Approved: 2-25-09
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 February 3, 2009, in Room 136-N of the Capitol.

All members were present.

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

Conferees appearing before the committee:

Melissa Calderwood, Principal Analyst, Research Department
Linda Sheppard, Director of Accident & Health, Kansas Insurance Department (Attachment 1)
Rick Cagan, National Alliance on Mental Illness (Attachment 2)
Shelley Sweeney, Association of Community Mental Health Centers (Attachment 3)
Shirley Faulkner, Kansas Association of Addiction Professionals (Attachment 4)
Kathleen Wilson, Kansas Mental Health Coalition
Amy Campbell, Kansas Mental Health Coalition (Attachment 5)
Aimee Nienstedt, (Attachment 6)
Brenda Patzel, PhD, ARNP, Kansas State Nurses Association (written only) (Attachment 7)
Rachelle Colombo, The Kansas Chamber (Attachment 8)

Others attending:
See attached list.

The Chair called the meeting to order and welcomed everyone to the meeting.

Hearing on

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

Melissa Calderwood, Principal Analyst, Research Department, gave an overview of the bill. Ms. Calderwood stated that this bill would require health insurance policies to provide the same benefits for the treatment of alcoholism, drug abuse or other substance use disorder as it does for any mental illness. She said those benefits would include the same co-payment, co-insurance, deductible requirements, out-of-pocket expenses and other limitations as provided by other covered services. She said such coverage would include annual coverage for not less than 45 days of inpatient care for mental illness and for 45 visits for out-patient care for mental illness. This would not apply to group policies if there is an increase in the cost of the plan of at least 2.0 percent of the first plan year and 1.0 percent each subsequent plan year, she said. Further, she said passage of SB 49 would require the Kansas Insurance Department to review and approve all policies that are required to contain this coverage to assure compliance with federal requirements within the Wellstone and Domenici Mental Health Parity Act (**HR 1424**). She noted that the agency states that the bill cold be implemented within existing budget and staffing resources. She said the Kansas Health Policy Authority indicates te federal requirements of **HR 1424** will be applied to the State Employee Health Plan beginning in January 2010, which will have a greater fiscal effect than the requirements of **SB 49.** She said KHPA states the agency would implement **SB 49** within existing staff and resources.

Linda Sheppard, Director of Accident & Health, Kansas Insurance Department, testified in support of **SB 49**.
Ms. Sheppard stated that 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. She said since 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. (Attachment 1)

Rick Cagan, Executive Director, National Alliance on Mental Illness - Kansas (NAMI) testified in support of **SB 49.** Mr. Cagan stated that as advocates for the mentally ill and their families, NAMI Kansas asserts that parity is good public policy because early diagnosis and treatment work. He said treatment and therapy promote recovery, including maintaining employment, which allows consumers to maintain private insurance coverage, community integration and support services, marital and family relationships, and stable housing. He said besides being fair, experience tells them that full mental health parity is affordable, reduces overall health costs, and increases productivity in the workplace. (Attachment 2)

Michelle Sweeney, Policy Analyst, Association of Community Mental Health Centers of Kansas, Inc. (CMHCs) testified in support of **SB 49**. She stated that **SB 49** would ensure that group health insurance coverages includes mental health coverage at the current levels. She said addition, they are pleased to see that the bill includes coverage of substance abuse treatment. She noted that research from the Journal of the American Medical Association shows that roughly 50 percent of individuals with severe mental disorders are affected by substance abuse as well. She said the Association supports the inclusion of treatment for substance use inpatient and outpatient treatment. (Attachment 3)

Shirley Faulkner, Kansas Association of Addiction Professionals, testified in support of **SB 49.** Ms. Faulkner stated SB 49 does add substance use disorders to the current statutes and to some extent places substance use disorders in the same categories of other mental health disorders. She said KAAP would suggest two changes to the bill. First, to add terms "or alcoholism, drug abuse or other substance use disorder" and second, amend the bill to include language "to require coverage for substance use disorders treated in outpatient, residential, or social detoxification settings. (Attachment 4)

