

MINUTES OF THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES.

The meeting was called to order by Chairperson Carlos Mayans, at 1:30 p.m. on February 24, 1997 in Room 423-S-of the State Capitol.

All members were present.

Committee staff present: Emalene Correll, Legislative Research Department
Norman Furse, Revisor of Statutes
Lois Hedrick, Committee Secretary

Conferees appearing before the committee:

Representative Jo Ann Pottorff
Representative Joann Freeborn
Linda Ridgeway-Morrison, R.N., Topeka
Kate McNorton, Office Manager, Women's Health Center, Topeka
Meg Henson, Director of Government Affairs, Kansas Medical Society
Harold Riehm, Executive Director, Kansas Association of Osteopathic Medicine

Others attending: See Guest List (Exhibit 1).

Chairperson Mayans opened the hearing on **HB 2360 - insurance coverage for osteoporosis.**

Representative Jo Ann Pottorff, one of the bill sponsors, advised the bill is also sponsored by all of the lady legislators on this committee, but she stated the bill is equally important to men. (See written testimony, Exhibit 2.)

Representative Joann Freeborn testified the bill will stimulate diagnosis and provide the possibility of early treatment for the disease (see Exhibit 3).

Linda Ridgeway-Morrison, R.N. presented testimony about osteoporosis as a disease, and stressed the importance of early diagnosis and treatment as a cost effective approach. She supports the bill because it mandates insurance coverage which is important to early detection of the disease for many people who otherwise would not be able to afford medical testing. (See testimony, Exhibit 4.)

Kate McNorton, Women's Health Center, testified in support of the bill, but also directed attention to the importance of consistent coverage guidelines for health insurers (see Exhibit 5).

Meg Henson, Kansas Medical Society, stated that the Society supports the bill's concept of requiring insurance companies to cover bone mass measurement if a physician finds it medically necessary. She offered two amendments relating to and the definition of "physician." (See testimony, Exhibit 6.)

Harold Riehm, Kansas Association of Osteopathic Medicine, presented support of **HB 2360** (see Exhibit 7).

Chairperson Mayans opened the hearing for questions. He pointed out that when this kind of law is mandated, 65% of those covered by insurance plans are under ERISA and not affected; approximately 14-15% are on Medicaid or Medicare and not affected; leaving 10% uninsured. This bill would only apply to that 10%, who either buy individual coverage or small group insurance coverage--and the mandate would surely increase premiums. Kate McNorton replied that even if only 10% are covered by this bill, the cost is worth it.

Norman Furse reviewed K.S.A. 40-2248, enacted in 1990, that requires before legislation of this type can be brought forth, an impact report must be submitted to the committee to assess the social and financial effects of the proposed mandated coverage. In effect, he said, this bill cannot be considered if compliance with the law is desired. Representative Haley questioned then if **HB 2255** passed by the committee last week was subject to this section. Mr. Furse said it was not since the state is the reimbursor under **2255**. Chairperson Mayans stated **HB 2360** will remain in committee pending receipt of the impact statement.

There being no others present to testify on the bill, the hearing was closed.

Chairperson Mayans asked if committee members were interested in considering action on **HB 2097 - regulation of fitness physical centers.** He directed attention to the proposed balloon amendments (see Exhibit 8) which was developed in response to Representative Gilmore's concerns on the bill. Representative Gilmore moved, seconded by Representative Freeborn, that the balloon amendments be adopted. Discussion

CONTINUATION PAGE

MINUTES OF THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES, Room 423-S of the State Capitol, at 1:30 p.m. on February 24, 1997.

on the bill followed. Chairperson Mayans paralleled the purchase of fitness club memberships with the purchase of insurance, or a car, asking if the cancellation provision was not a sufficient safeguard to those who buy such memberships. Representative Freeborn expressed support of the amendment. After discussion, Representative Shultz, in a substitute motion, seconded by Representative Geringer, moved that HB 2097 be tabled. On voice vote, the committee tabled the bill.

The meeting was adjourned at 2:30 p.m.

The next meeting is scheduled for March 5, 1997.

HOUSE COMMITTEE ON HEALTH AND HUMAN
SERVICES COMMITTEE GUEST LIST
FEBRUARY 24, 1997

NAME	REPRESENTING
Susan Baker	Flinn + Weir
Kate McWaters	Stormont-Vail Healthcare
Phyllis Hupe	Westy Comm Care Hm Westmoreland
Jean Potts	Valley Vista Good Samaritan Ctr. Namego
Rich Gutierrez	Health Midwest
Harrie Ann Brown	Kans. Hosp. Assoc.
MEGGAN GRIGGS	Keamy Law Office
Michelle Peterson	Peterson Public Affairs
Kathy Young HCAA	Home Care Assn of America
Richard C. Glin HCAA	Synergy Home Care
Cynthia Ridgeway Madison	Stormont Vail Home Health/WC.
Trish J. Decker	Junction City Good Samaritan Center
Paula Dean HCAA	Secs Home Health Pkwy, Ks.
Ann Palmer HCAA	Federated Registry of Nurses
Harold FLEXOR	HAAOM
Randy Fitzmaurice	Good Samaritan Touchy
Stephen J. Shields	Meadowlark Retirement Community Manhattan KS
Jean Reed HCAA	Caring Hearts Inc HCAA
Kathy Statler HCAA	HCAA

