Approved: 3-13-01
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 March 7, 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:

Others attending: See attached list.

Discussion and Action on HB 2033 - Insurance; report to the legislature concerning certain mental illnesses

The Chair called the Committee's attention to information contained in a report prepared by the University of Kansas, Institute for Public Policy and Business Research dated September, 1997, entitled: *The Cost of Equal Health Insurance Coverage for Major Mental Illnesses*, which was prepared for NAMI Kansas (formerly Kansas Alliance for the Mentally Ill), as well as information on Mental Health Parity Costs that was distributed to the Committee, (Attachment 1), an executive summary on a final report to Congress by the National Advisory Mental Health Council entitled, *Statewide Experiences of Other States Following Passage of Mental Health Parity*, and a Comparison of Mandated Mental Illness Insurance Coverage by States, (Attachment 2).

The Chair briefed the Committee on a balloon of **Senate Substitute for House Bill 2033**. (Attachment 3).

During Committee discussion it was suggested the words "individual or" be deleted on page 1, line 14 of the Substitute bill, and the date "January 1, 2005" be inserted in subsection (b) relating to the date that a report be delivered to the President of the Senate and the Speaker of the House of Representatives by the State Insurance Department indicating the impact of providing mental illness benefits under the act.

Senator Teichman made a motion the Committee adopt the proposed amendments to **Senate Substitute for HB 2033**, and that the Committee recommend **Senate Substitute for HB 2033 as amended** favorable for passage, seconded by Senator Steineger. The motion carried.

Adjournment

The meeting was adjourned at 10:20 a.m. The next meeting of the Committee is scheduled for March 8, 2001.

SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: 3-7-01

NAME	REPRESENTING
Ernest C. Fogge	AARP
Derek McDonnell	Ottawa University
Amy Kennedy	Ottawa University
Ethan Harrington	Ottawa University - Golf Team
Lisa Beil	Ottawa University
Sheryl Fields	Ottawa University
Rhonda Higginbottom	Ottawa University
Rachel Vernon	Ottawa University
Amy Hampton	Ottawa University
Mark Dennis	Ottawa University
Jeanie Tudor-Hays	KDOA
Amy A. Campbell	KMHC
Jeremy Anderson	KS Ins Dept.
Tonia Salvini	Ottawa University
Tonda MacCarley	KS Ins. Dept
Terry Leatherman	KCCI
Natalie Bright	WIBA
Anne Spiess	KAIFA
Cheryl Dillard	HealthNet

SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: 3-7-01

NAME	REPRESENTING
Ron Auer	Coventry Healthcare
John Frederick	The Boeing Company
Bill Sneed	HIAA
Larry Magill	KAIA
Jerry Slaughter	KMS
Bryce Miller	NAMI Kansas
Sarah Adams	Keep for Networks
Chris Collins	Kansas Medical Society
Amylynn Turner	Sen. Feleciano
Bruce Witt	Preferred Health Systems
Kevin Barone	Hein/Lueir Chtd.

Mental Health Parity Costs
Summary by Gene Blobaum, Miller and Newberg, Inc.
Actuary, Overland Park Kansas

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

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

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

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

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

Senate Financial Inst. & Insurance
Date: 3-7-01
Attachment No. 1

Charges for Mental Conditions Proposed in SB 274 (1999 DATA)

Disease Specific Charges:

Disorder Type	*Procedure Code*	*Frequency*	*MeanTotal Charge*	*MeanPaid Charge*
Schizophrenia	295	210	$1,768.8	$757.3
Manic Disorder	296	2597	$2,208.6	$758.6
Delusional Disorder	297	16	$1,353.8	$297.0
Psychoses with Origin Specific to Childhood	299	35	$845.4	$320.3
Panic Disorder	300.01	131	$1,146.9	$434.1
Obsessive Compulsive Disorder	300.3	117	$1,585.5	$554.3
Personality Disorder	301	103	$1,176.6	$461.0
Attn Deficit Disorder	314	1258	$588.9	$266.2

As a Percentage of All Health Care Charges:

		TOTAL CHARGES	ALLOWED CHARGES	PAID CHARGES
All Reporting Companies	Overall Charges	$12,240,660	$6,268,530	$4,674,017
	Mental Health			
	Overall Charges	$1,378,898,126	$548,800,844	$470,699,941
	All Health Care			
	% of Total Cost	0.89%	1.14%	0.99%

Source: Kansas Health Insurance Information System(KHIIS), Kansas Insurance Departement and Center for Health and Environmental Statistics, KDHE

Insurance Parity for Mental Health: Cost, Access, and Quality
Final Report to Congress by the National Advisory Mental Health Council

EXECUTIVE SUMMARY[1]

In Senate Report No.105-300, the Senate Appropriations Committee observed,"The Committee has recently received from the National Advisory Mental Health Council [NAMHC] the report requested in its fiscal year 1998 appropriations report and notes the impact of managed care on keeping costs of parity at a low level." The Committee requested from the NAMHC an additional report on its findings from emerging health services research data that would, where possible "...address both employer direct costs, and the impact of indirect cost savings from successful treatment of employees." The NAMHC was also asked to "consider the costs and quality of coverage for children, and the development of outcome measures of quality for all mental health coverage." This report was developed in response to the Committee's request.

Building upon a body of knowledge developed in the course of three prior NAMHC reports on parity to the Senate Appropriations Committee, an analysis of recent studies reveals the following major findings:

- What is the current status of parity legislation in the US? Thirty-one of the 50 States have now passed some form of parity legislation, with benefits that range from limited to comprehensive. The 1996 Mental Health Parity Act (which is now being considered for reauthorization) appears to have accelerated the passage of State-level parity legislation. And in mid-1999, President Clinton announced that a parity-level benefit would be implemented for 8.7 million beneficiaries of the Federal Employees Health Benefit Program (FEHB) beginning in calendar year 2001.

- Does implementing parity increase the total cost of health benefits? Recent research supports and expands earlier findings that implementing parity benefits results in minimal if any increase in total health care costs. A recently updated simulation model estimates an approximately 1.4 percent increase in total health insurance premium costs when parity is implemented. In addition, data from a large State show that total health care costs decreased after the implementation of parity.

- Does implementing parity cause cost shifting between different health system sectors? The issue is complex. Data are not available under parity, but recent research indicates that high-cost consumers may not shift completely to coverage under the public system; rather, some may be covered by both the private and public systems. The implications of this finding remain unclear.

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[1] NOTE: This report does not necessarily reflect the views of the Department of Health and Human Services.

- How does parity affect access and quality? A recent study with a large State database shows that when parity mental health benefits are introduced with managed care, an increased proportion of adults and children used some outpatient mental health services. However, the intensity of services (number of visits) did not increase and inpatient use declined. Although the reduction in inpatient use was most pronounced for children, there was evidence that their access to specialty mental health services increased. What is unknown is the quality of care and impact of these changes.

- How can the quality of mental health services be measured and improved? Although research in this area offers the promise of new and feasible measures, no currently available quality measures provide all the answers that consumers, providers, employers and policy makers want. Even with appropriate measures of quality and the ability to put them into place, interventions need to be developed that actually improve the quality of mental health care. Some recent evidence suggests that even small-scale interventions can ensure the delivery of appropriate services.

- How does parity or managed care affect disability and productivity in the workforce? Data are not yet available to assess the impact of parity in these areas. However, studies under non-parity conditions suggest that mental health services can decrease the amount of lost wages and reduce lost days from work and the number of disability claims.

In summary, mental health parity is now the law in the majority of States. The cost of parity in combination with managed care is less than initially anticipated, and it has some beneficial effects on access. Yet, it is still unclear what impact parity has on the quality of mental health services and the well-being of people with mental illnesses. As Mechanic and McAlpine note in a recent issue of *Health Affairs*:

> "The challenge for the coming decade is to develop clear standards based on the best evidence and clinical judgment so that parity has substance in implementation as well as in concept. Parity is not simply some match in service limits to what a medical or surgical patient experiences. It should be a configuration of management strategies fitted to careful assessment of patients' needs and a response that is consistent with our best scientific knowledge." (Mechanic and McAlpine1999)

It remains to be seen how the balance will be struck over the next few years between State legislation, large employer initiatives (public and private), and federal legislative expansions of the 1996 Mental Health Parity Act.

