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 15, 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:
Brad Smoot, Blue Cross Blue Shield of Kansas
Larrie Ann Lower, Kansas Association of Health Plans
William W. Sneed, Health Insurance Association of America
Terry Leatherman, Kansas Chamber of Commerce and Industry
Sarah Adams, Director, Information Systems for Keys for Networking, Inc.
Kathy Byrnes, Olathe

Others attending: See attached list.

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

Brad Smoot, Blue Cross Blue Shield of Kansas, presented testimony to the Committee in opposition to **SB 274**. He pointed out that insurance mandates and the premium increases they cause fall most heavily on individuals, their dependents and small businesses. Information was also provided to the Committee relating to mental health mandate laws as applied to different groups and a comparison of mandated mental illness insurance coverage state by state. (Attachment 1) During Committee discussion it was noted that mental health coverage can be offered to members that belong to a large group. Mr. Smoot was asked if he knew whether Blue Cross Blue Shield could offer catastrophic coverage for mental health, and why the insurance industry is opposed to grouping small businesses into one large group. He will get back with more information.

Larrie Ann Lower, Kansas Association of Health Plans, expressed her opposition to **SB 274** and pointed out to the Committee that members of KAHP are willing to sit down with the proponents of this bill to discuss the issues involved, but as the bill is written cannot support a mandate that could potentially lead to higher premiums for those Kansans they insure. (Attachment 2)

William W. Sneed, Health Insurance Association of America, expressed his opposition to the bill and noted that HIAA opposes health benefit mandates because they constrain the ability of insurance purchasers and consumers to choose for themselves what the best allocation is of available health insurance dollars and the appropriate level of coverage for their needs based on the best available information about medical technologies and treatments. (Attachment 3) During Committee discussion it was suggested the Committee may want to look at what states with managed care or co-pays are doing in regard to mental health coverage.

Terry Leatherman, Kansas Chamber of Commerce and Industry, also testified in opposition to the bill saying that KCCI is concerned that government mandates show a lack of trust in the private insurance marketplace and its ability to develop an insurance product that would meet the needs of insurance customers. Other concerns about the bill were outlined in his written testimony. (Attachment 4)

Speaking in support of the bill was Sarah Adams, Director, Information Systems for Keys for Networking, Inc., who talked about the gross inequity between insurance coverage for mental health services and physical health services, (Attachment 5); and Kathy Byrnes, Olathe, who told the Committee of her ordeal in managing her son's mental illness because of poor mental health benefits. (Attachment 6)

Adjournment
The meeting was adjourned at 10:30 a.m. The next meeting of the Committee is scheduled for February 19, 2001.

SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: 2-15-01

NAME	REPRESENTING
Lori Nuebel	SRS/Health Care Policy - Mental Health
Sharon Huffman	KCDC/KDHR
Amy Campbell	KMHC
Darrell Donahue	AARP
Dick Lawrence	AARP
Kathy Byrnes	consumer
MIKE LARKIN	KS EMPLOYER COALITION ON HEALTH
Harry Boos	KS Dept of Admin
Bill Sneed	NIAA
Janice Ann Rowe	KAHP
Brad Smoot	BCBS
[illegible]	[illegible]
Whitney Damron	KS Psychological Assn
Glenn Null	Kathy Damron & Assoc
Chris Collins	KNIS
Sarah Adams	Keys for Networks Inc
Jane Adams	Keys for Networks

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 SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE

2001 SENATE BILL 274

February 15, 2001

Madam Chair 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. On behalf of these families and employers, we must respectfully oppose 2001 Senate Bill 274, in its current form.

Allow me to note at the outset that S 274 does not adversely impact BCBS plans. It is our customers -- Kansas employers and families -- who will bear the burdens of this and other mandates enacted by the state. On their behalf, we annually express our concern that any changes made to Kansas law should be founded on good medical and financial information, a thorough understanding of Kansas law and the actual experience of other states. To that end, allow me to provide background on some key elements of this discussion.

First, it is important to know just which of your constituents are affected by state insurance mandates. Only insured groups and individuals (non group) are impacted. As you can see from the attached chart, such state mandates impact slightly more than one third (37%) of our fellow Kansans. Thus, 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. And while large groups are better able to absorb premium increases, 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.