HOUSE COMMITTEE ON HEALTH AND HUMAN
SERVICES COMMITTEE GUEST LIST
FEBRUARY 24, 1997

NAME	REPRESENTING
Callie Hill Denton	K. Peterson's Assoc.
KEITH R LAWDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS

JO ANN POTTORFF
REPRESENTATIVE, EIGHTY-THIRD DISTRICT
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ROOM 183-W
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TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
MEMBER:: APPROPRIATIONS
NCSL ASSEMBLY ON STATE ISSUES
EDUCATION COMMITTEE

Testimony on HB 2360

February 24, 1997

House Committee on Health and Human Services

Thank you Mr. Chairman and members of the Committee for holding a hearing on HB 2360 regarding insurance coverage for bone mass measurement tests.

HB 2360 calls for insurance to cover bone-density testing for the purpose of identifying low bone mass, detecting bone loss and osteoporotic risk. These tests are non-invasive, safe and accurate ways of determining the probability of an individual developing a fracture. The tests are needed because they are the only way to diagnose osteoporosis early and they can inform the patient of their degree of risk. It has been scientifically proven that these tests can be used effectively to reduce the pain it inflicts upon its victims and the financial burden it causes.

Osteoporosis is the most common and potentially debilitating disease in the world, posing a threat to 25 million Americans each year. It is a disorder in which bone mass gradually is lost in the skeleton, causing the bones to become progressively weaker. Once bone mass is lost, it cannot be replaced. Prevention is the key. Surveys show that women know very little about the disease and they are not motivated to prevent its damage and do not know how to prevent it.

Fifty percent of women over the age of fifty will suffer from an osteoporotic fracture in their lifetime. A woman's risk of hip fracture is equal to her combined risk of breast, uterine and ovarian cancer. Although people do not die from osteoporosis, they do die from fractures related to the disease. Because osteoporosis progresses silently, often times the disease goes undetected until a fracture occurs.

Currently there is no cure for osteoporosis. Prevention by early diagnosis and treatment, therefore, is the key to fighting this disease. It would be beneficial for Kansas to provide education on the early detection of symptoms and healthy preventative practices. In the long run, the State would save money and lives.

Because there are more elderly people today than there were ten years ago, it is expected that the number of people with osteoporosis will double in the next five years. Osteoporosis costs Americans \$27 million daily, a figure that will continue to rise with the aging curve. Hip fractures relating to osteoporosis alone costs the United States an estimated \$10 to \$18 billion dollars per year.

In the State of Kansas, 11% of the population has some degree of osteoporosis. One in every two women and one in five men will develop fractures as a direct result of osteoporosis. New legislation calls for a public health education effort to help give women the tools they need to fight osteoporosis.

Presently, only about one half of private insurance policies cover these tests for diagnostic purposes. Medicare is inconsistent in its coverage of bone mass measurements, due to the fact that United States health care is set up to handle crisis rather than preventive care. Physicians are threatening to stop providing the tests to Medicare beneficiaries because of the low reimbursement rate.

I have attached osteoporosis prevalence figures for 1996 and 2015, in which Kansas is ranked 14% in 1996 and 13% in 2015. These figures from the National Osteoporosis Foundation uncover the idea that this disease is not going to go away in the near future. Additional information regarding Kansas specifically is also attached.

I urge you to favorably recommend this bill for passage.

STATE BURDEN OF FRACTURES MODEL Kansas

Some 25 million Americans -- 20 million of them women -- have or are at risk for osteoporosis, a disease characterized by thinning of the bones so that the bones are prone to fracture. It is estimated that at age 50, nearly 40 percent of postmenopausal women will suffer an osteoporotic fracture during their remaining lifetime.

The disease is responsible for about 1.3 million broken bones each year in the U.S. and costs Americans \$10 billion a year, more than congestive heart failure at \$7.5 billion or asthma at \$6.2 billion.

A new model, presented at the 1996 annual meeting of the American Society of Bone and Mineral Research, predicts the number and cost of fractures expected to be suffered by women age 45 and older for each of the 50 U.S. states and Washington, D.C., through 2015, assuming nothing is done to change the current fracture rates in this population.

