Approved Feb. 12, 1992
Date

MINUTES OF THE House COMMITTEE ON Insurance.

The meeting was called to order by Representative Turnquist at
Chairperson

3:35 ~~x~~/p.m. on Monday, February 10, 1992 in room 526 S of the Capitol.

All members were present except: Representative Cozine - Excused
Representative Sebelius - Excused

Committee staff present: Mr. Fred Carman, Revisor
Mr. Chris Courtwright, Research
Mrs. Nikki Feuerborn, Secretary

Conferees appearing before the committee: Mr. Bob Williams, KS Pharmaceutical Assoc.
Ms. Sheryl Sanders, KS Alliance for Mentally Ill
Mr. Paul M. Klotz, ACMHC
Mr. Chip Wheelan, KS Psychiatric Society
Mr. David Hanzlick, KDA

The meeting was called to order at 3:35 p.m. by Chairman Turnquist.

Continued Hearing on HB 2511

Mr. Bob Williams, representing the Kansas Pharmaceutical Association, spoke as a proponent for the bill. A potential problem recognized by the Association is the forgiving of the co-payment by well-intentioned providers. He requested the reconsideration of language which would prohibit the forgiving of a co-payment. Preliminary research and studies indicate that considerable dollars can be saved by the implementation of drug utilization and review (DUR) and the "value added" services of community based pharmacists. His association recommends the incorporation of a strong DUR program into the bill. The association recommends the method SRS uses to calculate the pharmacists dispensing fee but is opposed to the method used by Kansas Medicaid. In order to avoid costing problems, it is imperative that the drug formulary be updated at least every six months. (See Attachment 1).

Ms. Sheryl Sanders, Kansas Alliance for the Mentally Ill, appeared as an opponent of **HB 2511**. Their opposition is based on the exclusion of mental illnesses from coverage for medical treatment and excepts the plan from any mandated coverages required by state law. She stated that mental illness can be cyclical with periods of acuteness followed by periods of relative stabilization not requiring hospitalization. Early intervention for mental health problems can prevent the development of related ailments such as ulcers, heart disease, etc. The rising costs of coverage, the limited access many people have to insurance, and the abuse of systems resulting from mandates need to be addressed in comprehensive systemic reform. (See Attachment 2).

Mr. Paul M. Klotz, Executive Director of the Association of Community Mental Health Centers of Kansas, Inc., appeared in opposition to the bill. He stated that the bill as currently written is worthless to over 400,000 Kansans who are mentally ill. Mr. Klotz quoted statistics regarding mental health and made suggestions regarding improvement of care via mental health services. (See Attachment 3).

Mr. Chip Wheelan, Kansas Psychiatric Society, expressed opposition to subsection (d) of new section 7 of the bill. It specifically excludes coverage for mental illness and nervous disorders. Mr. Wheelan presented the committee with a copy of a proposed amendment correcting this situation. (See Attachments 4 and 5).

MINUTES OF THE House COMMITTEE ON ~~Insurance~~,

room 526 S Statehouse, at 3:35 ~~a~~p.m./p.m. on ~~Monday, February 10, 1992~~, 19__.

Mr. David Hanzlick, representing the Kansas Dental Association, appeared before the committee and presented an amendment to the bill. This amendment would allow the services of all licensed dentists to be covered rather than only oral surgeons. It would also allow dentists to prescribe medications as well as physicians under this plan. (See Attachment 6).

HB 2754 was discussed by the committee. Representative Welshimer moved for favorable passage from committee. Representative Flower seconded the motion. Motion carried.

HB 2771 was discussed by the committee. Representative Ensminger moved to amend the bill on Page 3 Line 9 by changing $250 to $100. Representative Cornfield seconded the motion. Motion carried.

Representative Flower moved for favorable passage of **HB 2771** as amended. Representative Gilbert seconded the motion. Motion carried.

Representative Cornfield moved for the approval of the minutes of February 5 and 6. Representative Helgerson seconded the motion. Motion carried.

