Approved: March 19, 2009
Date

MINUTES OF THE HOUSE INSURANCE COMMITTEE

The meeting was called to order by Chairman Clark Shultz at 3:30 p.m. on March 17, 2009, in Room 784 of the Docking State Office Building.

All members were present.

Committee staff present:
Bruce Kinzie, Office of the Revisor of Statutes
Sean Ostrow, Office of the Revisor of Statutes
Melissa Calderwood, Kansas Legislative Research Department
Cindy Lash, Kansas Legislative Research Department
Sue Fowler, Committee Assistant

Conferees appearing before the Committee:
Barbara Torkelson, Kansas Insurance Department
Aimee Nienstedt, Self
Rick Cagan, National Alliance on Mental Illness, NAMI
Jackie Shufelberger, Self/Daughter
Amy Campbell, Kansas Mental Health Coalition
Michelle Sweeney, Association of Community Mental Health Centers of Kansas
Stuart Little, Kansas Association of Addiction Professionals
Marlee Carpenter, Kansas Association of Health Plans
Ira Stamm, Psychologist
Jim Hall, American Council of Life Insurers
Representative Cindy Neighbor, District 18
Tom Bryon, Kansas Association of Health
Ken Daniel, Topeka Independent Business Association
Larry Magill, Kansas Association of Insurance Agents
Dan Murray, National Federation of Independent Businesses
Bill Sneed, America's Health Insurance Plans
Larry Ann Lower, Aetna, Inc.
Melissa Calderwood, Kansas Legislative Research Department
Joe Thesing, National Association of Mutual Insurance Companies
Bren Abbott, Farmers Insurance
Dave Hanson, Kansas Association of Property & Casualty Insurance Companies & PCI
Senator Oletha Faust-Goudeau, District 29
Callie Hartle, Kansas Association for Justice
Phil Ray, Self

Others attending:
See attached list.

Hearings on:

SB 49 - Insurance coverage, mental health, alcoholism drug abuse or other substance use disorder benefits.

Melissa Calderwood, Kansas Legislative Research Department, gave a brief overview for **SB 49**.

The Chairman opened the hearing on **SB 49**.

Proponents:
Barbara Torkelson, Kansas Insurance Department, (Attachment 1), appeared before the committee in support of **SB 49**.
Aimee Nienstedt, Self, (Attachment 2), gave testimony before the committee in support of **SB 49**.
Rick Cagan, National Alliance on Mental Illness, NAMI (Attachment 3), presented testimony before the committee in support of **SB 49**.

Minutes of the House Insurance Committee at 3:30 p.m. on March 17, 2009, in Room 784 of the Docking State Office Building.

Jackie Shufelberger, Self/Daughter, (Attachment 4), appeared before the committee in support of **SB 49**.
Amy Campbell, Kansas Mental Health Coalition, (Attachment 5), gave testimony before the committee in support of **SB 49**.
Michelle Sweeney, Association of Community Mental Health Centers of Kansas, (Attachment 6), presented testimony before the committee in support of **SB 49**.
Stuart Little, Kansas Association of Addiction Professionals, (Attachment 7), appeared before the committee in support of **SB 49**.
Marlee Carpenter, Kansas Association of Health Plans, (Attachment 8), gave testimony before the committee in support of **SB 49**.
Sky Westerlund, Kansas Chapter National Association of Social Workers, (Attachment 9), presented written testimony in support of **SB 49**.
Ira Stamm, Psychologist, (Attachment 10), appeared before the committee in support of **SB 49**.

Hearing closed on **SB 49**.

SB 174 - Removal of mandatory participation requirements for group life insurance.

Melissa Calderwood, Kansas Legislative Research Department gave a brief overview for **SB 174**.

The Chairman opened the hearing on **SB 174**.

Proponent:
Jim Hall, American Council of Life Insurers, (Attachment 11), gave testimony before the committee in support of **SB 174**.

Hearing closed on **SB 174**.

HB 2262 - Health care insurance and health reimbursement arrangements.

Melissa Calderwood, Kansas Legislative Research Department gave a brief overview for **HB 2262**.

The Chairman opened the hearing on **HB 2262**.

Proponents:
Representative Cindy Neighbor, District 18, (Attachment 12), presented testimony before the committee in support of **HB 2262**.
Tom Bryon, Kansas Association of Health, (Attachment 13), appeared before the committee in support of **HB 2262**.
Ken Daniel, Topeka Independent Business Association, (Attachment 14), gave testimony before the committee in support of **HB 2262**.
Larry Magill, Kansas Association of Insurance Agents, (Attachment 15), presented testimony before the committee in support of **HB 2262**.
Dan Murray, National Federation of Independent Businesses, (Attachment 16), appeared before the committee in support of **HB 2262**.
Kevin Jeffries, Leawood Chamber of Commerce, (Attachment 17), presented written testimony in support of **HB 2262**.
Ashley Sherard, Lenexa Chamber of Commerce, (Attachment 18), presented written testimony in support of **HB 2262**.
Dave Holtwick, Overland Park Chamber of Commerce, (Attachment 19), presented written testimony in support of **HB 2262**.
Tim Whitsman, The Wichita Independent Business Association, (Attachment 20), presented written testimony in support of **HB 2262**.
Rachelle Colombo, Kansas Chamber, (Attachment 21), presented written testimony in support of **HB 2262**.

Opponents:
Bill Sneed, America's Health Insurance Plans, (Attachment 22,), appeared before the committee in opposition

Minutes of the House Insurance Committee at 3:30 p.m. on March 17, 2009, in Room 784 of the Docking State Office Building.

to **HB 2262**.
Larry Ann Lower, Aetna, Inc., (Attachment 23), gave testimony in opposition to **HB 2262**.

Hearing closed on **HB 2262**.

SB 260 - No cause of action for recovery of certain loss while operating uninsured motor vehicle.

Melissa Calderwood, Kansas Legislative Research Department, (Attachment 24), provided a brief informational report from the Interim Task Force on **SB 260**.

The Chairman opened the hearing on **SB 260**.

Proponents:
Joe Thesing, National Association of Mutual Insurance Companies, (Attachment 25), appeared before the committee in support of **SB 260**.
Bren Abbott, Farmers Insurance, (Attachment 26), presented testimony before the committee in support of **SB 260**.
Dave Hanson, Kansas Association of Property & Casualty Insurance Companies & PCI, (Attachment 27), gave testimony before the committee in support of **SB 260**.
Bill Sneed, State Farm Insurance Company, (Attachment 28), presented written testimony in support of **SB 260**.
Lee Wright, Farmers Insurance, (Attachment 29), presented written testimony in support of **SB 260**.
Brad Smoot, American Insurance Association, (Attachment 30), presented written testimony in support of **SB 260**.
Larry Magill, Kansas Associated of Insurance Agents, (Attachment 31), presented written testimony in support of **SB 260**.
Rich Welborn, Farmers Alliance, (Attachment 32), presented written testimony in support of **SB 260**.

Opponents:
Senator Oletha Faust-Goudeau, District 29, (Attachment 33), appeared before the committee in opposition to **SB 260.**
Callie Hartle, Kansas Association for Justice, (Attachment 34), gave testimony in opposition to **SB 260**.
Phil Ray, Self, (Attachment 35), presented testimony in opposition to **SB 260**.

Hearing closed on **SB 260**.

The next meeting is scheduled for March 19, 2009.

The meeting was adjourned at 6:08 p.m.

House Insurance Committee
Guest Sign In Sheet
Tuesday, March 17, 2009

Name	Representing
Bill Sneed	AHIP / State Farm
Barbara Bokelson	KID.
Craig VanDalst	KID
[illegible]	KGC
[illegible]	Farmers
Bren Abbott	"
Marlee Carpenter	KAHP
Kerri Spielman	KATA
Larry Magill	KAIA
Mike Reecht	KAHM
[illegible]	KHPA
Cheryl Allard	Coventry Health Care
Jim Hall	ACLI
Robin Clements	Chd of Wesfarm C.
Alex Kotsopoulos	P.I.A.
Larry Magill	KAIA
John Reetz	KID
Derek Klein	Klenda Law Firm
[illegible]	BCBSKS
Rick Cagan	NAMI
Tom Bunyan	KHHA
Russ Peterson	KsAJ
Callie Hartle	KsAJ
[illegible]	UHG
Lori Church	KAPCIC
Keith Pangburn	Kearney & Assoc
David Hanson	Ks Insur Assns
[illegible]	KS Chamber
Claudia Larkin	KAAP
Stuart Little	Ks Assoc of Addiction Professionals

House Insurance Committee
Guest Sign In Sheet
Tuesday, March 17, 2009

Name	Representing
Sheli Sweeney	ACMHCK
Natalie Bright	WIBA
KEN DANIEL	TIBA
Larrie Ann Lower	AETNA
[illegible]	KSAJ

Kansas Insurance Department
Sandy Praeger, Commissioner of Insurance

TESTIMONY ON
SENATE BILL 49

COMMITTEE ON INSURANCE
March 17, 2009

Chairman Shultz and Members of the Committee:

Thank you for the opportunity to testify today regarding Senate Bill No. 49 concerning mental health and substance use disorder benefits. My name is Barbara Torkelson and I am a policy examiner in the Insurance Department's Accident & Health Division.

In order to reconcile Kansas law with the provisions of federal H.R. 1424, the Wellstone and Domenici Mental Health Parity Act, the Department introduced this bill to amend certain provisions of K.S.A. 40-2,105a and 40-2258 relating to insurance coverage for mental illness and mental health benefits, as those terms are defined in these statutes.

The proposed changes to K.S.A. 40-2,105a include the addition of the words "copayments" and "out-of-pocket" expenses in Section 1 of the bill, which are terms included in the federal legislation, and the phrase "not less than," referring to both the number of days to be provided for in-patient care and the number of visits for out-patient care for mental illness. Since the provisions of 40-2,105a are applicable to both large and small group policies the addition of the "not less than" language was required to clarify that large group policies, which are also subject to the provisions of the federal parity law, will actually be providing benefits beyond the 45 days or 45 visits, as needed.

House Insurance
Date: 3-17-09
Attachment # 1

420 SW 9th Street
Topeka, Kansas 66612-1678

785-296-3071 Phone
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Consumer Hotline
800-432-2484

Website
www.ksinsurance.org

The most significant change to K.S.A. 40-2258, which is the Kansas version of the federal mental health parity law and applicable only to large group policies, is the addition of requiring parity for "alcoholism, drug abuse or other substance use disorder" benefits, which is included in the federal law. Under our current law, benefits for the treatment of substance abuse or chemical dependency were specifically exempted from the definition of "mental health benefits" and there was no requirement for parity for those types of benefits.

We have also proposed a change to subsection (e) of 40-2258 to adopt the 2% cost figure stated in the federal law for purposes of determining the applicability of the requirements of this statute in cases where there may be an increase in the cost under the plan for the inclusion of mental health and substance use disorder benefits. Our existing law permitted an insurer to apply to be exempted from these requirements if a health plan experienced a 1% or greater increase in the cost during the first plan year in which it provided the benefits required in the statute.

Finally, since the annual sunset provision stated in the federal law has been deleted it is no longer needed and has been deleted from our statute.

I would be happy to stand for any questions you may have regarding this testimony.

Barbara Torkelson, Policy Examiner II
Accident & Health Division, Kansas Insurance Department

Today I stand here before you in support of current mental health legislation in the state of Kansas, SB 49. After spending the past six years in between inpatient therapy, outpatient therapy, residential treatment, and nutritional counseling related to Obsessive-Compulsive Disorder, depression and anxiety, and an eating disorder, I know that it is past time to change the status quo. Even though mental health treatment is generally open to people with or without insurance coverage, is it often times unaffordable to the average Kansan for the level of necessary care.

Due to co-existing disorders, residential treatment was the best option to set me on the road to wellness. Even after a secondary insurance, the coverage for the treatment was minimal, at best. I was prematurely released from residential treatment due to insurance complications. Since then, I've required care from emergency rooms, out patient professionals, and a specialized inpatient unit to manage these disorders.

In the time that I have been receiving mental health treatment, I have been limited not only to where I can go for care, but how much care I can receive if it is to be even partially covered. This is detrimental not only to me as a patient, but the rest of consumers. If treatment had been more readily available without jumping hurdles, I would be a more productive member of society. At this time I would have long finished my college degree, be able to maintain a more stable lifestyle without fear of facing everyday symptoms and relapse, and would be overall healthier.

If better mental health coverage were a requirement in health care plans, it seems there would be an overall cost reduction. If I had received more intense mental health treatment, there would have been less hospital stays, less cardiologist, neurologist, and other specialist on board my case, there would have been less medication to manage these symptoms. All of these things were related to my eating disorder and other conditions. By not offering equal coverage for the root of the problem, many people will never truly be able to live a full life that they otherwise could.

People in serious need of treatment are routinely denied coverage. The message that is being sent out is that somehow diseases of the mind are on a lower rung of the ladder than diseases of the body, even though both are essentially diagnosable, treatable, and real. Currently, though, reality is that because I struggle with a mental condition, I am not allowed as much insurance coverage in my lifetime on top of higher co-pays and deductibles to treat these ailments nor am I allowed as much time in therapy. Furthermore, I have to fight for and justify the coverage that is available when I otherwise might not have to for another physical ailment.

As a representative of my voice, I strongly urge you to support legislation to help raise uniformity between physical and mental ailments. As a citizen of Kansas, I deserve to have equality in my coverage of needed care.

Aimee Nienstedt

NAMI Kansas
National Alliance on Mental Illness

House Insurance Committee

March 17, 2009

Presented by:
Rick Cagan
Executive Director

Mr. Chairman and members of the Committee, my name is Rick Cagan. I am the Executive Director of NAMI Kansas, the National Alliance on Mental Illness. NAMI Kansas is a statewide grassroots membership organization dedicated to improving the lives of individuals with mental illness. Our members are individuals who are living with mental illnesses as well as their family members who provide care and support.

We support SB 49 as a necessary step to conform the Kansas statutes to the federal mental health parity legislation passed in 2008. This historic federal legislation was passed with the support of the business community and the insurance industry. In light of the 2006 Parity Task Force Report to the Governor's Mental Health Services Planning Council (see attached Executive Summary), we are now poised to think beyond the limited changes called for in SB 49 and to focus on the broader concept of full parity in insurance coverage for the treatment of mental illnesses.

NAMI supports full parity in individual and employer-based insurance coverage for mental illnesses. We seek a level of parity in mental health benefits with other medical/surgical benefits but not a greater or special benefit.

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

Central to an understanding that mental illnesses are both "blameless" and treatable is non-discriminatory coverage for the necessary medical care for these illnesses. The discrimination in access to care is evidenced by limited coverage, punitive co-pays, and restricted access to hospitalization during acute episodes of mental illness. The outcomes for people with untreated or under-treated mental illnesses include unnecessary emergency department visits, repeated

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hospitalizations, homelessness, incarceration, and even death by suicide. Absent parity, the costs for privately insured individuals are shifted to the state through county jails, juvenile and adult correctional facilities and increased pressure on a declining number of beds in our state mental health hospitals. In the U.S., the annual economic, indirect cost of mental illnesses was estimated to be $79 billion in 1999. Most of that amount—approximately $63 billion—reflects the loss of productivity as a result of illnesses.[1]

Over the course of the last fifty years, Americans have come to understand the importance of providing insurance against the possibility of catastrophic illness. We know that it is all that stands between us and financial ruin or the inability to get treatment. The business community also understands that it is to their advantage to have a healthy workforce. It is cost-effective to provide comparable insurance against disorders of the brain as it is for disorders of other organ systems. It does not require a significant increase in cost to ensure parity in the treatment of mental illnesses.

The Washington Business Group includes corporations that are some of the most innovative purchasers of insurance in America. They were employed by the U.S. Office of Personnel Management to study and report on the parity issue. In May 2000, they reported, "...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 bottom line. Small employers can least afford a deficit in employee productivity and feel the threatening impact of absenteeism and disability claims more immediately."

Opponents of mental health parity have argued that mental health parity represents a new mandate. Kansas's statutes already regulate the insurance industry and these statutes specifically address coverage for mental illnesses. Parity proponents are not asking for a new mandate. We are simply asking that the current mandate be governed by a parity policy which reflects the present state of scientific and medical knowledge about the treatment of mental illnesses. We propose that in light of this new knowledge, it is neither reasonable nor fair to treat mental illness differently than any other illness.

Opponents also suggest that requiring the same coverage for all illnesses might cause large increases in the cost of health insurance and, as a result, many employers would drop this benefit or their employees would not be able to afford it. The national data consistently shows that providing coverage for mental health and substance treatment on par with other illnesses is cost-effective.

The federal, private and state experience (regardless of variations in the laws) show consistently that *mental health parity is affordable, reduces overall health costs, increases productivity in the workplace, and the insurance cost increase is negligible.*

- The Congressional Budget Office estimates that the new federal requirement passed in 2008 will increase premiums by an average of about two-tenths of 1 percent.
- The National Mental Health Advisory Council, in its 2000 final report to Congress, estimated an approximate 1.4% increase in total health insurance premium costs when parity is implemented. Older simulation models had predicted a 5.6% increase, then two years later a 3.6% increase, finally giving way to the 1.4% figure. As more actual experience is incorporated into the actuarial models, the better the proven outcomes are demonstrated to be.

- With the implementation of North Carolina's state employees' parity law in 1992, mental health payments as a portion of total health payments decreased from 6.4% to 3.4% in FY 2001. This represented a 72% reduction in costs. During the same time period, there was a 70% reduction in hospital days paid by the State Employees Health Plan for mental illness.
- We know that early diagnosis and treatment of mental illnesses both promotes recovery in children and in adults, while it generates savings in the long run for that individual. While the estimated annual cost to the nation of providing mental health coverage commensurate to physical health coverage for all children and adults is $6.5 billion, it is also estimated that this mental health coverage would result in savings for general medical services and indirect costs in the amount of $8.7 billion – a net savings of $2.2 billion.

As advocates for persons living with mental illnesses and their family members, NAMI Kansas asserts that parity is good public policy because early diagnosis and treatment work. Treatment and therapy promote recovery – including the ability to maintain employment – which allows consumers to maintain private insurance coverage, community integration and support services, marital and family relationships, and stable housing. Besides being fair, experience tells us that full mental health parity is affordable, reduces overall health costs, and increases productivity in the workplace.

It is critically important for this committee to understand the impact of individuals who are employed in the private sector to get the services they need in order to achieve a level of recovery and to maintain employment, their private insurance and their status as taxpayers. Lacking the ability to get needed treatment due to coverage denials by insurance companies or as a result of exhausting their insurance benefits, such individuals are at high risk for losing their employment and their insurance, becoming a part of the uninsured population and placing an increased burden on the community mental health centers and the state mental health hospitals.

At a minimum, we urge you to adopt SB 49 as proposed. Subject to ongoing negotiations between the Kansas Mental Health Coalition and the insurance industry, we would also urge you to favorably consider amendments to SB 49 which represent a prospective agreement with the insurance industry for a more comprehensive approach to parity. Regardless of the outcome of these negotiations, our ultimate goal for Kansans should be to achieve insurance parity for mental illness. It is not only the right thing to do, but it is also the fiscally responsible thing to do.

Thank you for the opportunity to appear before the Committee today to address these issues.

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[1] U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 1999, pp. 408-409, 411.

Mental Health Parity Task Force

A Sub-Committee of the Governor's Mental Health Planning Council
State of Kansas – November 2006

EXECUTIVE SUMMARY

Mental health parity is valued because it is fair. It provides an opportunity to improve care. Parity reduces the stigma of mental illness by treating it like any other illness. Stigma often keeps people from seeking treatment. In addition, excessive limits on mental health benefits can create major financial burdens for patients, their families, and providers. There is substantial evidence that parity is affordable. Major corporations have demonstrated significant savings with less than 1% increase in health care premiums, when they provided parity in insurance coverage to their employees.

Among the barriers to achieving mental health parity in Kansas are:

1. Discriminatory limits on in-patient and out-patient treatment;
2. The absence of Kansas Administrative Regulations governing the application of KSA 40-2105 and 105a;
3. Inconsistent utilization review;
4. Concern about the confidentiality of information shared with third party payers;
5. Discriminatory gate keeping;
6. Limited definition of mental illness in statute;
7. Inaccessible, relevant, valid and reliable utilization review data;
8. Mental and somatic disorders are not treated by insurers as equally valid parts of the health continuum.

The Task Force classified its recommendations into two categories:

<u>Elimination of barriers to mental health parity within the framework of the existing statutes</u>

- Managed care/insurance companies should reimburse for the full continuum of care for psychiatric illness.
- Require insurers to recognize mental disorders as chronic and require them to pay for maintenance/supportive therapy;
- The Kansas Insurance Department should promulgate regulations governing the application and oversight of the parity statutes.
- Definitions, criteria, policies and procedures used in utilization review should be uniformly applied to treatment of mental and physical disorders and should be based on clinical need.
- The criteria for access to in-patient treatment should be developed by a panel of expert stakeholders and should be uniformly applied by all insurers.
- Decisions of insurers regarding continued in-patient and outpatient treatment should be determined by research-based clinical standards.
- All information related to a diagnosed mental disorder and its treatment obtained by an insurer must be protected from data mining by unauthorized entities.
- The Governor's Mental Health Services Planning Council should survey insured individuals who have used their mental health benefits in order to determine what issues are most important to them.

<u>Elimination of barriers to mental health parity that require legislative changes</u>

- Mental health parity statutes should be amended to:
  - Delete 45 day in-patient and 45 visit outpatient limits from KSA 40-2105a.
  - Disallow disparate authorization, monitoring and compensation for treatment of mental illness;
  - Disallow excessive co-payments and annual limits; and
  - Redefine mental illness to include all mental disorders listed in the most current edition of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association.

Mental Health Parity Task Force Report

TASK FORCE MISSION

The Mental Health Parity Task Force was created by the Governor's Mental Health Services Planning Council at the request of Kansas Governor Kathleen Sebelius. The directive to the task force was to study the barriers to coverage in a state-regulated insurance plan that exists under the current mental health parity law. The Governor noted that, although Kansas has moved closer to full insurance parity for mental disorders, the current law still limits coverage of mental illnesses to 45 days of in-patient care and 45 days of outpatient care.

TASK FORCE PROCESS

The Mental Health Parity Task Force met fourteen times between January 2006 and October 2006. It considered documents and testimony from task force members, a consumer of service, members of the public, the Kansas Departments of Insurance and Social and Rehabilitation Services, the Department of Veterans Affairs, and the Director of a Mental Health Unit of a not-for profit community hospital. The task force felt that:

1) Some barriers to mental health parity within the current statutes could be remedied by rigorously adhering to the letter and spirit of the statutes; and

2) Other barriers could be overcome only through amendment of the statutes.

Part I

Mental Disorders and Somatic Disorders Are Not Treated by Insurers as Equally Valid Parts of the Health Continuum

Since the publication of ***Mental Health: A Report of the Surgeon General*** (1999), if not earlier, it has been generally accepted that the only distinction between mental and somatic disorders is the locus of the predominant alterations in function. For example, the report notes that when a stroke produces paralysis and that symptom is predominant, the disorder is somatic. Alternatively, when the stroke causes alterations of thought, mood, or behavior and those symptoms are predominant, the disorder is mental. The point that must be understood and that must form the basis of all health insurance statutes is that mental illness and somatic illness are inseparable points on a continuum of function.

