mental illnesses can realize significant offsets

Offset studies reveal evidence that less severe mental disorder diagnoses, the conditions most amenable to psychotherapy, also demonstrate the greatest offset effects. Numerous sources provide support for this claim.

- Borus corroborated these findings in a 4-year study of 8,100 enro- llees at an ambulatory medical clinic in Boston. He found that while patients who received psychotherapy for a non-chronic condition *decreased* their nonpsychiatric services utilization by 7.2 percent, similarly diagnosed patients who did not receive mental health intervention increased their utilization by 9.5 percent. The cumulative difference between these groups was a substantial 16.7 percent--and lasted for the next 24 months of observation. *Borus, J.F. & Olendzki, M.C. (1985). The offset effect of mental health treatment on ambulatory medical care utilization and charges. Archives of General Psychiatry, 42, 573-580.*

- The Columbia Medical Plan, rendering medical and psychiatric services to predominantly white, educated, middle class enrollees, provided the site for this offset study. The study group originally included nearly 1200 enrollees whose utilization rates were studied for one year prior to the first psychiatric visit. After psychiatric treatment was implemented, subjects were studied for two more years to determine changes in utilization patterns. The total sample of psychiatric care recipients decreased their medical utilization an average 11.1% during the six months following treatment. Significant offset effects were still present up to two years after completion of the psychiatric intervention. Results were even more striking for patients with less disabling diagnoses who received high intensity therapies. *Kessler, L.G., Steinwachs, D.M. & Hankin, J.R. (1982). Episodes of psychiatric care and medical utilization. Medical Care, 20, 1209-1221.*

2. Those with serious physical illnesses can also realize offsets

- A study of a large population of Medicaid recipients and federal employees found that patients with chronic medical illnesses (e.g., diabetes, hypertension, etc.) lowered their medical costs 18-31% after receiving targeted psychological services. *Lechnyr, R. (1992). Cost savings and effectiveness of mental health services. Journal of the Oregon Psychological Association, 38, 8-12.*

- Patients with more severe physical disorders can realize significant reductions in medical utilization if provided with mental health care. A study of the Georgia Medicaid population (see Sec. III) showed that patients who used inpatient services during a ten quarter period spent $11,391. Outpatients spent a comparatively small $2,574 during the same period. Thus, patients undergoing surgery or other traumatic inpatient procedures have the highest potential to realize offset effects. *Fiedler, J.L. & Wight, J.B. (1989). The medical offset effect and public health policy: Mental health industry in transition. New York: Praeger.*

- Other studies have shown that patients with functional limitations, including physical handicaps and debilitating physical ailments, show high potential for offset. The Rand Corporation designed a study involving nearly 4,500 subjects from six geographically diverse sites. Researchers assigned families to one of 14 fee-for-service insurance plans

which ranged in mental health coverage from free psychiatric care to almost no coverage. Each enrolle was tested for psychological and physical well-being using a battery of standard tests. The authors found that in every category of mental health status (low, medium, or high functioning) those who had functional limitations (defined as physically caused impairment in ability to carry out the activities of daily living) used 50% to 100% more mental health services than those without such limitations. The study concluded that those with functional limitations due to poor health are high users of both medical and mental services. The high-price of these subjects' health care makes them excellent candidates for offset. *Ware, J.E., Manning, W.G., Duan, N., et al. (1984). Health status and the use of outpatient mental health services. American Psychologist, 39, 1090-1100.*

3. **Those with serious mental illnesses can realize an offset in terms of slowing their consumption of expensive medical services**

   - 'Diagnosing and treating patients with multiple personality disorder resulted in net savings of $84,900 per patient, in direct [medical] costs alone, during the first ten years following treatment.' *Dua, V., & Ross, C. (1993). Psychiatric health costs of multiple personality disorder. American Journal of Psychotherapy, 47, 103-112.*

