Approved 2/5/91
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by SENATOR RICHARD L. BOND at
Chairperson

9:00 a.m./~~p.m.~~ on MONDAY, FEBRUARY 4, 1991 in room 529-S of the Capitol.

~~All~~ members ~~were~~ present ~~except~~:

Senators Anderson, Francisco, Kerr, Moran, Parrish, Reilly, Salisbury, Strick and Yost.

Committee staff present:

Bill Wolff, Legislative Research
Fred Carman, Revisors Office
Louise Bobo, Secretary

Conferees appearing before the committee:

None

Chairman Bond called the meeting to order at 9:12 a.m.

SB 15 - mammogram coverage in certain health and accident policies.

Chairman Bond reminded the committee that this bill was referred by the Special Committee on Insurance and that the question was whether to keep the mandates passed three years ago covering pap smears and mammography examinations. Chairman Bond then recognized Richard Morrisey, Department of Health and Environment for the purpose of explaining to the committee an amended version of SB 15. Mr. Morrisey referred to the correct citation for the federal law on Screening Mammography and also indicated Section 4163 of the Omnibus Reconciliation Act of 1990 which includes the revised language. Mr. Morrisey further continued that there would be no advantage in delaying the effective date of the bill. Mr. Morrisey also advised the committee that the state would expect to be reimbursed for the $58,000 it would cost to implement the program; however, there was no assurance of this. Attachment 1) He informed the committee that there are now 28 accredited mammography centers in the state, 76 are registered but not accredited and there are 31 non-hospital centers.

During a brief discussion, a committee member asked if BCBS would have to pay for mammogram examinations even though the examining clinic did not meet federal standards. Nancy Zogleman, BCBS, replied that her company would be required to pay for the assigned coverage. Chairman Bond informed the committee that SB 15 would "rest" in committee unless there was a motion otherwise. Senator Strick made a motion to pass SB 15 favorably with the federal requirements. The motion failed for lack of a second.

Chairman Bond announced that SB 15 would "rest" in committee.

SB 51 - relating to health maintenance organizations.

The committee chairman informed the committee of the balloned version before them which contained the new language as requested by the committee and prepared by Cheryl Dillard, Kaiser Permanente, Nancy Zogleman, Blue Cross Blue Shield, and the Insurance Department Staff. Chairman Bond pointed out the two amendments to the bill: (1) extending the right to conversion from 15 days to 30 days, and (2) the events that need to occur that would activate requirements for conversion. (Attachment 2)

Senator Reilly made a motion to accept the amendments as written. Senator Anderson seconded the motion. The motion carried.

Senator Reilly questioned why he would have the word "similar", page 2, line 15, circled. Ms. Zogleman answered that Ms. Dillard had said that "similar" and "identical" were sometimes used interchangeably but she continued that Ms. Dillard was apparently satisfied with the language in the bill.

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.

CONTINUATION SHEET

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE,

room 529-S, Statehouse, at 9:00 a.m./p.m. on MONDAY, FEBRUARY 4, 1991.

Senator Salisbury made a motion to pass SB 51 as amended. Senator Reilly seconded the motion. The motion carried.

The minutes of Wednesday, January 30 and Thursday, January 31, were approved as written on a motion by Senator Strick with Senator Parrish seconding the motion. The motion carried.

The meeting adjourned at 9:36 a.m.

GUEST LIST

COMMITTEE: FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE DATE: Mon. Feb 4, 91

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Joseph Kroll	Topeka	KDHE
Greg Rose	Topeka	KDHE
TERRY TIEDE	Topeka	Ks. Ins. Dept.
Donald W. Bond	Topeka	"
Nancy Zogleman	Topeka	BC/BS of Ks
Bill Sneed	TOPEKA	NFDA

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

DIVISION OF HEALTH

M E M O R A N D U M

TO: Fred Carmen
Assistant Revisor of Statutes

Bill Wolf
Legislative Research Department

FROM: Richard Morrissey

DATE: January 30, 1991

SUBJECT: Senate Bill No. 15

The correct citation for the federal law on Screening Mammography is 42 U.S.C. 1395x. I have attached a copy of Section 4163 of the Omnibus Reconciliation Act of 1990 which includes the revised language.

I am also attaching a list of the currently registered mammography sites in Kansas.