This model uses U.S. census data (1993) and estimates of fracture risk from epidemiological data from the town of Rochester, Minn., and a sampling of Medicare patients to predict future fracture risk. According to the model,

- Between 1995 and 2015, 55,600 Kansas women age 45 and over are expected to suffer hip fractures, which are often devastating and rob women of their independence
- Kansas women age 45 and over will suffer 12,661 hip, spine and wrist fractures in the year 2015.
- The cost of these fractures in Kansas will rise by more than 29% by the year 2015.
- The annual cost to Kansas' health care system will rise from \$58 million in 1995 to \$196 million in 2015.

Methods

- U.S. Census population projections are used to estimate the female population for each of the years of interest.
- Estimates of fracture risk come from two sources: epidemiological studies conducted in the town of Rochester Minn., which are based on the experiences of white women only, and a 5 percent sampling of Medicare patients reported in five-year age intervals and by race (Caucasian, African-American, other/unknown).
- The projected fracture incidences are calculated by multiplying the population of a specific age group by the corresponding fracture rate. Once the number of fractures have been calculated, the annual total costs are determined by multiplying the number of fractures by the corresponding cost and adding the costs of the three separate types of fractures.
- Cost estimates assume 5 percent rate of annual inflation.

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1996 Osteoporosis Prevalence Figures *

U.S. Population Age 50 and Over

State	Women With Osteoporosis	Women With Low Bone Mass	Total Women With Osteoporosis and Low Bone Mass	Men With Osteoporosis	Men With Low Bone Mass	Total Men With Osteoporosis and Low Bone Mass	Total Men and Women With Osteoporosis and Low Bone Mass	Percent of Men and Women With Osteoporosis
AL	124,270	244,904	369,174	31,408	47,112	78,520	447,694	13%
AK	9,090	17,504	26,594	2,649	3,974	6,623	33,218	12%
AZ	135,284	257,685	392,969	36,917	55,375	92,292	485,261	14%
AR	80,621	154,680	235,302	21,310	31,965	53,276	288,577	14%
CA	926,185	1,788,242	2,714,427	241,974	362,960	604,934	3,319,361	14%
CO	102,917	195,423	298,340	26,848	40,272	67,119	365,460	14%
CT	109,235	207,378	316,613	28,340	42,510	70,850	387,462	14%
DE	20,930	40,396	61,326	5,377	8,066	13,443	74,769	14%
DC	12,112	29,214	41,326	3,438	5,157	8,594	49,921	10%
FL	596,495	1,148,526	1,745,021	164,856	247,284	412,141	2,157,162	14%
GA	177,169	350,438	527,607	44,341	66,512	110,853	638,460	13%
HI	34,669	64,965	99,634	8,163	12,245	20,408	120,042	14%
ID	31,741	59,276	91,017	9,075	13,612	22,686	113,704	14%
IL	349,346	675,079	1,024,426	90,192	135,288	225,480	1,249,906	14%
IN	176,050	333,309	509,359	44,658	66,987	111,646	621,005	14%
IA	96,216	179,407	275,623	25,674	38,511	64,186	339,809	15%
KS	80,031	150,805	230,836	21,607	32,411	54,018	284,854	14%
KY	117,578	222,034	339,612	29,457	44,185	73,642	413,254	14%

12/23/96

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* Due to rounding, "Total" figures may not be exact.

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2015 Osteoporosis Prevalence Figures U.S. Population Age 50 and Over

State	Women With Osteoporosis	Women With Low Bone Mass	Total Women With Osteoporosis and Low Bone Mass	Men With Osteoporosis	Men With Low Bone Mass	Total Men With Osteoporosis and Low Bone Mass	Total Men and Women With Osteoporosis and Low Bone Mass	Percent of Men and Women With Osteoporosis
IA	120,596	225,513	346,109	28,956	43,434	72,391	418,499	14%
KS	113,895	215,810	329,706	25,447	38,171	63,618	393,324	13%
KY	166,258	314,624	480,882	33,567	50,351	83,918	564,800	13%
LA	157,079	318,561	475,640	33,011	49,517	82,528	558,169	12%
ME	57,546	107,096	164,642	12,030	18,045	30,075	194,717	14%
MD	200,096	404,899	604,995	41,664	62,497	104,161	709,156	12%
MA	258,491	490,160	748,651	56,048	84,072	140,120	888,770	13%
MI	354,250	687,806	1,042,056	82,338	123,507	205,845	1,247,901	13%
MN	204,035	381,578	585,613	42,551	63,826	106,376	691,989	13%
MS	104,523	211,539	316,062	21,115	31,672	52,787	368,850	12%
MO	234,204	446,972	681,177	50,143	75,214	125,357	806,534	13%
MT	38,410	71,980	110,390	8,471	12,707	21,178	131,568	13%
NE	69,788	131,350	201,137	15,792	23,688	39,479	240,617	13%
NV	84,953	163,434	248,387	14,623	21,935	36,558	284,945	12%
NJ	54,368	101,338	155,705	51,580	77,370	128,951	284,656	21%
NM	97,538	191,743	289,280	17,953	26,930	44,884	334,164	12%
NY	734,643	1,456,244	2,190,887	164,451	246,677	411,129	2,602,015	13%
NH	54,368	101,338	155,705	10,374	15,561	25,936	181,641	13%
NC	332,856	655,309	988,164	66,870	100,305	167,176	1,155,340	12%
ND	25,553	47,755	73,308	6,180	9,270	15,450	88,759	14%

