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STATEMENT OF BRAD SMOOT
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BLUE CROSS AND BLUE SHIELD OF KANSAS
HOUSE INSURANCE COMMITTEE
Regarding HB 2459
February 10, 2020

Mr. Chairman and Members:

Blue Cross Blue Shield of Kansas (BCBSKS) is a locally operated mutual insurance company with more than 1,600 Kansas-based employees. We have offices in 11 different Kansas communities with corporate headquarters located in Topeka, serving approximately 930,000 of your fellow Kansans in 103 of the Kansas counties. The company's service area includes all Kansas counties except Johnson and Wyandotte.

We appear today in opposition to HB 2459 as written. We sympathize with the proponents of this bill and share their desire to see better mental health and substance abuse outcomes in our state. We also appreciate lawmakers desire to do "something" to achieve this goal. But we respectfully suggest that this committee also wants to do the "right something" and not create unnecessary costs or unintended results.

Please note that I cannot and will not comment on the facts of the tragic story that gives rise to this bill. I am forbidden by federal law to discuss the matter. I can, however, discuss some federal and state requirements regarding mandates, some intricacies of the bill itself and the potential impact on customers, patients and the health insurance market. I hope this context will help you in evaluating this legislation

First, let's look at the Kansans that will be directly affected by this government mandate. Attached is a chart we prepared for the interim committee last year describing which Kansans are likely to be impacted by state mandated policy provisions. You'll note that less than 25% of your constituents are in the individual and insured employer marketplace. This is also a shrinking population for several reasons: 1) ERISA, passed decades ago, allows employers (ASO groups) to "self-insure" their employee health plans and design the benefits subject only to the rules of the federal Department of Labor; 2) the increase in short term limited duration policies, religion-based funding programs, and more recently, legislation exempting Farm Bureau policies from all state requirements, including mandates and finally; 3) the trend for even very small employers to elect to self-insure their employee plans. These factors have significantly diminished the number of Kansans who are subject to legislative health policy mandates. Any government requirement that increases costs for employers or individuals encourages Kansans to purchase plans with lesser benefits, lower costs and less government control.

Second, the bill itself raises several questions. We understand from proponents' statements that deductibles and copay requirements may be a deterrent to seeking emergency care or other treatment for some at risk mental and substance abuse patients. That topic is addressed in Section 1 but it is unclear how the suggested language would change cost sharing requirements. Current state and federal law already require these cost sharing obligations to be the "same." See page 1, line 29.

Patients may also be surprised to learn that their 14-day inpatient care or 180-day outpatient treatment required by this bill costs them $5000 or more out of pocket even if they have coverage (depending on policy type). Under the bill, utilization review by the insurer is forbidden during these times. In 2019, the average BCBSKS mental health inpatient stay was 4.3 days. Providers may have little incentive to discharge patients when payment is guaranteed by law with no review for medical necessity. In many cases, it will be the insured who pays these costs until the insurance payments kick in.

The bill does not appear to limit the number of 14-day inpatient stays that a person may have in a year or a lifetime.

Third, cost. The purpose of insurance is to spread the risk (cost) from those who use a service to those who might have but didn't. Adding a new benefit as proposed in HB 2459 is, according to the initial Fiscal Note, estimated to add $884,941 or $.99 per member per month to the SEHP plan in FY '21 and $933,613 in Fy'22. That's for the 74,490 members of the state plan. That number appears to be based solely on the mental health mandate. We estimate the cost for our customers of an additional $2.27 per member per month for the substance abuse portion of the bill, possibly raising just the SEHP cost to $3 million per year.

In any case, there will be an increase in premiums to be paid by the many thousands of individuals and/or employers impacted by the mandate. As you know, these are costs that you as lawmakers will have to appropriate for the state plan and that those in charge of cities, counties, school districts and other municipal governments will have to add to the obligations of the local taxpayers. Those taxpayer costs are not included in the Fiscal Note.

And who will pay the added costs of this mandate for the private sector? We can assume that much of it will be included in increased premiums or larger deductibles and copays paid by insureds. But there is a twist. The Affordable Care Act (ACA) requires that new state mandates enacted after the Essential Health Benefits (EHB) were established must be paid by the state of Kansas for those individuals on the Exchange receiving subsidies. This provision is designed to prevent states from increasing benefits and funding them with federal subsidy dollars. CMS just issued a proposed rule requiring states to identify any mandates adopted since December 31, 2011 and explain why they have not been paying for the increased costs of such new benefits. This feature of the ACA has been ignored for some time but the proposed rule now seems to put a burden back on states for new mandates affecting individuals on the Exchanges. This could be an added cost to the State that also is not included in the Fiscal Note.

Fourth, there is a statutorily required process for legislative consideration of health insurance mandates. Adopted in part in 1992 and expanded in 1999, the law requires any proposed health insurance mandate to go through a specified process: 1) Proponents must first submit a cost/benefit

analysis of the proposal (KSA 40-2248); 2) the requirements of the analysis are spelled out in KSA 40-2249; 3) after consideration by the legislature, the mandate must first be imposed on the SEHP to verify the information presented and the SEHP reports to the Legislature so that 4) lawmakers may determine if the mandate should be imposed on other populations of the state.

