Approved: 2-4-09

Date

MINUTES OF THE SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

The meeting was called to order by Chairman Ruth Teichman at 9:30 a.m. on January 22, 2009, in Room 136-N of the Capitol.

All members were present.

Committee staff present:
Beverly Beam, Committee Assistant
Melissa Calderwood, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Bruce Kinzie, Office of the Revisor of Statutes

Conferees appearing before the committee:

John Federico, Lobbyist, Kansas Credit Union Association
Ron Hein, Mental Health Credentialing Coalition
Larry Magill , KAIA
Brad Smoot, Blue Cross & Blue Shield of Kansas and KC (Attachment 1)
Marlee Carpenter, Kansas Association of Health Plans (Attachment 2)
Rachelle Colombo, Sr. Director of Legislative Affairs, Chamber of Commerce (Attachment 3)
Amy Campbell, Kansas Mental Health Coalition (Attachment 4)
Michelle Sweeney, Association of Community Mental Health Centers of Kansas (Attachment 5)
Rick Cagan, Executive Director, National Alliance on Mental Illness (Attachment 6)
Ira Stamm, Phd. (Attachment 7)
Dan Murray, Kansas State Director, NFIB (Written only) (Attachment 8)

Others attending:
See attached list.

The Chair welcomed everyone to the meeting and called for bill introductions.

Bill introductions

John Federico, Kansas Credit Union Association, stated that during the 2008 legislative session, the KCUA engaged in negotiations seeking changes to the credit union statute. He said they were encouraged to sit down with the proponents of the bill in hope of finding compromise language. Late in the session, they did, he said, and eventually the bill was signed into law. He noted, however, that since that time, it was discovered that there were some ambiguities in the new law. He said the bill being introduced is a clean-up bill that seeks to remove those ambiguities and do nothing more than capture the intent of the agreement reached last year. He said the language in this bill draft was agreed upon after three or four meetings with KBA and after consultation with the Community Bankers, Heartland Community Bankers Association and the Credit Union Administration. We seek introduction as a committee bill, he said.

Senator Masterson moved introduction of the bill. Senator Kelsey seconded. Motion passed.

Ron Hein, representing Kansas Mental Health Credentialing Coalition, said he was only requesting introduction of Sub HB 2601. He noted that currently, the law requires reimbursement of two of the mental health providers licensed by the regulatory board which are social workers and psychologists. Mr. Hein said this bill would add the other three master's level providers who are licensed by the BSLC which diagnose and treat mental disorders and would make it so insurance companies could not discriminate against them with regard to reimbursement of such mental health services.

Senator Steineger moved introduction of the bill. Senator Masterson seconded. Motion passed

Larry Magill, KAIA, requested legislation that would close the records maintained by the Division of Workers's Compensation. Mr. Magill said it was discovered last session that this was not closed currently and the division has had some people request the entire data base of all Kansas businesses, which we don't think was the intent of the Kansas Legislature. Our amendment would simply close the records except for the purpose it was intended which is to identify individual employer coverage and for administration of the

act by the Division of Worker's Compensation.

Senator Brownlee moved introduction of the bill. Senator Barnett seconded. Motion passed.

COMMENTS ON HEALTH INSURANCE MANDATES

Brad Smoot, representing Blue Cross and Blue Shield of Kansas and Blue Cross and Blue Shield of Kansas City, commented that Kansas statutes regarding health insurance framework provide an orderly and studious methodology for considering the endless list of mandates proposed each year. The required cost/benefit analysis; test tracking of any proposed mandate on the state employees' health care plan and the five-year review of existing mandates reflect the Legislature's respect for the premium payers, and those employers, employees and families who must pay for the cost of health insurance. Mr. Smoot discussed three questions: First, What is Health Insurance? Second, Where to Draw the Line? Third, Who is affected by state mandates? Mr. Smoot said BCBS understands the needs and desires of those who advocate for state mandates. He said BCBS employees have the same ailments and healthcare cost issues that other Kansans have but, BCBS also understands that the biggest problem in health insurance is the rising cost of coverage for many. He said BCBS is appreciative that the Kansas Legislature is willing to be careful about adding additional burdens to premium payers across the state. (Attachment 1)

Marlee Carpenter, Executive Director, Kansas Association of Health Plans, commented that health insurance mandates were enacted to force health insurance companies to cover a service or type of provider that companies have refused to cover. She said many of the health insurance mandates that have been offered over the last few years are services currently covered by health plans in Kansas. Ms. Carpenter said there is much debate around the cost of health insurance mandates. She said while actuaries, insurers, and health economists agree that virtually all mandates increase the cost of health insurance, the magnitude of their effects has been subject to debate. She noted that every health insurance mandate is brought to the legislature with good intention, but as additional mandates have been enacted, health insurance companies have become limited in the types of lower cost plans they can offer. She said mandates place additional requirements upon health insurance companies in Kansas and limit their ability to offer new, innovative and lower cost health insurance products. In conclusion, she said Kansas Association of Health Plans requests that as the committee looks at newly proposed health insurance mandates, it consider the impact they will have on the health and insurance market and ability to offer cost effective insurance products to Kansas citizens. (Attachment 2)

Rachelle Colombo, Senior Director of Legislative Affairs, Kansas Chamber of Commerce, commented that the Chamber represents small, medium and large employers all across Kansas. She said managing health care costs remains one of the top three issues affecting profitability as identified by Kansas CEOs surveyed in the Chamber's annual CEO poll. She said the Kansas Chamber supports meaningful health care reform aimed at lowering the overall cost of health care so it is more affordable for employers. She continued that because of the increased cost they often induce, the Chamber generally opposes health care mandates and supports efforts to reduce the number of cost-increasing mandates insurers are required to provide in policies. She said before employers are burdened with increasing premium costs fattened by mandates and forced to shoulder the cost of an even greater health care bill, we should study the financial and physical impact of new mandates on the market and the health of individuals. She said the Kansas Chamber and its members believe that before higher premiums on employers are imposed, additional mandates should meet the financial impact requirements paid out in statute so their cost can be accurately determined. (Attachment 3)

