Approved: 3-6-01
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 28, 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:

Amy Campbell, Kansas Mental Health Coalition
Sharon Huffman, Kansas Commission on Disability Concerns
Elizabeth Adams, Executive Director, NAMI Kansas
Barbara Bohm, NAMI Kansas, Spirit III
Sarah Adams, Keys for Networking, Inc.
John Gann, Kansas Association of Insurance and Financial Advisors
Brad Smoot, Blue Cross Blue Shield
Larrie Ann Lower, Kansas Association of Health Plans
Linda DeCoursey, Kansas Insurance Department

Others attending: See attached list.

Hearing on HB 2033 - Insurance; report to the legislature concerning certain mental illness

Amy Campbell, Kansas Mental Health Coalition, testified before the Committee in support of mental health parity and suggested amendments to **SB 274** that would reflect the coverage definitions currently included in the State Employees Plan. **HB 2033**, as written, is not a mental health parity bill, but is a directive to the Kansas State Employees Health Care Commission to provide additional information to the Legislature regarding the plan experience for 2001. Ms. Campbell provided the Committee with additional information on how mental health parity is implemented in the State Employees Health Plan, an overview of state parity laws of other states, and comments from the Surgeon General's Report on Mental Health and the Washington Business Group on Health which was included in her written testimony. (Attachment 1)

Sharon Huffman, Kansas Commission on Disability Concerns, expressed her support for mental health parity and would like language from **SB 274** amended into **HB 2033** with changes that would reflect the same diagnoses that are covered in the state plan. (Attachment 2)

Also speaking in support of mental health parity was Elizabeth Adams, Executive Director, NAMI Kansas, (Attachment 3); Barbara Bohm, NAMI Kansas, Spirit III, (Attachment 4); and Sarah Adams, Keys for Networking, Inc., (Attachment 5).

John Gann, Kansas Association of Insurance and Financial Advisors, spoke in support of **HB 2033**. He noted that the information that would be obtained by this legislation would be helpful in evaluating the impact of the mental illness first dollar benefit for state employees, but it would not be appropriate to apply it to the other private health insurance plans in the state. Therefore, he does not believe in mental health parity for all Kansans, because the premium costs to individual Kansas policyholders and Kansas employer groups would be adversely affected.. (Attachment 6) During Committee discussion the Chair noted that she would provide the Committee with copies of mental health parity data from the states of Vermont, Connecticut, North Carolina and Texas.

Brad Smoot, Blue Cross Blue Shield, expressed his support for **HB 2033** that would evaluate any new health care costs without imposing them on individuals, families and employers in the private sector and the "test track" procedure that was enacted by the Legislature in 1999. (Attachment 7) He also reminded the Committee that Kansas statutes call for a cost-benefit study to be performed before any new health insurance

mandates are adopted.

Also speaking in support of **HB 2033** and the "test track" procedure was Larrie Ann Lower, Kansas Association of Health Plans, as noted in her written testimony. (Attachment 8)

Linda DeCoursey, Kansas Insurance Department, testified as a neutral conferee on the bill. She noted that thirty-two states now have parity laws. The Surgeon General's report, along with many other studies, suggests that implementing parity laws is not as expensive as once suggested. Case studies of five states that had a parity law for at least a year revealed a small effect on premiums. Other statistics on mental health parity was covered in her written testimony. (Attachment 9)

The Chair noted that the bill would be worked the following week and would like the Committee to consider several approaches on mental health parity.

Adjournment

The meeting was adjourned at 10:30 a.m. The next meeting of the Committee is scheduled for March 1, 2001.

SENATE FINANCIAL INSTITUTIONS & INSURANCE
COMMITTEE GUEST LIST

DATE: 2-28-01

NAME	REPRESENTING
John Gann	KAIFA
Ernest C. Pogge	AARP
Jeanne Urban-Shultz	KDOA
Fran Miller	NAMI-Ks
Bryce Miller	NAMI-Kansas
Chip Wheelen	Assn of Osteo. Med.
Harry Bossi	Dept of Admin
Anne Spiess	KAIFA
LARRY MAGILL	KAIA
BARBARA BOHM	NAMI-KANSAS & SILCK
Amy A. Campbell	KMHC
Jeremy Anderson	KS Insurance Dept
Brad Smoot	BCBS
Sarah Adams	Keys for Networking
David Hanson	Ks Insur Assns
Kevin Barone	Hein Law
Linda DeCoursey	KS Ins. Dept
Jennifer Crow	Federico Consulting
Chris Collins	Kansas Medical Society

Lorrie Ann Fowler KAHP

KANSAS MENTAL HEALTH COALITION
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Telephone: 785-234-9702 Fax: 785-234-9719
Joining together in one voice to meet critical needs of persons with mental illness.

Testimony presented to the
Senate Committee on Financial Institutions and Insurance

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

The Kansas Mental Health Coalition is comprised principally of statewide organizations representing consumers, families, community service providers, and dedicated individuals as well as community mental health centers, hospitals, nurses, physicians, psychiatrists, psychologists, and advocates. The Coalition is a roundtable where differences are discussed and common goals are developed. All share a common interest; we are dedicated to improving the lives of Kansans with mental illnesses. Last year, and again yesterday, hundreds of individuals from across the state came to Topeka to join the Coalition, Keys for Networking, NAMI, and the Association of Community Mental Health Centers to advocate mental health legislation, including and emphasizing mental health parity.

Our highest public policy priority is the elimination of discrimination in health insurance coverage. We believe that because mental illnesses are diagnosable, treatable medical conditions, health insurance coverage should be the same as it is for other illnesses or diseases. This is one step toward reducing the stigma associated with mental illnesses. Removing stigma and discrimination will encourage appropriate and effective treatment for consumers who often seek inappropriate care.

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

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

Senate Bill 274
Senate Bill 274 takes the next logical step to eliminate discrimination from private insurance plans regulated by the State. This bill follows the lead established by the Governor of Kansas on behalf of State employees and the Federal Government on behalf of Federal Employees. The Kansas Mental Health Coalition is thrilled to have the opportunity to come forward to talk about parity with this committee and to support each step toward offering parity to the working Kansans who pay for their health insurance. We would, however, suggest amendments to the legislation to reflect the coverage definitions currently included in the State Employees Plan.

Senate Financial Inst. & Insurance
Date: 2-28-01
Attachment No. 1

In every study I have read regarding mental health parity, the conclusion is made that children and families stand to gain the most through mental health parity legislation. Unfortunately, the current bill does not include all of the diagnoses in the State Plan, and childrens' diagnoses are notably absent. We recommend amending the definitions in Section 1 to read:

(1) Schizophrenia, schizoaffective disorder, **schizophreniform disorder, brief reactive psychosis, paranoid or delusional disorder, atypical psychosis;** *(subsets in DSM-IV)*
(2) major affective disorder (bipolar and major depression), **cyclothymic and dysthymic disorders**; *(also subsets in DSM-IV)*
(3) obsessive compulsive disorder;
(4) panic disorder;
(5) **pervasive developmental disorder, including autism; and**
(6) **attention deficit disorder and attention deficit hyperactive disorder.**

House Bill 2033

House Bill 2033 is a directive to the Kansas State Employees Health Care Commission to provide additional information to the Legislature regarding the plan experience for 2001. It is not, as written, a mental health parity bill. Kansas has historically been an innovative state in the area of mental health treatment and has fallen behind when it comes to parity. A list of parity states is attached.

In 1999, the Kansas State Employees Health Care Commission began its first year of incorporating equal coverage for state employees in HMO and PPO plans. Statistics provided by the Commission indicated that the increased cost for what was provided in 1999 for biological based mental health parity benefits, compared to what was provided under the 1998 benefit schedule (no parity) was approximately 73 cents per participating beneficiary per month. Additional data reported by Terry Bernatis, plan administrator, including an estimate total cost increase for the managed care plans of $106,076. There were 26,832 HMO participants and 1,459 PPO participants.