The Final Report of the President's New Freedom Commission On Mental Health (2003) makes the point, *"... that mental health is key to overall health. Therefore, improving services for individuals with mental illnesses requires paying close attention to how mental health care and general medical care interact. While mental health and physical health are clearly connected, a chasm exists between the mental health care and general health care systems in financing and practice."*

WHY PARITY IS IMPORTANT

Parity is valued because it is fair. It provides an opportunity to improve care. Parity reduces the stigma of mental illness by treating it like any other illness. Results from the *2004 National Survey on Drug Use and Health*, by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), found that of the 5.6 million adults who reported an unmet need and who did not receive mental health treatment, 47.2% attributed that unmet need to cost/insurance issues.

When private insurers fail to cover needed mental health services, an already overburdened public mental health system must pick up the slack, straining existing resources.

The National Mental Health Association estimates that the combined indirect and related costs of mental illness, including costs of lost productivity, lost earnings due to illness, and social costs is, at least, $113 billion annually (Rice & Miller, 1998)

Cutting dollars for mental health care can increase overall medical costs. For example, a 30 percent cost reduction in mental health services at a large Connecticut corporation triggered a 37 percent increase in employee use of mental health services and sick leave. Investigators reported that overall medical care costs decrease for those using behavioral health care services, when such costs were generally increasing (Rosencheck, et al. 1999).

While the estimated annual cost to the nation of providing mental health coverage commensurate to physical health coverage for all children and adults is $6.5 billion, it is also estimated that this mental health coverage would result in savings for general medical services and indirect costs in the amount of $8.7 billion – a net savings of $2.2 billion (National Advisory Mental Health Council, 1993)

Extensive limits on mental health benefits can create major financial burdens for patients and their families. One economic study modeled the out-of-pocket burden that families face under existing mental health coverage using different mental health expense scenarios (National Advisory Mental Health Council, 2000). For a family with mental health treatment expenses of $35,000 a year, the average out-of-pocket burden is $12,000. For those with $60,000 in mental health expenses a year, the burden averages $27,000. This is in stark contrast to the out-of-pocket expenses of only $1,500 and $1,800, respectively, that a family would pay for medical/surgical treatment.

According to a survey conducted in September of 2002 by Opinion Research Corporation, 83% of Americans believe it is unfair for health insurance companies to limit mental health benefits and require people to pay much more out-of-pocket for mental health care than for any other medical care. In addition, 79% support parity legislation even if it results in an increase in their health insurance premiums.

CONTINUED EVIDENCE OF AFFORDABILITY

- Kirschstein (2000) estimated that parity would increase premiums by only 1.4 to 1.6 percent yet acknowledged that this estimate may still be too high.

- In 2000, the National Advisory Mental Health Council requested that the Hay Group update its estimate of the average annual premium increase associated with mental health parity. That update showed a predicted cost increase of only 1.4%.

- In Minnesota, Blue Cross/Blue Shield reduced its insurance premiums by five to six percent after one year's experience under the State's comprehensive parity law.
- In North Carolina, mental health expenses have decreased since comprehensive parity for State and local employees was passed in 1992.

Part II

BARRIERS TO MENTAL HEALTH PARITY WITHIN THE EXISTING STATUTES

(The relevant statutes can be found in Appendix A)

The Mental Health Parity Task Force based its assessment of the barriers to parity of access to services for mental disorders and somatic disorders on information received from its membership and a number of experts from government, the service provider community, and the insured public. Much of the information received by the task force was anecdotal and little hard data was available. There was a consensus that while the anecdotal evidence was compelling, it is important to identify and acquire hard data that can be used to check the validity of observations about the operation of the health insurance system.

The task force heard considerable information regarding disparity between the ways mental health treatments and somatic treatments are authorized, monitored, and compensated. These disparities reflect a continuing misapplication and/or misperception of the continuity of mental and somatic health. Moreover, they reinforce the stigma associated with mental illnesses.

The Task Force identified the following barriers to implementation of the existing statutes:

The Absence of Department of Insurance Administrative Regulations for KSA 40-2,105 and KSA 40-2,105a

In the absence of Kansas Administrative Regulations governing the application of KSA 40-2,105 and 105a, insurers are able, arbitrarily, to curtail the benefits guaranteed under the law. For example, the Mental Health Parity Task Force noted that:

a. The average number of inpatient days was 5 and the average number of out-patient visits was 6 regardless of diagnosis, versus the statute limit of 45 and 45;
b. Utilization review is inconsistently applied across insurers and between mental and somatic disorders and is apparently required more frequently for mental disorders.
c. Authorization for treatment is often more difficult to obtain for mental disorders or nervous and mental conditions than for somatic disorders.

Inconsistent Utilization Review Focused On Economics Rather than Outcome Variables

Utilization Review (UR) is the process of assessing the delivery of medical services to determine if the care provided is appropriate, medically necessary, and of high quality. UR may include review of appropriateness of admissions, services ordered and provided, length of stay, and discharge practices, both on a concurrent and retrospective basis. The task force heard from providers that there are no uniform clinical outcome standards governing utilization review for either in-patient or outpatient treatments for mental disorders. As a result, payment decisions appear to be made not on the patient's clinical need and the therapist's professional judgment, but on actuarial data regarding length of stays and number of office visits. This gives the appearance that treatment decisions are made based on cost instead of clinical necessity. This is not the case with the treatment of somatic disorders. For the first line of review, some insurance companies use inexperienced clinicians who are not licensed to practice independently in Kansas. For insurance reviews at the appeal level, some insurers use out-of-state psychiatrists who are not licensed to practice medicine in Kansas.

Lack of Confidentiality in Reporting Requirements

Because of the continuing stigma attached to mental illness, the reporting requirements of some insurance companies may deter some people from using their insurance benefits. For example, the task force heard that practicing attorneys rarely use their insurance for mental health services and usually pay for treatment out-of-pocket to avoid embarrassment and stigma. In this regard, while the reporting procedures may be the same for somatic and mental disorders, the perception is that, for the latter, a higher standard of confidentiality is necessary to assure parity. One might expect that HIPAA regulations would make this issue moot, but from a number of sources, we know that underwriters, other industry personnel, human resources professionals, and other interested parties can access this information through a variety of data mining services.

Discriminatory Gate-Keeping

People who have diabetes, cancer, asthma, and other serious somatic disorders are not subjected to the same restrictive gate-keeping as are those with mental illnesses. A person who has a major depressive episode, with recurrent suicidal ideation, is at grave risk of death and yet the task force heard that, depending upon the insurer, that person may face greater difficulty in obtaining approval for inpatient treatment than a person with a heart attack.

Data on Costs of Kansas Parity

During hearings on the 2001 Mental Health Parity Bill, the insurance lobby argued that to include more of the disorders would make the cost of insurance prohibitively high. The audit on mental health parity requested by the Kansas legislature (Blobaum, 2000) showed that the annual increase in insurance costs from mental health parity from 1999 to 2001 was less than 1% per year.

Discriminatory Limits on Coverage for Mental Illness

The task force notes that the Insurance Statute (KSA Chapter 40) does not limit coverage for certain somatic disorders, including some and excluding others, in the same way it does for mental disorders. This is clearly a parity issue.

Required Grading of Severity of Mental Illnesses

Some insurers require that providers code/grade mental illness as mild, moderate, or severe, in a way that is not required of providers treating somatic illnesses.

Discrimination in the Treatment of Severe, Chronic, and Recurrent Mental Illness

Patients with chronic medical conditions requiring long-term maintenance care receive approval for that care, while patients with severe, chronic, and recurrent mental illnesses do not. Many insurance contracts state that coverage is only for the treatment of acute mental illness.

Some utilization review companies ask the therapist to certify whether the treatment is for care of an acute illness or is for maintenance treatment. The insurer typically authorizes less frequent treatment for patients who need maintenance care. This ignores the fact that some patients may need weekly sessions to maintain their current level of functioning.

Discriminatory Higher Co-payments for Mental Illness

Patients with a non-biologically based mental illness, as defined in KSA 40-2,105, by statute may have a co-pay as high as 50%. No equivalent language exists in statute regarding somatic illnesses. Insurers have consistently increased the co-pay for biologically based mental illnesses.

Relevant, Valid, and Reliable Utilization Review Data for Mental Disorders Are Inaccessible

The Kansas Insurance Department was extremely cooperative about providing data to the task force and obviously recognizes that effective monitoring of the insurance system requires acquisition of rationally selected data. This is illustrated by the KID data showing that individuals received, on average, **five outpatient sessions** – regardless of the nature of their psychiatric illness – whether it be schizophrenia, bipolar disorder, major affective disorder, or panic disorder -- and that people who needed to be hospitalized for a psychiatric disorder spent, on average, **five to six days in the hospital** regardless of their diagnosis. These data may indicate that payment for mental health services is driven by bottom line considerations rather than the clinical need of the insured. That can only be determined by access to relevant, valid, and reliable hard data that can be used to identify and test specific differences between the ways in which insurers pay for treatment of somatic and mental disorders. At this time, those data are not accessible.

BARRIERS TO MENTAL HEALTH PARITY THAT REQUIRE LEGISLATIVE CHANGE

Limited Definition of Mental Illness

KSA 40-2,105a defines "mental Illness" to include only a limited number of the diagnoses found in the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Fourth Edition (DSM-IV)*. The rationale for focusing on these diagnoses was that they represent the most serious and most prevalent mental disorders. Some described them as "biologically based" and argued that they were therefore more amenable to treatment.

The Mental Health Parity Task Force agrees with the **Report of the Surgeon General on Mental Health (1999)** regarding the etiology of mental disorders, viz., *What is most important to reiterate is that the causes of health and disease are generally viewed as a product of the interplay or interaction between biological, psychological, and socio-cultural factors. This is true for all health and illness, including mental health and mental illness.*

Discriminatory Limits on In-patient and Outpatient Treatment

The statute (KSA 40-2,105a) declares a 45-day annual limit on in-patient treatment and 45-visit annual limits on outpatient treatment. If an insured person has a somatic disorder, the decision to pay for either in-patient or outpatient treatment is not time- or event-limited. It is based upon medical necessity. Annual limits are not imposed and lifetime limits are, at the least, two orders of magnitude greater. The Parity Task Force is not aware of any scientific or clinical evidence to support the assumption that all mental disorders can be effectively treated in 45 days or visits. These limits are arbitrary and reflect a bias against equal treatment of people suffering mental disorders.

National Data on Costs of Parity

A meta-study of the costs of mental health parity revealed that when employers offer broad mental health benefits, the costs for medical-surgical treatment for employees is reduced by 20% (Chiles, et. al., 1999)

Continuum of Care

In the treatment of physical disorders, acute care is often followed by intermediate care, i.e. "Med A" beds in nursing homes and rehabilitation hospital stays. These stays can extend for relatively long periods and they are paid for by insurance. Treatment of acute mental disorders is usually followed by discharge to the community, with supports that may range from outpatient therapy and some community services to essentially no follow-up. The result depends upon the person's insurance plan and availability of community services. Full parity would require insurers to offer the same benefits for physical and mental treatment. One reason for the "revolving door" often seen in psychiatric hospitals is that follow-through on recommendations for rehabilitation services are not implemented because of a lack of insurance coverage. Just as one would receive rehabilitation with some physical disorders, so, too, should one be rehabilitated for some mental disorders.

Part IV

RECOMMENDATIONS

Changes needed in Utilization Review process:

- The Kansas Department of Insurance should promulgate regulations assuring compliance of insurers with both the letter and intent of the parity statutes.

- Definitions, criteria, policies, and procedures used in utilization review of mental health treatments and services should be uniformly applied and should be neither more nor less restrictive than those applied to general health.

- The utilization review criteria used to evaluate the need for specific mental health services or continuation of services should be based upon clinical need determined by a practitioner licensed by the Behavioral Sciences Regulatory Board or the Board of Healing Arts. They should be accessible to both the insured and the insured's service provider.

- A panel of expert Kansas stakeholders should develop the criteria for access to in-patient treatment. These criteria should be uniformly applied by all insurers. In no case should they be more stringent than those applied to somatic disorders.

- Insurers should be required to base decisions about continuing in-patient or outpatient treatment on research-based clinical outcome criteria.

- The Kansas Insurance Department should convene an expert panel of stakeholders to develop recommendations regarding the acquisition of relevant, valid, reliable, and easily accessible data that can be used to monitor compliance with KSA 40-2, 105, 105a and 2258.

Modifications to the statute needed to eliminate barriers to parity

- The annual 45 day in-patient and 45 visit outpatient limit should be deleted from KSA 40-2,105a.

- The managed care/insurance companies should reimburse for the full continuum of care for psychiatric illness the way they reimburse for provision of the full continuum of care for medical illness. This includes outpatient treatment, intensive outpatient treatment, partial and day hospital, residential treatment, and inpatient treatment for children, adolescents, and adults.

- The mental health parity statutes should be amended to require insurers to recognize that many mental disorders, like many somatic disorders, are recurrent. Therefore, in order to continue recovery from symptoms, it is necessary to provide maintenance therapy and support.

- Treatment of mental illness should be guided by scientific research and data. Insurers should not be allowed to mandate one treatment over another on the basis of limited scientific study.

- The mental health parity statutes should be amended to reflect contemporary thinking regarding the inseparability of mental and somatic disorders. Disparate authorization, monitoring, and compensation of treatment should not be allowed.

- Excessive co-payments and annual limits should be deleted, while the lifetime maximum should be the same as for somatic conditions under KSA 40-2,105.

- No DSM-IV-R diagnosis should be excluded from full insurance coverage unless the same criteria used to exclude a somatic disorder have been applied. The process of establishing legitimate diagnoses is long and

rigorous and involves medical and mental health professionals from many disciplines. Insurers should not be able to pick and choose which disorders they consider serious enough to cover.

- All information related to a diagnosed mental disorder and its treatment obtained by an insurer must be considered private and confidential. It should never become available to any other database except in the aggregate.

- Some insurance companies are beginning to cover preventive somatic health treatments such as smoking cessation classes, weight loss clinics and chronic disease management programs. The insurers know this saves them money in the end and we know this is true in mental health as well. Early intervention can prevent more serious mental illness from developing. For example, by treating people having relationship problems jointly with their family or relationship groups (a treatment modality not currently reimbursed by most insurers), we may well prevent individuals within those groups from developing life threatening depression. The mental health treatment modalities covered by insurers should therefore be expanded to include preventive care, as they have been for somatic illnesses.

Further Study Needed

- The task force notes that it is composed of mental health service providers, advocates, professionals and a single consumer of services. While there was an opportunity to hear from an insured parent of a service consumer, our perspective may not be fully representative of the insured community. The Governor's Mental Health Services Planning Council should survey insured individuals who have used their mental health benefits, in order to determine what issues are most important to them and what changes they believe are necessary. Moreover, complaints about mental health treatment reimbursement or indemnification filed with the Kansas Department of Insurance should be analyzed to determine if trends can be identified.

Attachments to Task Force Report

- Blobaum, G. (2002) Mental health parity experience (audit) – Kansas Insurance Department – Topeka, Kansas

- Kline, D. (2006) Mental health utilization review data. Kansas Insurance Department – Topeka, Kansas

References:

Chiles, J.A., et.al. (1999): "The Impact of Psychological Interventions on Medical Cost Offset: A Meta-analytic Review," Clinical Psychology: Science and Practice, V6, Summer.

Gooseneck, Robert, et. al., (September 1999): "Effect Of Declining Mental Health Service Use On Employees Of A Large Corporation," *Journal of Health Affairs: 18(5).*

Kirschstein, R. L., MD (2000): "Insurance Parity for Mental Health: Cost, Access, and Quality", Final Report to Congress by the National Advisory Mental Health Council. Rockville, MD: Department of Health and Human Services.

Mental Health: A Report of the Surgeon General (1999): U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institutes of Mental Health.

National Advisory Mental Health Council (October 1993)."Healthcare reform for Americans with severe mental illnesses: Report of the National Advisory Mental Health Council. *American Journal of Psychiatry*,150(10),1447-1465.

National Advisory Mental Health Council (June 2000): "Insurance Parity for Mental Health: Cost, Access and Quality." A report to Congress. National Institute of Mental Health.

New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America, Final Report.* DHHS Pub. NO. SMA-03-3832. Rockville, MD: 2003.

Rice, D. P. & Miller, L. S. (1998) "Health economics and cost implications of anxiety and other mental disorders in the United States." British Journal of Psychiatry, 173 (34),4-9.

Rosenheck R. A., Druss B., Stolar M., Leslie D., and Sledge W., *Effect of declining mental health service use on employees of a large corporation.* Health Affairs, 18, (5), 193-203.

Substance Abuse and Mental Health Services Administration. (2005).*Results from the 2004 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-28, DHHS Publication No. SMA 05-4062).Rockville, MD., p.98.

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Appendix A

The Three Kansas Mental Health Statutes

40-2,105

Chapter 40.--INSURANCE
Article 2.--GENERAL PROVISIONS

40-2,105. Insurance coverage for services rendered in treatment of alcoholism, drug abuse or nervous or mental conditions; applicability or nonapplicability of section. (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 alcoholism, drug abuse and nervous or mental conditions, limited to not less than 100% of the first $100, 80% of the next $100 and 50% of the next $1,640 in any year and limited to not less than $7,500 in such person's 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:

(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 K.S.A. 2005 Supp. 40-2,105a 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 criminal actions, 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 federal law if such plan is purchased in connection with a medical or health savings account pursuant to that federal law, regardless of the effective date of the insurance policy. 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).

History: L. 1977, ch. 161, § 1; L. 1978, ch. 166, § 1; L. 1986, ch. 299, § 8; L. 1986, ch. 174, § 1; L. 1996, ch. 170, § 1; L. 1997, ch. 190, § 15; L. 1998, ch. 174, § 1; L. 2001, ch. 178, § 5; L. 2004, ch. 128, § 2; May 20.

40-2,105a

Chapter 40.--INSURANCE
Article 2.--GENERAL PROVISIONS

40-2,105a. Kansas mental health parity act; insurance coverage for services rendered in the treatment of certain mental illnesses. (a) (1) Any 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. Except as provided in paragraph (2), such coverage shall be subject to the same deductibles, coinsurance and other limitations as apply to other covered services.

(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 visits for 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 January 1, 2003, 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) For the purposes of this section, "mental illness" means the following: 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 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.

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

(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 and municipal funded pools.

(g) 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 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.

(h) 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.

(i) There shall be no coverage under this section for evaluations and diagnostic tests ordered or requested in connection with criminal actions, divorce, child custody or child visitation proceedings.

History: L. 2001, ch. 178, § 1; July 1.

40-2258

Chapter 40.--INSURANCE
Article 22.--UNIFORM POLICY PROVISIONS

40-2258. Group policies; aggregate lifetime limit; exceptions; definitions. (a) An accident and sickness insurer which offers coverage through a group policy providing hospital, medical or surgical expense benefits pursuant to K.S.A. 40-2209 and amendments thereto which includes mental health benefits shall be subject to the following requirements:

(1) If the policy does not include an aggregate lifetime limit on substantially all hospital, medical and surgical expense benefits, the policy may not impose any aggregate lifetime limit on mental health benefits;

(2) if the policy includes an aggregate lifetime limit on substantially all hospital, medical and surgical expense benefits the plan shall either: (A) Apply the applicable lifetime limit both to the hospital, medical and surgical expense benefits to which it otherwise would apply and to mental health benefits and not distinguished in the application of such limit between such hospital, medical and surgical expense benefits and mental health benefits; or (B) not include any aggregate lifetime limit on mental health benefits that is less than the applicable lifetime limit on hospital, medical and surgical expense benefits;

(3) if the policy does not include an annual limit on substantially all hospital,

medical and surgical expense benefits, the plan or coverage may not impose any annual limit on mental health benefits; and

(4) if the policy includes an annual limit on substantially all hospital, medical and surgical expense benefits the policy shall either: (A) Apply the applicable annual limit both to hospital, medical and surgical expense benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such hospital, medical and surgical expense benefits and mental health benefits; or (B) not include any annual limit on mental health benefits that is less than the applicable annual limit.

(b) If the group policy providing hospital, medical or surgical expense benefits is not otherwise covered by subsection (a) and either does not apply a lifetime or annual benefit or applies different lifetime or annual benefits to different categories of hospital, medical and surgical expense benefits, the commissioner may adopt rules and regulations under which subsections (a)(2) and (a)(4) are applied to such policies with respect to mental health benefits by substituting for the applicable lifetime or annual limits an average limit that is computed taking into account the weighted average of the lifetime or annual limits applicable to such categories.

(c) Nothing in this section shall be construed as either:

(1) Requiring an accident and sickness policy to offer mental health benefits except as otherwise required by K.S.A. 40-2,105 and amendments thereto; or

(2) affecting any terms and conditions of a policy which does include mental health benefits including provisions regarding cost sharing, limits on the number of visits or days of coverage, requirements relating to medical necessity, requirements relating to the amount, duration or scope of mental health benefits under the plan or coverage, except as specifically provided in subsection (a).

(d) This section shall not apply to any group accident and health insurance policy which is sold to a small employer as defined in K.S.A. 40-2209 and amendments thereto.

(e) This section shall not apply with respect to a group policy providing hospital, medical or surgical expense benefits if the application of this section will result in an increase in the cost under the plan of at least 1%.

(f) In the case of a group policy providing hospital, medical or surgical expense benefits that offers an eligible employee, member or dependent two or more benefit package options under the policy, subsections (a) and (b) shall be applied separately with respect to each such option.

(g) As used in this section:

(1) "Aggregate lifetime limit" means, with respect to benefits under a group policy providing hospital, medical or surgical expense benefits, a dollar limitation on the total amount that may be paid with respect to such benefits under the policy with respect to an eligible employee, member or dependent;

(2) "annual limit" means, with respect to benefits under a group policy providing hospital, medical or surgical expense benefits, a dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the policy with respect to an eligible employee, member or dependent;

(3) "hospital, medical or surgical expense benefits" means benefits with respect to hospital, medical or surgical services, as defined under the terms of the policy, but does not include mental health benefits;

(4) "mental health benefits" means benefits with respect to mental health

services, as defined under the terms of the policy, but does not include benefits with respect to treatment of substance abuse or chemical dependency.

(h) This section shall be effective for group policies providing hospital, medical or surgical expense benefits which are entered into or renewed after January 1, 1998. This section shall not apply to benefits for services furnished on or after December 31, 2005.

(i) The commissioner is hereby authorized to adopt such rules and regulations as may be necessary to carry out the provisions of this section.

History: L. 1997, ch. 190, § 13; L. 2002, ch. 158, § 19; L. 2003, ch. 88, § 1; L. 2004, ch. 157, § 1; L. 2005, ch. 163, § 11; July 1.

Mental Health Parity Experience

I have been engaged to measure the impact of the mandated mental health group medical insurance benefit codified in KSA 40-2, 105a., effective January 1, 2002. That mandate requires that if mental illness coverage be provided at all, the same coverage be given for a set of listed mental illnesses as given for medical conditions generally with the exceptions that in-patient and out-patient care can be limited to 45 visits each. Quoting from the statute, the listed mental illnesses are: "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 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."

With respect to the above listed conditions Kansas goes beyond Federal law in two respects. One, requiring the same cost sharing, copayments and coinsurance, as medical and surgical benefits except for the 45 visit limit, and secondly, applying the mandate to all group medical plans, not just employer groups of 51 or more. Like Federal law, Kansas does not mandate coverage, but as far as I can determine all fully insured employer groups in Kansas have such coverage. However, association group plans, which are often marketed on an individual basis, may not in some cases. That can not be determined from available data.