Chip Whelan and I are agreed that delaying the effective date of the bill would have no beneficial effect in phasing in the requirement since the federal requirement is already in effect and being implemented.

Finally, the best assurance of avoiding a future State General Fund impact Would be to not establish a state requirement at all. If Senate Bill No. 15 becomes law, even with the reference to the federal program, it is possible that the Health Care Financing Administration will conclude the cost of the program should be shared equally with the state, as is the case in other situations where federal and state regulatory requirements overlap.

Please let me know if you need anything further.

cc: Senator Dick Bond
Chip Whelan
Dr. Charles Konigsberg, Jr.
David Traster
Joe Kroll
Art Schumann

FI + I
2/4/91
Attachment 1

OBRA 1990

"(B) The Secretary may not grant such a waiver under subparagraph (A) to a facility if the request for the waiver is made less than 6 months after the date of the expiration of any previous such waiver for the facility.

"(C) A waiver which is requested under this paragraph shall be deemed granted unless such request is denied by the Secretary within 60 days after the date such request is received.".

(3) PRODUCTIVITY SCREENS.—In employing any screening guideline in determining the productivity of physicians, physician assistants, nurse practitioners, and certified nurse-midwives in a rural health clinic, the Secretary of Health and Human Services shall provide that the guideline shall take into account the combined services of such staff (and not merely the service within each class of practitioner).

(4) PRRB REVIEW OF COST REPORTS FOR RURAL HEALTH CENTERS.—Section 1878(j) of the Social Security Act (42 U.S.C. 1395oo(j)), as added by subsection (a)(6), is amended by inserting "a rural health clinic and" after "includes".

(5) EFFECTIVE DATE.—This subsection shall take effect on October 1, 1991, except that the amendment made by paragraph (4) shall apply to cost reports for periods beginning on or after October 1, 1991.

SEC. 4162. PARTIAL HOSPITALIZATION IN COMMUNITY MENTAL HEALTH CENTERS.

(a) IN GENERAL.—Section 1861(ff)(3) of the Social Security Act (42 U.S.C. 1395x(ff)(3)) is amended—

(1) by striking "(3)" and inserting "(3)(A)";

(2) by striking "outpatients" and inserting "outpatients or by a community mental health center (as defined in subparagraph (B)),"; and

(3) by adding at the end the following new subparagraph:

"(B) For purposes of subparagraph (A), the term 'community mental health center' means an entity—

"(i) providing the services described in section 1916(c)(4) of the Public Health Service Act; and

"(ii) meeting applicable licensing or certification requirements for community mental health centers in the State in which it is located.".

(b) CONFORMING AMENDMENTS.—(1) Section 1832(a)(2) of such Act (42 U.S.C. 1395k(a)(2)) is amended—

(A) by striking "and" at the end of subparagraph (H);

(B) by striking the period at the end of subparagraph (I) and inserting "; and"; and

(C) by adding at the end the following new subparagraph:

"(J) partial hospitalization services provided by a community mental health center (as described in section 1861(ff)(2)(B)).".

(2) Section 1866(e) of such Act (42 U.S.C. 1395cc(e)) is amended by striking "include a clinic" and all that follows through the period and inserting the following: "include—

"(1) a clinic, rehabilitation agency, or public health agency if,

agency meets the requirements of section 1861(p)(4)(A) (or meets the requirements of such section through the operation of section 1861(g)), or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B) (or meets the requirements of such section through the operation of section 1861(g)), but only with respect to the furnishing of outpatient physical therapy services (as therein defined) or (through the operation of section 1861(g)) with respect to the furnishing of outpatient occupational therapy services; and

"(2) a community mental health center (as defined in section 1861(ff)(3)(B)), but only with respect to the furnishing of partial hospitalization services (as described in section 1861(ff)(1)).".

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply with respect to partial hospitalization services provided on or after October 1, 1991.

SEC. 4163. COVERAGE OF SCREENING MAMMOGRAPHY.

(a) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended—

(1) in subsection (s)—

(A) in paragraph (11), by striking all that follows "(bb))" and inserting a semicolon,

(B) in paragraph (12)(C), by striking all that follows "area)" and inserting "; and", and

(C) by inserting after paragraph (12) the following new paragraph:

"(13) screening mammography (as defined in subsection (jj));"; and

(2) by inserting after subsection (ii) the following new subsection:

"Screening Mammography

"(jj) The term 'screening mammography' means a radiologic procedure provided to a woman for the purpose of early detection of breast cancer and includes a physician's interpretation of the results of the procedure.".