Summary of Modeling Results

MENTAL HEALTH AND SUBSTANCE ABUSE COMBINED

Type of Delivery System	#	Distribution	Percentage Increase in Base Medical Plan for Change to Type of Parity			
			Partial	SMI	Full	Comprehensive
Fee-for-Service	1	30%	1.3%	3.5%	4.3%	4.9%
Managed Indemnity	2	25%	0.9	2.5	3.1	3.6
PPO & POS	3	10%	0.6	2.3	2.9	3.8
HMO & Gatekeeper	4	35%	0.6	1.0	1.3	1.8
Composite Market Analysis			0.9%	2.3%	2.8%	3.4%
Composite PMPM			$.91	$2.33	$2.84	$3.45

MENTAL HEALTH ONLY

Type of Delivery System	#	Distribution	Percentage Increase in Base Medical Plan for Change to Type of Parity			
			Partial	SMI	Full	Comprehensive
Fee-for-Service	1	30%	0.9%	2.4%	3.0%	3.2%
Managed Indemnity	2	25%	0.6	1.8	2.3	2.6
PPO & POS	3	10%	0.5	1.9	2.4	2.9
HMO & Gatekeeper	4	35%	0.5	0.8	1.0	1.4
Composite Market Analysis			0.6%	1.7%	2.1%	2.4%
Composite PMPM			$.61	$1.73	$2.13	$2.44

Employers respond to any potential increase in benefit costs in a 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 insurance would rise about 40% of the estimate or only 1.4 percent.

Based upon an analysis using generally accepted actuarial practices, the total impact of the proposed Vermont mental health and substance abuse parity bill is equal to 3.4% of current employer claims or about $3.45 per member per month. However, the employer will respond in various ways to partially offset any potential cost increases. Therefore, the expected employer contributions for health insurance will rise about 1.4% or $1.38 per member per month. Assuming an average of 3 members per family, this translates into an equivalent wage increase of $.025 per hour.

2-3

State-wide Experiences Following Passage Of Mental Health Parity

Vermont

Summary of attachment

Mental Health and Substance Abuse Parity was effective 1/1/98 with a phase in on policy anniversaries. Kaiser Permanente/CHP transformed all of its products into parity on January 1, 1998, regardless of renewal dates. Because parity was to become effective for new business and renewals on or after January 1, 1998, health insurers have not had sufficient time to measure the actual effect of parity on rates. However, as companies filed their proposed rates for 1998, the Division (of Insurance) asked them to identify, to the extent possible, the proportion of their rate increases attributable to MH/SA parity.

The premium rate impact in Vermont as report to the Vermont General Assembly by the Department of Banking, Insurance, Securities and Health Care Administration was:

"BCBSVT estimated the impact of the parity law on its 1998 rates as 0% for the Vermont Health Partnership (a managed care product), between 1%-3% for the Vermont Freedom Plan, 1% for its comprehensive plan, and 2% for its base plan."

"Kaiser Permanente/CHP estimated a 2.07% increase in its 1998 rates as attributable to parity."

BCBS of Vermont Q&A

Given the initial legislative resistance by BCBS to the parity law, it is interesting to read their implementation comments. The tone is – no big deal, we have been providing this type of care for years in partnership with our managed behavioral health care vendor.