I conducted my evaluation using two sources, data from the Kansas Health Insurance Information System (KHIIS), and interviews, including gathering subsequent information, with representatives of major health insurers active in Kansas. KHIIS data is reported quarterly by all Kansas health insurers. The lag time before full availability is about six months. The data available and used included claims incurred, as measured by service dates, in the calendar years 1999 through 2002 with claim payments made through the third quarter of 2003. There may be some incomplete claims in these years but, according to our models, any remaining payments are almost certainly well under 2% of the total for 2002 and are totally insignificant for earlier years. Claim experience was presented for 17 insurers, encompassing nearly all Kansas employer group medical insurance and some association group. However, three insurers were eliminated from study because they did not have experience both before and after January 1, 2002. Insurers will not be identified by name in any details of this paper. The experience for 1999 through 2001, the last three years prior to the effective date of KSA 40-2, 105a, was

compared to 2002, the first year of effectiveness. In addition, experience for 2001 alone was compared to 2002. Plan types examined separately were indemnity, preferred provider, health maintenance organizations, and point of service (POS). Five insurers had $20 million or more in claim amounts allowed in each of the years. These insurers make up about 85% of the group medical business in Kansas by premium and claim payments. They were also studied as a group and compared to the total.

We know from interviews, see below, that all the large insurers and thereby at least the great bulk, perhaps nearly all, group insurance products were changed to meet the mandate. However, we do not have available to us just what those changes were. All plans contained mental health coverage on some basis prior to the mandate.

To analyze KHIIS data for the mandate impact, we first had to determine the best means to measure them. We found no means to be perfect. There are too many variables. There are changes in plan offerings every year. There are changes and trends in copayments, networks, design elements, etc., and even if the plans were constant over time, demographics and medical practice evolution would still change results to some extent. A major item, noted below, is capitation which can artificially decrease (or inflate) claim charges, allowances, and payments because such are not directly dependent on services. A germane instance of medical practice changes in the mental health field is drug treatments replacing or augmenting other therapies for many conditions. All in all, we find the best measure to be from claim amounts allowed. "Claim amounts allowed" means charges eligible for payment before the application of an insured's aggregate copayments of any type. This measure is better than paid measures because it nearly eliminates the effects of plan changes (except when claims may no longer be filed at all, but this is very uncommon). An example of an alternative prime measure reviewed is paid claims as a percentage of allowed. We found that the results depended fully on claim size. As mental health claims are typically smaller and copayments are weighted to smaller claims, the resulting pattern was of no value in analysis.

KHIIS data show that mental health claims allowed charges in aggregate increased as a percentage of total allowed charges in 2002. The increase, however, was quite small, from .84% in 2001 to .89% in 2002. Moreover, this increase reversed a general slight downward trend that could be attributed to product design, medical practice and other changes. The five largest insurers had aggregate results almost identically the same, .85% to .90%. Overall, 6 of the 14 showed an increase in the proportion of mental illness claims allowed, but 8 actually showed decreases.

Table 1 shows the raw, unadjusted data for all insurers combined.

Table 1 Allowed Charges - Raw Data

	Allowed Charges for All Claims	Allowed Charges for MH Claims	% MH Allowed
1999	$882,687,636	$7,585,120	0.86%
2000	1,034,989,015	8,207,664	0.79%
2001	1,223,234,901	10,329,265	0.84%
2002	1,376,877,307	12,313,097	0.89%
1999-2001	$3,140,911,552	$26,122,049	0.83%

One of the large insurers carved out a capitation agreement for mental illness in 2000 and 2001. This artificially suppressed allowed mental health charges. Table 2 and subsequent table remove this aberration and results show a different pattern, one where the percentage of allowed mental health actually decreases in 2002 compared to 2001 but is virtually unchanged from the full period 1999 through 2001.

Table 2 Allowed Charges - Adjusted for Capitation

	Allowed Charges for All Claims	Allowed Charges for MH Claims	% MH Allowed
1999	$773,170,984	$6,436,170	0.83%
2000	927,560,510	7,488,952	0.81%
2001	1,068,836,997	9,486,168	0.89%
2002	1,198,304,864	10,065,583	0.84%
1999-2001	$2,769,568,491	$23,411,290	0.85%

Table 3 shows the same information as Table 2 with similar results except that 2002 has the lowest percentage of mental health allowed charges of any year.

Table 3 Large Plans Only - Adjusted for Capitation

	Allowed Charges for All Claims	Allowed Charges for MH Claims	% MH Allowed
1999	$584,625,493	$5,259,446	0.90%
2000	735,700,440	6,492,659	0.88%
2001	903,812,314	8,129,993	0.90%
2002	1,087,262,508	9,104,507	0.84%
1999-2001	$2,224,138,247	$19,882,098	0.89%

Several problems surfaced in comparing plan types. Some insurers did not split data by plan type or submitted some as unclassified. This makes up about 12% of the total. Secondly, we found that the indemnity classification has shrunk to just over 2% of the total and had widely varying results year to year from changes in insurer's offerings. Thirdly, we found that HMO and POS data were not always reported consistently. Some POS plans were reported as HMO, for example. We thought a combination of HMO and POS was more meaningful (certainly more stable) in as much as POS plans are essentially HMOs with an additional option.

Table 4 shows that PPO allowed mental health charges make up a greater percentage of total allowed charges than the corresponding HMO charges. The patterns over time are similar, however. It must be noted that we are examining small percentages and changes, no where does the mental health allowed charges reach 1% of the total. I'm not sure why the PPO percentage is higher. It may have to do with the PPO demographics being generally older. Alternatively, it may involve network contracts and their changes.

Table 4 Plan Type Comparison

PPO	Allowed Charges for All Claims	Allowed Charges for MH Claims	% MH Allowed
1999	$392,221,925	$3,776,023	0.96%
2000	547,161,526	4,832,148	0.88%
2001	752,327,396	7,169,110	0.95%
2002	915,284,086	8,178,884	0.89%
1999-2001	$1,691,710,847	$15,777,281	0.93%

HMO/POS	Allowed Charges for All Claims	Allowed Charges for MH Claims	% MH Allowed
1999	$177,219,693	$1,386,507	0.78%
2000	275,261,986	1,958,854	0.71%
2001	222,200,601	1,504,152	0.68%
2002	193,377,651	1,172,453	0.61%
1999-2001	$674,682,280	$4,849,513	0.72%

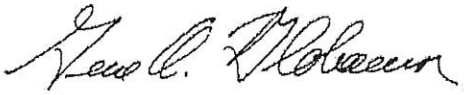
Interviews were conducted with the five largest current writers. All companies made coverage changes to meet the mandate. Four of the companies made explicit recognition of an expected cost increase. Their estimates ranged from .2% to .8% increase in annual claim costs. Actual results were not conclusive, three companies placed demographic and plan adjusted cost increases to be in the .2% to .4% range, one could determine no change, and one experienced a decrease. It should be noted that the plan design changes

may have offset the mandate by a reduction in benefits elsewhere, a reduction in maximum benefits for example. Any such changes are unknown to me. From the perspective of the companies, little change was anticipated and little change was noted. Obviously, there was an additional cost of compliance, but no company noted that as being significant. All companies had premium increases due to medical trend and experience which were much larger than those resulting from the mandate.

It is difficult to determine any cause and effect here because the changes observed and illustrated in the above Tables may more probably be from other reasons previously mentioned, such as plan design changes, market composition, and underwriting.

My conclusion is that there is no evidence that the mental health mandate discussed here had any meaningful impact on Kansas healthcare cost in aggregate.

Respectively submitted,



Gene A. Blobaum, FSA, MAAA
Consulting Actuary

General Notes

Tables were generated from administrative data in the KHIIS database. Claims were selected whose primary diagnosis matched one of the statute-specified mental illnesses. From this subset, specific line-item procedures were examined, as described below.

Claims paid by multiple insurers, as well as procedures under capitation agreements, were excluded from this initial consideration.

The claim volume in KHIIS varies between years based on the contributing companies, among other things. Measures of total expenditures would have been skewed by variation in KHIIS's representation, so are not presented in these tables; however, annual averages (which are adjusted for volume) remained fairly steady.

"Inpatient Bed Days" Notes

Inpatient healthcare providers bill insurers with a specific code indicating room and board. These figures are specifically for semi-private psychiatric beds (code 124), and do not include therapeutic procedures performed during the inpatient stay.

Semi-private psychiatric beds make up just over 99% of all billed psychiatric bedtypes in KHIIS for the statute-specified diagnoses. It is therefore expected that these values represent typical room and board experience for psychiatric patients.

"Psychological/Psychiatric Therapy" Notes

Healthcare providers indicate a specific type of treatment in their claims. The types of treatment range from a 70-minute, face-to-face office visit to family psychotherapy, and are all included in these figures. Resolution down to the procedure level is available.

These data are specifically for outpatient or professional treatments. Therapeutic procedures performed in an inpatient setting are not included in the calculations.

Contact Information

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Mental Health Experience
Inpatient Bed Days
All Plans, Years 2000 to 2004

Diagnosis Category	Number of Insureds	Length of Stay (days)			Average Charged per Visit	Average Charged per Day
		Mean	*50th Percentile*	*75th Percentile*		
Schizophrenic	63	7.9	6.0	9.0	$ 7,442.78	$ 940.88
Schizoaffective	95	9.3	6.0	12.0	7,647.57	822.68
Schizophreniform	10	10.9	5.5	7.0	7,531.57	690.97
Reactive Psychosis	9	8.3	6.0	7.0	5,733.58	688.03
Paranoid/Delusional	7	6.3	6.0	8.0	3,084.71	490.75
Atypical Psychosis	102	8.1	6.0	11.0	6,424.11	792.44
Major Affective Disorders	2431	5.3	4.0	6.0	5,313.04	1,002.05
Dysthymic	36	6.2	4.5	8.0	5,903.77	953.08
Cyclothymic	2	4.0	4.0	5.0	4,860.00	1,215.00
Obsessive Compulsive	19	6.6	5.0	8.0	6,598.16	994.96
Panic Disorder	6	3.5	4.0	5.0	2,818.43	805.26
Pervasive Developmental	19	5.5	5.0	6.0	5,666.12	1,035.16
Attention Deficit	54	6.5	5.0	7.0	5,159.98	791.59

Dexter Kline
Kansas Insurance Department

Mental Health Experience
Inpatient Bed Days
All Plans, Years 2000 to 2004

Length of Stay	Frequency	Average Charged	Average Allowed	Average Paid
1	341	$ 1,475.15	$ 816.65	$ 626.07
2	354	2,555.11	1,212.68	869.44
3	455	3,414.25	1,704.72	1,333.56
4	379	4,142.73	2,220.92	1,799.81
5	339	5,528.42	2,846.95	2,294.43
6	257	6,001.32	3,373.91	2,826.53
7	195	7,212.13	3,969.16	3,315.99
8	114	8,172.19	4,437.14	3,741.06
9	82	8,133.10	4,473.16	3,971.72
10	65	9,580.22	5,649.60	4,907.36
11-12	94	10,064.29	5,243.80	4,475.79
13-14	61	12,094.09	6,675.60	5,855.76
15-16	35	14,239.21	7,264.66	6,703.68
17-18	26	13,895.28	6,674.61	5,919.90
19-20	30	14,365.50	7,944.70	7,159.75
21-25	28	20,186.90	9,742.00	8,053.81
26-45	29	19,061.78	9,630.72	8,819.62
46+	10	22,880.00	18,560.65	15,736.78

Mental Health Experience
Inpatient Bed Days
All Plans, Years 2000 to 2004

Diagnosis Category	Total Hospitalized Insureds	Insureds Using >45 Days in a Year	Percent
Schizophrenic	64	1	1.56%
Schizoaffective	99	2	2.02%
Schizophreniform	10	1	10.00%
Reactive Psychosis	9	0	0.00%
Paranoid/Delusional	7	0	0.00%
Atypical Psychosis	103	2	1.94%
Major Affective Disorders	2440	5	0.20%
Dysthymic	36	0	0.00%
Cyclothymic	2	0	0.00%
Obsessive Compulsive	19	0	0.00%
Panic Disorder	6	0	0.00%
Pervasive Developmental	19	0	0.00%
Attention Deficit	55	0	0.00%
Total	**2869**	**11**	**0.38%**

Dexter Kline
Kansas Insurance Department

Mental Health Experience
Psychological/Psychiatric Therapy
All Plan Types

Average Charge per Visit

	2000	2001	2002	2003	2004
Schizophrenic	$ 66.34	84.77	85.70	85.67	89.75
Schizoaffective	78.16	92.90	93.22	94.84	96.59
Schizophreniform	84.70	97.94	94.35	89.86	97.22
Reactive Psychosis	97.40	110.30	105.19	105.97	102.07
Paranoid/Delusional	85.67	90.73	90.46	99.10	95.44
Atypical Psychosis	74.91	93.76	94.32	104.12	100.58
Major Affective Disorders	91.58	99.09	102.25	104.42	107.39
Dysthymic	95.20	99.74	104.01	105.83	109.25
Cyclothymic	83.06	102.32	100.96	99.54	102.21
Obsessive Compulsive	94.83	100.34	102.08	102.43	108.86
Panic Disorder	94.58	100.79	101.31	104.24	107.01
Pervasive Developmental	97.08	104.46	100.60	106.99	112.86
Attention Deficit	89.58	95.51	101.13	103.02	108.33

Average Number of Visits

	2000	2001	2002	2003	2004
Schizophrenic	5.8	5.3	5.6	5.8	5.7
Schizoaffective	7.3	5.9	7.0	6.2	6.3
Schizophreniform	4.7	4.7	3.4	5.3	3.8
Reactive Psychosis	3.6	4.8	4.3	4.1	3.2
Paranoid/Delusional	5.2	4.4	5.5	6.0	4.5
Atypical Psychosis	6.3	4.4	4.0	5.1	4.7
Major Affective Disorders	5.5	5.4	6.2	6.2	5.8
Dysthymic	6.2	5.8	6.1	6.0	5.6
Cyclothymic	5.0	4.6	4.1	5.5	4.9
Obsessive Compulsive	4.5	5.1	5.2	5.1	4.6
Panic Disorder	4.6	3.9	4.6	4.7	4.2
Pervasive Developmental	4.3	4.9	6.3	5.4	4.8
Attention Deficit	4.1	4.3	4.4	4.3	4.1

Dexter Kline
Kansas Insurance Department

Mental Health Experience
Psychological/Psychiatric Therapy
All Plans, 2000

Diagnosis	Insureds using more than 45 Visits	Average Number of Visits	Average Charged per Visit	Percent of Expenditures
Schizophrenic	1.1%	5.82	$ 66.34	0.73%
Schizoaffective	1.0%	7.28	78.16	1.31%
Schizophreniform	0.0%	4.71	84.70	0.06%
Reactive Psychosis	0.0%	3.57	97.40	0.05%
Paranoid/Delusional	0.0%	5.19	85.67	0.16%
Atypical Psychosis	1.7%	6.28	74.91	0.62%
Major Affective Disorders	0.4%	5.47	91.58	56.95%
Dysthymic	0.3%	6.22	95.20	20.08%
Cyclothymic	0.0%	5.00	83.06	0.52%
Obsessive Compulsive	0.3%	4.52	94.83	2.73%
Panic Disorder	0.0%	4.60	94.58	1.61%
Pervasive Developmental	0.0%	4.32	97.08	1.17%
Attention Deficit	0.3%	4.08	89.58	14.01%

Dexter Kline
Kansas Insurance Department

Mental Health Experience
Psychological/Psychiatric Therapy
All Plans, 2001

Diagnosis	Insureds using more than 45 Visits	Average Number of Visits	Average Charged per Visit	Percent of Expenditures
Schizophrenic	0.0%	5.26	$ 84.77	0.74%
Schizoaffective	0.0%	5.87	92.90	1.10%
Schizophreniform	0.0%	4.71	97.94	0.05%
Reactive Psychosis	0.0%	4.79	110.30	0.10%
Paranoid/Delusional	0.0%	4.39	90.73	0.17%
Atypical Psychosis	0.0%	4.44	93.76	0.47%
Major Affective Disorders	0.3%	5.43	99.09	60.11%
Dysthymic	0.3%	5.77	99.74	16.45%
Cyclothymic	1.1%	4.56	102.32	0.60%
Obsessive Compulsive	0.5%	5.10	100.34	3.17%
Panic Disorder	0.0%	3.93	100.79	1.37%
Pervasive Developmental	0.0%	4.93	104.46	1.20%
Attention Deficit	0.2%	4.29	95.51	14.47%

Dexter Kline
Kansas Insurance Department

Mental Health Experience
Psychological/Psychiatric Therapy
All Plans, 2002

Diagnosis	Insureds using more than 45 Visits	Average Number of Visits	Average Charged per Visit	Percent of Expenditures
Schizophrenic	0.8%	5.56	$ 85.70	0.58%
Schizoaffective	0.0%	7.02	93.22	1.20%
Schizophreniform	0.0%	3.43	94.35	0.04%
Reactive Psychosis	0.0%	4.27	105.19	0.10%
Paranoid/Delusional	0.0%	5.47	90.46	0.15%
Atypical Psychosis	0.0%	3.98	94.32	0.37%
Major Affective Disorders	0.2%	6.18	102.25	62.28%
Dysthymic	0.3%	6.13	104.01	14.79%
Cyclothymic	0.0%	4.14	100.96	0.45%
Obsessive Compulsive	0.2%	5.24	102.08	2.77%
Panic Disorder	0.0%	4.58	101.31	1.22%
Pervasive Developmental	0.4%	6.28	100.60	1.41%
Attention Deficit	0.1%	4.41	101.13	14.62%

Dexter Kline
Kansas Insurance Department

Mental Health Experience
Psychological/Psychiatric Therapy
All Plans, 2003

Diagnosis	Insureds using more than 45 Visits	Average Number of Visits	Average Charged per Visit	Percent of Expenditures
Schizophrenic	0.0%	5.81	$ 85.67	0.67%
Schizoaffective	0.0%	6.18	94.84	1.11%
Schizophreniform	0.0%	5.29	89.86	0.03%
Reactive Psychosis	0.0%	4.12	105.97	0.07%
Paranoid/Delusional	0.0%	5.97	99.10	0.20%
Atypical Psychosis	0.0%	5.09	104.12	0.45%
Major Affective Disorders	0.3%	6.17	104.42	64.00%
Dysthymic	0.3%	5.95	105.83	13.63%
Cyclothymic	0.0%	5.46	99.54	0.48%
Obsessive Compulsive	0.0%	5.13	102.43	2.74%
Panic Disorder	0.0%	4.71	104.24	1.23%
Pervasive Developmental	0.0%	5.44	106.99	1.36%
Attention Deficit	0.1%	4.27	103.02	14.03%

Dexter Kline
Kansas Insurance Department

Mental Health Experience
Psychological/Psychiatric Therapy
All Plans, 2004

Diagnosis	Insureds using more than 45 Visits	Average Number of Visits	Average Charged per Visit	Percent of Expenditures
Schizophrenic	0.0%	5.70	$ 89.75	0.62%
Schizoaffective	0.0%	6.31	96.59	1.11%
Schizophreniform	0.0%	3.75	97.22	0.04%
Reactive Psychosis	0.0%	3.20	102.07	0.05%
Paranoid/Delusional	0.0%	4.48	95.44	0.13%
Atypical Psychosis	0.0%	4.68	100.58	0.38%
Major Affective Disorders	0.2%	5.85	107.39	64.13%
Dysthymic	0.1%	5.64	109.25	12.35%
Cyclothymic	0.0%	4.86	102.21	0.47%
Obsessive Compulsive	0.0%	4.62	108.86	2.51%
Panic Disorder	0.4%	4.22	107.01	1.11%
Pervasive Developmental	0.7%	4.84	112.86	1.38%
Attention Deficit	0.1%	4.09	108.33	15.73%

Good afternoon, my name is Jackie Shufelberger, and I am here today on behalf of my daughter. While others today talk about technicalities, bills, and statutes, we cannot lose sight of those who are impacted by the lack of parity. Unless you have been touched by someone with a mental illness, you cannot begin to comprehend the effect it has on your life. If you have been touched by any other major health condition, you can begin understand, but compound that by the fact that there remains a stigma around mental illness.

My daughter, Sara, has struggled with depression off and on since 2000. Prior to 2006, it was controlled by one medication and no therapy. However, when she had my grandson, late-September 2006, her world and her family's world turned upside down. She was hospitalized, at Stormont Vail West, for what we thought was post-partum depression. She has had a couple of other diagnoses, but basically suffers from a major depression, which, early on, was proven to be resistive to treatment.

Here's a quick history:
In 2006, she was hospitalized on,

- Nov. 26, 27, 28, and 29
- Dec. 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15 (first ECT), 16, 17, 18 (ECT), 19, 20 (ECT), 26, 27 (ECT), 28, 29(ECT)

In 2007, she was hospital on,

- Jan 3 (ECT), 4, 5(ECT), (10 outpatient ECT)
- Feb 21, 22, 23
- April 9, 10, 11, 12, 13
- Nov. 23, 24, 25, 26, 27, 28 (ECT), 29, (30 outpatient ECT)
- Dec (3 outpatient ECT), 4, 5 (ECT), 6, 7 (ECT), (10 outpatient ECT), (12 outpatient ECT)

From November 2007 through February 2008, Sara had over $4,000 in therapy not covered because she hit the 45 per year therapy limit her insurance carries. Included in the calculation were two ECT therapies not covered by insurance, which would have been covered had she been in Vail West. On top of that, she had $1,856 out of pocket for prescriptions, which is a small percent of the total cost of her prescriptions. The insurance calendar year begins March 1 and therapy coverage starts over, but she has to meet a deductible and then $1,000 co-pay before they begin covering therapy in full. And, keep in mind, that during the year, she had other medical expenses as well.

Because she is so ill, she is unable to work. She and her husband sold their house in late 2007 and moved in with me because they were struggling to make ends meet on one income, and it was impossible to keep up with the uncovered medical expenses. For someone who feels they are worthless and a burden on everyone as my daughter does, selling a house only heightens those feelings.

She has not been hospitalized since December 2007, but continues with weekly therapy and medicine adjustments. She again hit her therapy limit this year towards mid-November and had to cover the full cost of sessions until the year started over on March 1. She noted a couple of thousand dollars worth of therapy bills in that short time frame, and now is working on meeting the calendar year deductible and co-pay. She was going to attend today, but she has been struggling a bit and opted to attend her therapy session instead.

Yes, she has good coverage compared to some, and she actually gets to use the benefits allowed, but it is not adequate for her. I am here to ask you to consider a 'mental' brain illness the same as any other brain illness or any other illness for that matter. Just as chemotherapy and radiation can save cancer victims, therapy can save those suffering from severe depression. Frankly, without therapy, there is a good chance Sara, literally, might not be here today. We don't limit the number of chemotherapy treatments needed, why do we limit the number of therapy sessions needed?

I ask you to act favorably to help take away some of the stigma that comes with 'mental' illness and allow those suffering to be treated the same as someone with any other illness.

I thank you for your time and would be happy to answer any questions you might have.

KANSAS MENTAL HEALTH COALITION

.....Speaking with one voice to meet the critical needs of people with mental illness

SENATE BILL 49
HOUSE INSURANCE COMMITTEE

The Kansas Mental Health Coalition supports Senate Bill 49 as introduced by the Kansas Insurance Department to bring Kansas statutes into compliance with federal mental health parity legislation passed in October 2008. This session, the Coalition also introduced HB 2231 to promote important improvements to the Kansas mental health insurance statutes.