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

Opponents to SB 274 may suggest that we need to study the cost data requested in HB 2033 to more accurately predict the impact of a parity bill for private insurance in Kansas. The data from 2001 would be no more relevant than the statistics we already have.

1. It is only cost statistics - not overall cost-benefit analysis. *(See Report to the Office of Personnel Management, Washington Business Group on Health, March 2000; and the National Advisory Mental Health Council Report to Congress, National Institutes of Health, June 2000.)*
2. Mental health benefits offered for 2001 are offered as a managed program. Benefits offered in 1999 and 2000 were also managed care programs. These numbers will change some in the first few years of implementation and involve more participants, but not a different population.
3. The benefits for state employees include first dollar coverage, which is eliminated in this bill for private insurance policies covering these mental illnesses. This would elevate the total State costs higher than what it will cost private insurance.
4. The benefits for state employees were already enhanced compared to those offered in current private plans - which would minimize the increase in costs compared to what will happen in the private market.
5. The defined benefits proposed in this bill are less extensive than those currently covered for state employees, which elevates the State costs over what the private industry would experience.
6. This mirrors nearly all of the arguments made by opponents to legislation this year, who state that other states' experiences are not relevant because they cover different items OR because their coverage is more or less extensive than ours. The point is, we now have the benefit of all of these sources of information in order to make our decision. We have the State experience. We have the cost data from Kansas and other

states. We also have cost-benefit analysis conducted by the federal government and by private industry. Neither are biased toward mental health organizations or the insurance industry.

As we know, when parity is implemented, statistical data is incorporated and the estimated costs are mitigated by actual cost data. Subsequently, as more individuals access appropriate care, those numbers may temporarily increase, and then decrease further. Initial increases in utilization result in even greater efficiency in medical services usage.

In response to requests from the U.S. Senate Appropriations Committee regarding their concern about the potential costs and consequences of implementing mental health parity, the NAMHC Workgroup, assisted by staff of the National Institute of Mental Health and other federal agencies, as well as nonfederal consultants, provided systematic analyses of empirical data and economic models to clarify the costs. The report presented findings from three types of studies. The following is one example of the cost estimates changes we have seen with actual experience.

"Predictions based on an updated simulation model"

May 1996 - Congressional Budget Office estimated cost increases for enacting parity in fee for service benefits to be 5.3%, then lowered to 4 % to reflect managed behavior health care plans.
1998 - Sing and Colleagues, based on Hay Group models, lowered the estimate to 3.6%.
2000 - Hay Group updated its simulation models using actuarial data from the Federal Employees Health Benefit Program, data from several large health care companies, and a large State employees health plan and reduced this prediction to 1.4%.

"Nevertheless, even models such as the newest one developed by the Hay Group may overestimate the cost of parity because they do not account adequately for many of the recent changes in the mental health care delivery system." *Insurance Parity for Mental Health: Cost, Access, and Quality: Final Report to Congress by the National Advisory Mental Health Council.*

First Dollar Coverage

It has been suggested that equal coverage might cause insureds to lose "first dollar coverage" for outpatient mental health services. The provisions of current law at K.S.A. 40-2,105 sub. (a) stipulate that if a patient can be treated for alcoholism, drug addiction, or a mental disorder on an outpatient basis, the insurer is required to pay for the treatment according to a formula: 100% of the first $100, 80% of the next $100, and only 50% of the next $1,640 per year. In other words, the maximum amount that an insurer is required to pay for outpatient treatment in any one year is $1,000; while the patient must pay up to $840; a net 45.65% copayment. If the total cost of treatment exceeds $1,840 per year, the insured must pay 100% of the balance. **Equal coverage for the mental illnesses specified in the act would be subject to the usual health insurance deductibles, 80/20 co-pay, and much higher maximum limits and would no longer be subject to discriminatory annual limitations.** The bill offers true parity for defined mental illnesses by replacing the "first dollar coverage" with coverage equal to physical disorders. Mental disorders and conditions not listed in the bill will remain subject to K.S.A. 40-2,105, which provides for the "first dollar coverage".

Cost

According to the Surgeon General, states and employers could logically experience cost savings over time. To date, 32 states have implemented some form of equal coverage, and their experiences show that premiums are not increasing rapidly and employers are not trying to evade the new laws by becoming self-insured, nor do they tend to shift increased costs to employees.

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

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State Mental Illness Parity Laws

Overview of State Parity Laws

Officially designated "The Decade of the Brain," the 1990s brought unprecedented federal and state legislation to end health insurance discrimination against individuals with mental illnesses. After the Mental Health Parity Act of 1996 was signed into law, the momentum shifted to the states. A firestorm of legislative activity created a patchwork quilt of various parity laws around the country. A total of 32 states now have some degree of mental health parity, with fairness bills pending in many other state legislatures.

In 2000:

- 5 states passed parity legislation (Alabama, Kentucky, Massachusetts, New Mexico, South Carolina {state employees only})

In 1999:

- 12 states and two territories passed parity legislation (*states*: California, Connecticut {expansion of '97 law}, Hawaii, Indiana {expansion of '97 law}, Louisiana, Missouri {expansion of '97 law}, Montana, Nebraska, Nevada, New Jersey, Oklahoma, Virginia; *territories*: Guam, Puerto Rico)

In 1998:

- 5 states passed parity legislation (Delaware, Georgia, Pennsylvania, South Dakota, Tennessee)

In 1997:

- 8 states passed mental illness parity legislation (Arkansas, Colorado, Connecticut, Indiana {state employees only}, Missouri, North Carolina {state employees only, expansion of '91 law}, Texas {expansion of earlier requirement}, Vermont)

Between 1991 - 1996:

- 8 states affected mental illness parity measures (Maine, Maryland, Massachusetts {state employees only by administrative order}, Minnesota, New Hampshire, North Carolina {state employees only}, Rhode Island, Texas {state employees only})

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Federal Parity

Mental Health Parity Act of 1996: The Mental Health Parity Act of 1996, which became effective on January 1, 1997 and will sunset on September 30, 2001, requires employers that offer mental health benefits to set annual and lifetime caps equal to those for medical and surgical benefits. The measure excludes businesses with 50 or fewer employees, and allows all employers to be exempted from the law if their costs rise more than one percent as a result of complying with the requirements. The law allows health insurance plans to set different benefit levels for co-payments, deductibles, out-of-pocket payments, inpatient hospital days, and outpatient visits.

Relationship to State Law: A state law requiring more comprehensive coverage is not weakened by the federal parity law, nor does the federal law preclude a state from enacting stronger parity legislation.

States that Enacted Mental Illness Parity Laws that Mirror the Federal Mental Health Parity Act of 1996: The following 15 states enacted laws that mirror the federal Mental Health Parity Act of 1996 - -

Alaska (1997) Kansas (1997) North Carolina (1997)

Arizona (1997) Louisiana (1997) South Carolina (1997)

Delaware (1997) Montana (1997) Tennessee (1997)

Florida (1998) Nevada (1997) Utah (2000)

Indiana (1997) New Mexico (1998) West Virginia (1997)

Mental Health Equitable Treatment Act of 1999: On April 14, 1999, U.S. Senators Pete Domenici (R-NM) and Paul Wellstone (D-MN) introduced the Mental Health Equitable Treatment Act of 1999 which would require full health insurance parity for the most severe, biologically based mental illnesses. The legislation would prohibit unequal restrictions on annual and lifetime mental health benefits, inpatient hospital days, outpatient visits, and out-of-pocket expenses.

Federal Employees Health Benefits Program (FEHBP): On June 7, 1999, during the White House Conference on Mental Health, the Clinton Administration announced that it will require health insurance plans for federal employees to provide equal coverage for mental illnesses, mandating coverage for more than 9.5 million federal workers and their family members in 2001.