Amy Campbell, Kansas Mental Health Coalition, commented that in 1977, the Kansas Legislature recognized the importance of treating mental illness and required health insurance policies to provide such treatment under a specifically prescribed formula. She said stigma against people with mental health issues was prevalent at the time, and without the action of the Legislature, coverage for treatment was nonexistent. She said coverage for nervous and mental conditions includes very specific coverage specifications for the treatment of mental conditions not covered by the 2001 Kansas Mental Health Parity Act. She said this statute includes annual and lifetime limits that are much more restrictive than those applied to other health conditions, but were considered progressive at the time. She noted that in 2001, the legislature amended the statutes to pass the Kansas mental health parity act, which attempts to provide equal coverage for diagnosis and treatment of certain mental illnesses. She said equal coverage requires the same deductibles, coinsurance and other limitations as apply to other covered services. She said the goal of parity is to provide coverage that is no

more and no less than coverage provided for other medical treatment. She said passage of the 2001 legislation fell just short of this goal. She said covering mental health treatment is crucial to maintaining employment and independence and empowering families to care for their children with mental health needs. She noted that in 2005, Governor Sebelius asked the Governor's Mental Health Services Planning Council to create a group to study the implementation of the mental health parity statutes. In 2008, Congress passed a new Federal Parity Act which makes changes to the way that mental health coverage is regulated for corporations providing insurance under federal regulations. Finally, she said the Kansas Mental Health Coalition supports retaining Kansas statutes that require coverage for mental health treatment. (Attachment 4)

Michelle Sweeney, Policy Analyst, Association of Community Mental Health Centers of Kansas, commented that one in four adults experience a mental health disorder in a given year. She said group health insurance companies who offer coverage in the state must offer a minimum package of mental health services and care, both inpatient and outpatient, to policyholders. She said coverage directed under K.S.A. 40-2,103, 40-2,105 and 40-19C09, is not truly comparable with the physical health coverage provided by insurers. She said there are limits on the number of outpatient treatments and inpatient days available to insured members. She said there are also lifetime dollar limits on coverage and higher co-payments than physical coverage. She said when employees are provided treatment for mental and physical illness, the total cost of health care may be decreased for the employer. Finally, she noted that the State Employees Benefit Plan for 2008 increased coverage for mental health treatment, both inpatient and outpatient and, decreased co-payments. She said this expansion is beyond the mandate in the statute and provides state employees with better coverage and more access to mental health care treatment. She said 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. (Attachment 5)

Ira Stamm, Phd, commented that his main purpose for being there is to share information about how important mental health treatment is to our health care system. He said in 2006, he served as co-chair person of the Mental Health Services Planning Council. He said when the Kansas legislature passed mental health parity legislation in 2001, it requested that the Kansas Insurance Department do a follow-up study of the impact of mental health parity on the costs of health care in Kansas. Reviewing health care claims provided by providers from 1999 to 2002, the KID found that the costs of health care as reflected in these claims, rose less than 1% per year for preferred provider organizations and less than three-fourths of a percent a year for health maintenance organizations. Dr. Stamm said a different study published in 1999 in the Journal of the American Psychological Association reviewed the outcomes of 91 cost-offset studies between 1967 and 1997. This study of cost-offset concluded that when mental health services are available, average savings resulting from implementing psychological interventions was estimated to be about 20%. He said one study that was reviewed indicated that when patients visit a doctor with a physical complaint, 50-80% of the time the doctor can find no physical cause. He said another study showed that 20-40% of patients who report fatigue in primary care medicine suffer from depression. In summary, Dr. Stamm said the scientific data and weight of the evidence support the importance of mental health and other mandates as good public health policy. (Attachment 6)

Rick Cagan, National Alliance on Mental Illness, said millions of Americans are affected by mental illness, yet remain untreated or under-treated for their conditions. He said half of all lifetime cases of mental illness begin by age 14, three-quarters by age 24. He said despite effective treatments, there are long delays, sometimes decades, between first onset of symptoms and when people seek and receive treatment. He noted that individuals with serious mental illness face an increased risk of having chronic medical conditions. He said adults with serious mental illness die 25 years younger than other Americans, largely due to treatable medical conditions. (Attachment 7)

Dan Murray, Kansas State Director, National Alliance on Mental Illness (Written Only) (Attachment 8)

The next meeting is scheduled for 9:30 a.m., January 27, 2009.

The meeting was adjourned at 10:30 a.m.

FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST
DATE: 1-22-09

NAME	REPRESENTING
JEFF GLENDENING	KS CHAMBER
RACHELLE COLOMBO	KS CHAMBER
John Meetz	KS Ins. Dept.
Alex Kotoyantz	P.I.A.
Gary Robbins	Ks Optometric Assn
Jim Stamm	SCF
RICK CAGAN	National Alliance on Mental Illness
Marlee Carpenter	KAHP
Jarrod Forbes	UHG
Sunee Mickle	BCBSKS
Bill Sneed	AHIP
Lori Church	KAPCIC
Ethan Patterson	Little Government
ROBIN CLEMENTS	CHILD WELFARE COMPANIES
Anne Spiess	American Cancer Society
John P. Smith	KS Dept. of credit unions
Haley DaVee	KCUA
Glenda Maul	KCUA
Jarel Wright	"
John Federico	KCUA
LARRY MAGILL	KAIA
Kerri Spielman	KAIA
Amy Campbell	KMHC
Sheli Sweeney	4CMHCK

FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST
DATE: 1-22-09

NAME	REPRESENTING
Kathy Olsen	KS Bankers Assn.
Matthew Goddard	Heartland Community Bankers Assoc.
Shanelle Dupree	KHPA

BRAD SMOOT
ATTORNEY AT LAW

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Statement of Brad Smoot, Legislative Counsel
Blue Cross Blue Shield of Kansas
Blue Cross Blue Shield of Kansas City
Senate Financial Institutions & Insurance Committee
January 22, 2009

Madam Chair and Members:

On behalf of two independent Blue Plans (BCBSKS & BCBSKC) serving Kansas, I am pleased to appear today to discuss health insurance mandates. BCBSKS is a mutual life insurance company (meaning it is owned by its policyholders) serving approximately 700,000 in 103 counties and BCBSKC is a not-for-profit hospital and medical service corporation serving nearly 300,000 the counties of Johnson and Wyandotte. Other conferees have already provided the committee valuable information on the statutory framework for evaluating and changing health insurance mandates as well as volumes of statistics to assist you in understanding the costs and impact of such mandates. The Kansas statutes regarding health insurance framework provide an orderly and studious methodology for considering the seemingly endless list of mandates proposed each year. The required cost/benefit analysis; "test tracking" of any proposed mandate on the state employees' health care plan and the five year review of existing mandates also reflect the Legislature's respect for the premium payers – those employers, employees and families who must "foot the bill" for the cost of health insurance. Those of us who watch this process appreciate your thoughtful and deliberate approach. Thank you.