State-wide Experiences Following Passage Of Mental Health Parity

Texas, Maryland, Rhode Island, Minnesota

Interim Report to Congress by the National Advisory Mental Health Council

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

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

Maryland

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

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

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

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

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

Rhode Island

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

Minnesota

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

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

July 1, 1999
FOR IMMEDIATE RELEASE

CONTACT: Tricia Alvarez
202-336-5910

Connecticut Parity Law Will Boost Access To Mental Health Treatment

(Washington, DC) – The American Psychological Association (APA) today applauded Governor John Rowland (R-Connecticut) for signing a broad-based mental health parity bill into law. Connecticut is the first state to change a mental health parity law that covered a handful of serious mental illnesses – only a small portion of the population -- into a broad-based law that will help all people with mental health disorders.

"Connecticut has shown the wisdom of banning insurance discrimination against all persons with disabling mental health disorders, regardless of whether the disorders have a biological cause," says Russ Newman, Ph.D., J.D., APA's Executive Director for Professional Practice. "This new law is a victory for individuals and families whose lives have been affected by mental health disorders and have not been able to access the care they need simply because of financial barriers."

The Connecticut legislation, part of a larger health insurance bill, will now prohibit insurance policies from using higher co-pays and deductibles as well as arbitrary limits on visits to mental health professionals. Furthermore, this 1999 law broadens parity based on the Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (DSM-IV), instead of those only listed as severe mental illnesses (SMI). The original severe mental illness-only parity law passed in Connecticut in 1997.

"It became obvious to our state legislators that parity just for severe mental illness left too many people with various mental health disorders out in the cold, " explains Daniel Abrahamson, Ph.D., Director of Professional Affairs of the Connecticut Psychological Association.

Twenty-five states have now enacted some form of mental health parity legislation within the last eight years, with nine of those states having passed broad-based parity. The remaining states have parity for serious mental illnesses, such as schizophrenia, bipolar disorder, major depressive disorder and autism.

While SMI parity acknowledges the importance of treatment for mental illness, many individuals who experience mental health disorders not included in SMI legislation will continue to have difficulty accessing necessary treatment. For example, SMI parity does not offer as much protection for children, since severe emotional disorders for youth are typically not included in SMI legislation. Similarly, women may not receive adequate treatment for conditions not usually covered under SMI parity, such as anorexia nervosa, which is a much more common diagnosis for females, or Post Traumatic Stress Disorder, a common disorder for victims of rape.

"Parity laws with a limited set of diagnoses represent the old way to do things, and more state legislators will catch on that it's best to pass broad-based parity coverage," predicted Dr. Newman.

The Congressional Budget Office and several national actuarial studies have suggested that broad-based parity is affordable. Actuarial studies of state broad-based mental health parity legislation by PriceWaterhouseCoopers predict premium increases of just 0.6% to 3%, depending the type of health plan. Such broad-based parity is 0.1% or 0.2% higher than SMI parity, which translates to just pennies per month. (Premiums are usually split between employer and employee). Broad-based parity, such as that passed by the Connecticut legislature, is an affordable solution for ensuring treatment for all individuals who suffer from mental health disorders.

Dr. Newman adds that President Clinton's June 7 announcement of broad-based parity for the nine million people in the Federal Employee Health Benefit Program will further make the case for parity affordability.

State Health Plan Experience
With
Mental Health Parity

Texas

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

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

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

State Health Plan Experience
With
Mental Health Parity

North Carolina

Summary of attachment

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

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

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

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

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

Summary of OutPatient Utilizations of More Than 26 Visits

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

Other Cost Studies

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

By Roland Sturm, Ph.D.

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

The conclusions of the report are straightforward and profound:

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

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

2-13

DRAFT

Comparison of Mandated Mental Illness Insurance Coverage by State

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

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

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

KAHP working draft #1

Session of 2001

Senate Substitute for House Bill 2033

~~SENATE BILL No. 274~~

By Committee on Financial Institutions and Insurance

2-7

AN ACT concerning insurance; providing coverage for certain mental health conditions; amending K.S.A. 40-2,103, 40-2,105 and 40-19c09 and repealing the existing sections.

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

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

[(b)] For the purposes of this section, "mental illness" means the following: Schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive compulsive disorder and panic disorder as such terms are defined in the diagnostic and statistical manual of mental disorders, fourth edition, (DSM-IV, 1994) of the American psychiatric association but shall not include conditions not attributable to a mental disorder that are a focus of attention or treatment.