State-By-State Breakdown of Mental Illness Parity Laws

State	Year Enacted	Provisions of Law	Effective Date
Alabama	2000	Requires group health plans to offer to provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for other physical illnesses. The law defines mental illness as including schizophrenia, schizophrenia form disorder, schizoaffective disorder, bipolar disorder, panic disorder, obsessive-compulsive disorder, major depressive disorder, anxiety disorders, mood disorders, and any condition or disorder involving mental illness, excluding alcohol and substance abuse that falls under mental disorders listed in the International Classification of Diseases. The law does not apply to group health plans covering employers with 50 or fewer employees.	January 1, 2001
Arkansas	1997	Provides for equal coverage of mental illness and developmental disorders; exempts state employees, companies with less than 50 employees, and companies that anticipate a cost increase of more than 1.5 percent.	August 1, 1997
California	1999	Provides for persons of any age equal coverage for severe mental illnesses, including schizophrenia, bipolar disorder, major depressive disorders, schizoaffective disorder, panic disorder, obsessive-compulsive disorder, autism, anorexia nervosa, and bulimia nervosa. Covers children with one or more mental disorders other than a primary substance abuse disorder or a developmental disorder. No small business exemption.	July 1, 2000
Colorado	1997	Provides for coverage of schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, obsessive-compulsive disorder that is no less extensive than the	January 1, 1998

		coverage provided for other physical illnesses.	
Connecticut	1997	Provides for coverage of schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder and autism that is equal to coverage provided for medical or surgical conditions.	October 1, 1997
Connecticut	1999	Provides that policies shall not establish any terms, conditions or benefits that place a greater financial burden on an insured for access to diagnosis or treatment of mental conditions than are placed on treatment of other physical conditions. The statute defines mental conditions as the mental disorders included in the most recent edition of the DSM-IV, including addictive disorders.	January 1, 2000
Delaware	1998	Requires health insurers to provide coverage for biologically based mental illnesses, including schizophrenia, schizoaffective disorder, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive compulsive disorder, anorexia and bulimia, under the same terms and conditions of coverage offered for physical illnesses.	January 1, 1999
Georgia	1998	Requires larger employers (51 or more employees) that choose to provide mental health benefits to provide equal lifetime and annual caps for mental health benefits as is provided for other physical illnesses, and provide the same dollar limits, deductibles, and coinsurance factors. Employers cannot impose separate outpatient and visit limits on the treatment of mental illnesses. Requires smaller employers (2-50 employees) that choose to provide mental health benefits to provide equal lifetime and annual caps for mental health benefits as is offered for other physical illnesses, and provide the same dollar limits, deductibles, and	April 6, 1998

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		coinsurance factors. "Mental illnesses" cover all brain disorders listed in the DSM-IV, including addictive disorders.	
Hawaii	1999	Expands coverage for schizophrenia, schizoaffective disorder and bipolar mood disorder. Excludes coverage for substance abuse and other disorders, including major depression. Establishes a task force to study the impact of adding these illnesses at a later date. Exempts small businesses with 25 or fewer employees.	July 1, 1999
Indiana	1997	Requires the same treatment limitations or financial requirements on the coverage of services for mental illnesses for state employees only. The law also includes a provision that mirrors the federal mental health parity act of 1996.	July 1, 1997
Indiana	1999	Amends the 1997 parity law to cover "services for mental illness," as defined by a contract, policy or plan for health services. Does not mandate coverage or cover substance abuse treatment. Exempts small businesses with 50 or fewer employees and provides for a four-percent cost-increase exemption.	January 1, 2000
Kentucky	2000	Provides that treatment of a "mental health condition" must be under the same terms and conditions as provided for treatment of other physical health conditions. The law defines "treatment of a mental health condition" as including, but not limited to, any necessary outpatient, inpatient, residential partial hospitalization, day treatment, emergency detoxification or crisis stabilization services. The law defines "mental health condition" as any condition or disorder that is included in the DSM-IV or that is listed in the mental disorders section of the International Classification of Disease. The law includes alcohol and other drug abuse. The law exempts group plans covering fewer than 50 employees.	July 15, 2000
Louisiana	1999	Mandates equitable coverage for severe mental illness including schizophrenia,	

		schizoaffective disorder, bipolar disorder, pervasive developmental disorder (autism), panic disorder, obsessive-compulsive disorder, major depressive disorder, anorexia/bulimia, Asperger's Disorder, intermittent explosive disorder, post-traumatic stress disorder, psychosis (not otherwise specified) when diagnosed in a child under 17 years of age, Retts disorder and Tourette's disorder. Policies must offer optional coverage for other mental disorders not covered in the list (at the expense of the policyholder.) Minimum benefits are to include 45 in-patient days, per year (an exchange of two partial hospitalization days or two residential treatment days per one in hospital day may be provided) and 52 outpatient visits, including intensive outpatient programs. No small-business exemption.	January 1, 2000
Maine	1995	Provides for coverage of schizophrenia, bipolar disorder, pervasive development disorder, or autism, paranoia, panic disorder, obsessive-compulsive disorder, and major depressive disorder in group contracts that is no less extensive than medical treatment for physical illnesses; no substance abuse; excludes groups of 20 or fewer employees.	July 1, 1996
Maryland	1994	Prohibits insurers and HMOs from discriminating against any person with mental illness, emotional disorder, or drug abuse or alcohol abuse by failing to provide treatment or diagnosis equal to physical illnesses.	August 1, 1994
Massachusetts *(state employees only)*	1993 (Admin. Order)	Requires parity coverage for outpatient, intermediate and inpatient mental health and substance abuse care that the state employee plan determines to be medically necessary. The Order defines mental illnesses as the categories listed in the current version of the DSM-IV, excluding certain disorders.	1993
Massachusetts	2000	Requires non-discriminatory coverage , health plans are prohibited from including any annual or lifetime dollar	January 1, 2001

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		or unit of service limitation on coverage for the diagnosis and treatment of mental disorders which is less than any annual or lifetime dollar or unit of service limitation imposed on coverage for the diagnosis and treatment of other physical illnesses. Coverage includes non-discriminatory coverage for the diagnosis and treatment of biologically-based mental disorders (defined as schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, delirium and dementia, affective disorders and any biologically based mental disorders appearing in the DSM that are scientifically recognized and approved by the Department of Mental Health), rape related mental and emotional disorders and children and adolescents under the age of 19 for the diagnosis and treatment of non-biologically based mental, behavioral or emotional disorders. The law requires parity for co-occurring mental illnesses and addictive disorders, however does not require parity for a diagnosis of an addictive disorder alone. Small group health plans (1-50 employees) and non-group health plans are exempt from provisions of the bill until January 1, 2002, provided that benefits for mental health benefits are not reduced before January 1, 2001.	
Minnesota	1995	Requires cost of inpatient and outpatient mental health and chemical dependency services to be not greater or more restrictive than those for outpatient and inpatient medical services.	August 1, 1995
Missouri	1997	Covers all disorders in DSM-IV in managed care plans only, equal to that provided for physical illnesses (roughly 40 percent of population); part of larger managed-care regulatory measure.	September 1, 1997

1-10

Missouri	1999	Specifies that coverage for mental illness benefits shall not place greater financial burdens on the insured than for physical illnesses. The law specifies that substance abuse is covered only if the covered person also has a diagnosis of a mental illness. The substance abuse coverage can be limited to one detox session, which is not to exceed 4 days. Benefits to individuals with co-occurring disorders are limited to 45 in-patient days. However, the insurer may still apply different deductibles, co-pays or co-insurance terms. Businesses can apply for an exemption if compliance with this law results in a two-percent premium-cost increase. Provides for impact study. The law expires on January 1, 2005.	January 1, 2000
Montana	1999	Provides equitable health insurance and disability insurance for severe mental illness (schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, and autism) that is no less favorable than that provided for other physical illnesses.	January 1, 2000
Nebraska	1999	Prior to January 1, 2002: requires plans to provide coverage for schizophrenia, schizoaffective disorder, delusional disorder, bipolar affective disorder, major depression, and obsessive-compulsive disorder that shall not establish any rate, term, or condition that places a greater financial burden for treatment than for a physical health condition. Parity must be provided for lifetime and annual limits, and number of inpatient and outpatient visits. Parity is not required in co-pays, co-insurance and deductibles. After January 1, 2002: the law applies to "any mental health condition that current medical science affirms is caused by a biological disorder of the brain and that substantially limits the life activities of the person with the serious mental illness." Exempts plans	January 1, 2002 January 1, 2000