(b) PAYMENT AND COVERAGE.—Section 1834 of such Act (42 U.S.C. 1395m) is amended—

(1) in subsection (b)(1)(B), by inserting "and subject to subsection (c)(1)(A)" after "conversion factors", and

(2) by inserting after subsection (b) the following new subsection:

"(c) PAYMENTS AND STANDARDS FOR SCREENING MAMMOGRAPHY.—

"(1) IN GENERAL.—Notwithstanding any other provision of this part, with respect to expenses incurred for screening mammography (as defined in section 1861(jj))—

"(A) payment may be made only for screening mammography conducted consistent with the frequency permitted under paragraph (2);

"(B) payment may be made only if the screening mam-

"(C) the amount of the payment under this part shall, subject to the deductible established under section 1833(b), be equal to 80 percent of the least of—

"(i) the actual charge for the screening,

"(ii) the fee schedule established under subsection (b) or the fee schedule established under section 1848, whichever is applicable, with respect to both the professional and technical components of the screening mammography, or

"(iii) the limit established under paragraph (4) for the screening mammography.

"(2) FREQUENCY COVERED.—

"(A) IN GENERAL.—Subject to revision by the Secretary under subparagraph (B)—

"(i) No payment may be made under this part for screening mammography performed on a woman under 35 years of age.

"(ii) Payment may be made under this part for only 1 screening mammography performed on a woman over 34 years of age, but under 40 years of age.

"(iii) In the case of a woman over 39 years of age, but under 50 years of age, who—

"(I) is at a high risk of developing breast cancer (as determined pursuant to factors identified by the Secretary), payment may not be made under this part for a screening mammography performed within the 11 months following the month in which a previous screening mammography was performed, or

"(II) is not at a high risk of developing breast cancer, payment may not be made under this part for a screening mammography performed within the 23 months following the month in which a previous screening mammography was performed.

"(iv) In the case of a woman over 49 years of age, but under 65 years of age, payment may not be made under this part for screening mammography performed within 11 months following the month in which a previous screening mammography was performed.

"(v) In the case of a woman over 64 years of age, payment may not be made for screening mammography performed within 23 months following the month in which a previous screening mammography was performed.

"(B) REVISION OF FREQUENCY.—

"(i) REVIEW.—The Secretary, in consultation with the Director of the National Cancer Institute, shall review periodically the appropriate frequency for performing screening mammography, based on age and such other factors as the Secretary believes to be pertinent.

"(ii) REVISION OF FREQUENCY.—The Secretary, taking into consideration the review made under clause (i),

screening mammography may be paid for under this subsection, but no such revision shall apply to screening mammography performed before January 1, 1992.

"(3) QUALITY STANDARDS.—The Secretary shall establish standards to assure the safety and accuracy of screening mammography performed under this part. Such standards shall include the requirements that—

"(A) the equipment used to perform the mammography must be specifically designed for mammography and must meet radiologic standards established by the Secretary for mammography;

"(B) the mammography must be performed by an individual who—

"(i) is licensed by a State to perform radiological procedures, or

"(ii) is certified as qualified to perform radiological procedures by such an appropriate organization as the Secretary specifies in regulations;

"(C) the results of the mammography must be interpreted by a physician—

"(i) who is certified as qualified to interpret radiological procedures by such an appropriate board as the Secretary specifies in regulations, or

"(ii) who is certified as qualified to interpret screening mammography procedures by such a program as the Secretary recognizes in regulation as assuring the qualifications of the individual with respect to such interpretation; and

"(D) with respect to the first screening mammography performed on a woman for which payment is made under this part, there are satisfactory assurances that the results of the mammography will be placed in permanent medical records maintained with respect to the woman.

"(4) LIMIT.—

"(A) $55, INDEXED.—Except as provided by the Secretary under subparagraph (B), the limit established under this paragraph—

"(i) for screening mammography performed in 1991, is $55, and

"(ii) for screening mammography performed in a subsequent year is the limit established under this paragraph for the preceding year increased by the percentage increase in the MEI for that subsequent year.