I'd like to focus on a handful of fundamental issues that I hope will add some perspective to the discussion: First, is the issue of "What Is Health Insurance?" Attached to my comments is a chart which attempts to illustrate the services, conditions and situations that might be considered as part of health insurance coverage during the continuum of life. In bold type are the items that have historically been accepted as within the scope of insurance coverage and at the bottom in smaller type are other areas which advocates for mandates have advanced. Health insurance coverage is an evolutionary product (e.g. maternity benefits) but it will take a lot of thought and tough decision making to draw the lines on what should be included and what should not.

That leads us to our second chart, entitled "Where to Draw the Line." On the left of the chart are the existing mandates and to the right of "the line" are those that have been proposed or discussed over the years. Coverages on both sides of the line have some merit and it is entirely understandable that advocates for such coverages would want to spread the cost of certain health care services from their family budget to the larger pool of insureds. But that leads us back to the first chart about what is health insurance; what should be just the ordinary costs of living; what should be borne by government, etc. In

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1-22-09
Attachment 1

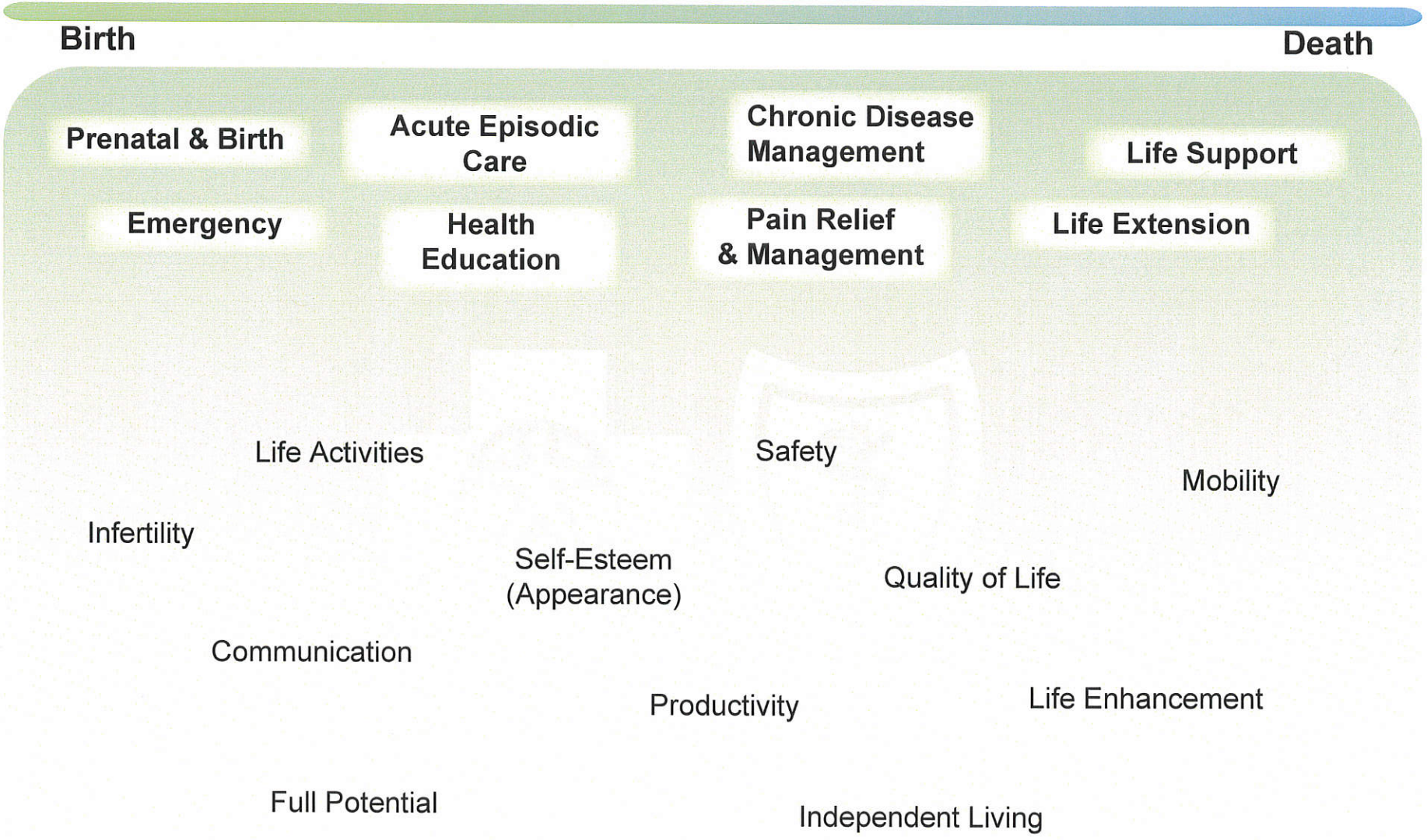
the twenty years that I've been observing this topic, I've never seen anyone advocate to remove an existing mandate or even substitute a new one for an older one. While mental health, drug & alcohol counseling, for example, may be most appropriate as mandated coverage, who would argue that pharmacy, vision or dental might not be just as important. Yet, these three basics to good health are not mandated by law and many insured Kansans don't have such coverage and can't afford it. In short, where the line is drawn today may change but it reflects as much the timing of the mandate proposals as it does a studied prioritizing of what is the optimum health insurance package.