Today, we are here to advocate for compromise legislation being developed by representatives of the Kansas Mental Health Coalition and representatives of the insurance industry. The discussions surrounding these proposed changes to Kansas statute have gone on for three weeks and have just reached consensus today. I apologize that we do not have the language to distribute today. We must get approval on the exact language first. As you know, the devil is in the details. Assuming the language will be acceptable to both parties, we expect to have it available for your consideration this week.

BACKGROUND

Federal Mental Health Parity Legislation:

The objective of the Paul Wellstone and Pete Domenici Mental Health Parity and Addictions Equity Act of 2008 is to require insurance coverage and administration that is equal to, but not superior to, other medical conditions such as cancer, diabetes or heart disease. It can be seen as an important step toward the greater goal of ensuring that persons with a mental illness have the same opportunities in their quest for receiving appropriate treatment as do those with a physical illness and a step towards ending discrimination against consumers seeking treatment for mental illness.

The law, for most health plans, will take effect Jan. 1, 2010. According to the *Washington Post (Oct. 10, 2008)*, supporters of the measure say change in coverage requirements for health plans "represents a fundamental shift in how the mentally ill are treated" and "an important step in erasing the stigma often associated with such illnesses as post-traumatic stress disorder or anxiety-related conditions." Doug Walter, counsel for legislative and regulatory affairs at the American Psychological Association, said, "This is absolutely milestone legislation for those people who have mental health and substance abuse problems," adding, "It ends the discrimination against people who have long needed the help."

The enactment of mental health parity legislation "resolved a 12-year struggle on Capitol Hill to close gaps in insurance coverage that have put at great disadvantage mental health patients and their families," an *Akron Beacon Journal* editorial stated. According to the editorial, "It is telling ... that critical as it is, parity in coverage made it into law only as part of a bill Congress and the White House desperately needed to approve to shore up confidence in the financial system."

The editorial states, "Disparities in coverage prove harmful to millions of patients when arbitrary caps force them to pay high out-of-pocket costs or abandon treatments that can restore mental stability and a degree of productivity." It concludes, "The new law closes a gap that long has been indefensible" (*Akron Beacon Journal*, 10/10).

Under the new law, the U.S. Department of Labor must submit biannual reports to Congress on group health plan compliance. The law allows managed care companies to refuse to pay for care if they deem it not medically necessary or "clinically appropriate," but insurers must reveal their criteria for determining medical necessity and their reason for denying any mental health claim, according to the *Times* (*New York Times*, 10/6).

This act, included as an amendment to the Emergency Economic Stabilization Act of 2008 signed by President Bush on October 3, amends the Mental Health Parity Act of 1996. Some major points of the act are as follows:

- Requires that a group health plan of 50 or more employees that provides both medical and surgical benefits and mental health or substance use benefits ensure that financial requirements/treatment limitations applicable to mental health/substance use disorder benefits are no more restrictive than those requirements and limitations placed on medical/surgical benefits.
- Equity coverage will apply to all financial requirements, including deductibles, copayments, coinsurance, and out-of-pocket expenses, and to all treatment limitations, including frequency of treatment, number of visits, days of coverage, or other similar limits.
- A plan may not apply separate cost sharing requirements or treatment limitations to mental health and substance use disorder benefits.
- If a plan offers two or more benefit packages, the requirements of this Act will be applied separately to each package.
- Mental health or substance use benefit coverage is not mandated. However, if a plan offers such coverage, it must be provided at parity in accordance with this Act.
- Out-Of-Network Benefits-A group health plan (or coverage) that provides out-of-network coverage for medical/surgical benefits must also provide out-of-network coverage, at parity, for mental health/substance use disorder benefits.
- Preservation of State Law-The current HIPAA preemption standard applies. This means stronger State parity and other consumer protection laws remain in place.

Kansas Statute

The Kansas Legislature intended for K.S.A. 40-2,105a-Kansas' mental health parity act passed in 2001-and K.S.A. 40-2258 (re: lifetime/annual limits) to be parity provisions and are examples of legislation that provided improved insurance coverage for certain mental illnesses. However, K.S.A. 41-2,105a is not true "parity" as it specifies annual coverage for 45 inpatient 45 and outpatient days of treatment. Also, K.S.A. 40-2,105a, applicable to group coverage only, is mandated coverage for services rendered in the treatment of certain, specifically defined, mental illnesses deemed to be biological in nature.

These are: Schizophrenia, schizoaffective disorder, schizophreniform disorder, brief reactive psychosis, paranoid or delusional disorder, atypical psychosis, major affective disorders (bipolar and major depression), cyclothymic and dysthymic disorder, including autism, attention deficit disorder and attention deficit hyperactive disorder.

The balance of the statute regulating state insurance policies coverage of mental health treatment – K.S.A. 41-2,105 – is an example of mandated minimum insurance coverage for mental health issues including specified co-pays and lifetime limits. Under K.S.A. 40-2,105, individual policies, large and small group coverage have mandated benefits for services rendered in treatment of alcoholism, drug abuse and nervous and mental conditions. This is "first-dollar" coverage, which is limited to not less than 100 percent of the first $100, 80 percent of the next $100 and 50 percent of the next $1,640. This first-dollar coverage is only applicable to this statute. Coverage for inpatient care is limited to 30 days a year.

The Kansas Mental Health Coalition supports amending these statutes to provide true parity – equal coverage - by eliminating "first dollar coverage" and specified "days of coverage" and including for parity treatment all mental health diagnoses as defined by the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, (DSM-IV) of the American Psychiatric Association.

The coverage specifications in current law have provided life saving treatment for Kansans since the original statute was passed in 1977. Unfortunately, the limits delineated in K.S.A. 40-2,105 are woefully inadequate today. These specifications are important to retain as long as we do not provide true equal coverage for Kansans with mental illness. However, it is time to move beyond these limitations.

GMHSPC Mental Health Parity Task Force

In 2006 the Governor's Mental Health Services Planning Council appointed a Mental Health Parity Task Force to study the impact and effectiveness of current law. A task force appointed by the Council met throughout 2006 and issued the "Mental Health Parity Task Force Report" in November 2006. Key findings of this report were:

-*Consumers are routinely denied full access to their mental health benefits by some insurance companies.* Data provided by the Kansas Insurance Department showed that the average number of outpatient sessions was six—no matter what the mental health diagnosis was or how severe the condition was. The average number of inpatient days per episode of acute illness was also only six days.

-*The increased cost of mental health parity to consumers, employers, and insurers is less than 1% a year.* Some argued that covering mental health care would dramatically increase the overall cost of healthcare. That did not turn out to be true. In fact, a study commissioned as part of the 2001 legislation showed that mental health parity increased costs of health care in Kansas by less than 1% a year.

-*Full mental health parity has the potential of reducing overall medical costs by 20%.* A 1999 study suggests that having full mental health coverage and benefits could reduce the overall cost of health care by as much as 20%. This is referred to as the "cost-offset" data. Every dollar spent on mental health care results in greater cost savings on the medical-surgical side. (Chiles, J.A., et.al. 1999: "The Impact of Psychological Interventions on Medical Cost Offset: A Meta-analytic Review," Clinical Psychology: Science and Practice, V6, Summer)

-*Confidentiality of patient material is seriously compromised by some insurance companies doing business in Kansas.* Some companies require more information than is necessary or more than they would request for treatment of a physical ailment. Information about a person's mental disorder is particularly sensitive and must be vigorously protected.

-*Full mental health parity is the desired outcome for all Kansans.* Full mental health parity would result in all mental illnesses being covered and treated in an equivalent way to illnesses requiring medical/surgical treatment.

Other Notes on Cost:

We know that the costs of implementing limited parity in Kansas have been minimal – less than 1% . We have data from the impacts of current statutes on the private market and the State Employees Health Care Plan. We also anticipate having additional data from the State Employees Health Care Plan regarding expanded access to mental health benefits as it was implemented in January 2009. We encourage you to invite representatives of the State Plan to discuss the benefit plan design.

Beyond our state, there have been volumes written on the subject. According to one analysis of the costs of mental health parity, "Parity in mental health benefits rectifies unfairness in health insurance coverage and reduces financial risk for those with mental illness. However, increased coverage for mental illness has been seen as creating inefficiencies and increasing total spending, based largely on results from the RAND Health Insurance Experiment conducted in the 1970s. Newer evidence suggests that cost control techniques associated with managed care give health plans alternatives to discriminatory coverage for containing costs. We review both eras of research on mental health insurance and conclude that comprehensive parity implemented in the context of managed care would have little impact on total spending." (Barry, Frank and McGuire, 2006, "The Costs of Mental Health Parity: Still an Impediment?", Health Affairs, 25, no.3: 623-634)

An actuarial study from 2005 examined the experience of the Office of Personnel Management and numerous states that implemented their own parity statutes. "The Mental Health Parity Act of 1996 required that the annual and lifetime dollar limits of mental health benefits and medical benefits be equal for employers with at least 50 employees offering mental health coverage. Since its implementation, new federal proposals have been presented that would extend the 1996 Act, some requiring full parity for all categories of mental health conditions as listed in the DSM-IV (the Diagnostic and Statistical Manual of Mental Disorders). Opponents of such legislation argue that the combined pressures of general cost increases and a need to pay fully for mental health care will make it impossible for employers to continue offering affordable coverage, often citing initial estimates that placed resulting premium increases from full parity between 3.2 percent and 8.7 percent. However, as actual experience has emerged, it has become clear that these estimates were conservatively high. In fact, with implementation of mental health parity at the same time as managed behavioral health care, many states have discovered that overall health care costs increased minimally and in some cases were even reduced.

"As debate over the federal legislation continues, 35 states have enacted their own versions of mental health parity laws. *(Note: now 39 states)* The emerging results of their programs dispel the cost arguments of parity critics. These states are finding cost increases of less than 2 percent and in some cases cost *decreases* of up to 50 percent, depending on whether mental health care management was already in place." (Melek, Steve, "The Costs of Mental Health Parity" Copyright 2005 by the Society of Actuaries, Schaumburg, Illinois, Health Section News, March 2005)

KMHC Principles for Comprehensive Parity:

Decades of research provide evidence that mental disorders can be treated effectively and that persons with mental illnesses who receive such treatments can lead fulfilling and engaging lives. The recent surgeon general's report on mental health provides important evidence to counter outdated beliefs that mental illnesses are somehow less real than physical ones, or that mental health treatments are ineffective.[1]

The current law, as demonstrated in the Task Force report, is clearly inadequate to assure persons with mental illness the treatment they need to recover both health and quality of life. Further, the current law reinforces stigma, by treating mental illness as "different" than other conditions.

KHMC has identified the following principles that it believes should guide the development of legislative changes so as to ensure that all Kansans receive the mental health care and treatment they deserve, and that illnesses of the brain are treated like any other biological illness.

- Equal co-pays for mental health care as for other providers
- One deductible for all health care expenses, including mental illness and medical/surgical
- Mandated coverage of mental health treatment
- Definition of covered conditions:
    - "Mental health condition" means any condition or disorder that involves mental illness or alcohol and other drug abuse as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders" (DSM). (DSM criteria are included in Medicare, virtually all state Medicaid laws and the Federal Employees Health Benefits Program. DSM criteria are used by the FDA and the legal system throughout the country)
- Uniform language for individual and small group plans
- Equivalent and no more restrictive financial and durational treatment limits
- Managed care provisions are no more restrictive or burdensome for mental illness than for other medical conditions
- Out of network coverage should be comparable for all medical conditions
- Equivalent coverage for prescription medications
- Establish administrative regulations to implement and ensure compliance with statutory provisions

[1] SAMHSA and NIH, *Mental Health: A Report of the Surgeon General. http://mentalhealth.samhsa.gov/features/surgeongeneralreport/home.asp*

- Apply utilization review statutes to mental health claims

The Parity discussion:
Obviously, the creation of any compromise necessitates concessions by both parties involved. By no means will our compromise bring comprehensive mental health parity to all Kansans who are covered by private insurance. It will provide significant improvement to mental health coverage overall.

In an ideal situation, the Kansas Legislature would:

- pass a parity bill which applies to health plans that provide medical, surgical and mental health benefits
- ensure that within these plans that treatment limitations for mental health are no more restrictive than any limitations applied to substantially all medical and surgical treatments, including limits on frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.
- ensure that within these plans that the financial requirements that apply to mental health benefits are no more restrictive than those applied to all medical and surgical benefits, including deductibles, copayments, coinsurance, out-of-pocket expenses, and annual and lifetime limits,
- prevent plans from establishing separate cost sharing requirements that are applicable only to mental health benefits.

The current compromise will streamline the administration of policy requirements, eliminate day limits, and eliminate dollar limits for large group policies. It will equalize coverage offered for different categories of mental health diagnoses and improve small group coverage. We urge you to support the compromise put forward this session to improve upon the language of SB 49 and to modernize and streamline our current insurance coverage statutes.

Thank you for the opportunity to submit these comments. Please do not hesitate to contact us to discuss this or any other issue relating to mental health.

The Kansas Mental Health Coalition is an Organization Dedicated to Improving the Lives of Kansans with Mental Illnesses and Severe Emotional Disorders. KMHC is a coalition of consumer and family advocacy groups, provider associations, direct services providers, pharmaceutical companies and others, all of whom share this common mission. Within the format of monthly roundtable meetings, participants forge a consensus agenda which provides the basis for legislative advocacy efforts each year. This design enables many groups otherwise unable to participate in the policy making process to have a voice in public policy matters that directly affect the lives of their constituencies. The result of this consensus building is greater success for our common goals. Our current membership includes 51 non-profit organizations, 5 for profit, and individuals who meet once a month to discuss issues of common concern and develop consensus.

For More Information, Contact:

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Association of Community Mental Health Centers of Kansas, Inc
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House Insurance Committee

Testimony on
Senate Bill 49

March 17, 2009

Presented by:

Michelle Sweeney, Policy Analyst
Association of CMHCs of Kansas, Inc.

Madame Chairman and members of the Committee, my name is Michelle Sweeney, I am the Policy Analyst for the Association Community Mental Health Centers of Kansas, Inc. The Association represents the 27 licensed Community Mental Health Centers (CMHCs) in Kansas who provide home and community-based, as well as outpatient mental health services in all 105 counties in Kansas, 24-hours a day, seven days a week. In Kansas, CMHCs are the local Mental Health Authorities coordinating the delivery of publicly funded community-based mental health services. The CMHC system is state and county funded and locally administered. Consequently, service delivery decisions are made at the community level, closest to the residents that require mental health treatment. Each CMHC has a defined and discrete geographical service area. With a collective staff of over 4,500 professionals, the CMHCs provide services to Kansans of all ages with a diverse range of presenting problems.

Together, this system of 27 licensed CMHCs form an integral part of the total mental health system in Kansas. As part of licensing regulations, CMHCs are required to provide services to all Kansans needing them, regardless of their ability to pay. This makes the community mental health system the "safety net" for Kansans with mental health needs, collectively serving over 123,000 Kansans with mental illness. I stand before you today to discuss mental health coverage that is mandated to be provided under group health insurance policies in the state and to support Senate Bill 49.

It is important to note that one in four adults—approximately 57.7 million Americans—experience a mental health disorder in a given year.[1] In reality, when employees are provided treatment for mental and physical illness and substance use, the total cost of health care may be decreased for the employer. Case in point is a study of health coverage provided by Bank One, which showed that increased emphasis on mental health benefits (combining low cost-sharing requirements, expanded services, no separate benefit caps, and a sophisticated EAP) can result in lower total health expenditures.[2]

The Community Mental Health Centers serve as the public mental health system in Kansas, and as such, do not serve a large number of privately insured individuals. In fact, only about 8% of reimbursement to the CMHCs is from private group heath insurers. However, we believe that coverage is important for all Kansans who need mental health treatment. The Kansas Department of Insurance commissioned a study of the costs and outcomes from the implementation of the mental health coverage statute in Kansas in July 2004 for the State Employees Health Plan (SEHP). What they found was that the overall increase to costs for the SEHP was around 1%.[3]

Another important note for the committee is that the State Employees Benefit Plan for 2008 increased coverage for mental health treatment, both inpatient and outpatient, and decreased co-payments. This expansion is beyond the mandate in the statute, and provides state employees with better coverage and more access to mental health care treatment. This shows a realization that coverage for mental health treatment is as important as physical health treatment, and that the cost to provide such coverage has proven to be minimal, as cited above.

Senate Bill 49 would ensure that group health insurance coverage includes mental health coverage at the current levels, at least. In addition, we are pleased to see that the bill includes coverage of substance abuse treatment. Research from the *Journal of the American Medical Association (JAMA)* shows that roughly 50 percent of individuals with severe mental disorders are affected by substance abuse as well. Given that very high percentage, the Association supports the inclusion of treatment for substance use inpatient and outpatient treatment under Senate Bill 49. We would also like to see all mental illnesses included for true equity between physical and mental health coverage in group health insurance.

The Association supports continued coverage for mental health treatment in group health insurance policies in Kansas, since we know that treatment works and recovery is possible for those who have a mental illness and substance use disorders. The Association is a member of the Kansas Mental Health Coalition, and is in agreement with the information and facts as presented today by that group.

Thank you for your support of mental health care and treatment for all Kansas, and the adoption of Senate Bill 49, which would continue and advance mental health coverage under group plans. Thank you for allowing me to appear before you today.

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[1] U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 1999, pp. 408, 409, 411.

[2] Comprehensiv Study of Mental Health Benefits: Bank One at http://mentalhealth.samhsa.gov/_scripts/printpage.aspx?FromPage=http%3A//mentalhealth.samhsa.gov/publications/allpubs/sma01-3481/SMA01-3481ch8.asp

[3] KHIIS Progress Report, Mental Health Parity, Appendix E, July 2004, Blobaum, Gene, Consulting Actuary.

STUART J. LITTLE, Ph.D.
Little Government Relations, LLC

March 16, 2009

House Insurance Committee

Testimony Supporting Senate Bill 49

Thank you Chairman and Members of the Committee,

I appear today on behalf of the Kansas Association of Addiction Professionals in support of the State's efforts to provide full and equitable coverage for substance use disorders.

The Kansas Association of Addiction Professionals (KAAP) began in 1974 and is the statewide organization comprise of over 450 members including individuals counselors in private practice and large treatment programs who provide counseling and treatment services to individuals with addictions. KAAP includes professionals in the fields of gambling addiction, prevention and treatment counselors, as well as other addiction related professionals such as educators, court services officers and members of special populations. KAAP provides education and certification in the addiction and prevention field. KAAP helps our members provide the highest quality and most up-to-date, science-based services to our clients, our families and our communities.

KAAP and our statewide members are concerned about the growing need and continued failure of the state and private insurance to address addiction services. In 2006 SRS funded an external study of the addiction and treatment system in Kansas that resulted in the October 2006 "Kansas Comprehensive Needs Assessment" which resulted in the following:

- Approximately 10 percent of Kansans do not receive the treatment they need
- 150,000 adults and 15,000 adolescents in need of services do not receive them and due to state standards, only one-half of those adults and adolescents in need are even eligible for state-funded services
- Only 12,791 of 225,155 in need of services receive them

It is clear with the passage of The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 that Congress and President George Bush agreed on unmet needs in the substance abuse treatment field. We support the state's efforts to implement parity of substance abuse treatment for all Kansans in need. Senate Bill 49, offered by the Kansas Insurance Department, does add "substance use disorders" to the current statutes and to some extent places substance use disorders on the same footing as mental illness.

KAAP would suggest one change to the bill:

1. Add terms *"alcoholism, drug abuse or substance use disorder benefits'' means benefits with respect to services for the treatment of alcoholism, drug abuse or other substance*

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use disorders, as defined under the terms of the policy" found on page 4 line 20 and inserting to page 2, line 2 by inserting this definition as a new (d) and re-numbering

Thank you for your support on these matters of critical importance to the State and all Kansans. I would be happy to answer questions.

Kansas Association of Health Plans

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March 17, 2009

SB 49
Before the House Insurance Committee
Marlee Carpenter, Executive Director

Chairman Shultz and members of the Committee;

I am Marlee Carpenter, 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 other entities that are associated with managed care. KAHP members serve the majority of Kansans enrolled in private health insurance. KAHP members also serve the Kansans enrolled in HealthWave and Medicaid managed care. We appreciate the opportunity to provide comments to this committee.

KAHP has been working with the Mental Health Coalition for the last few weeks on an agreement to simplify the mental health parity statues and ensure that the statues comply with federal law. As background, updated mental health parity provisions were passed as part of the federal stimulus package. SB 49 was proposed by the Kansas Department of Insurance to make Kansas laws comply with the new federal parity act. If Kansas' law does not comply, the federal law will preempt Kansas law and the Kansas Department of Insurance will no longer have enforcement powers over these statutes. KAHP wants to keep enforcement of these statutes with the Kansas Department of Insurance.

In reviewing SB 49, our members became concerned about provisions contained in the bill and do not believe that SB 49 brings Kansas into compliance with federal law. We met with the Department of Insurance and expressed our concerns but continue to agree to disagree with the Department in our understanding of the proposed bill. We have two concerns with SB 49. First and foremost, current law requires up to 45 days of in-patient and out-patient treatment. SB 49 adds new language that reads: "*not less than 45 days*". To comply with federal law, parity must exist. By not eliminating the 45 day language and adding the *"not less than"* language creates confusion between large and small group plans and raises questions about Kansas' compliance with the federal law.

House Insurance
Date: 3-17-09
Attachment # 8

In addition, current law requires first dollar coverage for individuals, small groups and large groups. Under the new federal parity act, large groups must have full parity. SB 49 does not eliminate the first dollar coverage for the large group plans. If SB 49 was enacted, large groups would receive both first dollar coverage and full parity. We believe that is parity plus.

In our discussions with the mental health community, we have focused on making the Kansas statutes easier to administer for the insurance companies as well as looking at some of the issues the mental health community has been requesting over the last few years. We have come to an agreement today and are working on language that will reflect this agreement. We believe that these items with make Kansas law comply with the new federal changes as well as simply the administration of mental health for insurance companies. We have notified the Kansas Department of Insurance of our agreement.

The agreement is as follows:

- Removal of the 45 day in-patient and out-patient limits.
- Removal of first dollar coverage for all groups.
- Parity for individual, small groups and large groups with the same deductibles, co-pays and co-insurance as with other conditions.
- Double the small business lifetime maximum from $7,500 to $15,000.
- Removal of the biologically based definitions.
- Retention of the DSM-IV 1994 edition.

We hope to have agreed to language either today or tomorrow and will continue to keep the committee informed as we move forward with this agreement.

Thank you for your time and I will be happy to stand for questions.

House Insurance
March 17, 2009

Testimony submitted by:
Sky Westerlund, LMSW
Executive Director

SB 49
Insurance coverage; mental health parity

The Kansas Chapter, National Association of Social Workers (KNASW) is the professional association working on behalf of the profession and practice of social work in Kansas. Social workers have been licensed to practice at three levels of expertise since 1976. These are the baccalaureate (LBSW), the master (LMSW), and the clinical social worker (LSCSW). The specialist clinical social worker is professionally and statutorily authorized to diagnose and treat persons with mental health conditions in an independent manner. The master social worker can do the same, under supervision and direction from an LSCSW. There are about 1700 clinical social workers practicing in the majority of the 105 counties in Kansas.

Mental health parity is about insurance paying for the care of persons who have a mental health diagnosis in an equivalent manner as paying for the care of persons who have a physical ailment.

Strong mental health is the keystone to success in our society. It creates the ability for persons to engage in productive activities, meaningful relationships, and the ability to solve problems and adapt to changes in life circumstances. Difficulties with mental health manifest through symptoms, behavior, and deterioration of healthy functioning. According to the 1999 U. S. Surgeon General's report on Mental Health, there are two primary findings from the mental health research:

- The efficacy of mental health treatments is well documented.
- A range of treatments exist for most mental disorders.