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Fast Facts on Osteoporosis

Definition

Osteoporosis, or porous bone, is a disease characterized by low bone mass and structural deterioration of bone tissue, leading to bone fragility and an increased susceptibility to fractures of the hip, spine, and wrist.

Prevalence

Osteoporosis is a major public health threat for more than 28 million Americans, 80 percent of whom are women. In the U.S. today, 10 million individuals already have the disease and 18 million more have low bone mass, placing them at increased risk for osteoporosis.

80% of those affected by osteoporosis are women.

One out of every two women and one in eight men over age 50 will have an osteoporosis-related fracture in their lifetime.

By age 75, one third of all men are affected by osteoporosis.

While osteoporosis is often thought of as an older person's disease, it can strike at any age.

Osteoporosis is responsible for 1.5 million fractures annually, including:

- ▶ more than 300,000 hip fractures
- ▶ 700,000 vertebral fractures
- ▶ 200,000 wrist fractures
- ▶ more than 300,000 fractures at other sites

Cost

The estimated national direct expenditures (hospitals and nursing homes) for osteoporosis and associated fractures is \$13.8 billion (\$38 million each day) – and the cost is rising.

Symptoms

Osteoporosis is often called the "silent disease" because bone loss occurs without symptoms. People may not know that they have osteoporosis until their bones become so weak that a sudden strain, bump, or fall causes a fracture or a vertebra to collapse.

Collapsed vertebrae may initially be felt or seen in the form of severe back pain, loss of height, or spinal deformities such as kyphosis or stooped posture.

Risk Factors

Certain people are more likely to develop osteoporosis than others. Factors that increase the likelihood of developing osteoporosis are called "risk factors." The following risk factors have been identified:

- ▶ Being female
- ▶ Thin and/or small frame
- ▶ Advanced age
- ▶ A family history of osteoporosis
- ▶ Early menopause
- ▶ Abnormal absence of menstrual periods (amenorrhea)
- ▶ Anorexia nervosa or bulimia
- ▶ A diet low in calcium
- ▶ Use of certain medications, such as corticosteroids and anti-convulsants
- ▶ Low testosterone levels in men
- ▶ An inactive lifestyle
- ▶ Cigarette smoking
- ▶ Excessive use of alcohol
- ▶ Caucasian or Asian, although African Americans and Hispanic Americans are at significant risk as well

Women can lose up to 20% of their bone mass in the 5-7 years following menopause, making them more susceptible to osteoporosis. However, 2 million American men are affected by osteoporosis and one out of eight men age 50 and older will develop fractures.

White women 60 years of age or older have at least twice the incidence of fractures as African-American women. However, one out of five African-American women are at risk of developing osteoporosis.

Detection

Specialized tests called bone density tests can measure bone density in various sites of the body. A bone density test can:

- ▶ Detect osteoporosis before a fracture occurs
- ▶ Predict your chances of fracturing in the future
- ▶ Determine your rate of bone loss and/or monitor the effects of treatment if the test is conducted at intervals of a year or more

Prevention

Building strong bones, especially before the age of 35, can be the best defense against developing osteoporosis, and a healthy lifestyle can be critically important for keeping bones strong. So to help prevent osteoporosis:

- ▶ Eat a balanced diet rich in calcium
- ▶ Exercise regularly, especially weight-bearing activities
- ▶ Don't smoke and limit alcohol intake
- ▶ Talk to your doctor if you have a family history of osteoporosis or no longer have the protective benefit of estrogen due to natural or surgically-induced menopause.

Fractures

The most typical sites of fractures related to osteoporosis are the hip, spine, wrist, and ribs, although the disease can affect any bone in the body.

Forty percent of all women will have at least one spinal fracture by the time they reach age 80.

Spinal osteoporosis is eight times more likely to afflict women than men.

The rate of hip fractures is two to three times higher in women than men; however the death rate for men within one year after a hip fracture is 26% higher than that in women.

A woman's risk of hip fracture is equal to her combined risk of breast, uterine and ovarian cancer.

In 1991, about 300,000 Americans age 45 and over were admitted to hospitals with hip fractures. Osteoporosis was the underlying cause of most of these injuries.

Individuals suffering hip fractures have a 5 to 20 percent greater risk of dying within the first year following that injury than others in their age group.