   - 'Earlier diagnosis of patients with multiple personality disorder could save $250,000 per case in direct [medical] costs alone if the [disorder] is identified within the first year of the patient's utilization of medical care.' *Dua, V., & Ross, C. (1993). Psychiatric health costs of multiple personality disorder. American Journal of Psychotherapy, 47, 103- 112.*

   - Borus showed that patients diagnosed with severe mental ailments who do not receive psychological treatment increase their medical utilization at significantly faster rates than those chronic patients who do receive treatment. These results indicate that unless the severely mentally ill enter the mental health system, they are likely to become voracious users of already limited medical resources. Borus and other offset analysts suggest that in the absence of appropriate psychiatric care, the cost to insurers and to the primary care system is astronomical. *Borus, J.F. & Olendzki, M.C. (1985). The offset effect of mental health treatment on ambulatory medical care utilization and charges. Archives of General Psychiatry, 42, 573- 580.*

B. Making Outpatient Mental Health Care Available can Offset the Cost of Expensive Inpatient Care

- 'Mental health costs at General Leonard Wood Army Community Hospital had risen every year significantly. By increasing the size and scope of outpatient care to reduce inpatient admissions, net costs were reduced by $1.7 million.' *Armstrong, S.C., & Took, K.J. (1993). Psychiatric managed care at a rural MEDDAC. Military Medicine, 11, 717-21.*

- Between 1989 and 1992, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) expanded its yearly outpatient psychiatric care expenditures from $81 million to $103 million which resulted in a net savings of $200 million because of greatly reduced psychiatric hospitalization. *Psychiatric Times, August, 1993.*

- Positive results such as these take on even more significance when considering the prevalence of the four chronic diseases studied. 40% of the American population suffers from diabetes, ischemic heart disease, hypertension, or airway-respiratory conditions Given the correct psychological

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intervention, a huge number could limit their medical expenditures while simultaneously improving their mental health status--at virtually no cost. *Cummings, N.A., Dorken, H., Pallak, M.S. et al. (1990). The impact of psychological intervention on healthcare utilization and costs. Biodyne Institute, April 1990.*

- '...individuals suffering from mental illness who also have severe enough physical health problems to be admitted inpatient for treatment provide the greatest vehicle for saving physical health treatment dollars via the offset effect.' (p 97) *Fiedler, J.L., and Wight, J.B. (1989). The medical offset effect and public health policy: Mental health industry in transition. New York: Praeger.*

- Numerous studies have confirmed that behaviorally disordered adolescents are more effectively treated in alternative or outpatient programs as opposed to inpatient programs. *Leone, Fitzmartin, & Foster (1986).*

C. Mental Health Care Utilization is Stable and Predictable

Insurance companies are fearful that generous mental health coverage will result in adverse selection and excessive use of services. Decades of research, however, have shown that mental health costs are a small percentage of total health care expenditures, and that utilization of mental health services is predictable and stable, regardless of a policy's generosity.

- For the past 20 years, behavioral health's share of total spending has remained constant at between 12-14%. *Health Care Professional, Sept. 1992.*

- The Rand Corporation designed a study involving nearly 4,500 subjects from six geographically diverse sites. Researchers assigned families to one of 14 fee-for-service insurance plans which ranged in mental health coverage from free psychiatric care to almost no coverage. In the study, both the probability of receiving mental health care and the intensity of care were directly related to amount of psychological distress. This finding indicates that those who need psychological services most are the ones most likely to seek it--regardless of cost. Enrollees were very unlikely to use mental health services inappropriately, even with the most plentiful coverage. *Ware, J.E., Manning, W.G. & Duan, N. (1984). Health status and the use of outpatient mental health services. American Psychologist, 39, 1090-1100.*

- Other data attesting to the stability of the mental health care system comes from the Blue Cross \ Blue Shield federal employees plan. These statistics show that after a slight initial increase in costs following the introduction of a broad mental health care package, psychiatric service utilization at Blue Cross \ Blue Shield did not vary more than .5 percent in over 11 years. *Sharfstein, S.S., Muszynski, S., and Arnett, G.M. (1984). Dispelling myths about mental health benefits. Business and Health, Oct. 1984, 7-11.*