Covering mental health is an important public policy because of the large number of persons affected. About 20% of the population struggles with a mental health issue. In Kansas, with a population of about 2.7 million persons, this translates to about 405,000 persons who have a mental health issue.

About 15% of the adults who have a mental health problem also have a co-occurring condition such as substance abuse or alcohol abuse. This translates to about 60,750 adults.

About 20% of Kansas children also experience and struggle with mental health. This translates to about 135,000 children. Of those, about 5% experience an "extreme functional impairment." This means about 6750 children.

*KNASW supports legislation, including **SB 49**, that secures and improves insurance coverage for persons with mental health needs.*

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Testimony to the Kansas House Committee on Insurance: SB 49 – 3/17/09

Dear Representative Schultz and Members of the Committee,

My name is Dr. Ira Stamm. I am a psychologist in private practice in Topeka. Before entering private practice I worked and treated patients at the Menninger Clinic in Topeka for twenty-three years.

In 2006 I served as the co-chairperson of the Kansas Task Force on Mental Health Parity. One of the key findings of the Task Force was that for mental health patients with commercial insurance the average number of sessions they were seen in outpatient therapy was five to six and the number of days spent in the hospital was also five to six days. These findings were surprising given that the Kansas Mental Health Parity law (40-2,105a) provides a benefit for these patients of 45 outpatient therapy sessions and 45 days in the hospital.

The findings were a surprise also in that patients with severe mental illness such as schizophrenia and bipolar illness had the same amount of treatment as those with mild disorders such as anxiety and panic disorder. The Task Force concluded that the managed care industry through its processes of pre-authorization and concurrent utilization review routinely denied patients access to the mental health benefits that were part of their insurance policy.

In 1972, when my wife and I first drove through downtown Topeka, we were greeted by a large billboard on I-70 near MacVicar that read, "Welcome to Topeka, Psychiatric Capitol of the World." The message was a comment on the many fine psychiatric treatment programs in Topeka. These included: Topeka State Hospital, Topeka Winter VA, the Menninger Clinic, the Youth Center of Topeka, and so on.

In 1983 I became director of an eleven bed unit for teenage boys and girls ages 14-18 in the Children's Hospital at the Menninger Clinic. At that time the average length of stay on this unit, known as Sunrise Hall, was eighteen months. Troubled teenagers came from different parts of Kansas and the United States for treatment of recurrent bouts of depression, anxiety, psychosis, behavioral problems, and so on. After a year and a half-of 24/7 round the clock care, these adolescents typically had good enough self esteem, control of their feelings and emotions, and the academic skills to return to their families and home communities. They were able to resume the normal course of their development.

The treatment model of Sunrise Hall flourished until managed care entered the picture. Managed care companies began to question most if not all medical decisions. "Doctor, does the patient really need to be in the hospital? Doctor, couldn't the patient get by with two weeks in the hospital instead of 60 days? Doctor, are you preparing the patient for discharge, and when will that be." Doctors began to think they were practicing medicine in an adult version of the children's game of Simon Says. You remember, "Simon Says you may take two steps forward – or have two more days in the hospital."

In 1991 when I completed my work on Sunrise Hall, patient length of stays had dropped catastrophically from eighteen months to one to two months. Teenagers were discharged in the middle of treatment, or before the positive gains they had made could be consolidated. Today, in 2009 the average length of stay for children and teenagers in Kansas with the same severity of illness is 3-6 days. All because of mental health utilization review.

From 1991 to 1995 I visited 80-100 managed care companies across America on behalf of Menninger. While touring one managed care company I encountered the following scene. I was ushered into a large room filled with case managers in their cubicles. At the front of the room high up on the wall was a large white board visible for everyone in the room to see. On the board were the names of a dozen psychiatric patients. Each name was followed by the psychiatric hospital the patient was in, the date of admission, the name of the admitting physician, the anticipated discharge date, and the last time the doctor had been contacted by the managed care company. These psychiatric patients had been singled out for extra scrutiny and review by the insurance company. In terms of mental health parity, I can think of no other medical or physical illness such as cancer, heart disease, diabetes, etc. that is subject to such intense scrutiny and review.

Aggressive utilization review is the main reason the Menninger Clinic closed its doors in Topeka and moved to Houston, Texas. Menninger could no longer sustain its mission of caring for individuals with severe and persistent mental illness in a climate where managed care would not allow or pay for needed care. In less than two decades, Topeka has gone from a city that was once the psychiatric capitol of the world to a city housed in a state that just two weeks ago received a grade of D for its mental health services from the National Alliance on Mental Illness.

The take-home message of my remarks is that Senate Bill 49 needs to contain strong and unequivocal language that allows patients to access the full benefits of their insurance policy, and that strengthens and preserves the confidential nature of the patient-therapist relationship. Such an amendment might read: *Due to the highly personal, unique, and private nature of mental illness, insurance companies will allow patients with a diagnosis of mental illness access to the full benefits of their insurance policy without bias or prejudice and with little or no pre-certification, concurrent review, or retroactive denial.*

Thank you.

Ira Stamm, Ph.D., ABPP
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Senate Bill 49 should also address the discrepancy between the annual and lifetime dollar limits for medical illness versus mental illness. If an individual sustained multiple physical injuries during the 2007 Greensburg, Kansas tornado they might have a million dollars of coverage to pay for treatment of their injuries. However, if they sustained an emotional injury such as Post-Traumatic Disorder their dollar coverage for outpatient treatment would be limited to $1,840 per year and $7,500 over their lifetime. This inequity between coverage for physical and mental illness needs to be changed. This might be called the *Greensburg, Kansas Mental Health Recovery Amendment.*

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James D. Hall
Regional Vice President, State Relations

March 17, 2009

Hon. Clark Shultz
Chair
House Insurance Committee
Room 141-W
State Capitol
300 SW 10th Street
Topeka, KS 66612

Re: Senate Bill 174 – Support

Dear Chairman Shultz:

I am writing on behalf of the American Council of Life Insurers (ACLI), a national trade association whose over 300 members account for 93 percent of the total life insurance premiums and 95 percent of the annuity considerations in the United States. ACLI has 299 members licensed in Kansas.

Thank you for the opportunity to appear in support of SB 174. With this bill, the life insurance industry hopes to modernize the state's existing group insurance law.

In recent years, employee benefits have changed significantly. There was a time when employers paid a substantial portion of the cost of employee benefits. Many corporations still do. But due to the increasing burden of health insurance costs, employers of all sizes have reduced or leveled their contributions to health care and to ancillary benefits in order to continue to afford employee health coverage.

In light of the employers' reduced ability to fund a vast array of employee benefits, they have sought voluntary benefits for their employees. These are benefits for which employees can pay 100% of the premiums or at least share the cost with employers. Today, 25% of the group life insurance market is fully voluntary.

By offering these voluntary products through an employer group, the employer can continue to offer their employees the advantages of payroll deduction, group rates, limited underwriting, and other efficiencies in administration.

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In looking at how best to meet the changing demands of the market place, and in particular to help small businesses, insurers discovered restrictions in the older group insurance laws of many states. These older provisions created an impediment to a number of otherwise common group insurance offerings. These limitations, written many years ago, restrict employee and dependent access to voluntary coverage. The Kansas group insurance law was originally enacted in 1951. It was updated to adopt the NAIC Model in 1972. It has been amended periodically since then, but the older restrictions were never removed.

Given the realities of today's employer group market, the outdated group insurance law appears ill-suited to protect and benefit consumers.

In SB 174, we are seeking to modernize Kansas law by repealing or amending four categories of limitations within group laws: 1) minimum number of lives requirements; 2) group participation requirements; 3) prohibitions on fully employee-paid group insurance; and 4) limitations on ability of dependents to obtain group life insurance. In addition, we are seeking to delete K.S.A. 2008 Supp. 40-433 Section (6)(e) [Bill page 5, lines 34-37] because the other amendments in the bill render this section unnecessary.

The above mentioned limitations were originally written in part to protect insurers from adverse selection and were also written at a time when it was believed that the employer must pay part, or all, of the premium for the coverage in order for the contract to be legitimately an employer group plan. These assumptions no longer hold true.

By offering these voluntary products through an employer group, the employer can continue to offer their employees the advantages of payroll deduction, group rates, limited underwriting, and other efficiencies in administration. The enactment of SB 174 will make these opportunities available to Kansans.

So far, thirty-three states have modernized their group insurance laws, including our neighbors Iowa, Nebraska, Oklahoma.

Thank you for the opportunity to comment in support of SB 174.

Very truly yours,

James D. Hall
American Council of Life Insurers
Lenexa, KS
913-599-2320

STATE OF KANSAS
HOUSE OF REPRESENTATIVES

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ENERGY AND UTILITIES
FINANCIAL INSTITUTIONS
HEALTH AND HUMAN SERVICES
INSURANCE

March 17, 2009

Chairman Shultz and members of the committee, thank you for allowing me the opportunity to come before you and discuss HB 2262. This bill was brought to my attention by several of the insurance groups to address a technical change that is extremely important to the small business owners of our state. You will find this change on page 10, line 22 of the bill.

The concern with this bill is that when an employer crosses someone off their payment list, the insurance company should immediately notify them to send out a C.O.B letter. Many small employers know they should stop paying, but are unaware of the obligation to notify. Also, COBRA does not apply to employers of fewer than 20–this is only a state law.

What happens if a business does not notify is that if a person presents a claim that comes after they have stopped paying and a C.O.B. letter has not been sent out, the small business owner is then liable for the claim. If it is a major claim, the business owner could virtually be put out of business. I do not believe we want this to happen to any of our small business owners, and it is a practice that is much easier addressed by the insurance companies who have the knowledge and ability to accomplish this in a much better manner.

Finally, Sec 3, page 18, will be struck in it's entirety with a balloon that has already been prepared, if this bill is worked. This is a change that we are not proposing at this time. Our intent is not to place any mandates, and the original language that is struck in lines 37 through 40 will be maintained, as is current law.

Providing this change in statute will eliminate a true burden for small businesses, and I ask for your support of this change. At this time, I would defer any questions to the proponents who are testifying today, as I know we have a full calendar.

Kansas Association of Health Underwriters
11184 Antioch, P.O. Box 223 Overland Park, KS 66210-2420
March 17 2009

Testimony for House Bill 2262
Thomas A. Bryon

Thank you Mister Chairman and members of the Committee for this opportunity to appear today in support of House Bill 2262 amending the "Kansas State Continuation of Benefits" statute. My name is Thomas Bryon and I am representing the Kansas Association of Health Underwriters. KAHU has nearly 200 member agencies licensed to conduct business throughout the state of Kansas. Our members are experts in all forms of health insurance related products and represent individuals, families and business owners in every county throughout the entire state.

Last year, we recommended and supported a change in the state health continuation regulations in an attempt to reduce the number of uninsureds in our great state. Over time, we believe this change will continue to have a positive affect in reducing the number of uninsured Kansans.

When the final regulation was written, not only did it extend the coverage period from 6 months to 18 months as intended, but a last minute change was made to shift the administrative responsibilities of the provision to the small business owner. Starting in July 2008, every small business in Kansas was left with the burden of notifying former employees of their continuation rights and becoming bill collectors for the continuation premiums on a monthly basis.

For many years, our great state was one that rightfully required this administrative task to be carried out by the insurance company. For small business owners, this is too costly of an administrative function, as well as one that could potentially do harm to an employer who fails to provide timely notification of the former employee's continuation rights. Small businesses, those with fewer than 20 employees, have way too much to deal with in today's tough economic times just trying to keep their doors open, let alone be saddled with additional administrative burdens for which they are not equipped to handle.

The insurance companies should be responsible for timely notification and premium collection. Small employers should continue to notify the insurance company when an employee has terminated by deleting them from their monthly group health billing

statements. It's a simple process for the insurer to then notify the former employee of their continuation rights. They are much better equipped to collect the premium than the small business owner. Up until July of last year, every admitted carrier in Kansas was performing this task anyway. It won't have to flow though the employer's hands causing possible delays and a lapse in coverage. Insurers have systems and safeguards for the efficient collection of premiums and the insurer can offer conversion privileges as well and handle the conversion process if the individual elects to take advantage of it under Kansas law.

We encourage the Committee to adopt our balloon amendments and pass HB 2262 out favorably. We would be happy to answer questions or provide additional information if necessary.

TOPEKA INDEPENDENT BUSINESS ASSOCIATION

TESTIMONY ON HOUSE BILL 2262
HOUSE INSURANCE COMMITTEE
By Kenneth Daniel
March 17, 2009

Kenneth L. Daniel is a volunteer lobbyist who advocates for the Topeka Independent Business Association and for Kansas small businesses generally. He is publisher of KsSmallBiz.com, a small business e-newsletter and website. He is C.E.O. of Midway Wholesale, a business he founded in 1970.

Mister Chairman and Members of the Committee:

Kansas has been doing a good job of driving small businesses out of offering Health Insurance to their employees, and in increasing the number of uninsured in Kansas.

Last year the health insurance providers slipped in a provision in an unrelated health bill that requires employers with fewer than 20 employees to be responsible for notifying terminated employees of their right to continue their company health insurance for up to 18 months. Furthermore, those small employers must now collect the premiums from those terminated employees and remit them to the insurance company.

Most small employers are not even aware of this responsibility, but they are greatly at risk because of it. Any terminated employee who suffers loss within 18 months, and was not notified, may sue their old employer and is highly likely to win.

This is a huge burden and risk for the small employer, but is easy for the insurance company to handle. A small employer will know if an employee is gone, and is highly likely to withhold further payment of health insurance premiums for that employee.

When the insurance company notes the short payment, it can easily notify the small employer of the need for a notice to the employee. If the employee wishes to continue coverage under the continuation of benefits statute, the insurance company can establish a billing for that person.

This is another example of a Kansas policy that puts our businesses at a disadvantage. In Oklahoma, instead of 18 months, the terminated employee is only entitled to thirty days of additional coverage under the small employer's policy.

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Kansas Association of Insurance Agents

Testimony on House Bill 2262
Before the House Insurance Committee
By Larry Magill
March 17, 2009

Thank you mister Chairman and members of the Committee for the opportunity to appear today in support of House Bill 2262 amending the "Kansas continuation of benefits" statute. My name is Larry Magill and I'm representing the Kansas Association of Insurance Agents. KAIA has approximately 550 member agencies and branches throughout the state and our members offer all types of insurance including health. Our members are free to represent many different insurance companies.

Our only interest in HB 2262 is in reversing the change made in last year's House Substitute for SB 81 shifting responsibility and liability for notifying former employees of their rights to continue their group health insurance and to collect the premium. These changes are found in Sections 1 and 2 of the bill. We have no interest in the change in Section 3 and do not care if it is deleted. As you have probably guessed, this was not our bill. We did not introduce one since it appeared there were two introduced in the House already, this bill and HB 2044. We did ask that the bill be blessed by the Speaker.

Almost as soon as the dust settled from the passage of SB 81, this change came to light. It was never the subject of hearings or discussion in the Conference Committee as far as we can tell. The small business community was justifiably upset when it took them by surprise.

The business community had not objected when the legislature decided last session to extend the Kansas version of COBRA from 6 months to 18 months although it has a cost impact for employers. Generally the employees who take the conversion option are the ones that expect to use it. Any increased claims as a result will count against the employer's experience rating up to the maximum allowed under small group.

KAIA set up a meeting at the Kansas Insurance Department to discuss the change and see if there was some way to undo it then. Of course there wasn't but the carriers present all agreed that they would continue to handle the notification and premium collection for the small employers. Unfortunately, this does not relieve the small employer of the ultimate liability if the carrier fails.

The employer's liability can be huge since it may be for the health care costs of a catastrophic accident or illness of the employee or their dependents, if they had dependent coverage.

Small employers, those not covered by federal COBRA, that have less than 20 employees, do not have a human resources department or a person well versed in human resource requirements, in all likelihood. Plus they likely have low turnover rates and may not have the issue come up for years.

But small employers are going to notify the insurance company when an employee has left when they delete them from their monthly group health billing. It's a simple process for the insurer to then notify the employee of their continuation rights and counsel them on their options. And the insurer is in a much better position to speed up collection of the monthly premium. It won't have to flow though the employer's hands with the possible delays and lapses in coverage. Insurers have systems and safeguards for the efficient collection of premiums. At the end, the insurer can make the offer of conversion coverage called for by Kansas law as well and handle that process if the insured elects to take advantage of it.

You will hear from the opponents that they were just making Kansas law consistent with federal COBRA where the employer is responsible for notification. But that overlooks the fundamental reason that COBRA does not apply to small employers. Congress recognized that small employers are not equipped to be saddled with the burden.

Attached to our testimony is a copy of the change made in SB 81, since that is not obvious from this year's bill. Secondly, we have attached a balloon of pages 10 and 16 amending sections 1 and 2 to make it clear that the insurer is responsible for both notification and collection of premium. Plus there was a drafting error on page 16 where "employer" was not struck. Section 1 deals with traditional indemnity plans and Section 2 deals with HMO's.

We encourage the Committee to adopt our balloon amendments and pass HB 2262 out favorably. We would be happy to answer questions or provide additional information.

such employee's or member's covered dependents if termination of the insurance under the group policy occurred because:

(1) The employee or member or such employee's or member's covered dependents failed to pay any required contribution after receiving reasonable notice of such required contribution from the insurer in accordance with rules and regulations adopted by the commissioner of insurance; (2) any discontinued group coverage was replaced by similar group coverage within 31 days; (3) the employee or member is or could be covered by medicare (title XVIII of the United States social security act as added by the social security amendments of 1965 or as later amended or superseded); (4) the employee or member is or could be covered to the same extent by any other insured or lawful self-insured arrangement which provides expense incurred hospital, surgical or medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination; or (5) coverage for the employee or member, or any covered dependent thereof, was terminated for cause as permitted by the group policy or certificate of coverage approved by the commissioner. In the event the group policy is terminated and not replaced the insurer may issue an individual policy or certificate in lieu of a conversion policy or the continuation of group coverage required herein if the individual policy or certificate provides substantially similar coverage for the same or less premium as the group policy. In any event, the employee or member shall have the option to be issued a conversion policy which meets the requirements set forth in this subsection in lieu of the right to continue group coverage.

(j) The continued coverage and the issuance of a converted policy shall be subject to the following conditions:

(1) Written application for the converted policy shall be made and the first premium paid to the insurer not later than 31 days after termination of coverage under the group policy or not later than 31 days after notice is received pursuant to paragraph 20 of this subsection.

(2) The converted policy shall be issued without evidence of insurability.

(3) *The employer shall give the employee and such employee's covered dependents reasonable notice of the right to continuation of coverage.* The terminated employee or member shall pay to the ~~insurer~~ *employer* the premium for the ~~six-month~~ *eighteen-month* continuation of coverage and such premium shall be the same as that applicable to members or employees remaining in the group. Failure to pay such premium shall terminate coverage under the group policy at the end of the period for which the premium has been paid. The premium rate charged for converted policies issued subsequent to the period of continued coverage shall be such that can be expected to produce an anticipated loss ratio of not less than 80% based upon conversion, morbidity and reasonable assumptions for expected trends in medical care costs. In the event the group policy is terminated and is not replaced, converted policies may be issued at self-sustaining rates that are not unreasonable in relation to the coverage provided based on conversion, morbidity and reasonable assumptions for expected trends in medical care costs. The frequency of premium payment shall be the frequency customarily required by the insurer for the policy form and plan selected, provided that the insurer shall not require premium payments less frequently than quarterly.

(4) The effective date of the converted policy shall be the day following the termination of insurance under the group policy.

(5) The converted policy shall cover the employee or member and the employee's or member's dependents who were covered by the group

which provides expense incurred hospital, surgical or medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination; or (5) coverage for the employee or member, or any covered dependent thereof, was terminated for cause as permitted by the group policy or certificate of coverage approved by the commissioner. In the event the group policy is terminated and not replaced the insurer may issue an individual policy or certificate in lieu of a conversion policy or the continuation of group coverage required herein if the individual policy or certificate provides substantially similar coverage for the same or less premium as the group policy. In any event, the employee or member shall have the option to be issued a conversion policy which meets the requirements set forth in this subsection in lieu of the right to continue group coverage.

(j) The continued coverage and the issuance of a converted policy shall be subject to the following conditions:

(1) Written application for the converted policy shall be made and the first premium paid to the insurer not later than 31 days after termination of coverage under the group policy or not later than 31 days after notice is received pursuant to paragraph 20 of this subsection.

(2) The converted policy shall be issued without evidence of insurability.

(3) The ~~employer~~ *insurance carrier* shall give the employee and such employee's covered dependents reasonable notice of the right to continuation of coverage. The terminated employee or member shall pay to the ~~employer~~ the premium for the eighteen-month continuation of coverage and such premium shall be the same as that applicable to members or employees remaining in the group. Failure to pay such premium shall terminate coverage under the group policy at the end of the period for which the premium has been paid. The premium rate charged for converted policies issued subsequent to the period of continued coverage shall be such that can be expected to produce an anticipated loss ratio of not less than 80% based upon conversion, morbidity and reasonable assumptions for expected trends in medical care costs. In the event the group policy is terminated and is not replaced, converted policies may be issued at self-sustaining rates that are not unreasonable in relation to the coverage provided based on conversion, morbidity and reasonable assumptions for expected trends in medical care costs. The frequency of premium payment shall be the frequency customarily required by the insurer for the policy form and plan selected, provided that the insurer shall not require premium payments less frequently than quarterly.

Insurance carrier

(4) The effective date of the converted policy shall be the day following the termination of insurance under the group policy.

(5) The converted policy shall cover the employee or member and the

contract for a period of 18 months following which such enrollee or dependent shall be entitled to obtain a converted contract in accordance with the provisions of this section. The ~~employer~~ *insurance carrier* shall give the employee and such employee's dependents reasonable notice of the right to continuation of coverage. The terminated employee shall pay the ~~employer~~ the premium for the continuation of coverage and such premium shall be the same as that applicable to members or employees remaining in the group. The converted contract shall provide coverage at least equal to the conversion coverage options generally available from insurers or mutual nonprofit hospital and medical service corporations in the service area at the applicable premium cost. The group enrollee or enrollees shall be solely responsible for paying the premiums for the alternative coverage. The frequency of premium payment shall be the frequency customarily required by the health maintenance organization, mutual nonprofit hospital and medical service corporation or insurer for the policy form and plan selected, except that the insurer, mutual nonprofit hospital and medical service corporation or health maintenance organization shall require premium payments at least quarterly. The coverage shall be available to all enrollees of any group without medical underwriting. The requirement imposed by this subsection shall not apply to a contract which provides benefits for specific diseases or for accidental injuries only, nor shall it apply to any employee or member or such employee's or member's covered dependents when:

(A) Such person was terminated for cause as permitted by the group contract approved by the commissioner;

(B) any discontinued group coverage was replaced by similar group coverage within 31 days; or

(C) the employee or member is or could be covered by any other insured or noninsured arrangement which provides expense incurred hospital, surgical or medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination. Written application for the converted contract shall be made and the first premium paid not later than 31 days after termination of the group coverage or receipt of notice of conversion rights from the health maintenance organization, whichever is later, and shall become effective the day following the termination of coverage under the group contract. The health maintenance organization shall give the employee or member and such employee's or member's covered dependents reasonable notice of the right to convert at least once within 30 days of termination of coverage under the group contract. The group contract and certificates may include provisions necessary to identify or obtain identification of persons and notification of events that would activate the notice requirements and conversion rights created by this section but such requirements and rights

(delete)

Insurance carrier

15-5

NFIB
The Voice of Small Business®

House Insurance Committee
Daniel S. Murray: State Director, NFIB-Kansas
Testimony in Support of HB2262
March 17, 2009

Mr. Chair, Members of the Committee: My name is Dan Murray and I am the State Director of the National Federation of Independent Business-Kansas. NFIB-KS is the leading small business association representing small and independent businesses. A nonprofit, nonpartisan organization founded in 1943, NFIB-KS represents the consensus views of its 4,000 members in Kansas. Thank you for the opportunity to comment on HB2262.