Amy Campbell, Lobbyist, Kansas Mental Health Coalition, testified in support of **SB 49.** She stated that it is critical that the Kansas Legislature pass a parity bill which applies to health plans that provide medical, surgical and mental health benefits. She said it is also critical that they 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. Continuing, Ms. Campbell said it is critical that the Kansas Legislature ensure that within these plans that the financial requirements that apply to mental health benefits are no more restrictive than those applied to all medial and surgical benefits, including deductibles, copayments, coinsurance, out-of-pocket expenses and annual and lifetime limits and prevent plans from establishing separate cost-sharing requirements that are applicable only to mental health benefits. (Attachment 5)

Aimee Nienstedt, testified in support of **SB 49** on her own behalf. After telling her story, she said every day, people in serious need of treatment are denied coverage. She said because of this, she was urging the Committee to take a serious look at how mental health policies and eligibility requirements are written in order to receive benefits. (Attachment 6)

Brenda Patzel, PhD, ARNP, submitted written testimony only. (Attachment 7)

Rachelle Colombo, Senior Director of Legislative Affairs, The Kansas Chamber, submitted written testimony only. (Attachment 8)

The Chair closed the hearing on **SB 49**.

The next meeting is scheduled for February 4, 2009.

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

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: 2-3-09

NAME	REPRESENTING
Aimee Nienstedt	
Robin Clements	Child Welfare Companies
Kari Presley	Kearney & Associates
Natalie Haag	Security Benefit
Tabitha Johnson	Disability Rights Center of KS
Shanelle Dupree	KHPA
Alex Kotoyantz	P.I.A
Sarah Tidwell	KSWA
Kyle Kessler	KVC Behavioral Health
Sky Westerlund	KNASW
Bill Sneed	AHIP
Marlee Carpenter	KAHP
Bud Burke	Lilly USA
Kerri Spielman	KAIA
Sarah Westgate	Washburn University
[illegible]	KAAP and Prairie View
Susan Crain Lewis	Mental Health America of the Heartland
Amy Campbell	KMHC
[illegible] Sweeney	Assoc. of CMHC's of KS, Inc.
Lori Church	KAPCIC
Charles Bartlett	SRS
John Meetz	KID
Cindy Hermes	KID
Linda Sheppard	KID

FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: ________________________

NAME	REPRESENTING
John C. Bottenberg	ValueOptions
Stuart Little	Ks Assoc of Addiction Prof
Larry Magill	KAIA
Dan Murray	NFIB

Kansas Insurance Department

Sandy Praeger, Commissioner of Insurance

TESTIMONY ON
SENATE BILL No. 49

COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE
February 3, 2009

Madam Chair Teichman 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 Linda Sheppard and I am Director of 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.

FI & I Committee
2-3-09
Attachment 1

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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.

Linda J. Sheppard, Director
Accident & Health Division, Kansas Insurance Department

Senate Financial Institutions and Insurance Committee

February 3, 2009

Presented by:
Rick Cagan
Executive Director

Madame Chair 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 the individuals who are living with mental illnesses as well as the 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 the butt of jokes 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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FI&I Committee
2-3-09
Attachment 2

pitalizations, 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 the mentally ill and their families, NAMI Kansas asserts that parity is good public policy because early diagnosis and treatment work. Treatment and therapy promote recovery – including maintaining 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.

We urge you to provide a hearing for the legislation which has been drafted to provide parity for mental health treatment in Kansas. 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.

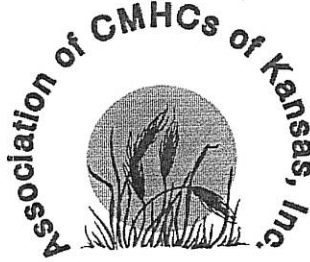
The Task Force classified its recommendations into two categories:

Elimination of barriers to mental health parity within the framework of the existing statutes

- 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.

Elimination of barriers to mental health parity that require legislative changes

- 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.



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Senate Financial Institutions and Insurance Committee

Testimony on
Senate Bill 49

February 3, 2009

Presented by:

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

FI&I Committee
2-3-05
Attachment 3

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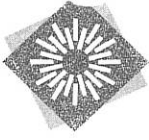
[1] U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 1999, pp. 408, 409, 411.

[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.



Prairie View
Behavioral & Mental Healthcare

February 03, 2009

To: Senate Financial Institutions and Insurance Committee
Re: 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 mental health and substance use disorders.