"(B) REDUCTION OF LIMIT.—The Secretary shall review from time to time the appropriateness of the amount of the limit established under this paragraph. The Secretary may, with respect to screening mammography performed in a year after 1992, reduce the amount of such limit as it applies nationally or in any area to the amount that the Secretary estimates is required to assure that screening mammography of an appropriate quality is readily and conveniently available during the year.

"(C) APPLICATION OF LIMIT IN HOSPITAL OUTPATIENT SETTING.—The Secretary shall provide for an appropriate allo-

cation of the limit established under this paragraph between professional and technical components in the case of hospital outpatient screening mammography (and comparable situations) where there is a claim for professional services separate from the claim for the radiologic procedure.

"(5) LIMITING CHARGES OF NONPARTICIPATING PHYSICIANS.—

"(A) IN GENERAL.—*In the case of mammography screening performed on or after January 1, 1991, for which payment is made under this subsection, if a nonparticipating physician or supplier provides the screening to an individual entitled to benefits under this part, the physician or supplier may not charge the individual more than the limiting charge (as defined in subparagraph (B), or if less, as defined in subsection (b)(5)(B) or as defined in section 1848(g)(2)).*

"(B) LIMITING CHARGE DEFINED.—*In subparagraph (A), the term 'limiting charge' means, with respect to screening mammography performed—*

"(i) *in 1991, 125 percent of the limit established under paragraph (4),*

"(ii) *in 1992, 120 percent of the limit established under paragraph (4), or*

"(iii) *after 1992, 115 percent of the limit established under paragraph (4).*

"(C) ENFORCEMENT.—*If a physician or supplier knowing and willfully imposes a charge in violation of subparagraph (A), the Secretary may apply sanctions against such physician or supplier in accordance with section 1842(j)(2).".*

(c) CERTIFICATION OF SCREENING MAMMOGRAPHY QUALITY STANDARDS.—

(1) Section 1863 of such Act (42 U.S.C. 1395z) is amended by inserting "or whether screening mammography meets the standards established under section 1834(c)(3)," after "1832(a)(2)(F)(i),".

(2) The first sentence of section 1864(a) of such Act (42 U.S.C. 1395aa(a)) is amended by inserting before the period the following: ", or whether screening mammography meets the standards established under section 1834(c)(3)".

(3) Section 1865(a) of such Act (42 U.S.C. 1395bb(a)) is amended by inserting "1834(c)(3)," after "1832(a)(2)(F)(i),".

(d) CONFORMING AMENDMENTS.—

(1) Section 1833(a)(2)(E) of such Act (42 U.S.C. 1395l(a)(2)(E)) is amended by inserting ", but excluding screening mammography" after "imaging services".

(2) Section 1862(a) of such Act (42 U.S.C. 1395y(a)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (A), by striking "subparagraph (B), (C), (D), or (E)" and inserting "a succeeding subparagraph",

(ii) in subparagraph (D), by striking "and" at the end,

(iii) in subparagraph (E), by striking the semicolon at the end and inserting ", and", and

(iv) by adding at the end the following new subparagraph:

"(F) *in the case of screening mammography, which is performed more frequently than is covered under section 1834(c)(2) or which does not meet the standards established under section 1834(c)(3), and, in the case of screening pap smear, which is performed more frequently than is provided under section 1861(nn);"; and*

(B) in paragraph (7), by inserting "or under paragraph (1)(F)" after "(1)(B)".

(e) EFFECTIVE DATE.—*The amendments made by this section shall apply to screening mammography performed on or after January 1, 1991.*

SEC. 4164. MISCELLANEOUS AND TECHNICAL PROVISIONS RELATING TO PART B.

(a) EXTENSION OF DEMONSTRATIONS.—

(1) PREVENTION DEMONSTRATIONS.—*Section 9314 of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended by section 9344 of the Omnibus Budget Reconciliation Act of 1986, is amended—*

(A) in subsection (a), by striking "4-year" and inserting "5-year";

(B) in subsection (e)(2), by striking "Not later than five years after the date of the enactment of this Act, the Secretary shall submit a final report" and inserting "Not later than April 1, 1993, the Secretary shall submit an interim report";

(C) in subsection (e), by adding at the end the following new paragraph:

"(3) *Not later than April 1, 1995, the Secretary shall submit a final report to those Committees on the demonstration program and shall include in the report a comprehensive evaluation of the long-term effects of the program.";*

(D) in subsection (f), by striking "$5,900,000" and inserting "$7,500,000"; and

(E) in subsection (f), by inserting before the period at the end the following: "and shall not exceed $3,000,000 for the comprehensive evaluation referred to in subsection (e)(3)".