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		with fewer than 15 employers. Not a mandate.	
Nevada	1999	Mandates coverage for those with severe mental illness including schizophrenia, schizoaffective, bipolar, major depression, panic, and obsessive-compulsive disorders. Annual and lifetime limits, and out-of-pocket limits are the same as for other medical/surgical benefits. Minimum 30 in-hospital days and 27 outpatient visits per year. Alternative to hospitalization available on a two for one exchange of the in-hospital benefits (up to 40 days), to include crisis respite, partial hospitalization and other residential treatment. Outpatient visits for medication management not counted towards mental health benefits but come out of standard medical coverage. Also: Co-pays and deductibles are maximum of $18 for outpatient visits and $180 per in-patient admission. Businesses with 25 or fewer employees are exempt from this mandate.	January 1, 2000
New Hampshire	1994	Provides for coverage of schizophrenia, schizoaffective disorder, bipolar disorder, paranoia, and other psychotic disorders, obsessive compulsive disorder, panic disorder, and pervasive developmental disorder or autism no less extensive than coverage for physical illnesses; applies only to groups and HMOs, regardless of size.	January 1, 1995
New Jersey	1999	Requires that every individual and group hospital service corporation contract that provides hospital or medical expense benefits and is delivered, issued, executed, or renewed in the State shall provide coverage for biologically-based mental illness under the same terms and conditions as provided for any other sickness.	August 13, 1999
New Mexico	2000	Provides that group plans must not impose treatment limitations or financial requirements on the provision of mental health benefits if identical	October 1, 2000

1-12

		limitations or requirements are not imposed on coverage of benefits for other conditions. The scope of the law includes those mental health benefits described in the group health plan, or group health insurance offered in connection with the plan. The law does not apply to benefits for the treatment of substance abuse, chemical dependency or gambling addictions. The law includes a cost exemption that allows employers that qualify to opt out.	
North Carolina *(state employees only)*	1991	Requires non-discriminatory coverage in state government employee health contracts. The law defines "mental illness" when applied to an adult -- an illness which so lessens the capacity of the individual to use self-control, judgment, and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance or control; and when applied to a minor -- a mental condition, other than mental retardation alone, that so impairs the youth's capacity to exercise age adequate self-control or judgment in the conduct of his/her activities and social relationships that the youth requires treatment. The law provides that the state employee plan must have the same deductibles, durational limits, and co-insurance factors as apply to other physical illness benefits.	January 1, 1992
North Carolina *(state employees only)*	1997	Requires non-discriminatory coverage in state government employee health contracts. The law is nearly identical to the 1991 parity law, described below, except that it broadens the law to require non-discriminatory coverage for "chemical dependency." The law defines "chemical dependency" as the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal, with a diagnosis found in	October 1, 1997

State

		the DSM -IV or the International Classification of Diseases (ICD).	
Oklahoma	1999	Provides equitable coverage for those with "severe mental illness," including schizophrenia, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder and schizoaffective disorder. Exempts "small employers" with 50 or fewer employees; also provides for a two-percent premium cost-increase exemption.	January 1, 2000
Pennsylvania	1998	Requires that benefits be provided for serious mental illnesses and that there be no difference in either the annual or lifetime dollar limits in coverage for serious mental illnesses and any other illnesses. The law also provides that cost-sharing arrangements, including but not limited to, deductibles and copayments for coverage of serious mental illnesses shall not prohibit access to care. The law sets minimum coverage for serious mental illnesses at 30 inpatient days and 60 outpatient days annually. The law exempts employers with 50 or fewer employees.	April 21, 1999
Rhode Island	1994	Provides for coverage of "serious mental illness" that current medical science affirms is caused by a biological disorder of the brain and substantially limits life activities. The law requires that benefits for serious mental illnesses include the same durational limits, amount limits, deductibles and co-insurance factors as for other illnesses and diseases.	January 1, 1995
South Carolina *(state employees only)*	2000	Requires the state health insurance plan to provide coverage for medically necessary treatment of a mental health condition and/or substance abuse disorder and provides that the plan must not establish any term or condition that places a greater financial burden on an insured for access to treatment for a mental health or substance abuse condition than is required for access to	January 1, 2001 *(includes a sunset provision of January 1, 2005)*

		treatment for other physical illnesses. The law provides that any deductible or out-of-pocket limits required under the state health insurance plan must be comprehensive for coverage of mental illnesses, alcohol or substance abuse and other physical health conditions. The law requires parity for biologically based mental illnesses. The law includes a cost exemption which allows the state plan to opt out of the requirements if it can show that the total health insurance costs of the state plan increase by more than 1% at the end of the 3-year period beginning 1/1/2002 and ending 12/31/2004; or by more than 3.39% at any time beginning 1/1/2002 and ending 12/31/2004.	
South Dakota	1998	Provides coverage for the treatment and diagnosis of biologically based mental illnesses, including schizophrenia, schizoaffective disorder, bipolar affective disorder, major depression, obsessive-compulsive disorder, and other anxiety disorders, with the same dollar limits, deductibles, coinsurance factors and restrictions as for other covered illnesses.	July 1, 1998
Tennessee	1998	Provides mandated mental health coverage, but does not cover alcohol or substance abuse treatment; annual and lifetime limits and out-of-pocket expense limits must be equal to other medical and surgical benefits; covers at least 20 inpatient hospitalization days and 25 outpatient visits per year; alternatives to hospitalization must be provided at two for one of the inpatient hospitalization days (up to 40 days), including crisis respite services for the consumer, residential treatment and partial hospitalization; outpatient visits for medication management do not count toward mental health benefits but are provided equal to a medical visit; does not require parity for co-pays and deductibles; and a business can file for	January 1, 2000

		an exemption after 12 months if its' costs increase by more than 1 percent; businesses with 25 or fewer employees are exempt.	
Texas *(public employees only)*	1991	Covers all public state and local employees, and all teachers and university system employees; plan covers schizophrenia, schizoaffective disorder, bipolar disorder, and major depression.	September 1, 1991
Texas	1997	Covers schizophrenia, paranoia and other psychotic disorders, bipolar disorder, major depressive disorder, schizoaffective disorder, pervasive developmental disorder, obsessive-compulsive disorder, and depression in childhood and adolescence; exempts businesses with fewer than 50 employees; grants 60 outpatient visits and 45 inpatient days annually.	January 1, 1998
Vermont	1997	The law provides that health plans shall not establish any lifetime or annual payment limits, deductibles, copayments, coinsurance and any other cost-sharing requirements, out-of-pocket limits, visit limits and any other financial component of coverage that places a greater financial burden on an insured than for other physical health conditions. The law requires a single limit for mental health and physical health deductibles and out-of-pocket limits. The law requires parity coverage for mental illnesses and addictive disorders.	January 1, 1998
Virginia	1999	Provides equitable coverage for schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, attention deficit/hyperactivity disorder, autism, and drug and alcoholism addiction. Employers with 25 or fewer employees are exempt.	January 1, 2000

NAMI has more than 1,200 state and local affiliates in all 50 states, the District of Columbia, Puerto Rico, American Samoa, and Canada.