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Second, Kansas already mandates mental health coverage. Known as "first dollar" coverage, this became a mandated benefit in 1986 to encourage persons to seek early treatment for mental disorders. It covers all insured group and non-group policies. In 1996, Kansas adopted the federal parity law requiring insurers to provide mental health parity for large employer groups (above 50 employees) who choose mental health coverage. The Kansas Insurance Department interpreted the change in law to require large insured groups to provide at least 50% copays for outpatient services to the extent of the medical benefits provided. Attached, is a graph comparing the current mental health minimum coverages required by law and a standard major medical policy ($500 deductible). As you can see, mental health services receive first dollar benefits, something not common to major medical coverage. You will also note that large employer groups receive extensive out patient benefits beyond the basic mandate. A written summary of the current benefits available to different insureds is also attached.

Third, biologically-based mental illnesses of the type listed in S 274 are increasingly treated with modern pharmacology. BCBSKS spent 13.25% of its prescription drug expenditures on drugs for the treatment of mental illnesses. We do not discriminate between drugs for mental and physical conditions. However, the "parity" mandate being discussed does not cover prescription drugs. It is only a mandate for the reimbursement of mental health providers. Stated differently, you already have mental health parity for prescription drugs yet prescription drugs for all illnesses are not required coverage.

Fourth, 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. If one were to analyze the body systems treated and covered by BCBSKS, one would discover that mental health services are one of the top cost drivers. Hence, even under the much-criticized current law, mental health services already outstrip services for most other physical conditions.

Fifth, "mental health parity" is not a precise term. It various widely from state to state. Only a small handful of states embrace the coverage proposed in S 274. Attached, is a draft KAHP working document derived from an NCSL publication. It clearly illustrates that other states, some of which the mental health advocates label as "parity" states, have significant exceptions to the full parity concept. See "parity" states in bold type. For many states, mental health parity is just a mandatory offer, for other states small groups and individuals are exempt from the mandate; still others limit benefits by capping visits for outpatient services, inpatient days or dollars reimbursed. So-called "parity" states are co-mingled with states which are not considered "parity" states, even though they have the same or similar benefits. Frankly, Kansas' current benefits compare favorably with several

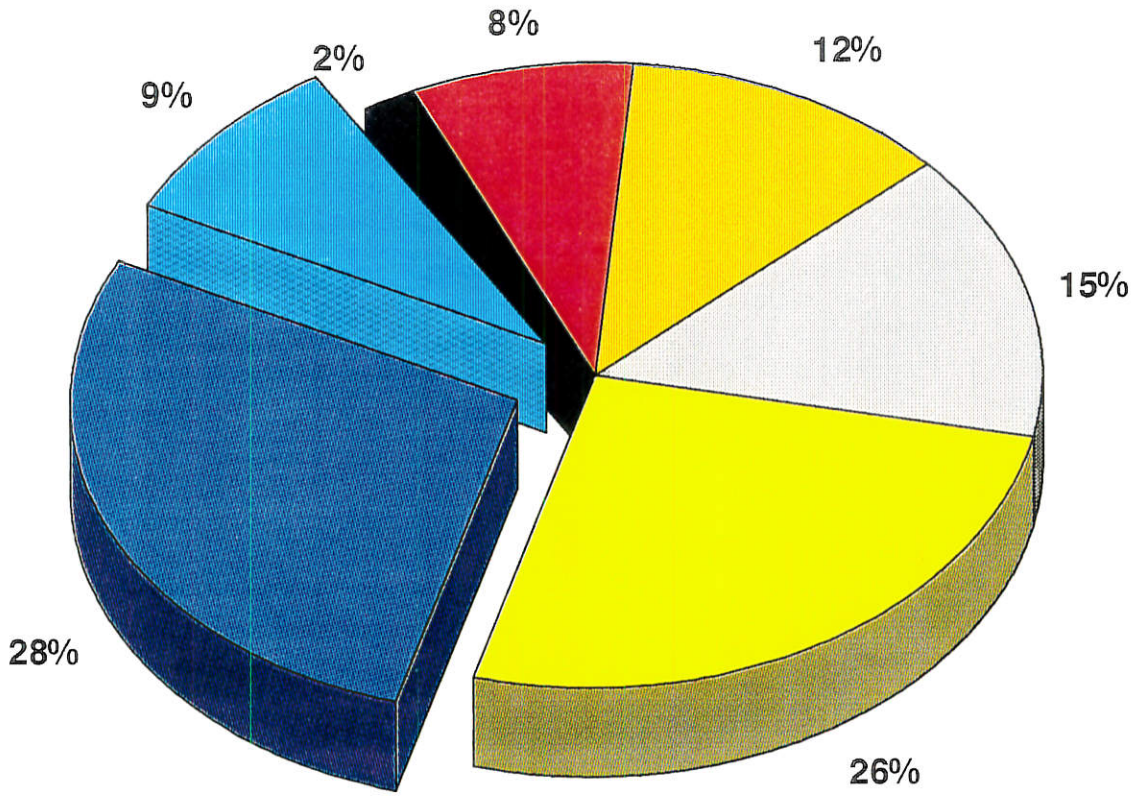
states presented as having "parity." Please do not feel that Kansas is falling behind a national trend.