Meeting adjourned at 4:40 p.m.

GUEST LIST

COMMITTEE: Insurance DATE: 2-10-92

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATIO
Chip Wheeler	Topeka	Ks Psychiatric Soc.
R. Epps	Topeka	SRS
Charles Walker	Topeka	SRS
Dick Block	"	Ins Dept
ALAN COBB	TOPEKA	Delta Dental
John Petelson	Topeka	Kaiser-Permanente
Skip Sanders	Topeka	Ks AMI
John Randolph	Emporia	Assoc of CMHC's of KS.
[illegible]	[illegible]	[illegible]
Bill Sneed	TOPEKA	NFIB
Bill Curtis	Topeka	Ks. Assoc. of School Bds.
Martha Hodgesmith	Topeka	Ks. Assoc. of Rehabilitation Facilities
[illegible]	Topeka	Ks Pharmacists Assn
David Haitlick	Topeka	Ks Dental Assn
[illegible]	Topeka	Ks. Assoc of Counties
[illegible] Brown	KC-	KS USA dealer

THE KANSAS PHARMACISTS ASSOCIATION
1308 SW 10TH STREET
TOPEKA, KANSAS 66604
PHONE (913) 232-0439
FAX (913) 232-3764

ROBERT R. (BOB) WILLIAMS, M.S., C.A.E.
EXECUTIVE DIRECTOR

TESTIMONY
HOUSE BILL 2511
HOUSE COMMITTEE ON INSURANCE
FEBRUARY 10, 1992

My name is Bob Williams, I am the Executive Director of the Kansas Pharmacists Association. Thank you for this opportunity to address the committee regarding HB 2511.

The Kansas Pharmacists Association would like to commend the committee for including in HB 2511 the coverage of prescription medication. While a 50% co-insurance is high by today's standards, a co-insurance is an effective means of controlling overutilization of prescription medication. A potential problem we see is the forgiving of the co-payment by well-intentioned providers. The committee may want to consider language which would prohibit the forgiving of a co-payment.

The overutilization of prescription medication and noncompliance by patients should not be taken lightly. There are 1.8 billion prescriptions dispensed annually in the United States and 50% of those are not taken correctly. As a result, 125,000 Americans die each year simply because they fail to take their medication properly. The economic costs include 20 million lost work days per year or about $1.5 billion in lost earnings. Nearly 10% of all hospital admissions have been reported to be the result of noncompliance and nearly one-fourth of all nursing home admissions result from older adults being unable to take their medications properly.

Preliminary research and studies are indicating that considerable dollars can be saved by the implementation of drug utilization and review (DUR) and the "value added" services of community based pharmacists. As a result of the "Medicaid Antidiscriminatory Drug Price and Patient Restoration Act of 1990" Medicaid programs are now mandated to provide drug utilization and review for Medicaid drug programs. Additionally, HCFA is in the process of

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lishing demonstration projects to evaluate the efficiency and cost effectiveness of prospective DUR as well as the impact on quality of care and cost-effectiveness of paying pharmacists under Medicaid for drug use review services whether or not a drug is dispensed. The Iowa Medicaid Drug Utilization Review Commission reported that for FY1990, as a result of changes occurring following drug utilization review and intervention, $1,000,063.42 Medicaid dollars were saved, with an average of $482.99 in annualized savings occurring per patient profile re-reviewed. A Purdue University study found that pharmacists, who screened for and corrected prescription problems saved an average of $2.32 in direct medical care costs for each prescription dispensed. The Kansas Pharmacists Association recommends the incorporation of a strong DUR program into HB 2511.

Reimbursement to a pharmacist is based on two factors, a dispensing fee and drug cost. While we have no objection to the method SRS uses to calculate the pharmacist's dispensing fee as outlined in KAR 30-5-94, we do have some concerns with the method Medicaid uses to reimburse for the cost of the drug. Under the Kansas Medicaid program, reimbursement for drug costs are based on 10% off the average wholesale price (AWP), a State Maximum Allowable Cost (SMAC), or a Federal Upper Limit (FUL); whichever is lower. There have been instances when the drug reimbursement was less than what the pharmacist could purchase the drug for. This can and has resulted in drug shortages. To eliminate these types of problems, it is imperative that the drug formulary be updated at least every six months.