We support HB2262 and support the balloon amendment offered by Mr. Larry Magill of the Kansas Association of Insurance Agents.

Very simply, the requirement to notify terminated employees of their right to continuation of benefits and the responsibility of collecting the premiums places an undue burden and liability on the smallest of small businesses.

There is a reason that Federal COBRA does not apply to small employers—those under 20 employees. Congress recognized that small employers are not equipped to handle the encumbrance and expense of certain human resources tasks. Kansas is one of a few states that require employers with fewer than 20 employees to offer continuation of benefits. I'm not certain why the Legislature decided to contradict Federal policy on this particular issue. Notwithstanding the larger argument against that requirement, I don't understand why the 2008 Legislature further burdened our small businesses with notification of benefits and collection of premium requirements.

I'm not asserting that Kansas' small businesses are inept or incapable of handling complex business issues. Indeed, our small businesses are the true measure of innovation and efficiency. I'm simply saying that small businesses do not have the resources to handle this additional burdensome red tape. Further, the notification of benefits and collection of premium requirements places undue liability on very small employers.

This issue affects thousands of your constituents. Nearly 220,000 Kansans are employed by small businesses with fewer than 20 employees. The failure to comply with notification and/or premium collection is a huge liability to these small businesses and could serve as the deathblow to job creators in your district.

Please take a step in supporting our small business community. We ask that you adopt the balloon amendment offered by Mr. Magill and pass out HB2262. Thank you for the opportunity to comment.

National Federation of Independent Business – KANSAS
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LEAWOOD CHAMBER OF COMMERCE

Building Connections, Building Community

March 16, 2009

The Leawood Chamber of Commerce respectfully submits this testimony in support of HB 2262 which corrects a very critical portion of SB 81.

Last session, SB 81 made changes to the Kansas Continuation laws that extended the health insurance continuation period for employees of small employers from 6 months to 18 months to more closely match Federal COBRA laws. While this change was supported by our organization, a portion of SB 81 created a huge new burden for small employers in Kansas.

SB 81 shifted the notification, collection, and record-keeping burden for this State Continuation coverage from the insurance provider (insurance company) to small employers. Insurance companies had been providing this service for small Kansas employers for many years, and this change came as a complete surprise to small employers in Kansas.

Imagine a Kansas company, trying to do the right thing by providing health care coverage for his employees, that employs 4 people. If one of these employees leaves, that employer will be required to send appropriate notice to the terminated employee, and collect monthly health insurance premiums from that employee for the next 18 months. What are the implications for the small employer if the employee misses a payment? Are there grace periods, or penalties if the employer wrongfully terminates coverage?

All these questions will make it even more onerous for small employers to provide insurance for their employees, and will serve as a reason for them NOT to provide health insurance for their employees.

Thank you for your consideration of our testimony, and please feel free to contact us if you need further information.

Sincerely,

Kevin W. Jeffries, President & CEO

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House Insurance
Date: 3-17-09
Attachment # 19

Lenexa Chamber of Commerce

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TO: Representative Clark Shultz, Chairman
Members, House Insurance Committee

FROM: Ashley Sherard, Vice-President
Lenexa Chamber of Commerce

DATE: March 17, 2009

RE: **HB 2262**

The Lenexa Chamber of Commerce would like to express its strong support for provisions in HB 2262 that would **amend previous legislation to place the primary burden of providing notice and information regarding right to continuation of coverage under COBRA on employees' insurance carriers rather than their employer.**

We also support efforts to facilitate and encourage health care coverage for an increased number of employees. The cost of providing health care coverage continues to be a major concern for employers. The lack of health care coverage endangers employees and their families, promotes costly emergency health care, reduces productivity, and makes it more difficult for businesses to attract and retain quality employees. For these reasons, we support creating flexible options that can help employers provide health care coverage for employees. We believe HB 2262 may provide an additional tool for employers and employees to work together to ensure affordable health care coverage.

For these reasons, the Lenexa Chamber of Commerce urges the committee to consider HB 2262 favorable for passage. Thank you for your time and consideration of this important issue.

Overland Park
Chamber of Commerce

Testimony in Support of House Bill 2262

Submitted by Dave Holtwick
On behalf of the Overland Park Chamber of Commerce

House Insurance Committee
Tuesday, March 17th, 2009

Chairman Shultz and Committee Members:

My name is Dave Holtwick and I am Vice President of Government Affairs with the Overland Park Chamber of Commerce. I am appearing today on behalf of our board of directors and our nearly 900 member companies. I appreciate the opportunity to share written testimony in support of House Bill 2262.

HB 2262 is a "fix" for Senate Bill 81 that was passed during the 2008 Session. When SB 81 was passed, it made some good changes including extending the opportunity for coverage under COBRA from 6 months to 18 months. However, SB 81 also shifted the responsibility for communication with the terminated employee from the insurance company to the employer. It also required the payment for COBRA coverage premiums to be made directly to the employer rather than to the insurer.

Passage of HB 2262 would correct this. Provisions of HB 2262 would shift the responsibility for communication with the employee and administration of the terminated employee's coverage back to the insurer, as it was prior to the change last session. This would reduce the burden of administration on the employer and place it back with the insurance company, where it makes more sense.

Continuation of coverage and the associated administration should be between the insurer and the covered party, not between the party and the former employer. Many smaller businesses don't have the staff or the technical expertise to handle the administration of this insurance service that is so critically important to the former employee.

Thank you very much for the opportunity to share our concerns on this issue. I encourage you to support House Bill 2262.

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Wichita Independent Business Association

THE VOICE OF INDEPENDENT BUSINESS

House Committee on Insurance
Written Testimony in Support of HB 2262
By: Tim Witsman

March 17, 2009

Chairman Clark and honorable committee members,

I am Tim Witsman, President of the Wichita Independent Business Association (WIBA), and I am submitting written testimony in favor of HB 2262. For those of you who are not familiar with WIBA, it is an organization that has been in existence for seventy-six years and has been providing health insurance for the past twenty years to independent, mostly small businesses. Any non-publicly traded company in Kansas can be a member and access our health insurance options. Currently, we have almost 1,000 members of which almost 80% are impacted by the recent changes made to how continuation of health benefits (COB) is administered in the state of Kansas.

Specifically, the members of WIBA support the provisions set out in HB 2262 that would require insurance carriers to be responsible for notifying employees and/or dependents of their eligibility for COB when their employment ceases. During the 2008 Veto Session, the Kansas Legislature passed House sub. for SB 81, which contained language that shifted responsibility from insurance carriers to employers for both notifying former employees' of their right to COB as well as the administration of COB for former employees and/or their dependents.

Historically, the administration of COB for small groups (groups of 20 or fewer) has been handled by insurance carriers. Those opposed to reversing last years efforts will argue that Kansas law is not consistent with federal COBRA, where employers are responsible for complete administration of the benefits and that the changes made last year will put Kansas more in line with how other states administered the COB. Unfortunately, you will find that trying to compare how COB are administer in other states is not apples to apples so this argument is not without its flaws. In addition, it is important to reiterate the main reason COBRA administration policy does not apply to

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small groups is that Congress recognized small employers neither have the staff nor the time to manage the administration of COB. As drafted, HB 2262 only reverses the notification of the COB back to the insurance carrier. I would like to add that WIBA also supports language that not only reverses responsibility of notification, but also the administration of COB back to insurance carriers.

Unfortunately, the changes made to the COB came late in the 2008 veto session and were **never** the subject of a bill or a public hearing where small employers could express their concerns. Though the shift in administration of the COB may appear minimal at first glance, the changes made last session are significant for both small employers and their former employees. Small employers are now exposed to increased liability if something goes awry with the administration of the COB and former employees and/or dependents may also experience coverage if the administration of COB becomes in question. As the law stood prior to the 2008 changes, the COB process was simple for insurance carriers to notify employees of their continuation rights and counsel them on their options. Insurance carriers are in a much better position to speed up collection of the monthly premium. By requiring payment to be processed by the small employer the possibility for delays and lapses in coverage increases. Insurance carriers have systems and safeguards for the efficient collection of premiums that small employers do not have.

As the economy worsens and more workers are laid off I fear the "take-up" rate of COB will increase and even a greater number of small employers will be faced with having to administer the COB. This will increase the risk for errors and the members of WIBA believe it makes better sense for insurance carries to administer the COB. It is their "business" and the risk for errors in coverage will be much less than if it remains in the hands of the small business owner who honestly are not versed in the administration of COB.

Thank you for opportunity to support the notification of the COB change proposed in HB 2262 as well as our recommendation for a further amendment that would also require insurance carriers to be charged with the administration of the COB. If you should have any additional questions, please feel free to contact myself or our lobbyist, Natalie Bright.

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achieve more

Legislative Testimony

HB 2262

March 17, 2009

House Insurance Committee

Rachelle Colombo, Senior Director of Legislative Affairs

Chairman Shultz, members of the Committee:

Thank you for allowing me to provide testimony on behalf of the business community in support of HB 2262. Specifically, the Kansas Chamber supports section 1 and 2 of this bill as they pertain to continuation of benefits coverage and correct a detrimental aspect of SB 81 enacted last session.

Historically, insurance companies have been responsible for notification, collection and record-keeping of State Continuation coverage. In an effort to keep State and Federal COBRA laws consistent, the responsibility of State Continuation coverage was shifted from insurance carriers to employers. Notwithstanding the intentions behind SB 81, the resulting changes created a massive burden for small employers otherwise exempt from federal COBRA laws. HB 2262 returns the administrative duties associated with State Continuation coverage from the employer back to the insurance provider.

Managing health care costs is vital to the profitability of Kansas businesses. Requiring small employers with less than twenty employees to appropriately manage the continuation of benefits is both unrealistic and costly. This requirement increases the administrative burden of small businesses and minimizes their incentive for providing health benefits. The extension of benefits from six to eighteen months coupled with the financial and administrative responsibility of paying health premiums to avoid liability for lapsed coverage is too big for small businesses.

Please vote "yes" on HB 2262 to redirect State Continuation coverage duties back to insurers who are more adequately able to administer them. Thank you for the opportunity to offer these comments today.

The Kansas Chamber, with headquarters in Topeka, is the leading statewide pro-business advocacy group moving Kansas towards becoming the best state in America to do business. The Chamber represents small, medium and large employers all across Kansas.

THE KANSAS CHAMBER

835 SW Topeka Blvd. **Topeka, KS** 66612 785.357.6321

Polsinelli Shughart PC

Memorandum

TO: THE HONORABLE CLARK SHULTZ, CHAIRMAN
HOUSE INSURANCE COMMITTEE

FROM: WILLIAM W. SNEED, LEGISLATIVE COUNSEL
AMERICA'S HEALTH INSURANCE PLANS

RE: H.B. 2262

DATE: MARCH 17, 2009

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I am Legislative Counsel for America's Health Insurance Plans ("AHIP"). AHIP is a trade association representing nearly 1,300 member companies providing health insurance coverage to more than two million Americans. Our member companies offer medical expense insurance, long-term care insurance, disability income insurance, dental insurance, supplemental insurance, stop-loss insurance and reinsurance to consumers, employers and public purchasers. Please accept this memorandum as my client's opposition to H.B. 2262.

As noted, my client has registered as an opponent to this bill, but we have done so based not on the merits of whether the changes sought in H.B. 2262 are justified, but rather that we believe the current timing of the changes to COBRA benefits require that the Legislature not take action on this bill at this time.

I am sure both the proponents and opponents of this bill will have adequately explained what occurred a year ago regarding the responsibilities and duties of administering the COBRA benefits between the insurance carriers and the employers. Historically speaking, my client favors this duty to be assigned to the employer inasmuch as that is how that is handled in a majority of the states. However, we also acknowledge that this is an issue of public policy and can change based upon the size of the state and other various practices.

Notwithstanding the above, we rise in opposition to this bill inasmuch as the federal government is still promulgating rules and regulations dealing with COBRA as it relates to continuation of coverage assistance under the American Recovery and Reinvestment Act of 2009. One fear my client has is that rules will come out in the next few weeks or months that may end up being in contradiction to various states laws, and create more difficulty in implementing any of those changes based upon the federal act.

We certainly recognize the potential difficulty with which some employers have been faced in dealing with current law. If the Committee believes, as a matter of public policy, that action should be taken, we would recommend that the law provide that either the employer or the

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insurer be required to manage this, and that such duty is subject to contracting to perform such functions. Several states, including California, Connecticut, and Florida have statutes that allow this type of flexibility. Further, more details of how to implement such a process could be left to rules and regulations to be implemented by the Kansas Insurance Department.

Based upon the foregoing, my client respectfully requests that the Committee not act favorably on H.B. 2262. If, however, the Committee believes, because of public policy, that action should be taken this year, we would respectfully request that the Committee consider amending H.B. 2262 to allow for either the insurer or employer to provide the functions subject to negotiation.

I am available for questions at your convenience.

Respectfully submitted,

William W. Sneed

WWS:kjb

Larrie Ann Lower
Attorney at Law
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Topeka, KS 66603
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Testimony before the House Insurance Committee
HB 2262
Aetna, Inc.
March 17, 2009

Mister Chair and members of the Committee. Thank you for allowing me to appear before you today on behalf of Aetna, Inc. Built on our 154-year heritage, Aetna will be a leader cooperating with doctors and hospitals, employers, patients, public officials and others to build a stronger, more effective health care system. Aetna is one of the nation's leaders in health care, dental, pharmacy, group life, and disability insurance, and employee benefits. Our membership includes: 17.668 million medical members, 14.117 million dental members and 11.054 million pharmacy members. Aetna's health care networks include: more than 874,000 health care professionals, more than 506,000 primary care doctors and specialists and 4,987 hospitals. In Kansas, Aetna serves as the health insurance carrier to 80,500 Kansans.

As a growing company hoping to serve the needs of more Kansans in the small group market we ask that you oppose HB 2262. This legislation seeks to reverse a needed change made by the Legislature last year. This change was suggested and agreed to in a public hearing with an action by a conference committee seeking to make Kansas continuation laws consistent with federal COBRA laws. An amendment was drafted to address this request. Unbeknownst to some, making Kansas law consistent involved more than simply increasing the length of required coverage to 18 months. It meant placing the responsibility of providing notice of the right to continuation and collecting the premiums on the employer. Placing the burden back on the insurance company to notify the employee of continuation rights would put Kansas back in the handful of states (KY and in a few specific situations NH) that place this requirement on the companies. It is difficult to perform this function in the extremely few states that have taken this route, because it requires a national company to perform an actual manual function that is completely inconsistent with virtually all of the other states we serve. Changing our law back to this burdensome process will only cause additional expense on the insurance companies which will add costs to Kansas policy holders. In a year when the legislature is exploring ways to lower the cost of health insurance policies for Kansans and encouraging companies to offer new products, even introducing bills that would allow insurance companies not currently licensed in Kansas to enter the state and offer coverage to Kansans, why would you consider any legislation that would discourage those companies currently serving Kansans from further competing in this market.

In addition, as many of you are aware, included in the federal stimulus package are expansions and changes to the federal COBRA continuation benefits, which may and probably will affect Kansans. There is talk of extending the length of time for eligibility and offering states increased stimulus money if they choose to be consistent with those changes. Any change now to our continuation laws is premature and would only make us inconsistent with the federal COBRA law at a time when there seems to be a necessity to stay consistent. We strongly recommend that you follow the same reasonable and responsible findings of the Special Committee on Insurance this past interim, which was to take no action on various insurance proposals during this Session and instead await action at the federal level, in order to make good, sound judgment in future consideration of these issues and their impact on Kansas.

We request that you oppose HB 2262. Thank you for your consideration and I'll be happy to answer any questions you may have.

Report of the Electronic Motor Vehicle Financial Security Verification System Task Force to the 2009 Kansas Legislature

CHAIRPERSON: Insurance Commissioner Sandy Praeger

VICE-CHAIRPERSON: Representative Delia Garcia

LEGISLATIVE MEMBERS: Senators Ruth Teichman and Anthony Hensley; and Representative Virgil Peck

NON-LEGISLATIVE MEMBERS: Consumer Interests representative, Gavin Wittman, Educational Credit Union, Topeka, Kansas; Law Enforcement representative, Major Mark Bruce, Kansas Highway Patrol, Topeka, Kansas; Law Enforcement representative, Jerry Little, Lawrence City Prosecutor, Lawrence, Kansas; Department of Revenue representative, Tim Blevins, CIO, Department of Revenue, Topeka, Kansas; Division of Motor Vehicles representative, Carmen Alldritt, Director of Motor Vehicles, Topeka, Kansas; KAIFA representative, Jean Curry, Shelter Insurance Company, Salina Kansas; KAIA representative, Doug Buckles, Newkirk, Dennis, and Buckles, Independence, Kansas; NAMIC representative, George Cooper, State Farm, Bloomington, Illinois; AIA representative, Ginny Boyles, ACE-INA Group, Philadelphia, Pennsylvania; KAPCIC, foreign company, Tony Kimmi, Farm Bureau, Manhattan, Kansas; KAPCIC, domestic company, Brad Miller, Farmers Alliance, McPherson, Kansas; PCI representative, Alex Hageli, PCI, Des Plaines, Illinois; Top 6 Auto Insurance Writers in Kansas, Lee Wright, Farmers Insurance Group, Overland Park, Kansas; Insurance Department representative, Commissioner Sandy Praeger, Topeka, Kansas

December 2008

Electronic Motor Vehicle Financial Security Verification System Task Force

Response to Uninsured Motorists—Third Year Report

Conclusions and Recommendations:

The Task Force notes that it received testimony from three families who shared their personal experiences with uninsured motorists. The Task Force appreciates the families' participation in its discussion and its consideration of an electronic verification system that is appropriate for Kansas.

In its discussion of the criteria established by 2008 SCR 1616 and in consideration of the recommendations and conclusions of the two previously authorized Task Forces, the Task Force makes a number of conclusions and recommendations:

- **Uninsured motorist solutions: Pool for compensation of property damages.** The Task Force considered the option presented by the Dodge City government representatives and appreciates the proposal to provide compensation for property damages through a surcharge on vehicle tags. ***As the Task Force considers how best to address uninsured motorists, it believes that this proposal does not warrant further study, however, as the proposal further penalizes those individuals who choose to license or tag a vehicle. The Task Force is unaware of the actuarial necessity for the Pool and the potential impact on those individuals who pay vehicle fees and tag renewal fees.***

- **Uninsured motorist solutions: No Pay, No Play.** After considerable discussion about the appropriate level of non-economic damages able to be recovered by impaired drivers and uninsured drivers, ***the Task Force is supportive of legislation that would bar uninsured motorists from the recovery of non-economic losses sustained as the result of an accident that occurred while the motorist was operating an uninsured vehicle.*** The Task Force recommends that such motorists should not be permitted to recover any property damages in accidents where the motorist fails to maintain financial security, as required by Kansas law. The Task Force notes its consideration of 2005 HB 2286.

- **Design of an Electronic Motor Vehicle Financial Security Verification System.** The Task Force cites its continued review, time spent during the past three Interim sessions, and its considerable discussion on defining "real-time" verification and how to best develop a verification system for Kansas. The Task Force has reviewed the experiences in other states including the potential for a web-based verification system while carefully considering the needs of law enforcement, the Division of Motor Vehicles, the courts, the insurers, and Kansas motorists. ***The Task Force acknowledges the importance of this time and review in developing a verification system and cites four goals to serve as the framework for addressing electronic real-time verification in the future:***

- *Assist the Director of Motor Vehicles and county treasurers in registration of motor vehicles in compliance with motor vehicle financial security law,*
- *Provide law enforcement officers with roadside information during traffic stops to determine whether vehicles are in compliance with motor vehicle financial security law,*
- *Provide greater assurance to the motoring public that other vehicles on the road are insured as required by law, and,*
- *Offer convenient insurance policy interface and reporting for companies required to provide insurance policy information to the state.*

Proposed Legislation: None. (The Task Force is not permitted to introduce legislation).

Background

The 2008 Legislature considered proposals to address uninsured motorists' issues, including the recommendations of a task force convened during the 2006 and 2007 Interim.

During its review the Legislature passed SCR 1616, which reauthorized the task force enacted by the 2006 Legislature (SCR 1619). The task force was reauthorized by the 2007 Legislature (SCR 1603).

The 2007 Task Force made three conclusions in its report to the 2008 Legislature:

- While the Task Force makes no recommendation on an electronic verification system, it does encourage continued monitoring of a number of issues identified during its meetings.
- The Task Force encourages AAMVA, NAIC, and NCOIL to adopt standards for states to use in developing their electronic financial security verification systems.
- The Task Force calls on the Legislature to evaluate lower-cost insurance options and review the compulsory requirements for proof of auto insurance.

The task force, as authorized by 2008 SCR 1616, was again called to study the design of an electronic motor vehicle financial verification system for real time verification of compliance with the financial security requirements of KSA 40-3401 *et seq.* to combat uninsured motorists.

The resolution stated that the design of an electronic motor vehicle financial security verification system needs to include the following factors:

- The likelihood the system would reduce the number of uninsured motorists in the state;
- The likelihood the system would aid law enforcement in the identification of uninsured motorists in this state;
- The reliability of the system;
- The cost-effectiveness of the system;
- Privacy protections of the system;
- Data security and integrity of the system; and
- Any other issue related to the proper design and implementation of the system.

A copy of the Task Force reports can be obtained from the Kansas Legislative Research Department.

The 18 members of the Task Force were appointed as follows:

- The Insurance Commissioner or designated representative;
- The Secretary of Revenue or designated representative;
- The Director of the Division of Motor Vehicles or designated representative;
- Four legislators—one member each appointed by the Senate President, the Senate Minority Leader, the Speaker of the House of Representatives, and the House Minority Leader;
- One member representing a domestic property and casualty insurance company appointed by the Insurance Commissioner from a list submitted by the Kansas Association of Property and Casualty Insurance Companies;
- One member representing a foreign property and casualty insurance company appointed by the Insurance Commissioner from a list submitted by the Kansas Association of Property and Casualty Insurance Companies;
- One member representing foreign stock insurance companies appointed by the Insurance Commissioner from a list submitted by the American Insurance Association;
- One member representing automobile insurance companies appointed by the Insurance Commissioner from a list of the top six automobile insurance premium writers in Kansas;
- One member representing a property and casualty company appointed by the Insurance Commissioner from a list submitted by the Property Casualty Insurers Association of America;
- One member representing a property and casualty company appointed by the Insurance Commissioner from a list submitted by the National Association of Mutual Insurance Companies;
- One member representing the Kansas licensed insurance agents appointed by the Insurance Commissioner from a list submitted by the Kansas Association of Insurance Agents;
- One member representing licensed Kansas insurance agents appointed by the Insurance Commissioner from a list submitted by the Kansas Association of Insurance and Financial Agents;
- Two members appointed by the Governor representing law enforcement; and
- One member appointed by the Governor representing the consumer interests.