Among those who were living independently prior to a hip fracture, 15 to 25 percent are still in long-term care institutions a year after the injury.

Treatment & Care Although there is no cure for osteoporosis, there are treatments available to help stop further bone loss and fractures:

- ▶ Studies have shown that estrogen can prevent the loss of bone mass in postmenopausal women.
- ▶ Alendronate, a bisphosphonate, has been recently approved by the Food and Drug Administration for treatment of postmenopausal osteoporosis.
- ▶ Calcitonin is another treatment used by both women and men for osteoporosis. This drug has been shown to slow bone breakdown and also can reduce the pain associated with osteoporotic fractures.
- ▶ Treatments under investigation include other bisphosphonates, sodium fluoride, vitamin D metabolites, and selective estrogen receptor modulators.

Medical experts agree that osteoporosis is highly preventable. However, if the toll of osteoporosis is to be reduced, the commitment to osteoporosis research must be significantly increased. It is reasonable to project that with increased research, the future for definitive treatment and prevention of osteoporosis is very bright.

The National Osteoporosis Foundation is the nation's leading resource for patients, healthcare professionals, and organizations seeking up-to-date, medically sound information on the causes, prevention, diagnosis, and treatment of osteoporosis. Please contact us to learn more about NOF, National Osteoporosis Prevention Week, or how to become a member.

National Osteoporosis Foundation, 1150 17th Street, NW, Suite 500, Washington, DC 20036
phone - 202/223-2226 fax - 202/223-2237 January 24, 1997

JOANN LEE FREEBORN
REPRESENTATIVE, 107TH DISTRICT
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TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
VICE-CHAIR: ENVIRONMENT
MEMBER: AGRICULTURE
PUBLIC HEALTH AND WELFARE
JOINT COMMITTEE ON CHILDREN
AND FAMILIES

February 24, 1997

Regarding: HB2360
To: House Health and Human Services Committee

As a member of this committee I do not often utilize the opportunity to stand before you and testify on issues. Today I have chosen to do so in support of HB2360.

Over the past several years considerable dollars have been spent trying to collect data to substantiate the bone density testing (bone mass measurement) which will aid in identifying the progression of Osteoporosis. Osteoporosis is a bone condition which, if it strikes, generally strikes women who are post menopause. One in five men are also afflicted by the condition. Due to the degeneration of the bones there are frequently fractures which are associated with the condition.

By the time the fracture has occurred the bones are well beyond significant recovery. The goal of this piece of legislation is to help in diagnosis and thereby provide for the possibility of early treatment. The early treatment can be effective and will reduce overall medical costs, reduce pain to the afflicted and contribute to the better quality of life for many older Americans.

Please join me in supporting HB2360.

Thank You,

A handwritten signature in black ink that reads "Joann".

Joann Freeborn

HOUSE HEALTH/HUMAN SERVICES

Attachment 3
2 - 24 - 97

TO CHAIRMAN CARLOS MAYANS

HOUSE BILL # 2360

INSURANCE COVERAGE FOR BONE DENSITY TESTING ("BONE MASS MEASUREMENT COVERAGE ACT") RELATED TO OSTEOPOROSIS.

TO THE CHAIR OF TOPEKA COMMUNITY.

2-24-1997

LYNDA RIDGEWAY-MORRISON

RNC (REGISTERED NURSE CERTIFIED)

RESIDENT OF SHAWNEE COUNTY.

Just being a woman automatically places the female population in the risk category of bone density loss or 'porous bones', leading to a serious condition commonly known as Osteoporosis. Osteoporosis is a systemic skeletal disease, characterized by low bone mass and micro architectural deterioration of bone tissue, with a consequent increase in bone fragility and susceptibility to fracture.⁽¹⁾ As many as 40% of 50 year-old women (one in two), and one in five men, will suffer from an osteoporotic fracture during their lifetime.⁽¹⁾

I myself have a very strong family history of osteoporosis. In 1992, at the age of 41, I was diagnosed, through a bone density test, with mild to moderate bone density loss. My sister, at the age of 44, was found, through early bone density testing, to have moderate to marked bone density loss, placing us both in a higher risk for fractures. This early detection allowed us both to begin receiving early appropriate medical treatment to prevent further bone density mass loss.

My mother, at the age of 57, who was 5 ft. 6" and weighed 110 lbs., suffered a stress hip fracture while simply walking. Although she had been an individual who exercised, ate foods high in calcium, did not smoke or drink alcohol, osteoporosis progressed silently.

In most cases, such as my mother, who went undiagnosed until a fracture occurred, the disease is already advanced, and the likelihood is high that another fracture will occur.

My mother's hip fracture at age 57, has changed the quality of her life to this day.