Finally, regarding costs of "parity." Obviously, depending on what exceptions and limitations are imposed, costs would vary widely. The Kansas Department of Health and Environment estimated 1% to 2.5 % increase in 1998. The same estimate was repeated to the Health Care Reform Legislative Oversight Committee last Fall. Health and Environment's latest estimate ranges from .26% to 2%. The state employees plan, which relies exclusively on managed care, estimates a 1.5% increase. When expressed as percentages, these numbers seem small. However, based on our group and non group business affected by state mandates, a 1% increase in premiums translates into $10 million in additional premium for those 37% of Kansans affected statewide. Thus, a 1% to 2.5% increase for mental health parity translates to $10 million to $25 million annually, spread across the individual and insured group markets.

These estimates and those of mental health proponents are admittedly based on the extensive availability and use of managed care to control costs. Please remember that the availability and acceptance of managed care in Kansas is low. HMO penetration is estimated at only 18%. To control costs as proponents hope, S 274 will need to be amended to require managed care.

On behalf of our insureds, we support an orderly, cost-conscious, detailed review of the current mental health mandates. Unfortunately, Senate Bill 274 abruptly moves Kansas into the minority of states regarding mental health coverage and does so without due consideration to the impact on individuals and small employers. We would ask the Committee to pause and deliberate on any changes in the current mandate with consideration for the concerns we have expressed. Thank you.