We feel consideration of the concepts outlined above are a necessary component of any insurance plan, particularly those plans where financial resources are limited. Kansas pharmacists are eager to be key players in providing affordable prescription medication for Kansas residents.

Thank you.

KANSAS AMI
KANSAS ALLIANCE FOR THE MENTALLY ILL
112 S.W. 6th, Ste. 305 • P.O. Box 675
Topeka, Kansas 66601
913-233-0755

DATE: February 5, 1992
TO: Members, House Insurance Committee
FROM: Sheryl Sanders, Kansas Alliance for the Mentally Ill
SUBJECT: Substitute for HB 2511

My name is Sheryl Sanders and I represent the Kansas Alliance for the Mentally Ill, which as many of you know, is composed of Kansas families with a member or members who suffer from severe and persistent mental illness, and who never thought it could happen to them.

We oppose the substitute for HB 2511 because it excludes mental illnesses from coverage for medical treatment and excepts the plan from any mandated coverages required by state law. (This would include HB 2202, passed last year, which mandated mental health coverage to all insured Kansans regardless of in which the policy was issued.) Public policy hereby compounds the stigma and discrimination toward diseases of the brain.

Schizophrenia and other affective disorders, as is proven by medical research, are catastrophic physical illnesses just like Parkinson's Disease, cancer, and heart disease. There are misconceptions about the causes, but the fact remains that these are physical illnesses warranting medical treatment and not self-induced or the result of bad parenting.

Neither is it true that severe and persistent mental illnesses automatically result in long doctor-ordered hospital stays. These are cyclical illnesses, with periods of acuteness followed by periods of relative stabilization not requiring hospitalization, as is the case with cancer and other diseases. However, when these illnesses progress untreated, as usually happens when there is no insurance coverage, they do require the more costly treatment interventions. These are usually at the public expense.

Additionally, early intervention for other mental health problems can prevent the development of related ailments such as ulcers, heart disease, etc. These are the very objectives alluded to in the supplemental note on this bill which states, "the coverage is that deemed to be most effective in keeping health conditions and disease from worsening and for preventing the onset of health conditions or disease."

The rising costs of coverage, the limited access many people have to insurance, and the abuse of systems resulting from mandates need to be addressed in comprehensive systemic reform. We support cost-cutting measures such as managed care systems and increased use of outpatient treatment and partial hospitalization programs where appropriate.

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Mandates, however, are enacted to protect citizens from profiteering and provide non-discriminatory access to care. Those specific to mental health were established because this coverage was deemed basic. Addressing abuse of the mandates by excluding them is wrong.

I've heard it expressed that mental illness/mental health is better addressed through the public system. Shunting those who should be insured into the state hospitals and community mental health centers will only blunt the efforts of mental health reform, which has a stated goal of downsizing the hospitals. The needs will not disappear because coverage is not extended. Someone, probably the Kansas taxpayer, will pay.

I thank you for the opportunity to appear before you today.

Association of Community Mental Health Centers of Kansas, Inc.

835 SW Topeka Avenue, Suite B, Topeka, KS 66612
Telephone (913) 234-4773 Fax (913) 234-3189

TESTIMONY TO:
THE HOUSE INSURANCE COMMITTEE
on
Substitute for H.B. No. 2511

Paul M. Klotz, Executive Director
Association of Community Mental Health Centers of Kansas, Inc.