III. Savings in Terms of Dollars

- NIMH released a study which found that the cost of covering mental illness on the same basis as medical illness would cost only $6.5 billion and that spending this extra amount would save U.S. taxpayers $8.7 billion in indirect costs associated with untreated mental illnesses. *Goodwin, F.K., & Moskowitz, J. (1993). Health care reform for Americans with severe mental illness: Report of National Advisory Mental Health Council.*
- The Group Health Association found that patients receiving mental health counseling trimmed their non-psychiatric usage by 30.7% and their use of laboratory and x-ray services by 29.8%.

Kansas City Health Care Consumer, Feb., 1993.

- When the Utah division of Kennecott Copper Corporation provided mental health counseling for employees, its hospital medical and surgical costs decreased 48.9%. The company's weekly claims costs dropped nearly 64.2%. In all, for every dollar spent on mental health care, the company saved $5.78. *Lechnyr, R. (1993). The cost savings of mental health services. EAP Digest, 22, 23.*

- 'A study of Kaiser Permanente patients who received psychotherapy showed a 77.9% decrease in the average length of stay in the hospital, a 66.7% decrease in frequency of hospitalizations, a 48.6% decrease in the number of prescriptions written, a 48.6% decrease in the number of physicians seen for office visits, a 47.1% decrease in physician office visits, a 45.3% decrease in emergency room visits, and a 31.2% decrease in telephone contacts.' *Lechnyr, R. (1993). The cost savings of mental health services. EAP Digest, 22, 23.*

- A study of the entire Georgia Medicaid population revealed substantial offset savings resulting from mental health treatments. Patients receiving inpatient physical health treatment in addition to their mental health treatment realized a cumulative savings of nearly $1,500 over a two and a half year period. The cost of the mental health intervention was entirely paid for (i.e totally offset) by these savings. The result is psychologically and physically healthier patients at essentially no charge. While not reaching total offset, patients without physical ailments requiring inpatient treatment who received mental health care still showed significant savings. This group, which contained both severe and less severe diagnoses, had medical health charges that were lower than comparison samples by $296 to $392 during the study period. *Fiedler, J.L. & Wight, J.B. (1989). The medical offset effect and public health policy: Mental health industry in transition. New York: Praeger.*

- A three year study of over 10,000 Aetna beneficiaries showed that after the initiation of mental health treatment, client medical costs dropped continuously over the next 36 months. The health costs of one mental health intervention group fell from $242 the year prior to treatment to $162 two years post-treatment. Other subject groups demonstrated similarly dramatic offset effects, leading the researchers to conclude that a decrease in total health care costs can be expected following mental health interventions *even when the cost of the intervention is included. Holder, H.D. & Blose, J.O. (1987). Changes in health care costs and utilization associated with mental health treatment. Hospital and Community Psychiatry, 38, 1070-75.*

IV. Special Cases: Nicotine and Chemical Dependency

A. Smoking

- It is estimated that lifetime excess expenditures of current or previous smokers to be about $6,239 per smoker, with a cumulative burden of $500 billion on the U.S. economy. *Hodgson, Journal of the American Medical Society, March, 1993.*

- Every year thousands die or are hospitalized as a direct result of their smoking. The economic costs are conservatively estimated to range between $336 and $601 a year per smoker--billions of dollars annually absorbed by insurers and the health care system. *Shipley, R.H., Orleans, C.T. & Wilbur, C.S. (1988). Effect of the Johnson & Johnson Live for Life Program on employee smoking. Preventive Medicine, 17, 25-34.*