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National Alliance for the Mentally Ill

1-17

WASHINGTON BUSINESS GROUP ON HEALTH
50 F Street, NW Suite 600 • Washington, D.C. 20001
202.628.9320 • Fax 202.628.9244

February 13, 2001

(Via Facsimile)
The Honorable Sandy Praeger, Chair
Senate Committee on Financial Institutions and Insurance
Kansas State Senate
Topeka, Kansas

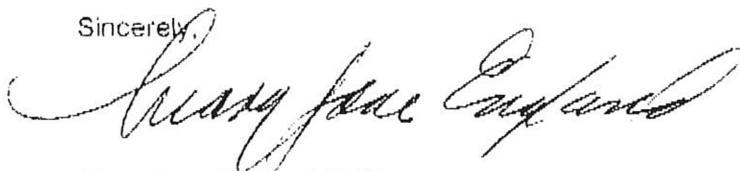
Dear Chairman Praeger:

I am writing on behalf of the Washington Business Group on Health (WBGH) with regard to mental health benefit matters currently before your committee. WBGH is a non-profit research organization made up of Fortune 500 and large public sector employers. As such, we do not take positions on pending legislation. However, I would like to offer the experience of our employers with regard to the expansion of behavioral health benefits through generous mental health and substance abuse treatment benefits.

Our employers firmly believe that early, appropriate treatment of mental illness is essential to productivity in the workplace, is cost effective, and is vital to our employees and their families. Indeed, for nearly a decade, many of our members have provided generous, parity or near-parity benefits. They have found that generous mental health benefits do not increase their health care costs. Rather, with appropriate care management, they were able to provide better access and quality of care to their employees and families. In addition, they found that early, appropriate treatment enabled employees to stay at work or to avoid costly, short and long-term disabilities. Indeed, their experience has been supported in research conducted at Johns Hopkins University (D. Salkever, et al, "Disability Management, Employee Health and Fringe Benefits, and Long-Term Disability Claims for Mental Disorders, *The Millbank Quarterly*, 78(1), 2000) and at Harvard Medical School (R. Kessler, et al, "Depression in the Workplace: Effects on Short-Term Disability," *Health Affairs*,18(5), 1999). Further, studies of the cost of implementing parity benefits for mental health suggest that cost increases, if any, will be very modest, no more than 1.4% (*Final Report to Congress* by the National Advisory Mental Health Council, June 2000). In sum, appropriate treatment for mental health does not result in excessive cost and is cost effective.

We hope that these important health policy considerations will assist the work of your committee as you consider legislative efforts to expand access to appropriate mental health services.

Sincerely,



Mary Jane England, M.D.
President

1-18

COMMENTS: THE SURGEON GENERAL'S REPORT ON MENTAL HEALTH
Roy W. Menninger MD, Topeka Kansas
February 14, 2001

In the not so distant past: mental illness was a source of embarrassment and shame for communities as well as those afflicted. The standard strategy: out of sight, out of mind -- the afflicted were exiled to remote asylums with virtually no treatment and forgotten, e.g., our own late but-not-lamented Topeka State Hospital. Our own hospital was forced to open outside city limits since it was illegal to hospitalize psychiatric patients in the city (1925).

Now: we have better understanding, earlier recognition, better diagnosis, AND effective treatment for virtually every psychiatric disorder. But one thing has not changed: stigma. Prejudice and fear persist. Reluctance to address the social problems, the financial limitations, and the treatment needs of the chronically mentally ill remains. Resistance to addressing their needs in the guise of cost-control remains.

The publication of the Surgeon General's Report on Mental Health (1999) heralds fresh recognition of the great scope of the problem of mental illness in this country. A few brief comments follow about the points that report makes.

Mental Illness is a **public health issue**, broader than the pain and distress experienced by individuals, more than the diagnosis and treatment of individuals. Mental illness itself is pervasive; it impacts communities, not just individuals.

Incidence:

> *Disorders of the nervous system, when taken as a whole, account for more hospitalizations, more long-term care, and more chronic suffering than nearly all other disorders combined. Mental disorders account for 15% of overall burden of disease from all causes, less than heart disease but slightly more than that caused by cancer.*
>
> *Serious depression affects 17 million Americans at a cost of $44 billion for Rx, disability and loss of productivity; as many as 1 in 5 with manic-depressive illness will suicide*
>
> ***Mental Illness is the 2nd leading cause of disability and premature mortality.***

A PUBLIC HEALTH PERSPECTIVE is concerned with

- incidence and frequency of illness
- disease prevention
- health promotion
- access to affordable services.

Public health practices address 3 things: they

1 – seek to identify risk factors
2 – mount preventive interventions, and
3 – actively promote good mental health.

A public health perspective focuses on the larger picture – looking at disability costs along with treatment costs. Experience in large businesses have shown that attention to the impact of appropriate behavioral health care on employee wellness produces reduced absenteeism and disability costs and improved productivity.

As the Surgeon General's report points out:

- Mental health is fundamental to health; mental health = successful performance of mental functions, resulting in productive activities, fulfilling relationships with others, and ability to adapt to change and cope with adversity.
- Americans are inundated with messages about success – in school in a profession, in parenting, in relationships – without recognizing / acknowledging / appreciating that successful performance rests on having good mental health
- Mind and body are inseparable: 2 parts of same whole – but language encourages the misperception that it is one or the other (physical or mental), not both. We recognize the need to treat the body, but we deny the same need to treat the mind as if they are not equal or not connected.

A disturbing statistic: nearly 2/3rds of people with severe mental illness <u>do not seek treatment.</u> Why? Because of

- **Inaccessibility** – limited services; variable comprehensiveness in varying parts of the state; significant gap between optimally effective treatment and what many individuals receive in actual practice settings
- **Cost** – beyond the reach of many, especially as health insurance has traditionally imposed much greater restriction on accessibility and payment for the costs of mental illness – nominally because of incorrect assumptions about exploding costs

- **Stigma** – persistent reactions to people with mental illness: fear, stereotyping, distrust, embarrassment, anger, avoidance of associating with, renting to, employing people with mental illness. The perception: "They are different from me." Personal denial: "it will never happen to me (or members of my family)" – though 1 in 5 adult Americans has a mental disorder in any one year.

  Stigma is based on persisting belief that mental disorders are not legitimate illnesses, but evidence of character flaws, moral weakness, limited will power, and something people should just "snap out of." Frequent event: people avoid diagnosis or treatment for fear that their illness will become known to their employer or fellow employees, with negative consequences.

  Stigma reduces patients' access to resources & opportunities, leads to low self-esteem, isolation, hopelessness, and deprives people of dignity. Basically, it interferes with their full participation in society.

  Stigma deters people – including me and thee – from seeking help.

  Stigma deters the public – including us all – from enabling equitable payment for care – it is the silent wall obstructing equal access. Hiding under the cloak of cost-control, it is a basic reason for denying parity,

IN SUMMARY, to repeat the primary emphases of the report:

1 – mental disorders are real health conditions
2 – efficacy of mental health treatments is well documented: treatment works
3 – a range of treatments exists for most mental disorders

Therefore, this single recommendation is offered: seek help if you have a mental problem or think you have symptoms of a mental disorder. We **must** make that opportunity more readily available and more socially acceptable.

These are simple ideas, yet – all recent scientific progress notwithstanding – they are still not widely recognized.

It is time we acknowledge them. It is time to end discrimination in health insurance in Kansas. We have been a leader in mental health in the past; it is time we do so again.

KANSAS

Bill Graves
Governor

DEPARTMENT OF HUMAN RESOURCES
Kansas Commission on Disability Concerns

Richard E. Beyer
Secretary

SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE
Wednesday, February 28, 2001
by Sharon Huffman, Legislative Liaison

Thank you for the opportunity to testify regarding HB 2033. The Kansas Commission on Disability Concerns (KCDC) is an advisory commission that provides information and education to the legislature and governor on issues of importance to Kansans with disabilities. The purpose of the Kansas Commission on Disability Concerns is to involve all segments of the Kansas community through legislative advocacy, education and resource networking to ensure full and equal citizenship for all Kansans with disabilities.

KCDC opposes HB 2033 in its current form because it would only delay the implementation of equal insurance benefits for treatment of mental illness. We would like to suggest that you substitute the language from SB 274 with a few changes. The definition of mental illness in SB 274 is much shorter than what is currently covered in the health insurance plans for State of Kansas employees. We would like to see this definition changed to reflect the same diagnoses that are covered in the state plan.