February 5, 1992

Thank you for this opportunity to comment once again on **S.H.B. 2511.** I honestly believe that this proposal is clearly aimed at trying to help the uninsured or the underinsured. However, the bill, as currently written, is utterly worthless to over 400,000 Kansans who happen, through no fault of their own, to be mentally ill. We therefore oppose **S.H.B. 2511.**

A few facts on Mental Illness:

- One in three adults will face a mental or substance abuse disorder in his or her lifetime. By comparison, the chances of getting cancer during a person's lifetime is only one in ten. Both illnesses can be, or often are, totally disabling or can result in death at any age.

- Suicide is now the third leading cause of death for young people aged 15 to 24.

- 60% of all visits to primary care physicians involve mental or substance abuse issues. Thus, discrimination against people with mental disorders, as a cost containment strategy, simply does not work.

This is not meant to suggest that all is well in the nation's mental health system--that we have all the answers. To the contrary:

- Our costs are also going up too fast--but no faster than overall health care costs. We are not **the** problem, but **part** of the problem.

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- Hospital beds are over utilized and under regulated, particularly free standing, for-profit hospitals. Children, particularly are over hospitalized.

- There is little accountability from private hospitals, even though they must receive public licensure.

- Community based, outpatient services have only recently achieved statewide capacity to provide an alternative to inpatient treatment.

What can be done:

- Pre-admission screening/certification together with responsibility and capacity to offer less expensive community based, out-patient services.

- Stricter regulation of free standing psychiatric institutions. Increase accountability standards, both program and fiscal.

- Financial and/or tax incentives to develop community out-patient services.

- Change mandate law to permit or require providers and consumers to convert in-patient days to partial or out-patient alternatives, whenever possible.

- Capitation of mental health services.

- Better data collection and improved utilization review.

Community mental health centers are already doing all of the above. We know it can produce real cost savings and that quality can be maintained. We stand ready to assist in any way possible.

Thank you for this opportunity to comment.

Kansas
Psychiatric
Society

1259 Pembroke Lane
Topeka, KS 66604
Telephone: (913) 232-5985
or (913) 235-3619

February 5, 1992

TO: House Insurance Committee

FROM: Kansas Psychiatric Society

SUBJECT: Substitute House Bill 2511; Kansas Health Insurance Association

Thank you for this opportunity to express our opposition to subsection (d) of new section 7 of HB 2511. We certainly agree that the general purpose of Sub. HB 2511 is commendable, but it does contain a major flaw in that it specifically excludes coverage for mental illness and nervous disorders. After all the testimony during a 1990 interim study on the subject of health insurance mandates, followed by hearings in this Committee during the 1991 Session, we are astonished that this Committee would propose a bill that excludes coverage for diagnosis and treatment of psychiatric disorders. We are also somewhat incredulous that you would exclude coverage for newborn infants of subscribers to this health association, as well as exclusion of coverage for mammograms and pap smears needed for the women covered under this type of insurance policy.

We respectfully recommend that you re-examine the very important features found at lines 8-13 of page 9 and make appropriate corrections. In addition, we are attaching a suggested amendment that would perhaps suffice in the event that you choose not to make major revisions to the subsection containing the exemption from statutory mandates.

We would be delighted to return at any time to discuss the merits of health insurance coverage for mental illness and nervous disorders. It would seem, however, that you have received sufficient testimony that it would not be necessary to elaborate at this time.

Thank you for considering our concerns. We respectfully request that you incorporate appropriate amendments prior to taking action on Sub. HB 2511.

CW/cb

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amendments drafted by Chip Wheelen
on behalf of Kansas Psychiatric Society

the board; or

(4) such person has been accepted for health insurance subject to a permanent exclusion of a preexisting disease or medical condition.

(b) The following persons shall not be eligible for coverage under the plan:

(1) Any person who is eligible for medicare or medicaid benefits;

(2) any person who has had coverage under the plan terminated less than 12 months prior to the date of the current application;

(3) any person who has received accumulated benefits from the plan equal to or in excess of the lifetime maximum benefits under the plan prescribed by section 8 of this act;

(4) any person having access to accident and health insurance through an employer-sponsored group or self-insured plan; or

(5) any person who is eligible for any other public or private program that provides or indemnifies for health services.