SCR 1616 requires a report that contains the results of the Task Force's study and its recommendations and conclusions be transmitted to the Speaker of the House of Representatives, the Senate President, the Chairperson of the House Insurance and Financial Institutions Committee, and the Chairperson of the Senate Financial Institutions and Insurance Committee no later than the convening of the 2009 Kansas Legislature.

Task Force Activities

The Task Force conducted its meetings in the State Capitol on Thursday, October 9. 2008, and Thursday, December 11, 2008. Task Force meetings included testimony from members of the general public who had automobile accident experiences with uninsured motorists, a state legislator and Dodge City representatives, Task Force members (low-cost auto insurance policies; pay-to-play options), and representatives of the

Kansas Insurance Department and the Kansas Department of Revenue. In December, the Task Force elected Representative Delia Garcia as its Vice-Chairperson.

During its October meeting, the Acting Chairman welcomed Task Force members and introductions were made. Task Force members were provided copies of the previous Task Force reports, the authorizing legislation, and other resource materials associated with the Task Force review.

Finding Solutions. Representative Pat George opened the discussion on finding solutions, including legislation, to addressing issues associated with uninsured motorists. Joining the representative were Dodge City Mayor, Kent Smoll, and the City Attorney, Terry Malone. Mayor Small spoke of the high incident of persons driving uninsured motor vehicles in western Kansas and suggested that one solution would be a requirement of an annual automobile insurance premium that is only refundable upon return of the vehicle tag. This solution, however, he continued, would create a real hardship for the average citizen, particularly many workers living from paycheck to paycheck. Mayor Smoll urged the Task Force to consider a fee that would be collected at the time of the securing a tag for a vehicle – this modest fee (projected at $10-$15/ vehicle) would be placed into an insurance pool to pay out property damage-only claims of less than $5,000. Each claim would be subject to a small deductible to discourage fraud. (The State would contract with insurance companies to offer UMI coverage). Mayor Smoll also encouraged the Task Force and the Legislature to consider enactment of stricter penalties for driving uninsured, noting that a number of the uninsured also are unlicensed. City Prosecutor Malone noted that during his tenure, he has encountered many situations involving uninsured motorist accidents and the devastating consequences on the working poor. The prosecutor encouraged the Task Force to study the concept of uninsured motorist property damage coverage and noted efforts in other states. Task force members discussed whether results had been seen in states mandating some level of Uninsured Motorist Property Damage (UMPD) coverage, whether current UMPD policyholders would cancel existing coverage (optional) and opt for coverage under the pool, and whether the suggested fee would be sufficient given the number of vehicles tagged in Kansas.

Perspectives. The Task Force next received written testimony from Rusty and Julie Russell of Independence. The Russells detailed information about Ms. Russell's parents injuries as a result of an auto accident near Caney in January 2005. While Ms. Russell's mother and the other driver sustained minor injuries, the auto accident proved fatal for her father. While dealing with the results of the accident and the resulting medical costs, the family learned that the other driver (who had failed to stop at a stop sign) had no auto insurance. The Russell family asked the Task Force to consider penalties for driving without insurance that are severe enough to help reduce the burden those motorists inflict on other drivers and their families. The Task Force also heard from Bill Bradt of Forsyth, Missouri, whose wife died as a result of an automobile accident on Highway 400 west of Fredonia. The driver at fault had no driver's license and the vehicle owner did not carry automobile insurance. Mr. Bradt asked that Kansas consider implementing a follow-up system (to the compulsory liability insurance requirement) to ensure that drivers retain that insurance coverage. New York and Louisiana were cited as states with systems Kansas could consider. Mr. Bradt encouraged the Task Force to consider whether or not a person involved in an accident with an uninsured motorist will be able to collect from the insured motorist's own insurance company and what will happen to the person's rates at the time of renewal, as well as the impact on an uninsured motorist's "rate" and effectively all insured drivers' rates. Mr. Bradt also encouraged the Task Force to review the Insurance Industry Committee on

Motor Vehicle Administration (IICMVA) report on using web-based auto insurance verification. Mr. Bradt also asked the Task Force to reconsider the severity of the penalties for driving without insurance. The Task Force discussed the status of states' verification systems as identified in the IICMVA report and a member distributed an article about the progress of web-based verification in Texas (TexasSure database, funded by an annual fee of $1 paid at the time of registration or registration renewal).

In December, the Task Force heard from Joe Francis, Humboldt, about a March 2008 accident affecting the life of his daughter. His daughter has over $500,000 in medical bills paid for by her health insurance. The other driver in the accident was at fault and driving a borrowed car. The car insurance on the vehicle had expired about three weeks prior to the accident. Mr. Francis asked the Task Force to consider the expenses an insured driver faces when in an accident, whether at fault or not at fault. He further stated that a proposal worthy of consideration would be denying compensation from insurers or other persons involved in an accident to uninsured motorists. Responding to a Task Force question, Mr. Francis indicated he was very supportive of pay-to-play options.

Low-Cost Policies. Task Force member Ginny Boyles (ACE representative), briefed the Task Force on low-cost auto insurance policies, including New Jersey's BASIC policy. Ms. Boyles noted this low-cost policy is designed for persons who have little or no assets to protect and provides minimum coverage protection. The BASIC policy provides: $5,000 in Property Damage Liability coverage and $15,000 in medical coverage (Personal Injury Protection or PIP). The BASIC policy does not include any coverage if the insured injures someone else in an at-fault accident. However, Ms. Boyles continued, optional $10,000 in Bodily Injury Liability is available. If the optional Bodily Injury coverage is not purchased, there is no coverage for pain, suffering or other personal hardships and the insured could be responsible for certain economic damages, such as lost wages, in an at-fault accident. No coverage is provided under this form for Uninsured/Underinsured Motorist or Physical Damage (although offered as an option by some insurers), and only the Limited Right to Sue option is provided for PIP. Ms. Boyles encouraged consideration of minimum limits for Property Damage and Medical Coverage. At the time the BASIC policy was developed, there was both an affordability and availability issue in the marketplace, with very few choices of insurers. Task Force members discussed addressing availability and the Dollar-A-Day medical coverage in New Jersey (eligible Medicaid recipients) and how a Kansas policy could look. Ms. Boyles' comments also addressed low-cost options in California.

Verification System Design Requirements. Neil Woerman, Director of Information Technology, Kansas Insurance Department, next briefed the Task Force on work by the Department, along with Department of Revenue staff (Task Force members Alldritt and Blevins) and law enforcement representatives, to create requirements for the design of an electronic motor vehicle financial security verification system. Mr. Woerman first outlined four goals or specifications for the system:

- Assist the Director of Motor Vehicles and county treasurers in registration of motor vehicles in compliance with motor vehicle financial security law;
- Provide law enforcement officers with roadside information during traffic stops to determine whether vehicles are in compliance with motor vehicle financial security law;
- Provide greater assurance to the motoring public that other vehicles on the road are insured as required by law; and,
- Offer convenient insurance policy interface and reporting for companies required to

provide insurance policy information to the state.

Mr. Woerman also addressed twelve suggested requirements for the system design. Among those requirements are: Searches must be national, and if possible international, in scope, not just for vehicles registered in Kansas (1); Information must be "near real-time". This term will need to be defined, but should occur as soon as practical following any motor vehicle transaction to initiate or cancel coverage (2); System must be easily, reliably and accurately accessible from a patrol car, fixed locations and from other computer applications such as the state's electronic vehicle registration system (5); System must maintain compliance with approved national data standards for exchange of electronic insurance reporting information (8); and a new system meeting these requirements should be established legislatively to replace the current system maintained by the Department of Revenue (10).

Task Force Discussion. The Task Force discussed the specifications and requirements at length, with questions about whether a vendor could meet all twelve requirements and what states have met all or most of the requirements. Task Force members representing the Kansas Department of Revenue discussed modernization efforts with registration and driver's licenses and the model presented by the National Law Enforcement Telecommunications System (NLETS) transactions. The Department representatives also discussed the Vehicle Information Processing System (VIPS) modernization, noting a target completion of 2010. The Task Force discussed the importance of a national scope and access to national data as part of the framework for verification. Task Force members then reviewed the requirements for insurance companies, with focus on how companies would report data (at the state level or to a national source), the impact of reporting requirements for smaller companies, and whether states had a common protocol for reporting, such as IICMVA protocols. Task Force members also discussed issues associated with enforcement and punishment of uninsured motorists and how to best approach a reduction in the number of uninsured motorists – from verification systems to ID cards (fraud prevention) to affordability and cost issues to education of the general public (risk of lawsuits, personal assets).

No Pay, No Play Options. In December, the Task Force received testimony from David Hanson, Kansas Association of Property and Casualty Insurance Companies (KAPCIC)/ Property Casualty Insurers Association of America (PCI) regarding the concept of no pay, no play (or pay to play). Mr. Hanson reviewed a provision in the Kansas Automobile Injury Reparations Act (KSA 40-3117) regarding tort actions and the ability to recover damages for pain and suffering. Mr. Hanson asked the Task Force to review 2005 HB 2286 which would have provided that persons who are injured in an automobile accident, but do not have PIP benefits protections (as required under the Act) ,would have no cause of action for the recovery of noneconomic loss sustained as a result of the accident. Additionally, persons convicted, in connection with the accident, under the state laws governing breath or blood alcohol test refusal or test failure, DUI, and DUI for persons under 21, would not have a cause of action for the recovery of the noneconomic damages.

Alex Hegeli, PCI representative to the Task Force, talked about states' laws addressing noneconomic damages and the uninsured motorist rates in those states. Mr. Hanson noted that KSA 40-3117 establishes a precedent by limiting recoveries. The Task Force members further discussed activities in other states including recovery of damages to vehicles, towing laws, the ability for passengers to sue for pain and suffering, and the recovery of medical expenses.

Consideration of Design System Requirements. The Task Force continued its discussion of the design goals and requirements at its December meeting. The Task Force discussed whether the requirements could be included in an RFP in the systems' modernization at the Kansas Department of Revenue. The Task Force then received testimony presented by William Sneed, State Farm Insurance Companies, on behalf of Task Force member, George Cooper. Mr. Cooper responded to the goals and requirements, noting that, in general, the goals serve as reasonable public policy objectives. Some of the suggested requirements, however, present a number of challenges for the insurance industry. Mr. Cooper responded to aspects of six of the requirements, including those requirements addressing the scope of the search, the expectation of having information "near real-time", multiple search fields being available for input, system compliance with approved national data standards, system ability to provide access to nearly 100 percent of vehicles operating on Kansas roads, and the issue of verifying financial security for all commercial vehicles. Mr. Cooper noted these requirements. Mr. Cooper noted that "near real-time" and the availability of insurance information can vary greatly based upon the business practices and technologies of individual insurance carriers. Making multiple search fields available for input will require cooperative dialogue between insurers and vehicle registration personnel, as each collects different data to verify coverage/ registration. Mr. Cooper also noted that verifying insurance for commercial vehicles is a difficult task, and there are differences between how states identify a commercial vehicle for registration purposes. In addition, commercial policies often are written on a fleet basis and do not identify specific vehicles (VINs would not be available as search criteria). Brad Smoot, American Insurance Association, also provided comments on the requirements. Mr. Smoot was supportive of Mr. Cooper's comment and suggested that the Task Force consider excluding commercial policies from verification requirements as was done in Wyoming and Oklahoma. Mr. Smoot encouraged the Task Force to support a verification system that is web-based to help achieve national access.

Task Force Discussion. The Task Force then discussed the requirements and the goals for the verification system. Members discussed the scope of the searches and the necessity for the term "international." The discussion also focused on defining "real-time", what information insurance companies currently can access and verify, and what role a data clearinghouse could play in verification. The Task Force members questioned what data would be reported to a clearinghouse or similar entity, including policy number and VIN. The Task Force also discussed the merits of a web-based verification system and the potential to impact the number of uninsured motorists and whether it would be appropriate to seek re-authorization for the Task Force.

Conclusions and Recommendations

The Task Force notes that it received testimony from three families who shared their personal experiences with uninsured motorists. The Task Force appreciates the families' participation in its discussion and its consideration of an electronic verification system that is appropriate for Kansas.

The Task Force makes a number of conclusions and recommendations:

- **Uninsured motorist solutions: Pool for compensation of property damages.** The Task Force considered the option presented by the Dodge City government representatives and appreciates the proposal to provide compensation for property damages through a surcharge on vehicle tags. *As the Task Force considers how best to address uninsured motorists, it believes that this proposal does not warrant further study, however, as the proposal further penalizes*

those individuals who choose to license or tag a vehicle. The Task Force is unaware of the actuarial necessity for the Pool and the potential impact on those individuals who pay vehicle fees and tag renewal fees.

- **Uninsured motorist solutions: No Pay, No Play.** After considerable discussion about the appropriate level of non-economic damages able to be recovered by impaired drivers and uninsured drivers, *the Task Force is supportive of legislation that would bar uninsured motorists from the recovery of non-economic losses sustained as the result of an accident that occurred while the motorist was operating an uninsured vehicle.* The Task Force recommends that such motorists should not be permitted to recover any property damages in accidents where the motorist fails to maintain financial security, as required by Kansas law. The Task Force notes its consideration of 2005 HB 2286.

- **Design of an Electronic Motor Vehicle Financial Security Verification System.** The Task Force cites its continued review, time spent during the past three Interim sessions, and its considerable discussion on the defining "real-time" verification and how to best develop a verification system for Kansas. The Task Force has reviewed the experiences in other states including the potential for a web-based verification system while carefully considering the needs of law enforcement, the Division of Motor Vehicles, the courts, the insurers, and Kansas motorists. *The Task Force acknowledges the importance of this time and review in developing a verification system and cites four goals to serve as the framework for addressing electronic real-time verification in the future:*

  - *Assist the director of motor vehicles and county treasurers in registration of motor vehicles in compliance with motor vehicle financial security law;*
  - *Provide law enforcement officers with roadside information during traffic stops to determine whether vehicles are in compliance with motor vehicle financial security law;*
  - *Provide greater assurance to the motoring public that other vehicles on the road are insured as required by law; and,*
  - *Offer convenient insurance policy interface and reporting for companies required to provide insurance policy information to the state.*

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March 17, 2009

The Honorable Clark Shultz
Chair, House Insurance & Financial Institutions Committee
Kansas State Capital, Room 141-W
300 SW 10th Street
Topeka, KS 66612

Dear Chairman Shultz,

Thank you for this opportunity to provide PROPONENT testimony on Senate Bill 260, legislation to prohibit the recovery of non-economic damages by uninsured drivers involved in accidents. This legislation would not affect an uninsured motorist's ability to recover economic damages.

Founded in 1895, the National Association of Mutual Insurance Companies (NAMIC) is a full service national trade association with more than 1,400 member companies that underwrite over 40% of the property/casualty insurance premium in the United States. In Kansas, 149 member companies, including 16 domiciled companies, underwrite 58% of the state's automobile insurance business.

Passage of "No Pay-No Play" legislation is a concrete and cost-effective step states can take to lower the number of uninsured motorists. Introduction of SB 260 is the result of a unanimous recommendation made last year by the Kansas Electronic Motor Vehicle Financial Security Verification Task Force. The Task Force was created by the legislature over three years ago to study the issue of uninsured motorists. The Task Force's report recommended the following:

> "The Task Force is supportive of legislation that would bar uninsured motorists from the recovery of non-economic losses sustained as the result of an accident that occurred while the motorist was operating an uninsured vehicle."

We respectfully request that SB 260 be swiftly approved by the committee and sent to the House floor for consideration.

Again, thank you for this opportunity to express our views on this important issue. If you have questions or require further information, please do not hesitate to contact me at (614) 262-4798 or via e-mail at jthesing@namic.org.

Sincerely,

Joe Thesing
Director-State Affairs

House Insurance
Date: 3-17-09
Attachment # 25

HOUSE INSURANCE COMMITTEE
SENATE BILL 260
TESTIMONY BY BREN ABBOTT
ABBOTT, DAVIDSON & SOUTHARD

Senate Bill 260 is a bill that limits in two situations when an injured person can make a claim for noneconomic losses:

1. When an illegally uninsured motorist is operating an uninsured automobile and

2. When he or she is convicted of, or pleads guilty to, refusing or failing a test for alcohol or drugs following the accident or is convicted of driving under the influence of alcohol or drugs.

The first one dealing with an uninsured motorist has two limitations. The driver must be illegally uninsured **and** the car itself must be uninsured. This provision actually provides the driver two opportunities to be insured. Even if he chooses to not get insurance as required by law, he may still have a cause of action for noneconomic losses if he or she is driving a car that is insured. The bill also has a provision that protects insured's that inadvertently allows a policy to lapse.

The second part of the law involves a situation when a drunk driver is involved in an accident.

As a civil defense attorney, I spend close to 50% of my law practice defending uninsured motorist claims. I see on a daily basis the devastation that is caused when people elect to illegally operate uninsured motor vehicles or operate them while under the influence of alcohol and/or drugs.

We often hear the phase "personal responsibility" used to justify legislation and I cannot think of a better phrase to use to describe this bill. Currently, motorists that are illegally uninsured can collect damages, which certainly drive up the price of auto insurance for law-abiding motorist. This bill provides another incentive for people to live by the rules expected of them.

In arguing against this bill, I have heard the example used of a single mother letting her insurance temporary lapse so that she could put food on the table. It is important to note that there is protection under the law for her children. The mother would still be able to collect her damages for past and future lost wages, loss of earning capacity, and past and future medical expenses.

I urge you to support the No-pay, No-play bill.

DAVID A. HANSON, LEGISLATIVE COUNSEL

800 S.W. JACKSON, SUITE 900

TOPEKA, KS 66612-1259

TELEPHONE NO. (785) 232-0545

FAX NO. (785) 232-0005

March 17, 2009

Testimony on Senate Bill 260 before the House Insurance Committee

Chairman Shultz and Members of the Committee:

Thank you for this opportunity to present information in support of Senate Bill 260 on behalf of the Kansas Association of Property and Casualty Insurance Companies, our state trade association for domestic property casualty insurance companies in Kansas and also on behalf of PCI, the Property Casualty Insurers Association of America, a national trade association with over 1,000 member insurers in the U.S. and whose member companies write over 40% of the property casualty business in Kansas.

In essence, this bill restricts the type of damages that an injured owner or operator of an uninsured vehicle can recover in Kansas in the event of an automobile accident. The bill does not restrict the amount of actual or pecuniary damages, such as reasonable medical expenses, lost earnings and property damage that can still be sought and recovered by an uninsured owner or operator. Also, there is no restriction on damages that may be sought by passengers (other than the uninsured owner), such as the uninsured motorist's children, in the event they are injured in the accident. This is not a new concept, but rather a legislative remedy to address the uninsured motorist problem found in most states.

Nearly every state has adopted mandatory automobile liability coverage similar to the required coverage in Kansas. And with the adoption of such mandated coverage, other states have also struggled to find a way to assure compliance and reduce the number of uninsured motorists. In fact, the problem has been more pervasive in most other states, while Kansas has generally been ranked among the states with the lowest uninsured motorist population. Looking back ten years ago, the Insurance Research Council, a division of the American Institute for CPCU and the Insurance Institute of America, which are independent, nonprofit educational and research organizations, conducted a national study and estimated that the uninsured motorist population nationwide averaged about 14%, with Kansas estimated to have and average of about 8%, ranking us in 7th place among the states with the lowest uninsured motorist populations. Since then, the estimates and rankings have changed somewhat and, depending on the estimates used, some would suggest that the percentages of uninsured motorists have been increasing nationally and in most states, including Kansas. Along with the

increasing estimates, there have been increased concerns raised about doing something to make uninsured motorists comply with the law.

In response to these growing concerns, the Legislature adopted a resolution three years ago establishing a task force to look into electronic verification of motor vehicle financial security compliance. A number of other states have already tried to use electronic verification and none have reported much success with reducing the number of uninsured motorists, nor with trying to avoid mismatches and erroneous matches. More recently, a web based system for comparing information is being tested in several states, but has not yet been in use long enough, nor on a broad enough scale to recommend in Kansas. We therefore looked for other alternatives to recommend and found that a few states have tried and had some success with the "no pay - no play" concept with some variations, such as increased restrictions for repeat offenders. In addition to addressing uninsured motorists, some states have also included similar restrictions on motorists driving under the influence of intoxicating liquor or drugs and we have included similar provisions in subsection (b) of the bill. We believe this is more than a fairness issue, it is a strong message to those who violate the laws of Kansas and put others' lives at risk, that such conduct now puts them at risk also. Thus, we recommended to the task force that this concept be adopted in Kansas and the task force concluded its work several months ago with a report that recommends passage of this type of legislation, rather than trying to implement electronic verification at this time. Considering the current financial situation, this legislation certainly has the advantage of not requiring any new funding. "No Pay - No Play" is essentially self-policing and it has the capability of catching those who have succeeded in evading our current system. In states that have tried it, there have already been legal challenges to the constitutionality in at least two states and the courts have ruled the provisions are constitutional. This bill passed the Senate 37-3.

We would therefore urge your favorable consideration of Senate Bill 260.

Respectfully,

David A. Hanson

David A. Hanson
Legislative Counsel

There is a clear lack of national insurance regulatory leadership regarding this issue. The Insurance industry, in the meantime, has clearly been working on a solution to address this issue. Despite everyone agreeing that this is an insurance issue it is unclear why these interested parties have not included the insurance commissioners and the NAIC in these discussions and studies, other than the limited presentation that was made on Sept. 13, 2003 before the NAIC's Industry Liaison Committee.

The Texas feasibility study concluded that although there was a need for a data verification system, and that such a system was feasible, none of the current and existing systems or those proposed in other states fully met the simple criteria of:

- Likelihood to reduce the number of uninsured motorists in this state;
- System reliability;
- Cost-effectiveness;
- Privacy protections; and
- Data security and integrity.

Their recommendation was to look for other solutions or to build a system themselves.

The NAIC's leadership role would be to assist in developing a cost effective uniform approach for reducing the number of uninsured motorists on the nation's highways. The goal is to not only provide support and tools for law enforcement but also to meet the criteria set forth by the NAIC. This provides necessary tools and support for the protection of the consumer, insurance regulatory bodies, states, insurers and other stakeholders. An NAIC recognized approach would go beyond mere data matching as indicated in the criteria established by Texas in their recent HB3588 Feasibility Study.

In conclusion, there is an obvious need for a uniform cost effective approach with law enforcement tools that would achieve the five criteria identified by Texas. There should also be strong leadership from the insurance regulatory community, insurance commissioners and the NAIC in this process. To that end, the Property and Casualty Insurance (C) Committee recommends that the NAIC, in cooperation with AAMVA, IICMVA and national insurance trade associations, proceed, subject to certain guidelines, with preliminary work on the possible development of a uniform cost effective approach including discussions with vendors on technology and operational issues surrounding implementation.

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SFGate.com

Road hazard: uninsured driver rates climb

By DAVID PITT, AP Personal Finance Writer
Friday, February 6, 2009

(02-06) 11:04 PST Des Moines, Iowa (AP) --

Chances are increasing that the next fender bender you're involved in could be with someone without car insurance. As the recession leaves millions of workers unemployed and pressures family budgets, one place many are cutting is their insurance coverage.

The Insurance Research Council estimates that by next year nearly one in six motorists may be driving without insurance. That's 3 million more uninsured drivers than just five years ago.

"We can't explain why people drive uninsured, we just know that a certain percentage of people do, and it does change with economic conditions like unemployment," said IRC Vice President David Corum.

For every 1 percent increase in unemployment nationwide, the percentage of uninsured motorists increases three-quarters of a percentage point, Corum said. That could result in a total of 16.1 percent by next year, an all-time high. The rate was 13.8 percent in 2007.