Third on my list is the subject of "who is affected by state mandates?" Only a limited number of Kansans are immediately impacted by state mandate legislation. Only those employer groups (often small businesses) that are insured and those in the non-group (or individual) market are subject to our mandate statutes. Large self insured ERISA exempt groups, government programs such as Medicaid and Medicare as well as the uninsured are simply not within the jurisdiction of state insurance laws. And as a practical matter, those that are affected are among the most vulnerable to price increases. As you know, Kansas does not mandate that employers or individuals carry health insurance. Absent such a universal mandate, costs of premiums may and do drive employers and families to reduce coverage or drop it altogether – a phenomenon we have seen more of in recent years, giving rise to the general concern over the increasing number of uninsured and underinsured Americans.

Finally, the issue of insurance premium costs leads us to the issue of where the money goes. At BCBSKS nearly 90 cents of every dollar goes to pay for services consumed by our policyholders. Simply stated, when a new benefit or provider group is added to the policy my virtue of a state mandate, more money will be paid out and carriers will either have to reduce payments to current providers for existing services, increase co-pays and deductibles or raise premiums. It is this aspect of the mandate issue which is addressed by the statutory requirement to perform a cost benefit analysis and to test track the mandate on the state employees plan. Health care costs and the corresponding premium increases continue to rise due to underfunding of government programs; an aging population; advances in technology and medications; increasing public demand for care and other factors. Consequently, your mandate discussions are often about how much more premiums will increase and will any given mandate be worth the adverse impact on the premium payers.

BCBS plans understand the needs and desires of those who advocate for state mandates. Our employees have the same aliments and health care cost issues that other Kansans have but we also understand that the biggest problem in health insurance today is the rising cost of coverage for many and we are most appreciative that the Kansas Legislature is willing to be careful about adding additional burdens to premium payers across the state. Thank you for considering our views and I would be pleased to respond to questions.

What is Health Insurance?

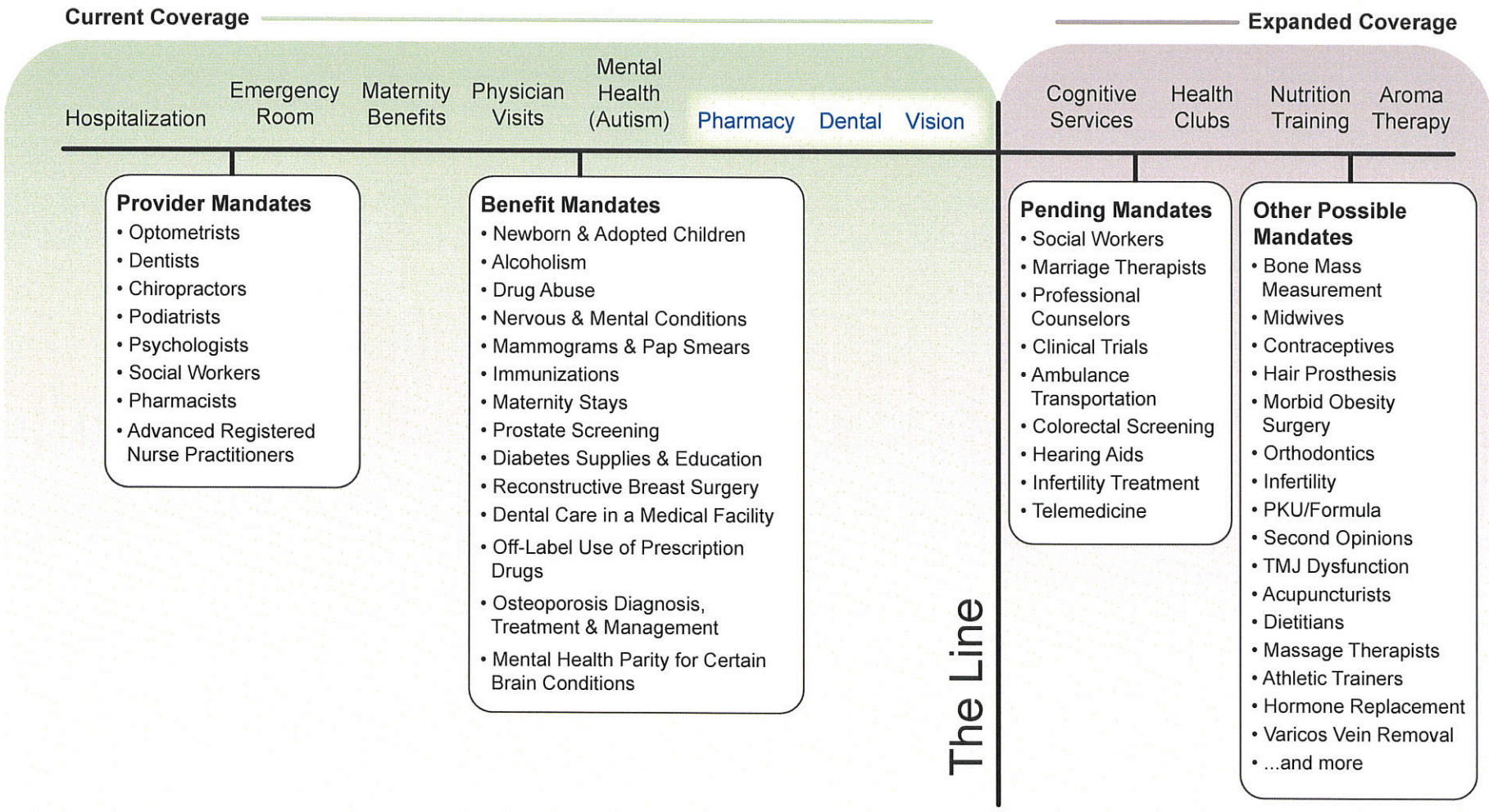


BlueCross BlueShield of Kansas*

Information prepared by Blue Cross and Blue Shield of Kansas, October 2007

h-1

Where to Draw the Line?



BlueCross BlueShield of Kansas*

Information prepared by Blue Cross and Blue Shield of Kansas, October 2007

* An Independent Licensee of the Blue Cross and Blue Shield Association.