(c) Any person who ceases to meet the eligibility requirements of this section may be terminated at the end of a policy period.

New Sec. 7. (a) The plan shall offer coverage to every eligible person pursuant to which such person's covered expenses shall be indemnified or reimbursed subject to the provisions of section 8 of this act.

(b) Except for those expenses set forth in subsection (c) of this section, expenses covered under the plan shall include expenses for:

(1) Services of persons licensed to practice medicine and surgery which are medically necessary for the diagnosis or treatment of injuries, illnesses or conditions, ~~other than mental;~~ including nervous or mental conditions specified in the diagnostic and statistical manual of mental disorders of the American psychiatric association;

(2) services of advanced registered nurse practitioners who hold a certificate of qualification from the board of nursing to practice in an expanded role or physicians assistants acting under the direction of a responsible physician when such services are provided at the direction of a person licensed to practice medicine and surgery and meet the requirements of paragraph (b)(1) above;

(3) services of licensed dentists issued certificates of qualification by the board of dental examiners to practice oral surgery as a dental specialty when such procedures would otherwise be performed by persons licensed to practice medicine and surgery;

(4) emergency care, surgery and treatment of acute episodes of illness or disease as defined in the plan and provided in a general hospital or ambulatory surgical center as such terms are defined in K.S.A. 65-425, and amendments thereto;

(5) medically necessary diagnostic laboratory and x-ray services as limited by the plan; and

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propriate medical board as the normal mode of treatment for the illness or injury involved;

(12) service of a blood donor and any fee for failure of the insured to replace the first three pints of blood provided in each calendar year; and

(13) personal supplies or services provided by a health care facility or any other nonmedical or nonprescribed supply or service.

(d) ~~The plan may contract for coverage within the scope of this act notwithstanding any mandated coverages otherwise required by state law. The~~ Notwithstanding the provisions of K.S.A. 40-2,100 to 40-2,105, inclusive, 40-2,114, 40-2209 and K.S.A. 1990 Supp. 40-2229, 40-2230 and 40-2250, and amendments thereto, ~~shall not be applicable with respect to any coverage provided by the plan.~~ the plan may contract for such coverage within the scope of this act and may apply the same deductible and coinsurance provisions set by the board.

New Sec. 8. (a) Coverage under the plan shall be subject to both deductible and coinsurance provisions set by the board. The plan may offer applicants for coverage thereunder a choice of deductible and copayment options or combinations thereof. At least one option shall provide for a minimum annual deductible of $5,000. Coverage shall contain a coinsurance provision for each service covered by the plan, and such copayment requirement shall not be subject to a stop loss provision. However, such coverage may provide for a percentage or dollar amount of coinsurance reduction at specific thresholds of copayment expenditures by the insured.

(b) Coverage under the plan shall be subject to a maximum lifetime benefit of $500,000 per covered individual.

(c) In the first two years of operation of the plan, coverage thereunder shall exclude charges or expenses incurred during the first 12 months following the effective date of coverage as to any condition which manifested itself during the six-month period immediately prior to the application for coverage in such manner or would cause an ordinarily prudent person to seek diagnosis, care or treatment or for which medical advice, care or treatment was recommended or received in the six-month period immediately prior to the application for coverage. In succeeding years of operation of the plan, coverage of preexisting conditions thereunder may be excluded as determined by the board except that no such exclusion shall exceed 12 months.

(d) (1) Benefits otherwise payable under plan coverage shall be reduced by all amounts paid or payable through any other health insurance, or insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workers compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any

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drafted by Chip Wheelen
on behalf of
Kansas Psychiatric Society

KANSAS DENTAL ASSOCIATION

K. David Hanzlick
House Committee on Insurance
Hearings on Sub HB 2511
February 5, 1992

Mr. Chairman and members of the Committee, my name is David Hanzlick. I represent the Kansas Dental Association. The KDA is the professional organization that represents 1187 dentists or 80 percent of all dentists in Kansas.