- In the last two decades smoking cessation techniques developed by psychologists have helped

millions cease this self-destructive habit. Scientists calculate that 70 percent of all smokers would stop smoking if introduced to rapid smoking or similar psychological treatments, and 40 percent or more would remain abstinent for at least 6 months to a year. *Yates, B.T. (1984). How psychology can improve effectiveness and reduce costs of health services. Psychotherapy, 21, 439-451.*

B. Alcoholism and Drug Dependency

Experts estimate that drug abuse alone costs General Motors corporation an estimated $520 million to $1.5 billion annually for treatment, absenteeism, and repair of defective work. *The Psychiatric Times, March, 1991.* In addition, according to an American Medical Association (AMA) study, nearly one dollar in four of total health care spending goes to victims of drug abuse, violence, and other kinds of social behaviour that could be changed. Such behaviour is adding $171 billion to our nation's health care bill, $85 billion of that cost is attributable to alcohol use. *New York Times, Feb. 23, 1993.*

- 'In Japan, the alcohol attributable costs of medical care were estimated to be 1,095.7 yen or 7% of the total national medical expenditure. Reduced productivity as a result of alcohol use was estimated at about four times that amount, or 4257.3 yen billion. Summing up the total cost of alcohol abuse was estimated at 6,637.5 yen billion.' *Nakamura, K., Tanaka, A., & Takano, T. (1993). The social cost of alcohol abuse in Japan. Journal of the Studies of Alcohol, 5, 618-25.*

- 'The costs attributable to smoking in Texas continue to rise. The most recent estimates show more than $4 billion in 1990 can be associated with the health care costs from treatments for disease and the indirect costs associated with mortality and morbidity.' *Franklin, J. & Williams, A.F. (1993). Annual economic costs attributable to cigarette smoking in Texas. Texas Medicine, 89, 56-60.*

- 'Medicaid patients with drug and alcohol problems who received targeted psychological services reduced their subsequent medical costs by [15%] . . . those not receiving psychological assistance increased their medical costs by [90%] . . . .' *Lechnyr, R. (1992). Cost savings and effectiveness of mental health services. Journal of the Oregon Psychological Association, 38, 8-12.*

- A University of California study found that every $1 spent on drug and alcohol treatment saves society $11.54 in health care and criminal justice costs and lost productivity for business. *Coalition '91.*

- Scientists have found that failure to receive treatment for alcohol and substance abuse diagnoses can result in a very rapid escalation of individual medical costs. Cummings very recently concluded a study of Medicaid recipients in Hawaii (See Sec I B 2). After a review of medical records, he found that patients diagnosed as chemically dependent who did not use mental health services increased their medical costs by 91% during the study period, com- pared to actual decreases in medical costs by treatment recipients. Some types of intervention produced net decreases of approximately $514 per person in the first twelve months after treatment. *Cummings, N.A. (1990). Psychologists: An essential component to cost-effective, innovative care. Paper presented to the American College of Healthcare Executives, Feb, 1990.*

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Senate Financial Institutions and Insurance Committee
Wednesday, February 14, 2001
Rochelle Chronister

Thank you Chairwoman Praeger and Members of the Senate Financial Institutions and Insurance committee for the opportunity to testify today in favor of providing parity for the coverage of mental illnesses in insurance policies in Kansas.

One of the main reasons that I appear before you today is my present position as chairman of the Kansas Advisory Group (KAG) on Juvenile Justice; the other reason is because of the experiences that I had as Secretary of the Kansas Department of Social and Rehabilitation Services which had the responsibility for overseeing the delivery of mental health services in the state.

In regard to my present position with the Kansas Advisory Group I would like to provide you with a copy of the annual report of the Coalition for Juvenile Justice which is the national association of state advisory groups on juvenile justice. I know that you get several thousand pieces of paper and numerous annual reports in your position; however this is one of the clearest pieces of evidence that I have seen in regard to mental illness and juvenile crime. The report has anecdotal evidence which is not my favorite kind, but the illustrations are clear as to what types of illnesses around 50% of the youth who are involved with the juvenile system have. The factual information and numbers in regard to untreated mental illnesses of juvenile offenders make it clear that one of the ways that society could pay for parity would be by the potential reduction in juvenile crime that treatment of some of these illnesses would hold.