Medical experts agree that osteoporosis is preventable, and treatable with early detection. However, once the disease progresses to the point of fracture, its associated consequences often lead to disability, institutionalization, and exact a heavy toll on the quality of life. My mother eventually underwent a total of two hip surgeries—first for a hip pinning, and years later, removal of the pins, followed eventually by a total hip replacement. In between these procedures, she suffered much pain in her right hip joint, secondary to arthritis, that had set in on her compromised hip. She is presently 82, and is fortunate to be under the watchful eye and medically treated by a very well respected Topeka Endocrinologist.

With her severe bone density loss, her continued treatment plan requires she receive a yearly bone density test. Since medicare will only cover treatment cost,

including mammographies, every other year, her AARP supplemental health insurance would not pay for the cost of the bone density screening in the alternate years medicare will not cover. Bone Mass Measurement, related to the early diagnosis and the timely treatment of osteoporosis is a cost effective approach to embrace.

My father also had severe kyphosis (curvature of the spine), secondary to osteoporosis. As a young man, he was tall (6 ft. 4") and thin (160 lbs.)-a strong farm boy, he fractured his ankle while playing basketball. Unable to fulfill his scholarship to the University of Georgia, he was unable to pursue his goal of a college education.

My paternal grandmother had such severe osteoporosis, causing such spinal deformity as literally leaving her bedridden for the last 30 years of her life. She lived to be 98 years old.

I shared this brief history of my family simply to reflect the severity of this devastating disease, and how it can affect a person's quality of life. A similar scenario can be heard from millions of Americans, not just myself.

Osteoporosis affects 25 million Americans, and each year results in 1.5 million fractures of the hip, spine, wrist, and other bones, costing the nation at least \$18 billion dollars.⁽²⁾

Early bone mass measurement is a reliable way to detect the presence of low bone mass to assess the individual's risk for fractures, and aids in selecting appropriate therapies and interventions.

Osteoporosis is a chronic disorder that may be asymptomatic for many years, and may only become evident when a fracture occurs, and the physician first sees the patient in the emergency room.

Bone loss is accelerated during the immediate postmenopausal years, and then continues progressively throughout life.^(4a)

Clinical Signs & Symptoms of Osteoporosis Can Be-

- 1.) Pain due to fracture or deformity (back, hip, etc.).
- 2.) History of recurrent or nontraumatic fracture.
- 3.) Height loss.
- 4.) Kyphosis (Curvature of the spine-the old term is 'humpback').

Postmenopausal status is the major risk factor for osteoporosis. Although it is possible to have osteoporosis when none of these risk factors are present.^(2,3 B)

- 1.) Early menopause (before age 45).
- 2.) Caucasian race or Asian heritage.
- 3.) Thin, small build.

- 4.) Chronic use of steroids, excessive thyroid hormone (hypothyroidism).
- 5.) Certain anticonvulsants.
- 6.) Family history of osteoporosis or fracture.
- 7.) Life style fractures: Inactivity, excessive alcohol or caffeine consumption, or smoking.

As you can well imagine, a large percentage of the population may well fit into these major risk factor categories.

The most accurate predictor of fracture risk is low bone mass measurement by means of a radiologic or radioisotopic procedure. Standard x-rays show bone loss, but only when loss exceeds 30% ^(1B) - which is already a dangerous and significant amount of bone loss.

Bone density testing may be particularly useful in early and/or asymptomatic cases.

The most accurate predictor of fracture risk is low bone mass. The association between low bone mass and fracture risk is stronger than that between systolic blood pressure and stroke or that between serum cholesterol and coronary events. ^(4B)

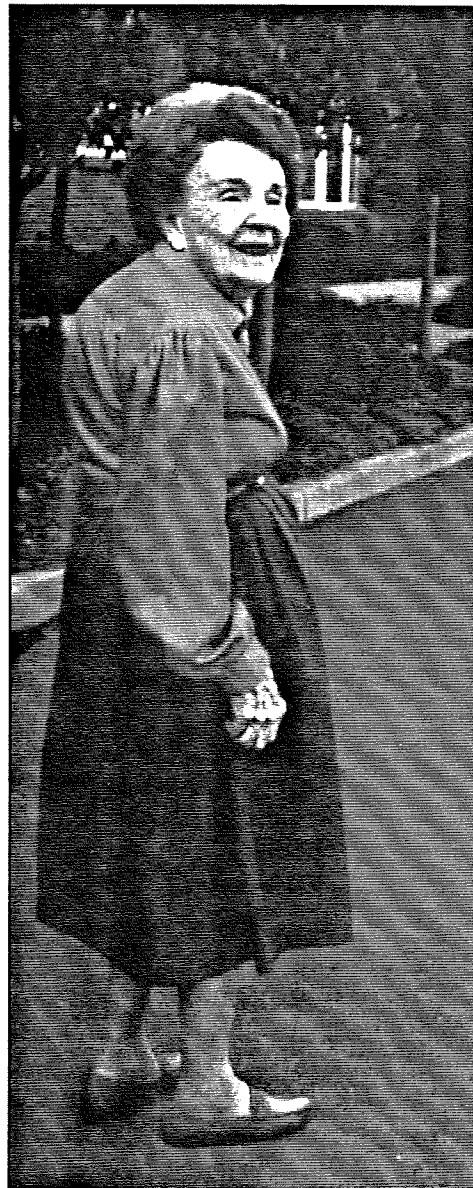
In Topeka alone, at the Women's Center where bone density testing is performed, approximately 70-80 individuals a month were tested in 1994 for osteoporosis. In 1995, approximately 115-120 patients per month were tested (almost double the physician referrals in one year). At the present time, there are approximately 135-140 individuals a month being screened for osteoporosis. Since an additional bone density machine was purchased, the facility is expected to screen approximately 280 patients a month. As you can see, the growing number of referrals is in direct correlation with the continued education of the general public and attending physicians on this very needed facility, in order to do early detection and early prevention.