The costs to society of untreated severe mental illness are significant. For example, at least one-third of all homeless people have a severe mental illness. Most of these people would not be homeless if they received appropriate treatment and supports. Similarly, the burden on our local jails when they are used as "surrogate treatment facilities" could be significantly reduced if adequate treatment and services were available for persons with severe mental illness. The direct and indirect costs incurred by our state and local governments for treating severe mental illness are very high. These costs to our taxpayers could be reduced if insurance policies would provide adequate coverage for severe mental illness.

Some opponents would have you believe that the reason severe mental illnesses are not covered equally in most insurance contracts is that there is limited data demonstrating the effectiveness of treatment for these disorders. This assumption is not true. According to a 1993 report issued by the National Advisory Mental Health Council, clinical studies demonstrate that diagnosis and treatment for severe mental illness is today as precise and effective as diagnosis and treatment for other disorders. For example, the efficacy rate in reducing symptoms for persons with schizophrenia who receive timely treatment is 60 percent, which compares with just a 41 percent efficacy rate for treatment of cardiovascular disease through angioplasty. The efficacy rate for reducing symptoms through timely treatment of persons with bipolar disorders is 80 percent.

The Kansas Commission on Disability Concerns urges this committee's support of substituting SB 274 with changes for HB 2033.

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Senate Financial Inst. & Insurance
Date: 2-28-01
Attachment No. 2

Testimony to the Senate Insurance Committee
February 28, 2001

Presented by: Elizabeth Adams
Executive Director, NAMI Kansas

Thank you Madam Chair and Senators for letting me briefly present current information related to concerns about mental health parity.

Have test tracking requirements proven parity's cost effectiveness?

Yes. According to the Governor, who recommended the administrative decision to implement parity for all state plan participants, and according to the Health Care Commission and management of the state benefits plan, the data collected after now two years of parity using managed care tools demonstrates cost effectiveness, without even considering the cost-benefit analysis other states have seen who have had parity longer. The data is available now for legislative examination. The conditions, diagnoses and management of parity insurance is remaining the same for Kansas plan participants, logically inferring that neither next year nor the next will this data vary significantly.

How does mandated parity affect employers, particularly small businesses?

One opponent listed parity with bone density and prostate cancer screening, as mandates having a negative effect on employers due to cost, particularly small business. This mandate analogy is not appropriate. Unlike asymmetrical breast reduction, mental illness is the second leading cause of burden in the world market economy. As the Washington Business Group has reported employers find "the cost of providing appropriate treatment for mental disorders… must be measured in a larger context that also considers disability costs, employee absenteeism and lost productivity." Focus on functional outcomes in a health and wellness work environment is "essential to the bottomline." Small employers can least afford a deficit in employee productivity and feel the threatening impact of absenteeism and disability claims more immediately. As the Delta Air Lines Report states: Like many other employers we began to realize that looking simply at the cost of treatment did not recognize the much greater costs to our company when employees were absent from work or even present with impaired functioning… we also realized that failure to diagnose and appropriately treat mental illness, in particular depression, results in high levels of absenteeism, related health care costs and reduced productivity at work.

What do other states and federal experience demonstrate concerning cost-benefit?

Comparing state to state is difficult as each is unique: there are clear trends, however. Whether parity began in the state employees' plan, or with limited diagnoses covered like our state is considering (nine states use the entire DSM for diagnoses included in parity) each legislative move has been to increase coverage. Not one state has demonstrated data the caused a reversal in parity.

Senate Financial Inst. & Insurance
Date: 2-28-01
Attachment No. 3

New Hampshire, a state which enacted Severe Mental Illness Parity in1994, in considering expansion of parity this session engaged PricewaterhouseCoopers L.L.P. (PwC) to develop a cost analysis and give consulting advice. Far more extensive than Kansas' law their parity expansion mandate includes mental health and substance abuse benefits the same as medical care. (See handouts.) Data findings recommend the expansion be enacted.

Simply put, the federal, private and state experience (regardless of variations in the laws) show consistently the MH parity is affordable AND reduces overall health costs AND increases productivity in the workplace.

Thank you.

Following notes are in response to opposing testimony:

The pie chart demonstrating that only 37% of Kansans are affected by the parity law may be accurate. However, beware the implication from the chart that the other sectors are outside the parity law; the federal employees have parity; state plan participants have parity; Medicaid offers rich benefits; and many self-insured plans offer near to full parity already – the law will only enable the other Kansans to catch up.

Chamber concerns: Mandates show a lack of trust in private insurance marketplace. Quite the contrary, in a recent discussion with the Pres and CEO of a very large insurance company in Kansas, the President stated that is was the duty of the industry to fight mandates on behalf of their purchasers. He said his argument was not that brain disorders should go uninsured, but that in the competitive market, the only way he could offer it was if it was mandated – leveling the playing field – so to speak. Mandates enable the private insurance market to initiate new coverage on to a level playing field.

A summary of the current and parity proposal is priced within the four delivery systems:

1. **Current** - typical mental health and substance abuse benefit design as in current market. In New Hampshire this includes the 1994 legislation with parity for serious mental illnesses (schizophrenia. schizoaffective disorder, major depression. bipolar disorder. paranoid & other psychotic disorders. obsessive-compulsive, panic disorder. pervasive developmental disorder or autism). Substance abuse coverage is provided on a limited basis.

2. **Comprehensive Parity** - mental health and substance abuse benefits treated the same as any other illness, generally. That is, there are no financial limits or cost sharing differences between a mental health or substance abuse claim reimbursement request for a covered eligible expense and any other claim reimbursement request for a covered eligible physical illness.

The following table summarizes the actuarial modeling results for mental health and substance abuse parity:

Summary of Cost Impact
for
Mental Health And Substance Abuse Parity

Type of Delivery System	#	Distribution	Percentage Increase in Base Medical Plan for Change to Type of Parity: Mental Health & S/A Parity
Fee-for-Service	1	15%	1.6%
Managed Indemnity	2	20%	1.1
PPO & POS	3	40%	0.8
HMO & Gatekeeper	4	25%	0.7
Composite Market Analysis			**1.0%**
Composite PMPM			**$1.24**
Net Market Impact			**0.39%**
Net PMPM Impact			**$0.50**

3-3

The PwC modeling assumes a reasonable, but conservatively low managed care penetration for New Hampshire. The assumptions were established conservatively to account for the impact of fewer small groups currently using intensive managed care and/or mental health carve-out programs. PwC did not find data available to determine the split of managed care for behavioral health plans in New Hampshire for just insured plans.

Employers respond to any potential increase in benefit costs in variety of ways including, competitively marketing the plan to obtain lower premiums, intensely negotiating lower provider costs, cutting plan administrative costs, increasing plan costsharing by members, increasing premium contributions by members, reducing other benefits, and in the extreme, dropping plan coverages and reducing wages (or wage increases).

The Congressional Budget Office (CBO) typically estimates that these employer responses to required coverages will result in cost offsets of about 60% of the gross cost estimates. Using the standard CBO economic modeling approach, employer contributions for health costs would rise about 40% of the estimate or only 0.39 percent.

Based upon an analysis using generally accepted actuarial practices, the gross impact of the proposed New Hampshire mental health and substance abuse parity bill is equal to 1.0% of current employer claims or about $1.24 per member per month. However, the employer will respond in various ways to partially offset any potential cost increases. Therefore, the expected net employer contributions for health costs will rise about 0.39% or $0.50 per member per month.

3-4

BARBARA BOHM'S TESTIMONY ON HB 2033

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

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

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

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

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

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

In conclusion, I would like to add that I am basically testifying today in support of SB274. I would like to both praise and thank the Senate Insurance Committee for their outstanding job in fashioning a milestone in mental health care policy for Kansas. Thank you!