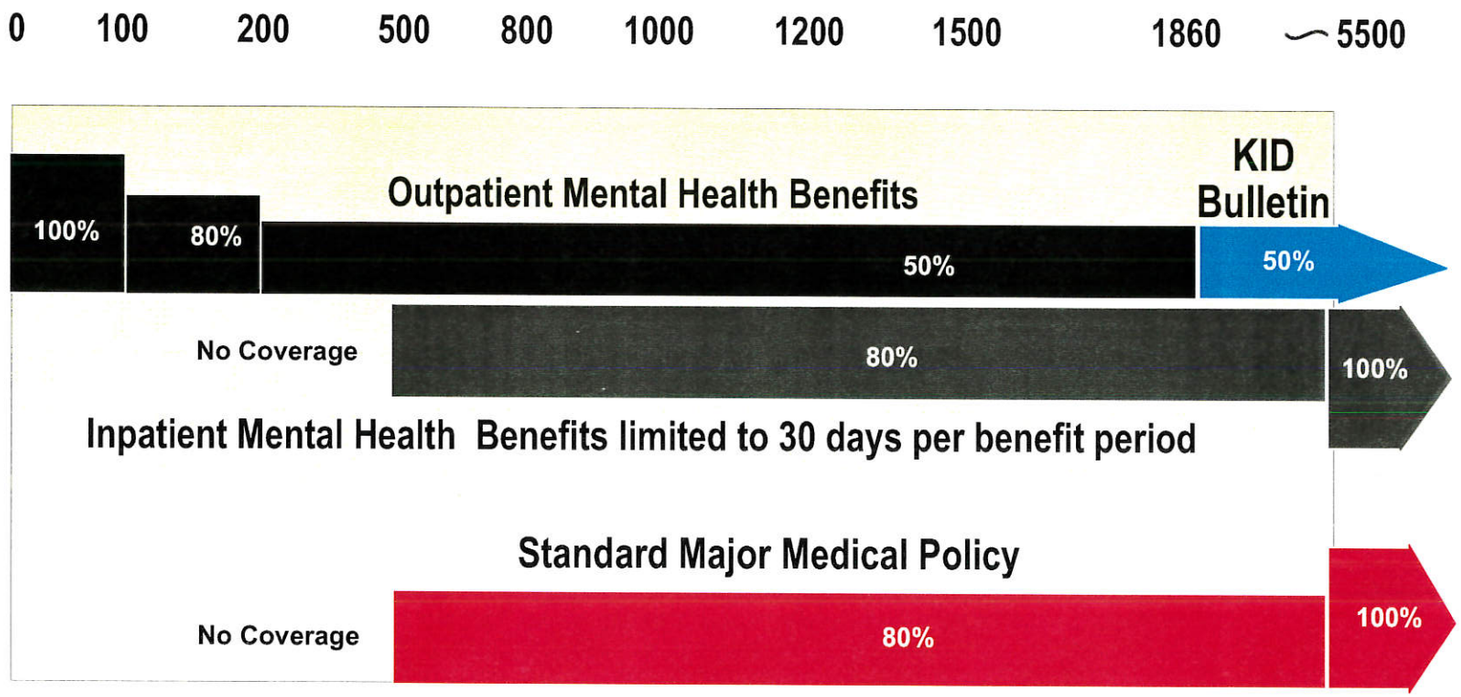
ALL KANSANS



BCBSKS

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

Allowable Charges



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.

Current Kansas mental health mandate laws as applied to different groups

There are essentially five classes of insureds affected by the MH mandates: large group insured (50 >); large group self-insured (50>); small group insured; non-group; and state employees health plan. Coverages are as follows:

Large Group Insured:

Inpatient: mandated coverage at same deductibles and copays as other health services for 30 days (subject to state and federal law)

Outpatient: parity plus -- mandated minimum first dollar coverage (first $100; 80% next $100; and 50% to annual medical maximum) (subject to state and federal law; KID Bulletin)

Large Group Self-insured:

Inpatient: parity, if mental health services are covered, no dollar limits; day limits and differences in copayments allowed. Mental health coverage not mandated (subject to federal law).

Outpatient: parity, if mental health services are covered, no dollar limits; day limits and differences in copayments allowed. Mental health coverage not mandated (subject to federal law).

Small Group Insured:

Inpatient: mandated coverage at same deductibles and copays as other health services for 30 days (subject to state law)

Outpatient: mandated minimum first dollar coverage (first $100; 80% of next $100; then 50% until $1,000 has been paid by carrier) (subject to state law)

Non-Group Insured:

Inpatient: mandated coverage at same deductibles and copays as other health services for 30 days (subject to state law)

Outpatient: mandated minimum first dollar coverage (first $100; 80% of next $100; then 50% until $1,000 has been paid by carrier) (subject to state law)

State Employees Plan:

Inpatient: parity for specified diseases -- managed care to medical maximum (pre-certification for both HMO's and PPO's) (required by administrative decision; not required by state or federal law)

Outpatient: parity for specified diseases -- managed care to medical maximum (pre-certification for HMO's and utilization review following 3 visits in self-insured PPO) (required by administrative decision; not required by state or federal law)

DRAFT

Comparison of Mandated Mental Illness Insurance Coverage by State

No Info Available on Mental Health Mandate	Mandatory Offer (includes Federal parity)	Exemption for Groups or Individuals	Exemptions for Rate Increase	Other Limitations on Benefits	Parity for State Employees	Mental Health Parity for Specified Illness	Full Parity
Idaho Iowa	**Alabama** Alaska (20 or less) **Arizona** Florida **Georgia** Illinois **Indiana** **Kentucky** **Maine** (for individual) Michigan (in-patient) **Minnesota** (except parity for HMO's) Mississippi **Missouri** **Nebraska** New York **North Carolina** (50 or more) Ohio **South Carolina** **Texas** (50 or less) **Utah** Washington West Virginia	**Alabama** (50 or less) Alaska (5 or less) **Arizona** (50 or less) **Arkansas** (50 or less) **Colorado** (no individual) Florida (no individual) **Hawaii** (25 or less) Illinois (no individual) **Indiana** (50 or less) Kansas (50 or less) **Kentucky** (50 or less) **Louisiana** (no individual) **Maine** (20 or less) **Nebraska** (15 or less) **Nevada** (25 or less) **New Hampshire** (no individual) **New Mexico** (50 or less) New York (no individual) **North Carolina** (50 or less) North Dakota (no individual) Ohio (?) **Oklahoma** (50 or less) Oregon (no individual) Pennsylvania (50 or less) **South Carolina** (no individual) **Tennessee** (25 or less; no individual) **Texas** (50 or less; no individual) **Utah** (no individual) **Virginia** (25 or less; no individual) Washington (no individual)	Alaska (1%) **Arizona** (1%) **Arkansas** (1.5%) **Indiana** (4%) Kansas (1%) Michigan (3%) **Missouri** (2%) **Nevada** (2%) **North Carolina** (1%) **Oklahoma** (2%) **South Carolina** (1%) **Tennessee** (1%) West Virginia (1%)	Alaska ($ limits) **Arizona** (different co-pays) Florida ($ limits; inpatient day limits) **Georgia** (visit & day limits) Illinois ($ limits; different co-pays) Kansas ($ limits; visit & day limits) **Louisiana** (day and visit limits) **Maryland** (day & $ limits) Michigan ($; visit limits) **Missouri** (day limits) **Nebraska** (co-pays) **Nevada** (visit & day limits; co-pays) New York (day & $ limits) North Dakota ($, visit & day limits; co-pays) Ohio ($ limits; co-pays; deducts) Oregon ($ limits) Pennsylvania (day & visit limits) **South Carolina** ($ limits) **Tennessee** (day & visit limits) **Texas** (day & visit limits) Washington (deducts; co-pays) West Virginia (day & $ limits) **Utah** (day & $ limits; co-pays)	**Indiana** **Louisiana** **North Carolina** **South Carolina** (2002) **Texas** (full)	**California** **Delaware** **Massachusetts** (?) **Minnesota** (HMO's only) **Montana** **New Jersey** **Rhode Island** **South Dakota**	**Connecticut** **Vermont**