While I served as Secretary of SRS I was appalled to discover how little help we were able to provide children who had serious mental illnesses. Many parts of the states only had professionals available at state hospitals and parents had to travel long distances to access any kind of treatment. SRS began working with Community Mental Health agencies to remedy this problem several years ago, but it has really only been in the last few months that a coalition of SRS and CMHC's has announced a newly funded mental health initiative which will have a focus on mental diseases of children and youth.

If we can identify and begin treatment of children who have mental illnesses when they are young we can, in many cases, reduce the long term effects on families and society that untreated illnesses cause. It is clear that some help is available through schools, but too often the burden falls on a family that is not able to pay for the type of treatment that is needed in addition to special education classes. I ask for your support of mental health parity and would be pleased to answer questions.

Route 2 - Box 321A, Neodesha, KS., 66757

Senate Financial Inst. & Insurance
Date: 2-14-01
Attachment No. 8

State-wide Experiences Following Passage Of Mental Health Parity

Texas, Maryland, Rhode Island, Minnesota

Interim Report to Congress by the National Advisory Mental Health Council

A report entitled "Parity in Coverage of Mental Health Services in an Era of Managed Care" is a product of the Department of Heath and Human Services, the National Institutes of Health and the National Institute of Mental Health. This report is an interim report to Congress by the National Advisory Mental Health council. The study's major findings are:

> "1. Based upon empirical studies and economic simulations across diverse populations, managed care approaches, and parity structures suggest that the introduction of parity in combination with managed care results in lowered costs and lowered premiums (or, at most, very modest cost increases) within the first year of parity implementation.
>
> 2. These findings do not support earlier concern about potentially high financial costs caused by parity. Prior estimates were based on fee-for-service (FFS) models that are no longer valid for a market dominated by managed care and likely to become even more so."

Maryland

On July 1, 1995, the State of Maryland implemented parity legislation that applied to all insurers. The legislation applied to those mental health and addictive disorders determined to be medically necessary and treatable. After parity was instituted, a small increase was observed in the number of inpatient admissions per 1000; that increase was more than offset by a more significant decrease in the average length of inpatient stays. Outpatient visits decreased as much as 9%, although isolated instances of increased outpatient utilization were seen. (1)

For one insurer, the proportion of the total medical premium attributable to the mental health benefit actually decreased by 0.2 percent after the implementation of full parity. A second managed care company with extensive experience in Maryland subsequently confirmed that their average that their average expense per member per month increase by less than 1.0 percent during the first 7 months after full implementation of parity. (1)

After parity was implemented there was a small increase in the number of inpatient admissions per 1000 members, a decrease in the average inpatient length of stay, and a decrease in outpatient visits. New findings indicate that in the past year inpatient admissions remained level or decreased, while length of stay continued to decrease, outpatient visits increased, and use of intermediate-care treatments (such as intensive outpatient care and partial hospitalization) increased over time. The percentage of the population receiving services (treated prevalence) remained steady or decreased since the introduction of parity. (2)

The cost of introducing parity in Maryland was low. Additional data received during the past year from Maryland indicate that after an initial increase following implementation of parity, PMPM mental health/substance abuse costs dropped back towards pre-parity baseline levels. (2)

In a group of Maryland residences for whom data on total health care costs are available, the cost for treating mental health/addictive disordrs rose by 0.84% of overall benefit costs in the first year following parity (transition to parity). During the second year (full parity), the costs were unchanged, and in the third year of follow up treatment costs decreased by 0.27% of total benefit cost. (2)

Rhode Island

On January 1, 1995, the State of Rhode Island implemented limited parity legislation. After parity was instituted in Rhode Island, there was a moderate increase in the number of inpatient admissions per 1000 members, and a moderate reduction in the average length of inpatient stays, with an overall increase in days per 1000 members. The average overall mental health cost increases resulted in an increase of total plan costs of less than 1 percent (specifically 0.33 percent of total benefit). (1)

Minnesota

Minnesota passed full parity effective August 1, 1995. Language to accomplish full parity is included in Minnesota's insurance statutes. The statute is similar to the following wording with separate sections to independently describe inpatient and outpatient parity. To date, there has been no recognized cost concerns or exodus of insured plans to ERISA status in order to avoid the Minnesota parity mandate.