Kansas Association of Health Plans

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January 22, 2009

Mandate Review
Before the Senate Financial Institutions and Insurance Committee
Marlee Carpenter, Executive Director

Chairman Teichman 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.

The KAHP is dedicated to providing low costs health insurance to Kansas citizens. We are committed to working with the Kansas Legislature, the Kansas Health Policy Authority and the Kansas business community on ways to reduce health insurance costs in Kansas.

KAHP is here today to provide comments about health insurance mandates. Historically, a health insurance mandate was enacted to force health insurance companies to cover a service or type of provider that companies have refused to cover. Many of the health insurance mandates that have been offered over the last few years are services currently covered by health plans in Kansas.

There is much debate around the cost of health insurance mandates. While actuaries, insurers, and health economists agree that virtually all mandates increase the cost of health insurance, the magnitude of their effects has been subject to debate. The

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Attachment 2

Council for Afforadable Health Insurance estimates that mandated benefits currently increases the cost of basic health coverage from a little less than 20% to more than 50%, depending on the state and its mandates. In Missouri, for every 1% increase in medical insurance premium costs, approximately 5,500 people lose medical insurance coverage due to their employer dropping all medical coverage due to cost. A similar conclusion in Kansas can be reached because the Missouri insurance market is similar to the Kansas market.

Every health insurance mandate is brought to the legislature with good intention, but as additional mandates have been enacted, health insurance companies have become limited in the types of lower costs plans they can offer. Mandates place additional requirements upon health insurance companies in Kansas and limit their ability to offer new, innovative and lower costs health insurance products.

The KAHP requests that as you look at newly proposed health insurance mandates that you consider the impact they will have on the health insurance market and ability to offer cost effective insurance products to Kansas citizens.

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

Legislative Testimony

achieve more

Review of Mandates

January 22, 2009

Senate Financial Institutions and Insurance Committee

Rachelle Colombo, Senior Director of Legislative Affairs

Chairman Teichman, members of the Committee:

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.

We appreciate the opportunity to provide input on the subject of health insurance mandates and the impact to the overall cost of health care. Managing health care costs remains one of the top three issues affecting profitability as identified by Kansas CEOs surveyed in the Chamber's annual CEO poll.

The Kansas Chamber supports meaningful health care reform aimed at lowering the overall cost of health care so it is more affordable for employers. Because of the increased cost they often induce, the Chamber generally opposes health care mandates and supports efforts to reduce the number of cost-increasing mandates insurers are required to provide in policies.

The Chamber's Annual Competitiveness Index is a nationwide comparison of nearly eighty economic indicators compiled to gauge Kansas's comparative business climate. This year's ACI found that Kansas improved from ranking 20th to 18th in health care cost competitiveness because our number of mandates remained constant while other states increased their mandates.

It is widely accepted that mandates increase the cost of health care but forecasting the impact of individual mandates on health care premiums before they have been enacted is difficult to determine. The specific cost of new mandates in one state is hard to extract for a number of reasons.

First, no state has zero mandatory benefits so we do not have an opposite controlled group for purposes of comparison and analysis. Second, there are national studies aimed at determining the impact of mandates on overall cost but these studies use broad averages of the number of benefits required to determine a per mandate cost.

In one such study, the Pacific Research Institute for Public Policy, a privately funded, non-profit, free market think tank found that each health insurance mandate increases the premium of a health policy by about 0.5 percent. However, because of the wide variance of definition and implementation of "mandate" from state to state, this number is truly a rough average and not a clear indicator of the cost per mandate.

According to the Council for Affordable Health Insurance mandates may currently have as much as a 12 percent impact on premium cost in Kansas. Here again, this data was derived from national data and may not accurately reflect exceptions in state mandate policy.

THE KANSAS CHAMBER

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

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Attachment 3

Though the federal mental health parody is mandated in each state, prevalence and utilization varies from state to state, resulting in different pricing and making the average unreliable. Additionally, the cost of each mandated benefit will vary dependent upon the targeted patient. There are more people who benefit from a mental health mandate for example than from a breast reconstruction mandate for obvious reasons.

Actuaries within the insurance industry in Kansas who are more familiar with the specific stipulations and cost of mandates required have estimated the overall impact of mandates on premiums to be lower than the previously mentioned statistics reflect. **Yet even a minimal increase in premium price makes health care less affordable and results in a growing number of uninsured.**

In the study previously referenced, the Pacific Research Institute found that if the cost of insurance premiums rises by 1 percent, the number of uninsured people increases by 0.5 percent. Here again, the importance of reducing the number of mandates and containing the growth of health care costs is demonstrated.

Although predicting the exact impact of new mandates on premiums before they are required on the market is unreliable, the cost impact of mandates **can** be accurately measured.

The best tool for determining the cost impact of mandates is the State Employee Health Benefit Plan Study as enacted in KSA 40-2249a. This statute stipulates that any new mandated health insurance coverage approved by the Legislature must apply onto the state health care benefits program for one year. This provides a controlled sample where the true cost of implementing a mandate can be determined.

The value of this statute can be seen in light of suggested mandates that are currently being considered. For instance, a growing number of our population is impacted by autism. In light of this fact, mandating coverage for autism prevention and treatment seems reasonable. However, determining the cost impact of such a proposed mandates which provides coverage for therapies and treatments unapproved by federal government regulatory agencies proves even more difficult to determine. If these mandates are not first implemented on a controlled sample, such as the State Employee Health Benefit Plan as prescribed in statute, there is no way to determine their cost other than by educated guesstimate.

Another good tool for determining the cost of mandates is the financial impact requirements outlined in KSA 40-2248. This statute essentially requires a cost benefit analysis to be conducted before implementation of a new mandate. Here again, when therapies and coverage are untested in a controlled sample, this impact report is at best, an informed guesstimate computed by insurers.

Before employers are burdened with increasing premium costs fattened by mandates and forced to shoulder the cost of an even heftier health care bill, we should study the financial and physical impact of new mandates on the market and the health of individuals. The state employee health benefit plan study provides an ideal environment and produces the clearest results on the financial impact of mandates on the overall cost of health care.

The Kansas Chamber and its members believe that before we impose higher premiums on employers additional mandates should meet the financial impact requirements laid out in statute so that their cost can be accurately determined.