The present cost of a bone density screening is \$200.00. Without adequate insurance coverage assistance, there will be a large percentage of individuals who, against the medical advice of their physicians, will be financially unable to seek early bone density screening, medically necessary for the individuals diagnosis and treatment of osteoporosis. After all, today's good medicine is early detection, early prevention. Because osteoporosis can fracture lives.

A Patient Profile



Linda at age 50:
Osteoporosis was present
but asymptomatic



Linda at age 75:
The sequelae included
kyphosis and disability

Statistics/information obtained through a brochure from Merck Co. Inc. Wyeth
Ayerst, "Osteoporosis Can Fracture Lives".

- (A.)
1. Consensus Development Conference: Diagnosis, prophylaxis, and treatment of osteoporosis, *Am. J. Med.* 94:646-650, June 1993.
 2. Melton, L.J. III et al.: Perspective: How many women have osteoporosis? *J. Bone Miner. Res.* 7(9):1005-1010, 1992.
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With regard to Blue Cross and Blue Shield of Kansas, all claims for Procedure Code 76075 - Bone Density Studies are processed via medical review. It is unclear as to what medical criteria must be met regarding coverage for this procedure. Recent review of claims indicate that Blue Cross and Blue Shield covers this procedure if there is a diagnosis of osteoporosis (733.00). However, we do not know if the patient has osteoporosis until the test is completed.

The need for testing by review of appropriate signs and symptoms including medical history can be done. Once again, it is unclear as to what signs and symptoms will meet criteria for coverage and as to where documentation of these signs and symptoms are to be kept (Primary care physician or place of procedure).

There are well-recognized legitimate signs and symptoms making bone density indicated. For example the National Osteoporosis Foundation has published four indications:

1. Estrogen-deficient women, to make decisions about hormone replacement therapy;
2. Vertebral or other bony abnormalities on routine radiographs which are suggestive, but not diagnostic of osteoporosis;
3. Patients on long-term glucocorticoid therapy;
4. Patients with hyperparathyroidism.

All the above are reasonable indications for a bone density test. One doesn't really know the presence of or degree of osteoporosis until the test is done. Therefore, it would make sense to accept some reasonable indications for the bone density to be done, rather than insisting on a diagnosis of osteoporosis before it will be reimbursed.

All insurance companies need to be consistent in their coverage guidelines. An example is Medicare will cover the testing using postmenopausal women as a sign and symptom, but Blue Cross and Blue Shield does not recognize this a covered sign and symptom. Another area of inconsistency is in the procedure code itself. Effective April 1, 1997, Medicare will no longer recognize Procedure code 76075 for reporting purposes. HCFA has created new HCPCS codes that are to be used in lieu of existing CPT codes. To date, Blue Cross and Blue Shield has not determined if they will consider coverage for these procedure codes when a patient has Medicare as primary coverage and Blue Cross as secondary.

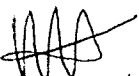
Another problem is the area of reimbursement. Reimbursement is for a single service even though more than one site may be examined. For Medicare the total RVU for the single service is grossly inadequate, even for one site. The "global" nature of Procedure Code 76075 for reimbursement for the single service must cover multiple scans. Procedure code 76075 are no more "global" than skeletal x-rays. Procedure codes for conventional x-rays allow one x-ray study per joint or body area, e.g. hand, shoulder, spine, pelvis, hip, foot, etc. Procedure code 76075 should be coded similarly.



KANSAS MEDICAL SOCIETY

February 24, 1997

To: House Health and Human Services Committee

From: Meg Henson 
Director of Government Affairs

Subj: SB 2360 - Diagnosis and Treatment of Osteoporosis

The Kansas Medical Society appreciates the opportunity to testify today in support of HB 2360, which would require insurance companies to provide coverage for bone density testing on certain individuals. KMS believes that public safety dictates this legislation be passed.