(2) ALZHEIMER'S DISEASE DEMONSTRATION PROJECTS.—*Section 9342 of the Omnibus Budget Reconciliation Act of 1986 is amended—*

(A) in subsection (c)(1), by striking "3 years" and inserting "4 years";

(B) in subsection (d)(1), by striking "third year" and inserting "fourth year";

(C) in subsection (f)—

(i) by striking "$40,000,000" and inserting "$55,000,000", and

(ii) by striking "$2,000,000" and inserting "$3,000,000".

(b) DISCLOSURE OF OWNERSHIP.—

2/1/91

The Honorable Dick Bond, Chair
Senate Committee on Financial
Institutions and Insurance

Mr. Chairman:

Attached is a balloon amendment to that portion of Senate Bill No. 51 which was heard by your committee last Tuesday. Both Cheryl Dillard and Nancy Zogleman have expressed agreement with the compromise language but I suspect both will be present if you take this up Monday and can state their views directly.

Incidentally, the Department is also in agreement.

Dick Brock
Kansas Insurance Department

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Attachment 2

frequency of premium payment shall be the frequency customarily required by the health maintenance organization, mutual nonprofit hospital and medical service corporation or insurer for the policy form and plan selected, except that the insurer, mutual nonprofit hospital and medical service corporation or health maintenance organization shall require premium payments at least quarterly. The coverage shall be available to all enrollees of any group without medical underwriting. The requirement imposed by this subsection shall not apply to a contract which provides benefits for specific diseases or for accidental injuries only, nor shall it apply to any employee or member or such employee's or member's covered dependents when:

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

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

(C) the employee or member is or could be covered by any other insured or noninsured arrangement which provides expense incurred hospital, surgical or medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination. Written application for the converted contract shall be made and the first premium paid not later than 31 days after termination of the group coverage *or receipt of notice of conversion rights from the health maintenance organization, whichever is later,* and shall become effective the day following the termination of coverage under the group contract. *The health maintenance organization shall give the employee or member and such employee's or member's covered dependents reasonable notice of the right to convert at least once within* ~~15~~ *days of termination of coverage under the group contract.* In addition, the converted contract shall be subject to the provisions contained in paragraphs (2), (4), (5), (6), (7), (8), (9), (13), (14), (15), (16), (18), (19)~~,~~ *and* (20) ~~and (21)~~ of subsection (D) of K.S.A. 40-2209, and amendments thereto.

(b) No health maintenance organization authorized under this act shall contract with any provider under provisions which require enrollees to guarantee payment, other than copayments and deductibles, to such provider in the event of nonpayment by the health maintenance organization for any services which have been performed under contracts between such enrollees and the health maintenance organization. Further, any contract between a health maintenance organization and a provider shall provide that if the health maintenance organization fails to pay for covered health care services as set forth in the contract between the health maintenance

EXPLANATION: This extends the time to provide notice from 15 to 30 days as suggested in Cheryl Dillard's (Kaiser Permanente) testimony.

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The group contract and certificates may include provisions necessary to identify or obtain identification of persons and notification of events that would activate the notice requirements and conversion rights created by this section but such requirements and rights shall not be invalidated by failure of persons other than the employee or member entitled to conversion to comply with any such provisions.

EXPLANATION: This incorporates the provision suggested by Nancy Zogleman (Blue Cross and Blue Shield) as well as the ability to impose some responsibility on group policyholders with regard to notifying HMOs of individual terminations or other known, related information. However, this amendment is intended to be drafted in such a way that the failure of an employer or other group policyholder to comply with any such notification requirements would not result in a loss of conversion rights by the employee or member for reasons beyond their control. This amendment does not mandate a written notice of termination of coverage from the employer in order to activate the notice of conversion rights as suggested in Cheryl Dillard's proposal. Such a requirement could result in the employee or member never receiving notice of the conversion through no fault of their own.