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

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

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

[(f)] The provisions of this section shall not apply to any policy or certificate which provides coverage for any specified disease, specified accident or accident only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance as defined by K.S.A. 40-2227 and amendments thereto, vision care or any other limited supplemental benefit nor to any medicare supplement policy of insurance as defined by

(1)

(2) The coverage required by paragraph (1) shall include annual coverage for both 45 days of in-patient care for mental illness and for 45 days of out-patient care for mental illness.

(b) Notwithstanding the provisions of K.S.A. 40-2249a, and amendments thereto, the state insurance department shall deliver to the president of the senate and to the speaker of the house of representatives on or before Jan. 1, 2005 a report indicating the impact of providing mental illness benefits required by this act. Such report shall include information regarding access to and usage of such services and the cost of such services.

(c)

schizophrenia, schizoaffective disorder, schizophreniform disorder, brief reactive psychosis, paranoid or delusional disorder, atypical psychosis, major affective disorders (bipolar and major depression), cyclothymic and dysthymic disorders, obsessive compulsive disorder, panic disorder, pervasive developmental disorder, including autism, attention deficit disorder and attention deficit hyperactive disorder

(d)

(e)

(f)

(g)

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the commissioner of insurance by rule and regulation, any coverage issued as a supplement to liability insurance, workers compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group, blanket or individual basis.

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

New Sec. 3. The provisions of K.S.A. 40-2249a, and amendments thereto, shall not apply to this act.

Sec. 4. On and after January 1, 2002, K.S.A. 40-2,103 is hereby amended to read as follows: 40-2,103. The requirements of K.S.A. 40-2,100, 40-2,101, 40-2,102, 40-2,104, 40-2,105, 40-2,114 ~~and 40-2250~~, ~~and amendments thereto and K.S.A.~~ 40-2,160 ~~and~~, 40-2,165 through 40-2,170, *inclusive, 40-2250 and section 1,* and amendments thereto, shall apply to all insurance policies, subscriber contracts or certificates of insurance delivered, renewed or issued for delivery within or outside of this state or used within this state by or for an individual who resides or is employed in this state.

Sec. 5. On and after January 1, 2002, K.S.A. 40-2,105 is hereby amended to read as follows: 40-2,105. (a) On or after the effective date of this act, every insurer which issues any individual or group policy of accident and sickness insurance providing medical, surgical or hospital expense coverage for other than specific diseases or accidents only and which provides for reimbursement or indemnity for services rendered to a person covered by such policy in a medical care facility, must provide for reimbursement or indemnity under such individual policy or under such group policy, except as provided in subsection (d), which shall be limited to not less than 30 days per year when such person is confined for treatment of alcoholism, drug abuse or nervous or mental conditions in a medical care facility licensed under the provisions of K.S.A. 65-429 and amendments thereto, a treatment facility for alcoholics licensed under the provisions of K.S.A. 65-4014 and amendments thereto, a treatment facility for drug abusers licensed under the provisions of K.S.A. 65-4605 and amendments thereto, a community mental health center or clinic licensed under the provisions of K.S.A. 75-3307b and amendments thereto or a psychiatric hospital licensed under the provisions of K.S.A. 75-3307b and amendments thereto. Such individual policy or such group policy shall also provide for reimbursement or indemnity, except as provided in subsection (d), of the costs of treatment of such person for alcohol abuse and nervous or mental conditions, limited to not less than the first $100, 80% of the next $100 and 50% of the remainder and limited to not less than $7,500 in such person's

(h) Managed care programs may be used in the implementation of this act as long as such program provisions are applied equally to all coverages under such health care plan.

New Sec. 2. On and after January 1, 2002, any group health insurance policy, nonprofit medical and hospital service corporation contact, fraternal benefit society, health maintenance organization, municipal group funded pool and state employee benefit program which provides coverage for prescription drugs, other than prescription drugs administered in a hospital or physician's office, shall provide coverage for psychotherapeutic drugs used for the treatment of mental illness under terms and conditions no less favorable than coverage provided for other prescription drugs.

lifetime, in the facilities enumerated when confinement is not necessary for the treatment or by a physician licensed or psychologist licensed to practice under the laws of the state of Kansas.