BARBARA BOHM, P.O.BOX 373, AMERICUS, KS 66835
316-443-5758 or barbbohm@americusks.net

Barbara Bohm
2/28/01

Senate Financial Inst. & Insurance
Date: 2-28-01
Attachment No. 4

Keys for Networking, Inc.

The Kansas Parent Information and Resource Ce r

The State Organization of the Federation of Families for Children's Mental Health

February 28, 2001

Chair Praeger, Members of the Committee:

My name is Sarah Adams. I am the Director of Information Systems for Keys for Networking, Inc. I am testifying today on behalf of Dr. Jane Adams who is ill.

As you know, a week ago, I testified to your committee on behalf of my own needs regarding mental health parity. I work for the state organization of the Federation of Families for Children's Mental Health, Washington, D.C. called Keys for Networking, Inc. In addition to my personal interest, our mission at Keys is to support and mobilize families with children with emotional problems through training, education, advocacy and systems change.

We are simply asking that you include children in this parity bill. We ask that you include children with serious emotional disabilities. We ask that you include children who qualify for services because licensed mental health practitioners have identified them as eligible for the state definition of SED.

At my place of employment, we hire parents who are raising children with serious emotional disturbances. None of these parents is on welfare. Keys offers health insurance as a benefit. These parents are working to support their families. I see these parents struggle, when their children cannot be maintained at school or at home, the parent must stay home. These parents need their employment insurance to help them get services they need. I know of parents who have had to quit working for us because they had to stay home with their children—when no services were available or affordable. This stress and this loss is the same whether a child is diagnosed with ADHD or Autism. I ask you to make this bill inclusive.

Finally, I am including the Vermont Parity Bill. In 1997, Vermont passed a parity bill which includes generous children's coverage. Today, representing Keys for Networking, Inc. I ask you to eliminate specific lists of and change the wording to "all mental health "conditions." (See attached, 2a).

Thank you for your time.

Senate Financial Inst. & Insurance
Date: 2-28-01
Attachment No. 5

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X-Sender: kelli@mail.keys.org
Mime-Version: 1.0
Date: Thu, 15 Feb 2001 11:52:15 -0600
To: jadams@keys.org
From: Kelli Finson <kelli@keys.org>
Subject: Vermont Mental Health Parity Law

>Date: Thu, 15 Feb 2001 10:19:41 -0500
>From: "Michael Chernick" <MIKEC@leg.state.vt.us>
>To: <kelli@keys.org>
>Subject: Vermont Mental Health Parity Law
>Mime-Version: 1.0
>
>Content-Type: text/html
>Content-Description: HTML
>
> <act025.wpd>Download this document in WordPerfect 6.1 format
>
>
>NO. 25. AN ACT RELATING TO HEALTH INSURANCE FOR MENTAL HEALTH AND SUBSTANCE ABUSE DISORDERS.
>
>(H.57)
>
>It is hereby enacted by the General Assembly of the State of Vermont:

>
>Sec. 1. 8 V.S.A. § 4089a(g) and (h) are added to read:
>
>(g) Members of the independent panel of mental health care providers shall be compensated as provided in 32 V.S.A. § 1010(b) and (c).
>
>(h) A review agent shall pay a license fee for the year of registration and a renewal fee for each year thereafter of $200.00. In addition, a review agent shall pay any additional expenses incurred by the commissioner to examine and investigate an application or an amendment to an application.
>
>Sec. 2. 8 V.S.A. § 4089b is added to read:
>
>§ 4089b. HEALTH INSURANCE COVERAGE; MENTAL HEALTH AND
>
>SUBSTANCE ABUSE
>
>(a) As used in this section,
>
>(1) "Health insurance plan" means any health insurance policy or health benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402(7). Health insurance plan includes any health benefit plan offered or administered by the state, or any subdivision or

5-2

instrumentality of the state.

>

>(2) "Mental health condition" means any condition or disorder involving mental illness or alcohol or substance abuse that falls under any of the diagnostic categories listed in the mental disorders section of the international classification of disease, as periodically revised.

>

>(3) "Rate, term or condition" means any lifetime or annual payment limits, deductibles, copayments, coinsurance and any other cost-sharing requirements, out-of-pocket limits, visit limits and any other financial component of health insurance coverage that affects the insured.

>

>(b) A health insurance plan shall provide coverage for treatment of a mental health condition and shall not establish any rate, term or condition that places a greater financial burden on an insured for access to treatment for a mental health condition than for accessto treatment for a physical health condition. Any deductible or out-of-pocket limits required under a health insurance plan shall be comprehensive for coverage of both mental health and physical health conditions.

>

>(c) A health insurance plan that does not otherwise provide for management of care under the plan, or that does not provide for the same degree of management of care for all health conditions, may provide coverage for treatment of mental health conditions through a managed care organization provided that the managed care organization is in compliance with the rules adopted by the commissioner that assure that the system for delivery of treatment for mental health conditions does not diminish or negate the purpose of this section. The rules adopted by the commissioner shall assure that timely and appropriate access to care is available; that the quantity, location and specialty distribution of health care providers is adequate and that administrative or clinical protocols do not serve to reduce access to medically necessary treatment for any insured.

>

>(d) A health insurance plan shall be construed to be in compliance with this section if at least one choice for treatment of mental health conditions provided to the insured within the plan has rates, terms and conditions that place no greater financial burden on the insured than for access to treatment of physical conditions. The commissioner may disapprove any plan that the commissioner determines to be inconsistent with the purposes of this section.

>

>(e) To be eligible for coverage under this section the service shall be rendered:

>

>(1) For treatment of mental illness,

>

>(A) by a licensed or certified mental health professional, or (B) in a mental health facility qualified pursuant to rules adopted by the secretary of human services or in an institution, approved by the secretary of human services, that provides a program for the treatment of a mental health condition pursuant to a written plan. A nonprofit hospital or a medical service corporation may require a mental health facility or licensed or certified mental health professional to enter into a contract as a condition of providing benefits.

>

>(2) For treatment of alcohol or substance abuse,

>

>(A) by a substance abuse counselor or other person approved by the secretary of human services based on rules adopted by the secretary that establish standards and criteria for determining eligibility under this subdivision, or

>

>(B) in an institution, approved by the secretary of human services, that provides a program for the treatment of alcohol or substance dependency pursuant to a written plan.

>

>Sec. 3. REPORT

>

>On or before January 15, 1999, the Department of Banking, Insurance, Securities, and Health Care Administration shall report to the general assembly on the following:

>

>(1) An estimate of the impact of this act on health insurance costs.

>

>(2) Actions taken by the department to assure that health insurance plans are in compliance with this act and that quality and access to treatment for mental health conditions provided by the plans are not compromised by providing financial parity for such coverage.

>

>(3) When a health insurance plan offers choices for treatment of mental health and substance abuse conditions as provided by 8 V.S.A. § 4089b(d), an analysis and comparison of those choices in regard to level of access, choice and financial burden.

>

>(4) Identification of any segments of the population of Vermont that may be excluded from access to treatment for mental health and substance abuse conditions at the level provided by this act, including an estimate of the number of Vermonters excluded from such access under health benefit plans offered or administered by employers who receive the majority of their annual revenues from contract, grants or other expenditures by state agencies.

>

>Sec. 4. CONSTRUCTION; TRANSITIONAL PROVISIONS

>

>(a) The provisions of this bill shall not be construed to:

>

>(1) Limit the provision of specialized Medicaid covered services for individuals with mental health or substance disorders.

>

>(2) Supersede the provisions of federal law, federal or state Medicaid policy or the terms and conditions imposed on any Medicaid waiver granted to the state with respect tothe provision of services to individuals with mental health or substance abuse disorders.

>

>(3) Affect any annual health insurance plan until its date of renewal or any health insurance plan governed by a collective bargaining agreement or employment contract until the expiration of that contract.