According to John Gross, Director of Health Care Policy – Insurance Federation, "No one has cited rising mental health costs as reasons for premium increases." The Minnesota Department of Commerce, the state agency that regulates indemnity insurance, estimated costs of 1% of total premium dollars for mental health parity. Medica, an independent consulting organization, estimated Minnesota costs for mental health parity is $.26 per member per month. (2)

State-wide Experiences Following Passage Of Mental Health Parity

Connecticut

Summary of attachment

In 1999, Connecticut became the first state to change a narrow diagnosis specific parity bill (SMI) into a broad-based law. This was apparently in response to perceived abuses under the old law that provided carriers wide latitude and loop-holes to avoid adequate coverage and unnecessarily limit mental health benefits for those conditions not stated in the original law.

SMI parity also creates the potential for misdiagnosis and faulty billing practices in order to "fit" patients within the covered diagnoses to receive the higher reimbursement rates. Broad-based parity, by not discriminating against certain diagnoses, eliminates these concerns and ensures that individuals and families who struggle with mental illness will receive the help they need. (3)

State Health Plan Experience
With
Mental Health Parity

North Carolina

Summary of attachment

Mental Health expenses as a percentage of total health benefit costs have decreased ever year since implementation of parity in 1992.

Year	MH Cost Per Member Per Month	Total Plan Cost Per Member Per Month	MH Costs as a % of Total Plan Costs
1992	$6.49	$101.46	6.4%
1993	5.21	100.27	5.2%
1994	4.67	103.87	4.5%
1995	4.10	110.79	3.7%
1996	4.11	120.88	3.4%
1997	4.06	122.98	3.3%
1998	4.11	132.66	3.1%

The interesting aspect of the North Carolina decreasing costs under parity is the contrasting increasing use of outpatient services. The percentage of State employees using mental health outpatient services has increased since 1992. While this relationship of decreasing cost and increasing use of services may seem contradictory, the pattern is consistent with other state health plan experiences. It seems that under parity more plan participants use lower cost outpatient services and plan management reduces the use of high cost inpatient services. In essence, with case management, more is saved from inpatient costs than is expended by providing more outpatient services to plan participants.

Year	# MH Outpatients Visits	Total Plan Participants (Members)	MH Patients As a % of total Members
1992	20,520	334,000	6.1%
1993	19,659	322,000	6.1%
1994	19,674	320,000	6.1%
1995	20,562	320,000	6.4%
1996	20,519	306,000	6.7%
1997	20,113	293,000	6.8%
1998	20,405	286,000	7.1%

The North Carolina data also debunks the myth of outpatients and providers becoming involved in never ending long-term outpatient treatments once the outpatient visit limits are removed. The population of members needing extended and/or intensive treatment is relatively small. Coverage on a parity basis is very important to those families, but the cost of their care is a small portion of the total plan costs.