The Kansas Association of Addiction Professionals (KAAP) began in 1974 and is the statewide organization of over 850 members including individual clinicians in private practice and larger treatment centers and programs who provide counseling, therapy and treatment to individuals and families experiencing addiction and other mental health disorders.

Our profession includes professionals in the fields of gambling addictions, prevention and treatment counselors, mental health clinicians licensed by the BSRB to practice independently, and other professionals such as educators, court supervision officers and members of special populations. KAAP provides education and certification in the addiction and prevention field and assists our members with providing the most up-to-date, science based services of the highest quality to our clients, their families and our communities.

KAAP and our statewide members are concerned about the growing need and continued failure and inability of the state and private insurance to effectively address addiction and mental health disorders in a manner that promotes public and private safety, and respect and dignity to the persons seeking those 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% 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 eligible for state-funded services;**

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McPherson, KS 67460-2318
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9333 E. 21st St. N.
Wichita, KS 67206-2927
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FI & I Committee
2-3-09
Attachment 4

- **An estimated 12,791 out of 225,155 persons in need of care for only addictions (not including those dual diagnosed individuals with addiction and mental health disorders) 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 agree on unmet needs in the substance abuse 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 in the same categories of other mental health disorders.

KAAP would suggest two changes to the bill:

1. **Add terms "*or alcoholism, drug abuse or other substance use disorder*" to page 1, line 19, and page 1, line 21 to ensure that substance abuse issues are equitable with mental illness;**
2. **We propose the bill to be amended to include language "*to require coverage for substance use disorders treated in outpatient, residential, or social detoxification settings*" as these are valuable modalities in the continuum of care and treatment.**

KAAP agrees with the Visions November, 2008 Special Issue: Analysis of H.R. 1412 statement as follows:

"There are important symbolic benefits to the new parity law regardless of its effects on utilization – it is now the universal "law of the land" that mental health and substance abuse disorders are "real" health conditions and deserve the same benefits as other diagnoses. Consumers can be confident that mental health and substance use disorders are included in their health plans and covered at the same level as their other benefits. This has the long-term potential to reduce stigma and help bring addiction treatment into the mainstream of the U.S. health care system."

We ask Kansas to join other states in leadership that protects and cares for its citizens as you are aware, we cannot allow the dollar to follow the person in addiction for the long term consequences and costs will be greater than we wish to bear.

The Congressional Budget Office, which had forecast a 4 percent increase for the original broad Domenici-Wellstone proposal, estimated that the finally enacted provision would result in a cost increase of only four-

tenths of 1%. Moreover, it said after many employers reduce other mental health benefits to compensate for the cost of removing the dollar ceilings, the law would increase employer costs only sixteen hundredths of 1%.

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

Shirley A. Faulkner, M.S., LCMFT
Licensed Clinical Marriage and Family Therapist
Director of Alcohol and Substance Abuse and Employee Assistance Services
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Hutchinson, KS 67501-4864
620-662-4700

KANSAS MENTAL HEALTH COALITION

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

SENATE BILL 49
SENATE FINANCIAL INSTITUTIONS AND 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. In addition to this bill, the Coalition supports the passage of legislation to provide for full parity coverage of all mental illnesses.

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.

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- 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, text revision (DSM-IV-TR) 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 Legislative Change:
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
- Apply utilization review statutes to mental health claims

It is critical that the Kansas Legislature:

- 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 Kansas Mental Health Coalition is prepared to work with you to achieve these important goals. We urge you to pass Senate Bill 49 and to consider additional amendments to the statutes that would implement the broader parity goals above.

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.

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

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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Today I am writing you with concern about mental health policies and procedures in the state of Kansas. Six years after first receiving an official mental health diagnosis, I still struggle with issues related to Anorexia Nervosa and anxiety related to Obsessive-Compulsive Disorder. Therapy appointments, psychiatry check-ups, and nutrition visits still cloud my weekly calendar. Had insurance covered treatment, I thoroughly believe I would be much closer to recovery than I am currently.

Due to my co-existing disorders, residential treatment was the best option. After repeatedly being turned down for approval, I was forced to pick up a secondary insurance. My secondary insurance preapproved my stay and coverage. Two weeks into my stay at the facility, coverage was denied "due to lack of medical necessity." Six weeks after my admission, I was prematurely released due to problems with insurance.