Thank you for the opportunity to offer these comments today.

Cole Hargrave Snodgrass & Associates

A Survey of 300 Business Owners/Executives in Kansas

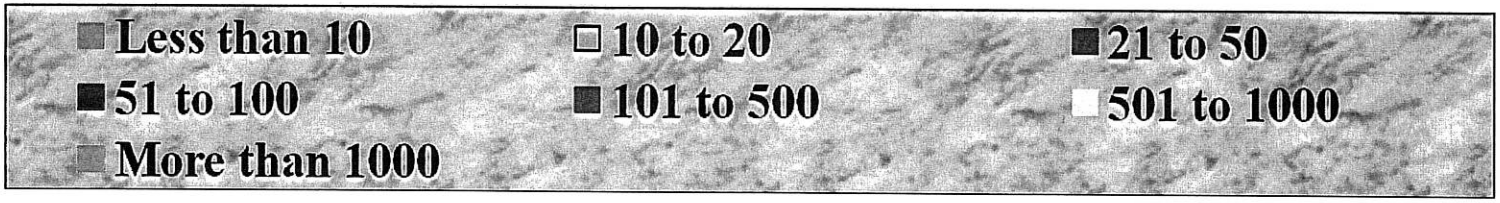
Margin of error: +/- 5.6%

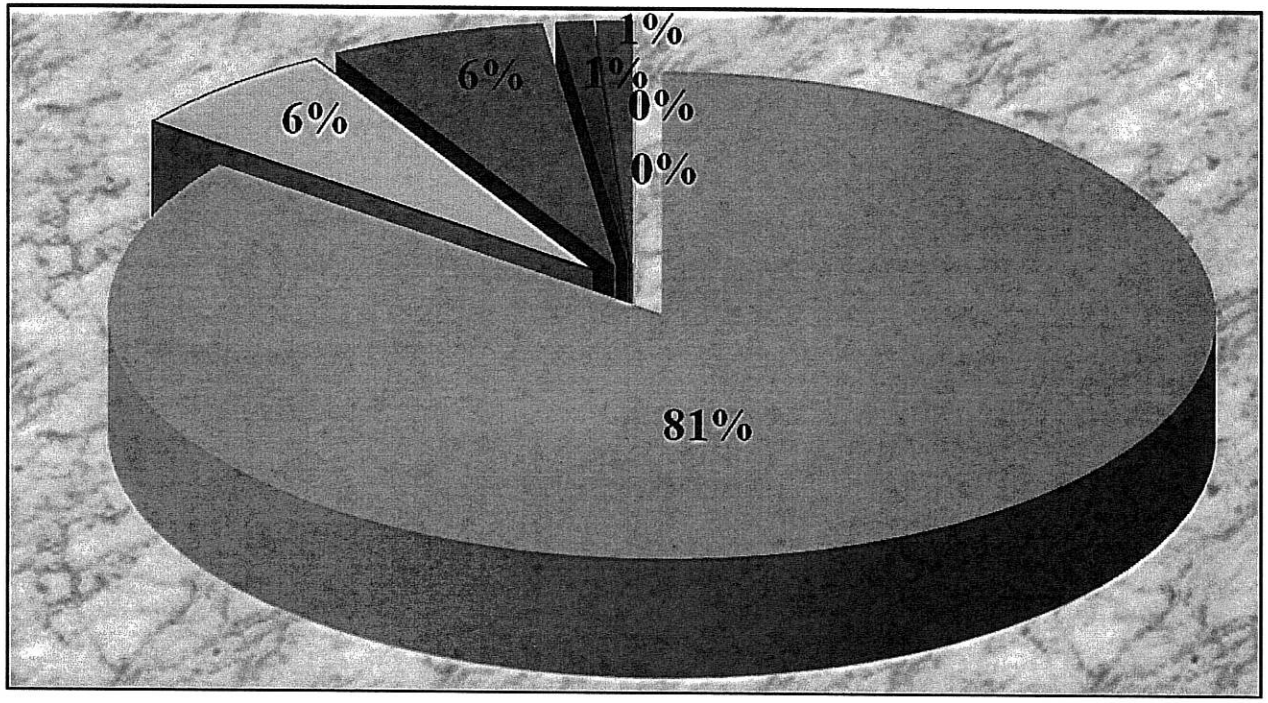
Surveys Conducted August 27 – September 3, 2008

by

Cole Hargrave Snodgrass & Associates

Number of Employees in Businesses Polled





Cole Hargrave Snodgrass & Associates

Most Important to Profitability without Fuel & Energy Costs

MENTIONED:	2008	2007	2006	2005	2004	Feb. 04
Workers' Compensation	11%	14%	13%	14%	11%	21%
Unemployment Compensation	5%	4%	4%	9%	5%	7%
Managing health care costs	37%	41%	47%	46%	42%	61%
Lower taxes on business	42%	46%	46%	39%	38%	40%
Decrease regulation/mandates	14%	18%	18%	14%	13%	19%
Stop friv. lawsuits/Tort reform	18%	18%	22%	21%	21%	20%
Limit growth of state gov.	11%	12%	7%	10%	8%	6%
Economic incentives for business	25%	21%	20%	20%	15%	10%

(2 responses accepted)

Most Important to Profitability: Including Energy Cost as an Option

MENTIONED:	Without	With
Workers' Compensation	11%	4%
Unemployment Compensation	5%	1%
Managing health care costs	37%	23%
Lower taxes on business	42%	35%
Decrease regulation/mandates	14%	13%
Stop frivolous lawsuits/Tort reform	18%	13%
Limit growth of state government	11%	16%
Economic incentives for business	25%	13%
Reduce fuel and energy costs		42%

(2 responses accepted)

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KANSAS MENTAL HEALTH COALITION

An Organization Dedicated to Improving the Lives of Kansans with Mental Illnesses

Senate Financial Institutions and Insurance Committee
January 22, 2009
"Review of Insurance Mandates"

Thank you, Senator Teichman and Members of the Committee, for the opportunity to comment on the Committee's review of insurance mandates.