Summary of OutPatient Utilizations of More Than 26 Visits

Year	# Patients Using More than 26 Visits	% of Patients Using More than 26 Visits	As a % of Total Plan Membership
1992	2,482	12.1%	0.75%
1993	1,842	9.4%	0.57%
1994	1,642	8.3%	0.51%
1995	1,508	7.3%	0.47%
1996	1,216	5.9%	0.40%
1997	1,203	6.0%	0.41%
1998	1,096	5.4%	0.38%

State Health Plan Experience
With
Mental Health Parity

Texas

On September 1, 1992, the State of Texas implemented legislation requiring parity in mental health insurance coverage for State and local government employees. Plans were prohibited from applying different durational, dollar maximum, deductible, and coinsurance limits for serious mental illness than for any other physical illness. Illnesses covered included schizophrenia, paranoid and other psychotic disorders, bipolar disorders, major depressive disorders, and schizoaffective disorders. Parity was also required for the treatment of chemical dependency. Foe less severe mental illnesses diagnoses, the inpatient limit became 30 days per year, the outpatient visit limit became 30 per year, and there was a lifetime maximum of $25,000. (1)

At the same time that parity provisions were initiated, an HMO plan was offered, and the insurance carrier responsible for other FFS, PPO, and point of service (POS) plans initiated a managed behavioral health care program. Since initiation of these changes, 60,000 individuals (26 percent) have joined an HMO and 170,000 have remained with the alternative managed insurance plans. Although no information is available yet on the HMO experience, between 1992 and 1995 there was a 47.9% decrease in the cost of care for 170,000 enrollees in the managed FFS/PPO/POS plans for mental health and chemical dependency. This level of decrease is consistent with other mental health premium decreases seen when managed behavioral health care companies enter an unmanaged indemnity market. (1)

A generally positive evaluation of this experience with State employees is reflected in the recent enactment of parity legislation covering the entire State, effective September 1, 1997.

Other Cost Studies

How Expensive is Unlimited Mental Health Care Coverage Under Managed Care?

By Roland Sturm, Ph.D.

Working with the UCLA/RAND Research Center on Managed Care, Roland Sturm, Ph.D. used actual utilization and cost data from managed behavioral health care firms to evaluate the cost of improving benefits for mental health care.

The conclusions of the report are straightforward and profound:

"Concerns about costs have stifled many health system reform proposals. However, policy decisions were often based on incorrect assumptions and outdated data that led to dramatic overestimates. For mental health care, the cost consequences of improved coverage under managed care, which by now accounts for most private insurance, are relatively low."

The cost of removing typical mental health limitations of 30 inpatient days and 20 outpatient visits, results in an annual cost increase of $6.90, from $37.0 to $43.90 (Table 4), or $0.575 per enrollee per month.

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The Correlation Between Uninsured Rates and State Mandated Benefits

- The data from 1997 reveals that the ten states with the highest uninsured rates are not the ten states with the largest amount of state mandated benefits.

  Highest Uninsured Rates (in order): *Texas*, Arizona, *Arkansas*, New Mexico, *California*, Mississippi, *Florida*, Montana, Louisiana and Alaska

  Most Number of Mandated Benefits (in order): Maryland (33), *Florida (31)*, Minnesota (29), *California (29)*, New York (27), Connecticut (26), *Arkansas (26)*, Virginia (25), *Texas (25)*, North Carolina (23), Nevada (23) and Pennsylvania (23)

- The data from 1997 reveals that the ten states with the lowest uninsured rates are not the ten states with the least amount of state mandated benefits.

  Lowest Uninsured Rates (in order): *Hawaii,* Wisconsin, Minnesota, *Vermont*, Pennsylvania, Rhode Island, Nebraska, Indiana, Washington and Ohio

  Least Number of Mandated Benefits (in order): Idaho (6), District of Columbia (7), Delaware (8), Wyoming (8), Alabama (10), *Vermont (10)*, Kentucky (11), *Hawaii (12)*, Iowa (12), New Hampshire (12), South Carolina (12), West Virginia (12)

- Minnesota and Pennsylvania are two states in the top ten for the most number of mandated benefits, yet the states are in the top ten for the lowest uninsured population.

- Idaho, which is the state with the least amount of mandated benefits (six) has the 12th highest percent of uninsured.

- Hawaii, which is the state with lowest percent of uninsured (7.5%) has the 8th lowest number of state mandated benefits.

Note: Hawaii is the only state with an employer-funded mandate to provide insurance coverage.

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