I appreciate having the opportunity to appear before this Committee to share dentistry's concerns about several specific provisions of the bill you are considering today.

First, as you see on the first sheet attached to this testimony, the Kansas Dental Association is concerned about the wording found on page 7, lines 34 through 36. This provision allows coverage only for dental services performed by dentists who are specialists in oral surgery.

The Kansas Dental Association recommends that the Committee strike the language that limits coverage only to oral surgeons. By striking the restrictive language, the services of all licensed dentists would be covered if those services would otherwise be provided by a physician. Because all dentists are licensed to perform oral surgery among other procedures, there is no reason to restrict the program to practitioners of one dental specialty.

The second amendment the KDA recommends is a conforming amendment on page 8, line 1. The KDA recommends inserting the words "or dentist" after the word "physician" on that line. Since both physicians and dentists will be treating patients under the provisions of the bill, the cost of medication prescribed by either a physician or dentist should be eligible for coverage.

The third amendment is found on page 9, line 10. The Kansas Dental Association recommends the elimination of the insurance equality statute from the list of mandates that will not apply to this program. The insurance equality statute (K.S.A. 40-2,100) simply states that if a procedure is within a provider's scope of practice and is covered by insurance, then the benefit must be paid whether the procedure was performed by a physician or a dentist. To illustrate, both a dentist and a physician are legally qualified to fix a broken jaw. If an insurance policy will pay for the treatment of a broken jaw, then the policy must provide the benefit whether the broken jaw is treated by a dentist or a physician.

K.S.A. 40-2,100 should be eliminated from the list of mandates since the bill already provides reimbursement for dentists who are providing services that would otherwise be provided by a physician.

Moreover, the provider equality statute should be struck from the list of mandates for the simple reason that it is not a mandate as it does not require coverage for any particular procedure. K.S.A. 40-2,100 simply increases access to care and increases patient choice in selecting a provider.

On behalf of the Kansas Dental Association, I appreciate your consideration of these concerns and would be glad to answer any questions. Thank you.

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Topeka, Kansas 66604
913-272-7360

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the board; or

(4) such person has been accepted for health insurance subject to a permanent exclusion of a preexisting disease or medical condition.

(b) The following persons shall not be eligible for coverage under the plan:

(1) Any person who is eligible for medicare or medicaid benefits;

(2) any person who has had coverage under the plan terminated less than 12 months prior to the date of the current application;

(3) any person who has received accumulated benefits from the plan equal to or in excess of the lifetime maximum benefits under the plan prescribed by section 8 of this act;

(4) any person having access to accident and health insurance through an employer-sponsored group or self-insured plan; or

(5) any person who is eligible for any other public or private program that provides or indemnifies for health services.

(c) Any person who ceases to meet the eligibility requirements of this section may be terminated at the end of a policy period.

New Sec. 7. (a) The plan shall offer coverage to every eligible person pursuant to which such person's covered expenses shall be indemnified or reimbursed subject to the provisions of section 8 of this act.

(b) Except for those expenses set forth in subsection (c) of this section, expenses covered under the plan shall include expenses for:

(1) Services of persons licensed to practice medicine and surgery which are medically necessary for the diagnosis or treatment of injuries, illnesses or conditions, other than mental;

(2) services of advanced registered nurse practitioners who hold a certificate of qualification from the board of nursing to practice in an expanded role or physicians assistants acting under the direction of a responsible physician when such services are provided at the direction of a person licensed to practice medicine and surgery and meet the requirements of paragraph (b)(1) above;

(3) services of licensed dentists ~~issued certificates of qualification by the board of dental examiners to practice oral surgery as a dental specialty~~ when such procedures would otherwise be performed by persons licensed to practice medicine and surgery;

(3) services of licensed dentists when such procedures would otherwise be performed by persons licensed to practice medicine and surgery;

(4) emergency care, surgery and treatment of acute episodes of illness or disease as defined in the plan and provided in a general hospital or ambulatory surgical center as such terms are defined in K.S.A. 65-425, and amendments thereto;

(5) medically necessary diagnostic laboratory and x-ray services as limited by the plan; and

(6) drugs and controlled substances prescribed by a physician. Coverage for outpatient prescriptions shall be subject to a mandatory 50% coinsurance provision, and coverage for prescriptions administered to inpatients shall be subject to a coinsurance provision as established in the plan.