This committee honored these laws recently in considering a mandate for baby formula and is awaiting a report from the SEHP. This process is the current law of the state. This process is not being followed in HB 2459.

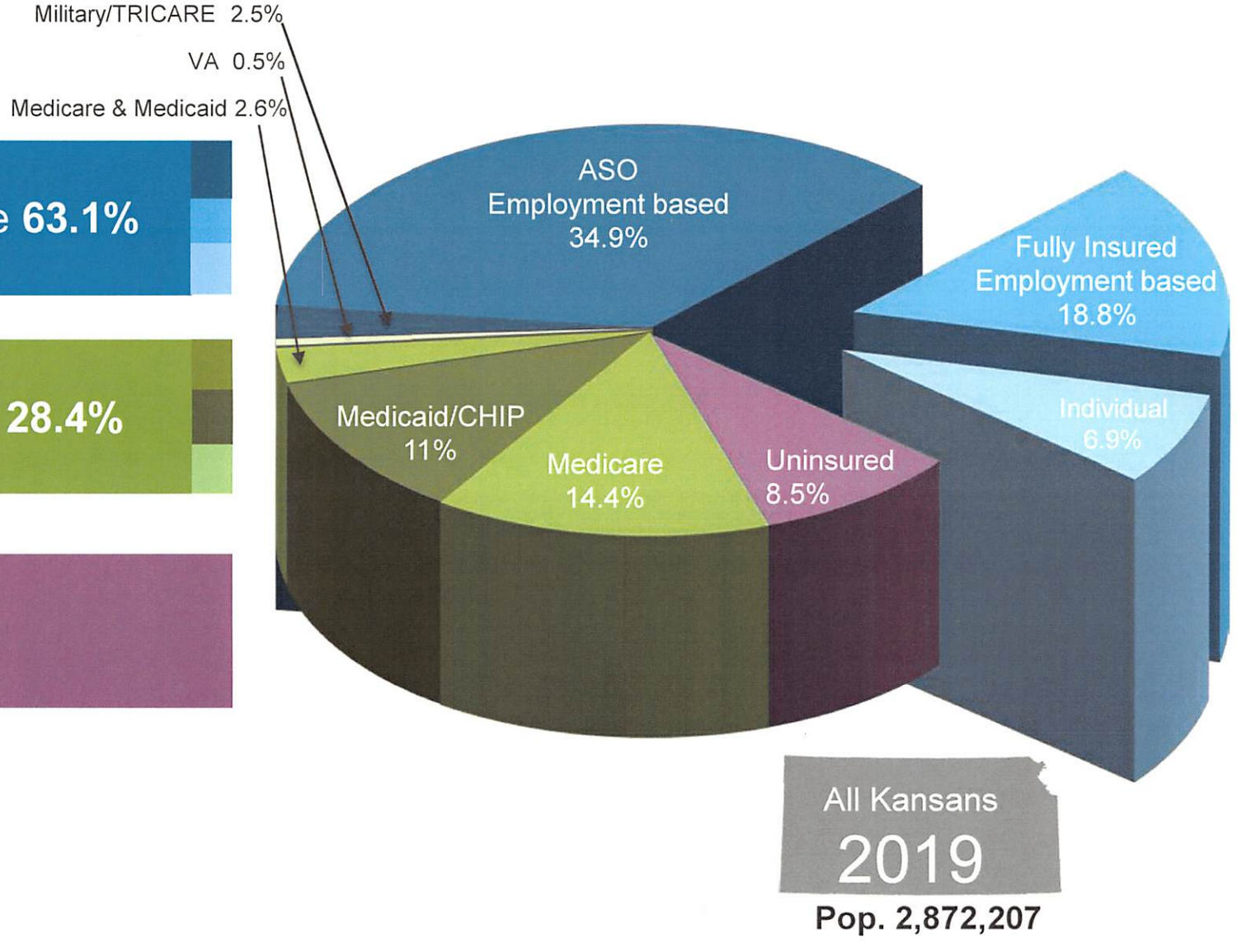
Finally, consider the rule of unintended consequences. Imposing this mandate and the corresponding cost will only drive some insureds to become uninsured, purchase cheaper, less comprehensive policies without this mandate or other valuable benefits. It may possibly change practice patterns for mental health providers or encourage patients to seek care out of state rather than utilizing available community mental health services. It creates even more unequal benefits and more confusing rules of coverage for patients and providers. It further burdens state and local taxpayers, small businesses and individuals. And maybe most importantly, HB 2459 doesn't appear to solve the problems that gave rise to it. Thank you for considering our views.

Sources of Health Insurance

Private Coverage **63.1%**

Public Coverage **28.4%**

Uninsured **8.5%**



Sources: Kansas Health Institute analysis of data from the *2017 American Community Survey Public Use Microdata Sample; Mark Farrah Associates, 2019*