Information derived from NCSL publications prepared by the Health Policy Tracking Service 10/2/200 and 12/31/2000.

3old type indicates states designated by NAMI as requiring mental health parity.

KAHP working draft #1

Kansas Association of Health Plans

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Testimony before the
Senate Financial Institutions and Insurance Committee
Hearings on SB 274
February 15, 2001

Madam Chair 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 Senate Bill 274.

The KAHP appears today in opposition to SB 274. 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, bone density testing, asymmetrical breast reconstruction, etc. the proponents of each of these issues strongly feel these should all be covered benefits. The opponents, must usually emphasize the potential costs of these benefits. When costs increase to an insurance company, I respectfully ask: who do we think pays for those increases? It's the employers who are trying to maintain health insurance for their employees and dependents, and individuals trying to maintain health insurance for their families. The potential reaction to higher premiums is employers choosing to discontinue health insurance benefits for possibly dependents or even all employees, and individuals also dropping their insurance coverage, therefore leading to an increase in the number of uninsured.

The proponents of "mental health parity" argue that studies show significant increases in premiums will not happen. However, the proponents talk about millions and millions of dollars of costs, huge debts, personal bankruptcies, etc due to mental illness. I understand and truly sympathize with them, however, I also ask: How do increases in costs to insurance companies not lead to higher premiums and why do the studies show no significant premium increases? I'm not sure anyone or any study can answer that question. My best answer is probably managed care. For example, according to the KID, the 1999 numbers for the Kansas state employees' health plan, reflected a 1.5% increase in premiums due to mental health parity. Please remember, those numbers are based only on the managed care portion of the state employes, approximately 25-30% of the state employees. The Commissioner also discussed the potential costs for the self insured portion which began on January 1, 2001 being around 1.5%. This benefit is also being offered with managed care like limits: tightly controlled, prior authorization required, medical necessity determinations, etc. As Brad Smoot pointed out in the chart titled "Comparison of Mandated Mental Illness Insurance Coverage by State", many of the other states with "mental health parity" impose the mandate only on larger employers and not on individual coverage. The bill before you does not limit the coverage to managed care, as in the

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state employees' plan; and does not exclude individuals or small employers and therefor, we believe the potential cost impact could be large for small employers and individual coverage.

After years of considering dozens of health insurance mandate proposals, numerous committee hearings and interim recommendations, the Kansas Legislature enacted two laws designed to give adequate information on which to make sometimes difficult decisions. In 1990, the legislature enacted a cost benefit report requirement detailing the information to be presented to the Legislature by advocates of any health insurance mandate. K.S.A. 40-2248 and 40-2249. The advocates of this bill have yet to satisfy this law. Two sessions ago the Kansas Legislature passed a law with strong bi-partisan support, 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. In an era of rapidly rising health care costs and health insurance premiums, at the time it seemed wise and responsible to the legislature and the public that government impose any new health insurance burden on itself first and evaluate those burdens before imposing them on individuals, families and employers in the private sector.