In 1977, the Kansas Legislature recognized the importance of treating mental illness and required health insurance policies to provide such treatment under a specifically prescribed formula. Stigma against people with mental health issues was prevalent at the time, and without the action of the Legislature, coverage for treatment was nonexistent.

The coverage for "nervous and mental conditions" is described in K.S.A. 40-2,105. It includes very specific coverage specifications for the treatment of mental conditions that are not covered by the 2001 Kansas Mental Health Parity Act. This statute includes annual and lifetime limits that are much more restrictive than those applied to other health conditions, but were considered progressive at that time.

In 2001, the Kansas Legislature amended the statutes to pass the "Kansas mental health parity act", which attempts to provide equal coverage for the diagnosis and treatment of certain mental illnesses. "Equal coverage" requires the same deductibles, coinsurance and other limitations as apply to other covered services.

The goal of "parity" is to provide coverage that is no more and no less than coverage provided for other medical treatment. The passage of the 2001 legislation fell just short of this goal – requiring equal treatment for only a specific list of illnesses and including limits of 45 days inpatient treatment and 45 outpatient visits per year. National comparisons list Kansas as a "Limited Parity" state.

Covering mental health treatment is crucial to maintaining employment and independence and empowering families to care for their children with mental health needs. The actions of the Legislature have had a significant impact on individuals and families who need to access treatment for mental illness. Perhaps the greatest impact has been the improved coverage for families with children who are diagnosed with mental illness. Prior to its implementation, testimony was presented by families who had exhausted their insurance coverage and were forced into serious financial hardship, including one family that was forced to sell their home. Other testimony was received from a young woman who ultimately was able to graduate college once her coverage was no longer limited to treatment lasting only part of the year.

Ultimately, it is an issue of fairness and not one of mandating a specific treatment. Why should a Kansan who is paying the same premiums as another be unable to access needed treatment for their medical condition, simply because it is a brain disorder rather than a cardiac or kidney ailment?

The Kansas Mental Health Coalition is particularly concerned with the assertion that Kansas required coverage for certain mental illnesses (K.S.A. 40-2,105a) costs 5% to 10% - "the cost range estimate if the mandate were added to a policy that did not include the coverage".

Kansas has several studies analyzing actual costs of implementation in our state. One was the analysis of the impact of providing coverage in the Kansas State Employees Health Care Plan prior to the passage of the legislation in 2001. The benefits were provided in 1999 in the managed care portions of the Plan, then expanded to the full Plan in 2000. Studies of each implementation, which were used by the Kansas Legislature in its decision to ultimately pass HB 2033 in 2001, showed that making coverage for those specified serious mental illnesses available on a basis no more restrictive than that for other biologically based illnesses cost less than 1%.

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Attachment 4

-The increased cost of mental health parity to consumers, employers, and insurers is less than 1% a year. In 1999 and 2000, 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 – after implementation - mental health parity increased costs to private health plans in Kansas by less than 1% a year. (Blobaum, G., 2002, Mental health parity experience (audit) – Kansas Insurance Department)

-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)

The current statutes are due for review and update. In 2005, Governor Sebelius asked the Governor's Mental Health Services Planning Council to create a group to study the implementation of the mental health parity statutes. The resulting report of the Mental Health Parity Task Force was published November 2006 and included several recommendations for improvement to the statutes.

The Coalition urges this Committee to host a presentation of the report of the Task Force in order to learn more about mental health coverage in Kansas and where there is room for improvement.

In 2008, Congress passed a new Federal Parity Act, which makes changes to the way that mental health coverage is regulated for corporations providing insurance under federal regulation. You will be receiving information from the Kansas Insurance Department regarding those amendments.

The Kansas Mental Health Coalition supports retaining Kansas statutes that require coverage for mental health treatment. We look forward to bringing you more information as you examine this important area of the law further.

For More Information, Contact:

Kansas Mental Health Coalition

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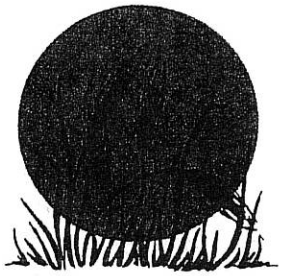
The Kansas Mental Health Coalition is an Organization Dedicated to Improving the Lives of Kansans with Mental Illnesses and Severe Emotional Disorders. KMHC is a coalition of consumer and family advocacy groups, provider associations, direct services providers, pharmaceutical companies and others, all 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 over 40 organizations which get together once a month to discuss issues of common concern and develop consensus.



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Senate Financial Institutions and Insurance Committee

Testimony on Insurance Coverage for Mental Health Treatment in Kansas

January 22, 2008

Presented by:

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

FI&I Committee
1-22-09
Attachment 5

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. 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] Per K.S.A. 40-2,103, 40-2,105 and 40-19c09, group health insurance companies who offer coverage in the state must offer a minimum package of mental health services and care—both inpatient and outpatient—to policy holders. The coverage directed under this statute is not truly comparable with the physical health coverage provided by insurers. There are limits on the number of outpatient treatments and inpatient days available to insured members. There are also lifetime dollar limits on coverage and higher co-payments than physical coverage.

The truth is, when employees are provided treatment for mental and physical illness, 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 CMCHs is from private group heath insurers. However, we believe that coverage is important for those Kansans who seek 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.

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.

Thank you for your support of mental health care and treatment for all Kansas, which includes continuation of 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.

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NAMI
National Alliance on Mental Illness

Fact Sheet

October 2007

Mental Illness: *Facts and Numbers*

Millions of Americans are affected by mental illness, yet remain untreated or under-treated for their conditions. Learn the facts about mental illness.