The group examined data collected from nine insurance companies, representing about 50 percent of the U.S. private passenger auto insurance market.

The Travelers Cos. Inc. reports it has seen a slight increase recently in uninsured claims and warns against dropping insurance as a way to save money.

"Not having auto coverage could mean financial ruin if you are in an accident where property is damaged or individuals are injured," said William Pearse, the St. Paul, Minn. company's vice president of product strategy and design.

Pearse notes it's equally important to carry liability insurance that covers people in the other car and to have uninsured motorist coverage on your policy, which protects you if the other car isn't insured.

The average cost for liability insurance in the U.S. is around $40 to $50 a month. Although costs can vary, uninsured motorist coverage typically adds from seven to 10 percent to an insurance premium.

Drivers without at least liability insurance are breaking the law in all but two states.

Wisconsin and New Hampshire only require motorists to provide proof th at they can pay minimal levels of damage, according to the Insurance Information Institute. Proof may include a surety bond or a certificate of self insurance, which is often purchased through the state's motor vehicle agency or a certificate of deposit.

Bloomington, Ill.-based State Farm Insurance Cos. is already seeing an increase in the number of accidents involving uninsured drivers.

The average payment on claims in accidents involving an uninsured driver is about $11,000, according to the most recent IRC information available.

The insurance industry also is watching the level of underinsured drivers — those carrying too little liability insurance

— and has concerns this number also will spike as people seek to cut insurance costs.

More uninsured drivers also means more people will be forced to take legal action to recover damages. Many will never be fully compensated for car damage and injuries in serious accidents, said Jim Quilty, an attorney with the Crawford Quilty Law Firm in Des Moines, Iowa.

"You may have a bankrupt or insolvent defendant from whom you can't collect," he said.

Before you consider driving without insurance, you should know that the penalties may include fines, which in many states cost more than the annual premium for the minimum insurance. Some states also revoke or suspend the car registration or license of uninsured drivers and in some cases take license plates or impound vehicles. A few states may jail violators.

In five states — Alabama, Florida, Mississippi, New Mexico, and Oklahoma — nearly a fourth of the drivers had no insurance in 2007, the most recent state statistics available, the IRC said.

States with the lowest uninsured driver estimates were Maine, New York, North Dakota, and Vermont, which all had less than 6 percent of drivers with no insurance. Massachusetts was the lowest, with just 1 percent.

Mark Martin, who runs an auto body shop in Ankeny, Iowa, on the northwest edge of Des Moines, said some of his customers have fallen victim to uninsured drivers.

"We do see that. I can't say that we've seen a higher percentage of that yet, but it's a problem," he said.

He experienced firsthand the frustration when an uninsured driver rear-ended his Lincoln Mark VIII a few years ago.

Damage came to about $3,500 and after his $1,000 deductible was taken out, about $2,500 remained to be collected. Martin said he was very frustrated when his insurance company decided not to go after the driver for the money. Martin ended up not filing the claim and later fixed the car himself.

"I didn't want to have a nervous breakdown over it so I just decided not to do anything and later on I repainted the whole car, so I fixed it at that point," he said.

While you may have a clean driving record, more than 6 million crashes were reported to police nationwide in 2007 and The National Highway Transportation Safety Administration estimates 10 million or more crashes are never reported to police each year.

http://sfgate.com/cgi-bin/article.cgi?f=/n/a/2009/02/06/financial/f110413S86.DTL

Polsinelli Shughart PC

Memorandum

TO: THE HONORABLE CLARK SHULTZ, CHAIRMAN
HOUSE INSURANCE COMMITTEE

FROM: WILLIAM W. SNEED, LEGISLATIVE COUNSEL
THE STATE FARM INSURANCE COMPANIES

RE: S.B. 260

DATE: MARCH 17, 2009

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I represent State Farm Insurance Companies ("State Farm"). State Farm is the largest insurer of homes in the United States and Kansas. We appreciate the opportunity to testify on S.B. 260. S.B. 260 restricts the tort liability of financially responsible Kansans who are involved in accidents with uninsured or drunk drivers. It limits the recovery of an uninsured vehicle owner who is driving an uninsured motor vehicle or an intoxicated driver to economic damages.

One of the perceived inequities of the tort system as it applies to motor vehicles is that an injured insured person has little hope of recovering from the at-fault driver for his or her injury if that driver is uninsured. On the other hand, after an auto accident, an uninsured injured person may make a claim against a financially responsible tortfeasor with a reasonable degree of certainty that he or she will recover not only out-of-pocket expenses but also non-economic intangible loss such as pain and suffering. The tort system, in effect, gives the uninsured a "free ride" entitling them to take advantage of a compensation structure to which they do not contribute. Responsible Kansans, by contrast must purchase increasingly expensive uninsured motor vehicle insurance in order to be fully protected for accidents caused by uninsured drivers.

S.B. 260 addresses this inequity by limiting the recovery of a driver of an uninsured motor vehicle, who is also the owner of a vehicle that does not comply with the Kansas Auto Reparations Act, to economic damages. Approximately 9% of all Kansas motorists are uninsured. (Source: study commissioned by the Insurance Research Council.) One of the purposes of this bill is to provide an incentive to uninsured owners and drivers to purchase insurance so they will pay their fair share of auto accident compensation costs. This sharing of costs enhances insurance affordability. In addition, S.B.260 has the potential of reducing insurance costs and the personal liability of insured Kansans, because the percentage of claim dollars now going to uninsured drivers will no longer be paid.

The Kansas Department of Transportation reported that in 2003, there were 2,280 injuries and 97 fatalities in alcohol related auto accidents. On average there are 9 alcohol related crashes per day in Kansas. Kansas has lowered the blood alcohol level to .08. In 1996, Kansas enacted

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stiffer penalties for those convicted of driving under the influence. Kansas also imposes stiffer fines and longer jail sentences on repeat offenders. These same individuals are able to avail themselves of the all the tort remedies that the law allows. Financially responsible Kansans are forced to compensate drivers whose intoxication may have contributed to the loss.

S.B. 260 was acted on favorably by the Senate Financial Institutions and Insurance Committee, and it passed the full Senate 37-3.

S.B. 260 redresses systemic fairness issues inherent in the current tort system, encourages the purchase of insurance, reinforces drunk driving laws by limiting the recovery of intoxicated drivers and enhances insurance affordability. State Farm appreciates the opportunity to speak to the Committee on this issue, and we respectfully urge the Committee to pass this bill out of committee.

Respectfully submitted,

William W. Sneed

WWS:kjb

FARMERS

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Bus. 913-234-3902

March 17, 2009

To: **Representative Clark Shultz, Chairman**
House Insurance Committee

From: **Lee Wright, Senior Governmental Affairs Representative**

Re: **Testimony on Senate Bill 260 – No Pay, No Play**

Position: Support

Chairman Shultz and members of the Committee, my name is Lee Wright and I am representing Farmers Insurance. Thank you for this opportunity to appear in support of SB 260. This legislation is often referred to as "No Pay, No Play".

The concept of the legislation is relatively simple. If an uninsured driver is involved in a vehicle accident, they are restricted to recovering only their economic damages. Economic damages would include medical expenses, lost wages, and property damage. The uninsured driver is not eligible to receive compensation for non-economic damages (pain and suffering).

Currently, California, Michigan, Louisiana New Jersey and Alaska have No Pay, No Play laws in place. No Pay, No Play legislation is also being considered this year in several of our border states.

SB 260 would also preclude a person involved in an accident and convicted of DUI from recovering for non-economic damages.

In addition, the interim Kansas legislative task force on Electronic Motor Vehicle Financial Security Verification Systems recommends supporting No Pay, No Play legislation.

At this time, I would like to introduce Bren Abbott from Farmers branch legal office. Bren can provide the Committee additional information as his practice handles motor vehicle accident claims involving uninsured motorists on a regular basis.

Thank you.

House Insurance
Date: 3-17-09
Attachment # 29

BRAD SMOOT
ATTORNEY AT LAW

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STATEMENT OF BRAD SMOOT, LEGISLATIVE COUNSEL
AMERICAN INSURANCE ASSOICATION
HOUSE INSURANCE COMMITTEE
REGARDING 2009 SB 260
MARCH 17, 2009
(Written Only)

Mr. Chairman and Committee Members:

I am writing on behalf of the American Insurance Association (AIA), a trade association comprised of over 350 member companies which write all lines of property and casualty insurance in all 50 states. AIA member companies write approximately 25% of the total auto insurance market in Kansas

As a member of Kansas Electronic Motor Vehicle Financial Security Verification Task Force which unanimously recommended SB 260, AIA strongly supports this legislation known as the "no pay, no play" bill. As the numbers of uninsured motorists climb nationwide, we applaud this effort to place some of the consequences of driving uninsured with those very motorists who have chosen to ignore Kansas's existing legal obligations. While not a complete solution for uninsured driving, placing some of the burden with those who chose to ignore their obligations should, of course, help encourage them to take the prudent and required step of maintaining minimum automobile insurance.

Moreover, such an approach should provide some relief for those Kansans who did the responsible thing and obtained the required insurance. Every uninsured driver involved in an accident can impact every Kansan who has obtained automobile insurance because those responsible Kansans often obtain uninsured motorist coverage to protect them against the risk posed by uninsured drivers. Not surprisingly, then, the cost of uninsured motorist coverage can be closely tied to the likelihood of accidents with uninsured drivers. Thus, people who drive without auto insurance can cost prudent drivers even more.

While some may have concerns about SB 260, we believe it is important to underscore what SB 260 would and would not do. SB 260 would only limit the ability of people to recover noneconomic damages for failing to maintain minimum automobile insurance. It would not preclude an injured person (who, incidentally, had not met their legal obligations) from pursuing claims for medical bills, lost wages or lost future income. Consequently, we think the bill strikes a fair balance and one that will encourage prudent behavior.

Finally, the changes proposed in SB 260 are neither new nor untested. Eight states already have some form of "no pay, no play"—Alaska, California, Iowa, Louisiana, Michigan, New Jersey, North Dakota and Oregon—and, indeed, legislators in more than 20 states have proposed similar laws.

AIA urges your support for SB 260. Thank you for your consideration of our views.

Brad Smoot

Brad Smoot
Legislative Council, American Insurance Association

House Insurance
Date: 3-17-09
Attachment # 30

Kansas Association of Insurance Agents

Testimony on Senate Bill 260
Before the House Insurance Committee
By Larry Magill
March 17, 2009

Thank you mister Chairman and members of the Committee for the opportunity to provide written testimony in support of Senate Bill 260 addressing uninsured drivers. My name is Larry Magill and I'm representing the Kansas Association of Insurance Agents. KAIA has approximately 550 member agencies and branches throughout the state and our members offer all types of insurance including auto. Our members are free to represent many different insurance companies.

Dealing with uninsured drivers and enforcing the auto insurance mandate are perennial issues the legislature wrestles with resolving. There are no easy answers but SB 260 will send a stronger message to those who scoff at the law and their responsibilities. They will not be able to have a full recovery from someone who was responsible and did carry auto insurance.

We support the amendment made on the Senate floor to allow a 30 day "grace period" for someone who may have unintentionally failed to make a payment and had maintained coverage for a full year prior to the lapse in coverage.

In addition, drunk drivers would not be able to collect non-economic damages in an auto accident.

The uninsured or drunk driver will still receive all their actual medical expenses, lost income and repairs to their vehicle but not non-economic damages like pain and suffering. This applies only to the driver, and not passengers.

We encourage the Committee to report Senate Bill 260 favorable for passage. We would be happy to answer questions or provide additional information.

FarmersAlliance

Insuring Rural America Since 1888

To: House and Insurance Committee

From: Richard E. Wilborn

Re: Senate Bill No. 260

Date: March 17, 2009

Mr. Chairman and Members of the Committee, I appreciate this opportunity to share our views relating to recovery of economic or noneconomic loss sustained as a result of an accident while operating an uninsured vehicle.

My name is Rick Wilborn. I am Vice President of Government Affairs for the Farmers Alliance Mutual Insurance Companies. Farmers Alliance is a Kansas domestic property and casualty company that has been operating in and committed to the State of Kansas since 1888. We also provide property and casualty insurance in eight other states.

You will have heard from a number of conferees, explaining the many benefits and empirical evidence supporting this measure. As a Kansas domestic Insurer providing auto insurance in many states, we are experiencing the increase in the number of uninsured motorists. The provisions contained in S.B. 260 provide immediate results in lowering uninsured motorist loss costs and send an immediate message to the motoring public, both Kansans and out of staters, of the consequences of not purchasing Automobile Liability Insurance that is required by law. This approach eliminates the costly installation of unproven and cumbersome electronic systems at the local government and state government levels. In addition, additional costs are not incurred by Insurers and thus are not passed on to the insuring public.

I respectfully urge your support of S.B. 260.

Thank you,

Rick E. Wilborn, CPCU

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MEMBER: COMMERCE
LOCAL GOVERNMENT
JOINT COMMITTEE ON ARTS AND CULTURAL RESOURCES

email: Oletha.Faust-Goudeau@senate.ks.gov

Testimony in Opposition to Senate Bill 260

Presented to the House Insurance Committee
March 17, 2009

Chairman Schultz, Esteemed Colleagues,

We are experiencing an economic downturn that is unprecedented in the lives of most of us. Jobs are being lost through no fault of the worker, and people are filing bankruptcy in droves. It is said that many families are only one lost paycheck away from ruin. In these times, the credit scores of people who have been spotless for years are going to be downgraded.

Given the current practice of insurance companies setting their premiums partly based on the credit score of the insured, we can expect to see more and more people driving without insurance, not because they are deadbeats, but only because life has temporarily beaten them down. To strip them of their rights to sue when they are involved in a car accident, is heartless to say the least.

That is why I voted against SB 260 on the Senate floor and it is why I am speaking against it today. In fact, I believe this is such a bad practice that I urge you, when you work the bill, to consider adding in the language from SB 206. SB 206 prohibits this cruel practice of adding insult to injury by increasing automobile insurance premiums because a family has had a temporary financial crisis and their credit score has been lowered. We can't help everyone who loses a job, but let's lift at least this burden from their shoulders.

Thank you for your time and your consideration of this matter.

Oletha Faust-Goudeau
Senator, 29th District

KANSAS ASSOCIATION FOR JUSTICE

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Your rights. Our mission.

To: Representative Clark Shultz, Chairperson
Members of the House Insurance Committee

From: Terry Humphrey & Callie Denton Hartle
F. Russell Peterson, Peterson Law Offices LLC, Overland Park

Date: March 17, 2009

Re: SB 260 As Amended by the Senate
An act concerning insurance; relating to the recovery of economic or non-economic loss--**OPPOSED**

The Kansas Association for Justice is a statewide nonprofit organization of attorneys who serve Kansans seeking justice. Our association's position on SB 260 As Amended by the Senate is OPPOSED.

Under SB 260, insurance companies would not have to pay non-economic damages to drivers of uninsured vehicles for injuries the driver suffers in an auto accident, even if the accident was not the uninsured motorist's fault. Non-economic damages are awarded by juries for injuries such as severe pain, disfigurement, and physical impairment. Under Kansas law, set in 1987, non-economic damages are limited to $250,000.

SB 260 is fatally flawed and should not advance. KsAJ does not condone failure to comply with Kansas laws requiring auto insurance. But SB 260 should not advance because it is significantly and fatally flawed.

SB 260 will not cause one person to buy and maintain mandatory auto coverage. Most average citizens don't even know what non-economic damages are, which means it is not likely that they consider losing them when deciding whether or not to purchase mandatory auto coverage.

House Insurance
Date: 3-17-09
Attachment # 34

SB 260 as drafted would protect the most dangerous drivers if they are fortunate enough to hurt or kill an uninsured motorist. Even if a driver is drunk or impaired, and the uninsured motorist is not at fault in any way, the uninsured motorist could still not recover non-economic damages resulting from the accident. Dangerous drivers should not be allowed to escape accountability, but that is exactly what SB 260 permits.

SB 260 is a complete wind fall for insurance companies who will no longer have to pay non-economic damages. The only ones that benefit from SB 260 are insurance companies.

SB 260 will apply even when lapses in coverage are unintentional or accidental. The Senate amendment does not fix the problem. Even though auto coverage is required by state law, insurance companies are not required to provide notice to consumers that their auto coverage has lapsed. Under SB 260, consumers have 30 days or less—not even a full billing cycle—to discover and correct any unintentional lapses in coverage. In addition, there is nothing in current law, or in the Senate amendment, that requires insurance companies to provide a "grace period" for consumers with short-term, unintentional lapses in coverage.

Kansans with a lapse in coverage are still not protected under SB 260 in the following situations:

- Consumers that pay their premium to an insurance agent and believe they have coverage, but the agent never pays the insurance company. It may be months or years before the consumer realizes they are uninsured. Consumers may not find out until they report claims following an accident, only to discover they have no coverage.
- Consumers that pay their insurance coverage with credit cards or automatic withdrawals. If the credit card is cancelled for any reason, or there is a change to the account, coverage may lapse and not may be immediately known by the consumer.
- Consumers with separate maintenance agreements (prior to a divorce.) If one spouse is responsible for paying auto premiums but fails to do so, the other spouse may have no knowledge that coverage is lapsed, or even any way to discover the lapse.
- Consumers who overlook or get behind in their bills for any reason. In these tough economic times, it is easy to imagine a cash-strapped family having to pick which bills to pay first or paying bills a few days late. Death, illness, or travel could result in a lapse in coverage that would leave unsuspecting consumers without a legal remedy following an auto accident, and they may be unable to correct the lapse within 30 days.
- Responsible citizens who don't understand the law. Drivers may intentionally not drive a vehicle because they know they have allowed insurance to lapse. However, if the uninsured motorist drives another

vehicle that is uninsured, or if they allow someone without insurance to drive their vehicle, SB 260 would apply. An example is an elderly woman that doesn't drive much, and can't afford to keep her insurance current. If her grandson is uninsured, and he drives his grandmother's vehicle without knowing the insurance is lapsed, SB 260 could apply.

SB 260 will affect not only an uninsured driver, but passengers too. The bill is drafted broadly enough to apply to passengers if the passenger has the authority to operate the vehicle and the duty to insure the vehicle. For example, if a family's coverage has lapsed and an accident occurs, SB 260 would limit not only the driver's non-economic damages (the husband) but also the passenger (wife). Other passengers that have similar duties may likewise be affected, even though they are not driving the vehicle.

SB 260 does nothing for drivers that are hurt by uninsured motorists. And current law relating to uninsured/underinsured motorist coverage (UM/UIM) is inadequate. UM coverage is an accident insurance benefit that protects a policyholder's family against bodily injury or death in a collision when the wrongdoer is uninsured or "hits and runs" and is never identified. UIM coverage is an accident insurance benefit that protects a policyholder's family against bodily injury or death in a collision when the wrongdoer carries inadequate liability coverage for the harm caused.

When a Kansas vehicle owner reviews the summary of his or her auto insurance policy and sees that the policy includes UIM coverage with limits of, for example, $25,000/$50,000, the assumption is that the policy actually provides UIM coverage in the amount of the declared limits. Unfortunately, this assumption is wrong.

Whenever the victim's UIM limit is equal to or less than the wrongdoer's liability limit, there is simply no effective UIM coverage even if the collision caused a catastrophic injury or death. Effective UIM coverage is calculated, after a collision, by subtracting the limit of the wrongdoer's liability coverage from the victim's limit of UIM coverage. Unfortunately, this calculation commonly leaves an often unsuspecting victim with no effective UIM coverage. For example, if the wrongdoer and victim both own basic auto insurance policies containing the minimum coverage mandated by Kansas law, which is often the case, the victim has no effective UIM coverage after the required computation is completed.

Kansas' minimum mandated auto liability coverage needs to be updated because it has not been increased in 36 years and it is insufficient in today's economy. The minimum auto insurance coverage limits for bodily injury or death is $25,000/$50,000 which means there is coverage of $25,000 for bodily injury to, or the death of, one person in any one collision, and a limit of $50,000 for bodily injury to, or the death of, two or more persons in any one collision. When two or

more persons are injured or killed, any one victim's access to the wrongdoer's liability coverage is still subject to the policy's limit for one person.

There are better ways to improve mandatory coverage laws that the Legislature must consider instead of passing SB 260. KsAJ believes there are better ways than SB 260 to improve mandatory coverage laws, assure there is sufficient coverage for those involved in auto accidents, and appropriate encourage compliance. We urge the Committee to abandon SB 260 and instead consider the following policy directions:

Pass stronger penalties for driving uninsured. Under current law, there are already significant penalties for failure to maintain the required coverage: fines and court costs, potential jail time and suspension of both the license of the driver and of the owner of the vehicle until damages are paid. Now, if an uninsured motorist loses their license or is jailed and cannot get to work, they risk losing their job—a significant punishment and deterrent. If the Legislature believes these penalties have become insufficient, reviewing and increasing them is an appropriate place to start, as opposed to enacting the policy of SB 260.

Fix mandatory minimum insurance laws so they protect Kansans. The current mandatory minimum benefit limits are outdated and have not kept pace with inflation. It is often the case that auto insurance settlements do not cover all the expenses that arise from an auto accident, including medical bills, property damage, and lost wages. Kansas law setting the minimum auto insurance coverage limits has not been changed for 36 years. Frequently, auto insurance coverage is not sufficient to cover all the expenses that arising from an auto accident, including doctors' bills, property damages, and lost wages, in addition to hospital charges. It is past time for the Legislature to increase the minimum coverage requirements.

Fix UM/UIM so it provides effective coverage for drivers hit by an uninsured or underinsured motorist.

Require insurance companies to provide a grace period of at least 60 days to protect consumers if they have an unintentional lapse in coverage, and to notify consumers in writing when a lapse occurs. In other types of insurance such as life, health, and long term care, insurance companies must give consumers written notice of coverage lapse and provide a grace period before coverage is cancelled. In auto insurance, there are no similar requirements, even though auto coverage is required by law.

Prohibit insurance companies from credit rating for auto coverage. In these difficult economic times, more and more Kansans will have difficulty paying their bills and maintaining auto coverage. Increased premiums due to credit rating will

just exacerbate compliance problems with mandatory auto coverage requirements.

Eliminate the caps on non-economic damages for wrongful death. A wrongful death action is a lawsuit brought on behalf of a deceased person's beneficiaries (parent, spouse, children) that alleges the death is attributable to the willful or negligent act of another. The caps of $250,000 were set in 1987 and no longer reflect today's economy.

We believe it is time for the Legislature to review the entirety of Kansas' mandatory coverage laws, including the penalties for non-compliance. Until that time, SB 260 is a step in the wrong direction.

We respectfully request that the Committee oppose SB 260.

Testimony

House Insurance Committee

March 17, 2009

Phil Ray

Dear Chairman Schultz,

I'm writing today to show my opposition to SB 260 and to replace the wording with SB 206.

I'm 54 years old and up until December of '08 had a credit score of 750+. With a medical situation I have and being laid off from my job of 11+ years of selling cars, my credit score unfortunately is in the tank. I do not feel that a person's credit score should in any way be tied to insurance rates. This is what the insurance lobbyist are calling for and it is extremely unfair for those of us who have fallen on hard times. My credit score has nothing to do with my driving abilities.

It has been implied that those with low credit scores are the ones who'll burn their car, have it stolen or wreck it for the insurance claim. Though there are people with or without good credit scores, this by no means should be an indictment on people who, as I've said, have fallen on hard times and now their credit score is in the tank. I'm asking that you gut the language of SB 260 and replace it with SB 206. A person's credit score has nothing to do with an individual's ability to drive.

May God bless,

Phil Ray
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