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, unfortunately, the House did not have time to act on the bill. As discussed yesterday, the health care commission recently decided to provide mental health parity in a managed care like setting to all state employees. This has been in effect since January 1, 2001. By March 1, 2002, 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 the working men and women of Kansas. At this point, the "test track law" has not been complied with either.

As you know, the legislature may change the law at any time, but is it not wise to remember the reasons these provisions were enacted and that there are several equally sympathetic mandate proposals waiting for your consideration. A single mandate may not over burden the system, however those that have already been enacted and those in the future, may.

As always, the members of the KAHP are willing to sit down with the proponents of this bill to discuss this issue if that is the Committees' desire, however as this bill is written, because it ignores two responsible laws and because of the large number of insureds we represent, we simply cannot support a mandate that could potentially lead to higher premiums for only those Kansans we insure.

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

Polsinelli | Shalton | Welte

A Professional Corporation

Memorandum

TO: The Honorable Sandy Praeger, Chair
Senate Financial Institutions And Insurance Committee

FROM: William W. Sneed, Legislative Counsel
Health Insurance Association of America

RE: S.B. 274

DATE: February 14, 2001

Madam Chair, Members of the Committee: My name is Bill Sneed and I represent the Health Insurance Association of America ("HIAA"). The HIAA appreciates this opportunity to provide comments on S.B. 274.

HIAA is the nation's leading advocate for the private, market-based health care system. Our 255+ members provide health insurance to approximately 110 million Americans, many of whom are Kansas residents. HIAA's members offer a wide variety of health coverages to meet the needs of Kansas citizens, including major medical health plans, long term care insurance, supplemental health coverage, disability income and prepaid dental plans.

BACKGROUND

Over the past two years, a number of states have considered legislation requiring coverage for mental health benefits beyond what is required under federal law. To date, 14 states have enacted a mental health parity mandate exceeding federal requirements. However, with only one exception (Vermont), these states have avoided enacting an open-ended mental health benefit mandate by placing significant restraints on parity requirements—for example, by exempting individual and small employer health plans; limiting the mandate to serious

biologically-based mental illnesses; or permitting employers who experience more than a minimal cost increase as a result of the mandate to opt out.

DISCUSSION

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

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

Forcing the purchase of benefits that consumers may not want or can't afford only ensures that many more individuals will be unable to afford <u>any</u> insurance at all. Independent research consistently shows that increasing the cost of health insurance results in fewer individuals being covered, though estimates of the precise impact vary from study to study. One study of the small employer health insurance market estimated that for every 1% increase in premiums, the number of covered employees drops by 0.9%[1] While some studies estimate a somewhat smaller impact, others indicate a significantly larger impact, such as a 2-2.6% reduction in the number of small employers offering health coverage for every 1% increase

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

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in cost.[2] Clearly, while there is some uncertainty regarding how many individuals would lose coverage due to an increase in the cost of coverage, the number is significant, and could potentially be quite large.

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

A number of studies commissioned by mental health providers and mental health advocates have predicted just a small increase in the cost of insurance due to mental health parity mandates. These studies share an important flaw: They wrongly assume that benefits will be provided in a tightly-controlled managed care setting. yet most consumers prefer less restrictive preferred provider organization (PPO) and point-of-service (POS) plans, which will experience significant premium increases if open-ended mental health "parity" is mandated. In addition, many consumers, especially rural Kansas residents, lack access to more controlled managed care plans. Other flaws common to these studies include the use of overly optimistic cost assumptions and a willingness to overlook the disproportionate effect of mandates on small businesses and persons who purchase their coverage individually.

Some of these studies also assume that benefits for physical illnesses will be reduced to compensation for additional mandated mental health benefits. For example, several studies conducted by Coopers & Lybrand place too much emphasis on **cost offsets** that may not

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

materialize, and ignore the true cost increases that will be borne by employees and consumers. It is also important to note that the final cost estimates developed by Coopers and Lybrand only reflect the financial impact on employers. The analysis assumes that employers will find various ways to offset the cost increases, such as passing the cost on to employees. This does not mean that those costs do not exist or are unimportant; it simply means that *someone else is paying the bill*, namely, the employee or individual health insurance purchaser. To understand the full impact of any proposal, the full cost should be considered rather than just the employer contribution portion.

Small Employers are singled out to bear the cost.