(b) For the purposes of this section "nervous or mental conditions" means disorders specified in the diagnostic and statistical manual of mental disorders, fourth edition, (DSM-IV, 1994) of the American psychiatric association but shall not include conditions ~~not~~:

(1) Not attributable to a mental disorder that are a focus of attention or treatment (DSM-IV, 1994); *and*

(2) defined as a mental illness in section 1 and amendments thereto.

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

(d) There shall be no coverage under the provisions of this section for any assessment against any person required by a diversion agreement or by order of a court to attend an alcohol and drug safety action program certified pursuant to K.S.A. 8-1008 and amendments thereto.

or for evaluations and diagnostic tests ordered or requested in connection with divorce, child custody or child visitation proceedings.

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

(f) The provisions of this section shall be applicable to the Kansas state employees health care benefits program developed and provided by the Kansas state employees health care commission.

(g) The outpatient coverage provisions of this section shall not apply to a high deductible health plan as defined in Section 301 of P.L. 104-191 and any amendments thereto if such plan is purchased in connection with a medical savings account pursuant to that act. After the amount of eligible deductible expenses have been paid by the insured, the outpatient costs of treatment of the insured for alcoholism, drug abuse and nervous or mental conditions shall be paid on the same level they are provided for a medical condition, subject to the yearly and lifetime maximums provided in subsection (a).

(h) Managed care programs may be used in the implementation of this section.

Sec. 5. On and after January 1, 2002, K.S.A. 40-19c09 is hereby amended to read as follows: 40-19c09. (a) Corporations organized under the nonprofit medical and hospital service corporation act shall be subject to the provisions of the Kansas general corporation code, articles 60 to 74, inclusive, of chapter 17 of the Kansas Statutes Annotated, applicable to nonprofit corporations, to the provisions of K.S.A. 40-214, 40-215, 40-216, 40-218, 40-219, 40-222, 40-223, 40-224, 40-225, 40-226, 40-229, 40-230, 40-231, 40-235, 40-236, 40-237, 40-247, 40-248, 40-249, 40-250, 40-251, 40-252, 40-254, 40-2,100, 40-2,101, 40-2,102, 40-2,103, 40-2,104, 40-2,105, 40-2,116, 40-2,117, *40-2,153, 40-2,154, 40-2,160, 40-2,161, 40-2,163 through 40-2,170, inclusive,* 40-2a01 *et seq.*, 40-2111 to 40-2116,

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inclusive, 40-2215 to 40-2220, inclusive, 40-2221a, 40-2221b, 40-2229, 40-2230, 40-2250, 40-2251, 40-2253, 40-2254, 40-2401 to 40-2421, inclusive, and 40-3301 to 40-3313, inclusive, ~~K.S.A. 40-2,153, 40-2,154, 40-2,160, 40-2,161, 40-2,163, 40-2,164 and 40-2,165 through 40-2,170~~ [and] *section 1*, and amendments thereto, except as the context otherwise requires, and shall not be subject to any other provisions of the insurance code except as expressly provided in this act.

(b) No policy, agreement, contract or certificate issued by a corporation to which this section applies shall contain a provision which excludes, limits or otherwise restricts coverage because medicaid benefits as permitted by title XIX of the social security act of 1965 are or may be available for the same accident or illness.

(c) Violation of subsection (b) shall be subject to the penalties prescribed by K.S.A. 40-2407 and 40-2411, and amendments thereto.

New Sec. [6]. Sections 1 and 2, ~~and~~ [7] amendments thereto, shall be known as the Kansas mental health parity act.

Sec. [7]. On January 1, 2002, K.S.A. 40-2,103, 40-2,105 and 40-19c09 are hereby repealed.

Sec. [8]. This act shall take effect and be in force from and after its publication in the statute book.