>

>(b) The rules of the secretary of human services adopted under 8 V.S.A. § 4089, relating to

eligibility for payment for treatment of mental illness, and adopted under 8 V.S.A. § 4099, relating to eligibility for payment for treatment of alcoholism, shall remain in effect until the effective date of this act and thereafter shall be deemed to be the rules adopted by the secretary under 8 V.S.A. § 4089b(e), to the extent that they are consistent with the provisions of this act and until amended or repealed by the secretary.

>

>Sec. 5. REPEAL

>

>8 V.S.A. § 4089 (mental illness) and §§ 4097-4099b (alcoholism) are repealed in regard to any health insurance plan only after the provisions of this act take effect in accordance with Sec. 6 of this act.

>

>Sec. 6. EFFECTIVE DATE

>

>This act shall take effect on passage and shall apply to any health insurance plan offered or renewed on and after January 1, 1998.

>

>Approved: May 28, 1997

>

>

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The test of the morality of a society is what it does for its children.
-Dietrich Bonhoeffer

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KANSAS ASSOCIATION OF
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FINANCIAL ADVISORS

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Law and Legislation Committee Chairman
Kansas Association of Insurance and Financial Advisors (KAIFA)

Testimony Before the Senate Financial Institutions and Insurance Committee
HB 2033
February 28, 2001

Madam Chairperson and Committee Members

I appreciate the opportunity to address you today on behalf of the many members of KAIFA. Our membership consists of 1,500 Kansans located in all Kansas counties who are actively engaged as insurance agents and brokers.

KAIFA is a proponent of HB 2033 for the following reasons:

- We believe that the overall context of this bill has much merit. The basis of the information should provide whether or not the first dollar coverage for mental illness should continue for the state employees. By outlining the costs for specific mental illnesses as defined in the bill, the proper recommendations can be made accordingly.

- We believe that the information gathered should be the basis of premium costs for this additional benefit and of course be a part of the overall costs for the state employees benefit plan.

- We believe that the definition of mental illness used in the bill should be a part of the definition used in any benefit plan.

Although we believe that this information will be helpful in evaluating the impact of the mental illness first dollar benefit for the state employees, it would not be appropriate to apply it to the other private health insurance plans in the state and therefore we do not believe in mental health parity for all Kansans. The premium costs to individual Kansas policyholders and Kansas employer groups would be adversely affected. Kansas policyholders are already experiencing annual double digit rate increase in some cases and these types of additional mandates will only make matters worse.

Thank you for your time and consideration.

Senate Financial Inst. & Insurance
Date: 2-28-01
Attachment No. 6

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STATEMENT OF BRAD SMOOT
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THE SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE

2001 HOUSE BILL 2033

February 28, 2001

Madam Chair and Members,

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

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

Last year the Senate passed S 547, imposing a mental health parity pilot project on the state health benefits plan and requiring a report to the 2002 Kansas Legislature of the state's experience with the expanded coverage. House Bill 2033 would impose a similar obligation and would enable the Legislature to consider a mental health mandate for the private sector next year, just as if it had passed the Senate bill last session. This is because the state employees health care commission voluntarily expanded its benefits to include parity coverage for similar biologically-based mental illnesses identified in H 2033. By this time next year, the state will have actual experience and data to give lawmakers a better view of the benefits and burdens mental health parity would impose on working men and women of Kansas.

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As you know, this Committee is considering S 274, which mandates mental health parity (for certain illnesses) on insured individuals and groups, both large and small. To date, no cost/benefit impact report has been prepared and provided as required by K.S.A. 40-2248 and 40-2249. See attached. The impact reporting requirements and the "test tracking" procedures were put into law for the benefit of lawmakers in assessing the pros and cons of numerous insurance mandates proposed each year. While each legislature is free to ignore or override the laws of previous legislatures, we believe the requirements of these statutes are valuable tools for lawmakers and give the public confidence that legislation has been thoroughly considered.

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

Health Insurance Mandates
Impact Report and "Test Tracking" Laws

40-2248. Mandated health benefits; impact report to be submitted prior to legislative consideration. Prior to the legislature's consideration of any bill that mandates health insurance coverage for specific health services, specific diseases, or for certain providers of health care services as part of individual, group or blanket health insurance policies, the person or organization which seeks sponsorship of such proposal shall submit to the legislative committees to which the proposal is assigned an impact report that assesses both the social and financial effects of the proposed mandated coverage. For purposes of this act, mandated health insurance coverage shall include mandated optional benefits. It shall be the duty of the commissioner of insurance to cooperate with, assist and provide information to any person or organization required to submit an impact report under the provisions of this act.

History: L. 1990, ch. 162, § 1; July 1.

40-2249. Same; contents. The report required under K.S.A. 40-2248 for assessing the impact of a proposed mandate of health coverage shall include at the minimum and to the extent that information is available, the following:

(a) The social impact, including:

(1) The extent to which the treatment or service is generally utilized by a significant portion of the population;

(2) the extent to which such insurance coverage is already generally available;

(3) if coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatment;

(4) if the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment;

(5) the level of public demand for the treatment or service;

(6) the level of public demand for individual or group insurance coverage of the treatment or service;

(7) the level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts; and

(8) the impact of indirect costs which are costs other than premiums and administrative costs, on the question of the costs and benefits of coverage.

(b) The financial impact, including:

(1) The extent to which insurance coverage of the kind proposed would increase or decrease the cost of the treatment or service;

(2) the extent to which the proposed coverage might increase the use of the treatment or service;

(3) the extent to which the mandated treatment or service might serve as an alternative for more expensive treatment or service;

(4) the extent to which insurance coverage of the health care service or provider can be reasonably expected to increase or decrease the insurance premium and administrative expenses of policyholders; and

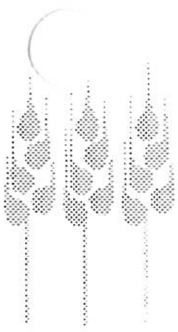
(5) the impact of this coverage on the total cost of health care.

History: L. 1990, ch. 162, § 2; July 1.

40-2249a. Same; state employee group pilot project for new mandated health benefits. (a) After July 1, 1999, in addition to the requirements of K.S.A. 40-2248 and 40-2249, and amendments thereto, any new mandated health insurance coverage for specific health services, specific diseases or for certain providers of health care services approved by the legislature shall apply only to the state health care benefits program, K.S.A. 75-6501, *et seq.*, and amendments thereto, for a period of at least one year beginning with the first anniversary date of the state health care benefits program subsequent to approval of the mandate by the legislature. On or before March 1, after the one year period for which the mandate has been applied, the Kansas state employees health care commission shall submit to the president of the senate and to the speaker of the house of representatives, a report indicating the impact such mandated coverage has had on the state health care benefits program, including data on the utilization and costs of such mandated coverage. Such report shall also include a recommendation whether such mandated coverage should continue for the state health care benefits program or whether additional utilization and cost data is required.

(b) The legislature shall periodically review all health insurance coverages mandated by state law.

History: L. 1999, ch. 162, § 5; July 1.



Kansas Association of Health Plans

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Testimony before the
Senate Financial Institutions and Insurance Committee
<u>Hearings on HB 2033</u>
February 28, 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 in support of House Bill 2033.

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

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

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

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As you know, the legislature may change the law at any time, but is it not wise to remember the reasons the test tracking provision was 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 continue to discuss the issues raised by this bill if that is the Committees' desire, however we support the responsible position proposed in HB 2033.

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

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

February 28, 2001

TO: Senate Committee on Financial Institutions & Insurance

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

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

Mdm. Chairwoman and members of the Committee:

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

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

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

Thirty-two states now have parity laws. The Surgeon General's report, along with many other studies, suggests that implementing parity laws is not as expensive as once suggested. Case studies of five states that had a parity law for at least a year revealed a small effect on premiums (plus or minus a few percent).

Research is bringing forth ways to identify, treat and even prevent disorders in some cases, and outpacing the capacities of the health service system to deliver mental health services to those who would benefit from it in a fair and equitable way.

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 28c/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.

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