- One in four adults—approximately 57.7 million Americans— experience a mental health disorder in a given year. One in seventeen lives with a serious mental illness, such as schizophrenia, major depression or bipolar disorder [1], and about one in ten children have a serious mental or emotional disorder.[2]

- About 2.4 million Americans, or 1.1 percent of the adult population, lives with schizophrenia.[1]

- Bipolar disorder affects 5.7 million American adults, approximately 2.6 percent of the adult population per year.[1]

- Major depressive disorder affects 6.7 percent of adults, or about 14.8 million American adults.[1] According to the 2004 World Health Report, this is the leading cause of disability in the U.S. and Canada in ages between 15 to 44.[3]

- Anxiety disorders, which include panic disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), generalized anxiety disorder, and phobias, affect about 18.1 percent of adults, an estimated 40 million individuals. Anxiety disorders frequently co-occur with depression or addiction disorders.[1]

- An estimated 5.2 million adults have co-occurring mental health and addiction disorders.[4] Of adults using homeless services, thirty-one percent reported having a combination of these conditions.[5]

- Half of all lifetime cases of mental illness begin by age 14, three-quarters by age 24.[6] Despite effective treatments, there are long delays—sometimes decades—between first onset of symptoms and when people seek and receive treatment.[7]

- Fewer than one-third of adults and half of children with a diagnosable mental disorder receive any mental health services in a given year.[2]

- Racial and ethnic minorities are less likely to have access to mental health services and often receive a poorer quality of care.[8]

- In the U.S., the annual economic, indirect cost of mental illnesses is estimated to be $79 billion. Most of that amount—approximately $63 billion—reflects the loss of productivity as a result of illnesses.[2]

- Individuals with serious mental illness face an increased risk of having chronic medical conditions.[9] Adults with serious mental illness die 25 years younger than other Americans, largely due to treatable medical conditions.[10]

- Suicide is the eleventh leading cause of death in the U.S., and the third leading cause of death for ages 10 to 24 years. More than 90 percent of those who die by suicide have a diagnosable mental disorder.[11]

"Simply put, treatment works, if you can get it. But in America today, it is clear that many people living with the most serious and persistent mental illnesses are not provided with the essential treatment they need."

Michael J. Fitzpatrick, Executive Director of NAMI National, Grading the States, 2006 [12]

- In July 2007, a nationwide report indicated that male veterans are twice as likely to die by suicide as compared with their civilian peers in the general US population . [13]

- Twenty-four percent of state prisoners and 21 percent of local jail prisoners have a recent history of a mental health disorder.[14] Seventy percent of youth in juvenile justice systems have at least one mental disorder with at least 20 percent experiencing significant functional impairment from a serious mental illness.[15]

- Over 50 percent of students with a mental disorder age 14 and older drop out of high school—the highest dropout rate of any disability group.[16]

♦♦♦

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Testimony – Kansas Senate Committee on Financial Institutions and Insurance
Review of Mandates – January 22, 2009 – Topeka, Kansas

Good morning. My name is Ira Stamm. I am a six year survivor of prostate cancer. Regular screenings and early detection saved my life. My PSA increased from 1 to 2 to 6.5 over a several year period. The first two biopsies found no cancer. The third biopsy – done six months after the second biopsy located the cancer. I was successfully treated with radioactive seed implants and am here today to underscore the importance of early detection and mandates in our health care system.

My mother, Sylvia Stamm, was less fortunate. She died of breast cancer. Perhaps with more frequent screenings and earlier detection she would have lived to see her wonderful grandchildren.

My main purpose in being here today is to share some information on how important mental health treatment is to our health care system. In 2006 I served as co-chairperson of the Mental Health Parity Task Force appointed by the Governor's Mental Health Services Planning Council.

When the Kansas legislature passed mental health parity legislation it requested that the Kansas Insurance Department do a follow-up study of the impact of mental health parity on the costs of health care in Kansas. Reviewing health care claims filed by providers from 1999-2002, the Kansas Insurance Department found that the costs of health care as reflected in these claims rose less than 1% a year for Preferred Provider Organizations (PPOs) and less than ¾% a year for Health Maintenance Organizations (HMOs).

A different study published in 1999 in the Journal of the American Psychological Association reviewed the outcomes of 91 cost-offset studies between 1967 and 1997. This meta-study of cost-offset concluded that when mental health services are available, "Average savings resulting from implementing psychological interventions was estimated to be about 20% (p.204). One study that was reviewed indicated that when patients visit a doctor with a physical complaint, 50-80% of the time the doctor can find no physical cause. Another study showed that "20-40% of patients who report fatigue in primary care medicine suffer from depression (p.204).

Another well known study found that 40% of patients who have open heart by-pass surgery develop a Major Depressive Disorder following surgery. Treatment for the depression is an important part of the recovery process for these heart patients.

In summary, the scientific data and weight-of-the-evidence support the importance of mental health and other mandates as good public health policy. - Thank you.

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Chiles, J.A., et. al. (1999) The Impact of Psychological Interventions on Medical Cost Offset: A Meta-analytic Review, American Psychological Association, pp. 204-220

FI & I Committee
1-22-09
Attachment 7

NFIB
The Voice of Small Business®

Senate Financial Institutions & Insurance Committee
Daniel S. Murray: State Director, NFIB-Kansas
Comments on Health-Insurance Mandates
January 22, 2009

NFIB-KS advocates free-market reforms that allow small-business owners to decide which benefits they can and cannot afford to offer.

Madam 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 health-insurance mandates-an issue that is extremely important to our members.

Small business owners want to and do offer healthcare plans that cover a wide variety of benefits such as preventive care and cancer screenings. Providing these types of benefits is important to the productivity of NFIB members and their employees. However, NFIB continues to be greatly concerned by government imposed mandates that discourage consumer control and innovative health plan design.

While mandates make small business health insurance more comprehensive, they also make it more expensive. Mandates require insurers to pay for care consumers may have previously funded out of their own pockets, thereby raising the price of premium to cover the increased claims the insurer anticipates to take place as a result of the mandate.

In some markets, mandated benefits increase the cost of health insurance by as much as 45 percent. Mandating benefits is like requiring auto insurance to not only cover collisions and auto damage but to also pay for new tires, engine tune ups and oil changes. Imagine what an auto insurance policy would cost if that were the case!

Mandates, regardless of the form they take or how well intentioned, drive up the cost of health insurance, especially in the small 2-50 employee market. NFIB-KS wants small business to have affordable benefit packages that can be tailored to their workforce needs. When contemplating proposed health-insurance mandates, we urge you to consider the impact on small business. Thank you for the opportunity to comment.

FI & I Committee
1-22-09
Attachment 8

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