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

Mandating mental health "parity" would result in a massive shifting of costs from existing social programs to private, largely small employer-based insurance.

In many states, mental health activists have proposed mandates that would classify problems such as learning disabilities as a mental illness subject to mandatory coverage. If enacted, such proposals would effect a massive shift of costs from existing social programs to employer-sponsored health plans. Because ERISA exempts self-funded health plans maintained by larger employers from state mandates, the weight of this cost shift will fall largely on small employers.

CONCLUSION

For all of these reasons, HIAA believes that mandating mental health "parity" is an unwise public policy option. Determining appropriate levels of coverage for health benefits,

whether they are mental or physical health benefits, should not be politicized. Rather, it is a decision that we believe should remain in the hands of the purchasers and consumers of health benefits, who are in the best position to judge what constitutes an appropriate allocation of their resources. We urge that the Senate Financial Institutions and Insurance Committee not endorse a mental health parity mandate in Kansas.

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

Respectfully submitted,

William W. Sneed

WWS:kjb

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LEGISLATIVE TESTIMONY

the Kansas Chamber of Commerce and Industry
The Unified Voice of Business

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SB 274

February 15, 2001

KANSAS CHAMBER OF COMMERCE AND INDUSTRY

Testimony Before the

Senate Committee on Financial Institutions and Insurance

by

Terry Leatherman
Vice President – Legislative Affairs
Kansas Chamber of Commerce and Industry

Madam Chairperson and members of the Committee:

My name is Terry Leatherman. I am the Vice President for Legislative Affairs for the Kansas Chamber of Commerce and Industry. Thank you for this opportunity to comment on the subject of mental health parity and explain why the Kansas Chamber opposes passage of SB 274.

First, let me stress an overriding concern KCCI has expressed in this Committee many times over the past several years. Establishing what must be in an insurance product through the imposition of legislative will is no way to build an insurance product for private sector employers to offer their

The Kansas Chamber of Commerce and Industry (KCCI) is a statewide organization dedicated to the promotion of economic growth and job creation within Kansas, and to the protection and support of the private competitive enterprise system.

KCCI is comprised of more than 2,000 businesses which includes 200 local and regional chambers of commerce and trade organizations which represent over 161,000 business men and women. The organization represents both large and small employers in Kansas, with 48% of KCCI's members having less than 25 employees, and 78% having less than 100 employees. KCCI receives no government funding.

The KCCI Board of Directors establishes policies through the work of hundreds of the organization's members who make up its various committees. These policies are the guiding principles of the organization and translate into views such as those expressed here.

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loyees. KCCI's general principles for opposing insurance mandate proposals are summarized below.

- Government mandates show a lack of trust in the private insurance marketplace and its ability to develop an insurance product to meet the needs of insurance consumers. Please remember that, while you listen to mandate bills on the inadequacy of today's insurance product, that the majority of Kansans are insured today because of the private initiative of their employer.
- A mandate calls for something to receive greater insurance coverage than it is receiving today. Expanded coverage comes at a cost. When it is a state insurance mandate is passed, the impact of higher insurance costs is felt by small employers and individuals. Those insurance consumers are also the most challenged in locating affordable health insurance.
- Mandate debates before the Kansas legislature are typically driven by emotional appeals. There are no unappealing mandates. Link by link, they make the chain of required coverages longer and longer.
- A mandate and a tax increase are very similar. In both, the cost of a service to a selected group of people are socialized to a larger group. In the case of mandates, all insurance purchasers pay higher costs so a group of individuals can receive the additional benefit.

In addition to those general concerns about mandates, we have the following specific comments regarding the mental health parity proposal in SB 274.

- Large Kansas employers governed by federal ERISA law are given as an example of mental health parity insurance providers. However, that coverage applies only to employers of 50 or more, and exempts other employers who experience a one percent or greater premium increase due to the parity provision. These restrictions don't exist in SB 274. In addition, many of the states touted as "parity" states have the federal restrictions or other limitations.
- SB 274, with some modifications, retains the current Kansas mandate regarding nervous and mental conditions. In the pursuit of parity, it seems this mandated coverage should be eliminated.
- Finally, please understand this legislation is not about requiring coverage where none exists, but proposes to expand existing coverage. In fact, by establishing statutory coverage requirements, any flexibility that exists today in providing a balance between services and costs would be lost.

Thank you for the opportunity to comment on SB 274. I would be happy to answer any questions.

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February 15, 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

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
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February 14, 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?

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