Osteoporosis is the most common skeletal disorder in the world and is second only to arthritis as a leading cause of musculoskeletal morbidity in the elderly. The condition is responsible for over 1.2 million bone fractures each year in the United States. One third of women over age 65 will have vertebral fractures. Additionally, by extreme old age, one in every three women and one in every six men will have had a hip fracture. This catastrophic fracture is fatal in 12-20 percent of cases and results in the need for long-term nursing home care for half those who survive the injury. It is clear that early detection of osteoporosis enables physicians to determine appropriate therapies and treatments for their patients before it is too late.

HB 2360 requires insurance companies to cover bone mass measurement only if, in the physician's professional opinion, such testing is medically necessary. KMS supports this concept.

We would suggest a couple of amendments, which are technical in nature. On page 2, line 30, the bill refers to the person's "attending physician or primary care physician." KMS suggests that the language be amended to read "physician." Second, we suggest that a definition of "physician" be included in the act. We have attached a balloon which includes both of these suggestions.

Thank you for the opportunity to comment. I would be happy to answer questions.

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1 detect osteoporosis until 25-40% of bone mass has been lost, and the
2 disease far advanced;

3 (8) while there are currently available technologies for bone mass
4 measurement, other technologies for measuring bone mass are under
5 investigation and may become scientifically proven technologies in the
6 future; and

7 (9) scientifically proven technologies for bone mass measurement and
8 other services related to the diagnosis and treatment of osteoporosis can
9 be used effectively to reduce the pain and financial burden that osteo-
10 porosis inflicts upon its victims.

11 (b) The purpose of this act is to provide insurance coverage to indi-
12 viduals with a condition or medical history for which bone mass meas-
13 urement (bone density testing) is determined to be medically necessary
14 for the individual's diagnosis and treatment of osteoporosis.

15 Sec. 3. (a) Any individual or group health insurance policy, medical
16 service plan, contract, hospital service corporation contract, hospital and
17 medical service corporation contract, fraternal benefit society or health
18 maintenance organization which provides coverage for accident and
19 health services and which is delivered, issued for delivery, amended or
20 renewed on or after July 1, 1997, also, shall provide coverage for a qual-
21 ified individual for scientifically proven bone mass measurement (bone
22 density testing) for the diagnosis and treatment of osteoporosis.

23 (b) For the purposes of this section:

24 (1) "Bone mass measurement" means a radiologic or radioisotopic
25 procedure or other scientifically proven technologies performed on an
26 individual for the purpose of identifying bone mass or detecting bone
27 loss.

28 (2) "Qualified individual" means a person with a condition for which
29 bone mass measurement is determined to be medically necessary by the
30 person's ~~attending physician or primary care physician.~~

31 Sec. 4. This act shall take effect and be in force from and after its
32 publication in the statute book.



KANSAS MEDICAL SOCIETY

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physician


(3) "Physician" means a person licensed by the state board of healing arts to practice medicine and surgery.

Kansas Association of Osteopathic Medicine

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February 24, 1997

To: Chairman Mayans and Members, House Public Health Committee
From:  Harold E. Riehm, Executive Director, KAOM
Subject: Testimony in Support of H.B. 2360 - DIAGNOSIS & TREATMENT OF
OSTEOPOROSIS

Thank you for this opportunity to testify in support of H.B. 2360. Osteoporosis is a serious, debilitating disease. Diagnosis and treatment of the condition necessitates periodic testing to determine bone density. It is a condition for which there should be no question of such tests being eligible for insurance company/managed care organizations inclusion in their respective listings of covered medical treatment, procedures and services.

If there are indeed insurance companies/managed care organizations not providing for coverage of bone mass measurement when medically necessary for diagnosis, monitoring of treatment, etc. THEN THEY SHOULD, IN OUR VIEW, BE PROVIDING SUCH COVERAGE. H.B. 2360 mandates such coverage and should be passed.

HOUSE HEALTH/HUMAN SERVICES
Attachment 1
2 - 24 - 97

1 ices at the center which is greater than the total the customer would be
2 charged for ~~six months~~ of such services or for ~~six months~~ of such services
3 on a pro-rated basis if the center charges fees on other than a ~~monthly~~
4 basis.

one year

yearly

5 Sec. 5. This act shall be part of and supplemental to the Kansas con-
6 sumer protection act and violation of any portion of this act shall be
7 considered an unconscionable act or practice pursuant to K.S.A. 50-627
8 and amendments thereto.

Such contract may provide for an optional service fee of not to exceed \$50 payable to the center if the contract is canceled by the customer as provided in section 3 and amendments thereto.

9 Sec. 6. This act shall take effect and be in force from and after its
10 publication in the statute book.

HOUSE HEALTH/HUMAN SERVICES
Attachment 8
2 - 24 - 07