I feel that if I would have had better insurance coverage for treatment, I would be a more productive member of society. Instead, I have been in and out of treatment, unable to attend school full time, and am socially isolated to due my disorders. In the long run, by refusing to pay for equal benefits for mental health coverage, insurance companies are paying more. If I were healthier and more able to maintain a stable lifestyle, there would be less hospital admissions, medications, and specialist appointments. Those are all effects of my eating disorder that insurance covers. In essence, Kansas insurance companies are just putting a band-aid on a gunshot wound. In fact, nutritional counseling is a major part of recovery from an eating disorder. Though would be covered – but only if I'm obese.

On behalf of myself, my parents and I completed three official appeals to Greatest Healthcare. We also appealed Blue Cross and Blue Shield of Kansas' decision four times. Each of these appeals was based on the necessity of treatment. Each of these appeals was denied. In December of 2006, we filed a formal complaint with the Kansas Insurance Department. From there, my appeal was sent to an outside expert who declared my treatment was in fact medically necessary. Even with this decision, we are still paying for much of the bill ourselves.

It is mostly established that mental health parity is no longer an "if", but "when". For many people struggling with mental health issues, the "when" is no more comforting as we're still paying thousands upon thousand out of pocket ever years. Mental illness still has a stigma attached. By refusing coverage comparable to physical needs, insurance carriers are adding to this negative out look on the mentally ill.

Every day people in serious need of treatment are denied coverage. Because of this, I am urging you to take a serious look at how mental health policies and eligibility requirements are written in order to receive benefits. Further more, legislative action is another must. I hope that you can see what significant problem mental health coverage continues to be. There is no better time then the present to step up for the citizens of Kansas.

Aimee Nienstedt

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The Voice & Vision of Nursing in Kansas

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President Susan Bumsted, MN, RN

Senator Teichman and Members of the Financial Institutions and Insurance Committee,

My name is Brenda Patzel and I am speaking on behalf of the Kansas State Nurses' Association. I am an Advanced Registered Nurse Practitioner with 30 years of experience in the mental health field. KSNA is supportive of the fact that SB 49 moves toward creating more parity in mental health insurance coverage that is in line with the Federal parity legislation. We suggest, however, that the listing is limited and would question if not all anxiety disorders, including post-traumatic stress disorder should be added.

The Kansas State Nurses Association has been supportive of the changes that were recommended by the 2006 Mental Health Parity Task Force. It is only right that the State move forward in ensuring that persons with mental illness have the same opportunities to receive appropriate treatment as those with a physical illness do. The treatment limitations for mental health should be no more restrictive than any limitations that are applied to medical and surgical treatments. The inclusion of a limited list of disorders for defining "mental Illness" may not be consistent with this intent. Insurance plans should ensure that the financial requirements that apply to mental health benefits are no more restrictive than those applied to all medical and surgical benefits and do not establish separate cost sharing requirements. Establishing "true" parity will require a bill, more extensive than SB 49; that addresses fairness in coverage for those with mental illness in our state with no question about legislative intent.

Thank you.

Brenda Patzel, PhD, ARNP

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Legislative Testimony

achieve *more*

SB 49

February 3, 2009

Senate Financial Institutions and Insurance Committee

Rachelle Colombo, Senior Director of Legislative Affairs

Chairman Teichman, members of the Committee:

We appreciate the opportunity to provide written testimony in opposition to SB 49 which mandates insurers to cover alcoholism, drug abuse and other substance use disorders commensurate with mental illness provision.

As with other mandates, the Kansas Chamber bases its opposition to this legislation on the financial impact that additional mandates have on the market and therefore the consumer.

Employers and individuals alike will be negatively impacted by the mandating of additional benefits. Data from the Kansas Chamber's annual CEO poll shows that employers want to provide health benefits for their employees but find the cost is too high. Additional mandates further increase the cost of health care and drive up premium price resulting in a growing number of uninsured.

Insurers should be able to choose which coverages they provide. Mandates prevent insurers from being able to provide lower cost plans not burdened with comprehensive benefits and better suited for portions of the population without complex health issues.

The financial impact on the market and the physical impact on the health of individuals should be studied and determined before insurers are required to provide those benefits and employers are required to cover the cost.

The Kansas Chamber opposes SB 49 because even small increases in the cost of health care are not feasible for employers and will result in a growing uninsured population.

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.

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