(c) Expenses not covered under the plan shall include expenses for:

(1) Illness or injury due to an act of war;

(2) services rendered prior to the effective date of coverage under this plan for the person on whose behalf the expense is incurred;

(3) services for which no charge would be made in the absence of insurance or for which the insured bears no legal obligation to pay;

(4) (A) services or charges incurred by the insured which are otherwise covered by:

(i) Medicare, medicaid or state law or programs;

(ii) medical services provided for members of the United States armed forces and their dependents or for employees of such armed forces;

(iii) military service-connected disability benefits;

(iv) other benefit or entitlement programs provided for by the laws of the United States;

(v) workers compensation or similar programs addressing injuries, diseases, or conditions incurred in the course of employment covered by such programs;

(vi) benefits payable without regard to fault pursuant to any motor vehicle or other liability insurance policy or equivalent self-insurance.

(B) This exclusion shall not apply to services or charges which exceed the benefits payable under the applicable programs listed above and which are otherwise eligible for payment under this section.

(5) Services the provision of which is not within the scope of the license or certificate of the institution or individual rendering such service;

(6) that part of any charge for services or articles rendered or prescribed which exceeds the rate established by section 13 of this act for such services;

(7) services or articles not medically necessary;

(8) care which is primarily custodial or domiciliary in nature;

(9) cosmetic surgery unless provided as the result of an injury or medically necessary surgical procedure;

(10) eye surgery if corrective lenses would alleviate the problem;

(11) experimental services or supplies not recognized by the ap-

---------- Insert "or dentist" following "physician".

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propriate medical board as the normal mode of treatment for the illness or injury involved;

(12) service of a blood donor and any fee for failure of the insured to replace the first three pints of blood provided in each calendar year; and

(13) personal supplies or services provided by a health care facility or any other nonmedical or nonprescribed supply or service.

(d) The plan may contract for coverage within the scope of this act notwithstanding any mandated coverages otherwise required by state law. The provisions of K.S.A. 40-2,100 to 40-2,105, inclusive, 40-2,114, 40-2209 and K.S.A. 1990 Supp. 40-2229, 40-2230 and 40-2250, and amendments thereto, shall not be applicable with respect to any coverage provided by the plan.

---------- Eliminate insurance equality statute K.S.A. 40-2,100 from the list of mandated coverages.

New Sec. 8. (a) Coverage under the plan shall be subject to both deductible and coinsurance provisions set by the board. The plan may offer applicants for coverage thereunder a choice of deductible and copayment options or combinations thereof. At least one option shall provide for a minimum annual deductible of $5,000. Coverage shall contain a coinsurance provision for each service covered by the plan, and such copayment requirement shall not be subject to a stop loss provision. However, such coverage may provide for a percentage or dollar amount of coinsurance reduction at specific thresholds of copayment expenditures by the insured.

(b) Coverage under the plan shall be subject to a maximum lifetime benefit of $500,000 per covered individual.

(c) In the first two years of operation of the plan, coverage thereunder shall exclude charges or expenses incurred during the first 12 months following the effective date of coverage as to any condition which manifested itself during the six-month period immediately prior to the application for coverage in such manner or would cause an ordinarily prudent person to seek diagnosis, care or treatment or for which medical advice, care or treatment was recommended or received in the six-month period immediately prior to the application for coverage. In succeeding years of operation of the plan, coverage of preexisting conditions thereunder may be excluded as determined by the board except that no such exclusion shall exceed 12 months.

(d) (1) Benefits otherwise payable under plan coverage shall be reduced by all amounts paid or payable through any other health insurance, or insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workers compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any