Approved: 3-18-98
Date

MINUTES OF THE HOUSE COMMITTEE ON INSURANCE.

The meeting was called to order by Chairperson Dennis Wilson at 1:36 p.m. on March 10, 1998 in Room 527-S of the State Capitol.

All members were present except: Representative Robert Krehbiel, excused
Representative Larry Campbell, excused

Committee staff present: Bill Wolff, Legislative Research Department
Robert Nugent, Revisor of Statutes
Beth James, Committee Secretary

Conferees appearing before the committee: Ron Hein, American Diabetes Association and Dietetic Association of Kansas
Marty Glenn, Diabetes Association of Kansas
Patricia Hohman, American Diabetes Association
Julie Hellman, American Diabetes Association
Bob Williams, Kansas Pharmacists Association
Terri Roberts, Kansas State Nurses Association
Callie Jill Denton, Kansas Association of Health Plans
William W Sneed, Health Insurance Association of America
James P Schwartz, Jr., Kansas Employer Coalition on Health
Brad Smoot, Blue Cross/Blue Shield of Kansas

Others attending: See attached list

The meeting was called to order at 1:36 p.m. by Chairperson Wilson. Four sets of minutes were handed out to the committee to look over. The Chairperson had the committee turn their attention to **HB2997.**

HB2997: **Insurance coverage for diabetic equipment and supplies.**

The Chairperson called Ron Hein to the podium. (Attachment #1). Mr. Hein is a diabetic. He brought with him a glucometer, a lancet, a hypodermic needle, and a bottle of insulin. He went through the supplies that would be covered by the bill if you had a prescription. He also said that the bill would require reimbursement for education. Then he talked about the disease and the complications it can cause. Mr. Hein stated that studies have been done that show that people who go through the education and manage their own disease lower the health care dollars spent. In conclusion, Mr. Hein urged the committee to pass **HB2997**.

Mr. Hein also brought with him written testimony from Dr. James Mack. (Attachment #2). He pointed out to the committee that Dr. Mack makes the analogy that diabetes management is like fighting a war. Mr. Hein talked about how he has to plan out his day, taking his insulin as the counter action to what he consumes and what he physically does.

A question and answer period followed. Then the Chairperson called Marty Glenn to the podium. (Attachment #3). Mr. Glenn is a registered/licensed dietitian. He works with diabetics every day, so he sees those that are treated and those that aren't. Because of this, he said, he can really appreciate the magnitude of this issue. He reviewed with the committee some of the statistics associated with diabetes. He then went over what parts of the body can be affected by diabetes: the brain, the eyes, the heart, the kidneys, and your general circulation which affects your limbs. He referred to the report put out by Fletcher Bell, eleven years ago, which recommended insurance coverage for diabetics. Mr. Glenn said that passage of this bill will save health insurers significant amounts of money by reducing costly complications of the disease.

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
HOUSE COMMITTEE ON INSURANCE, MARCH 10, 1998
ROOM 527 AT 1:30 P.M.

The Chairperson then called Patricia Hohman to speak. (Attachment #4). She too, spoke as a proponent on this bill. She essentially read her written testimony.

Chairperson Wilson then called Julie Hellman to speak. (Attachment #5). Ms Hellman said that the nation spends 138 million dollars a year on diabetes and diabetes related complications. She talked about the study she and a team had worked on for 14 years involving 780 patients. That study was published in 1987 in Diabetes Care , the March issue. Their research showed a reduction in morbidity and mortality in both Type 2 and Type 1 diabetes with an intensified program. That means the patient working with a team made up of physicians, nurses and dietitians to educate in diet and self-management skills, and to provide aggressive cardiovascular screening and risk reduction. The decrease in mortality overall was 22% and a 45% decrease in mortality in those who were in the lower risk group at the start of the fourteen year period.

There is more information in Ms Hellman's written testimony. She asked the committee to support **HB2997**.

The next proponent to speak was Bob Williams. (Attachment #6). Mr. Williams spoke about the importance of educating the patient. He said that pharmacists see diabetes patients 5 times more than any other health care provider, according to research studies. This is probably because they are more accessible then other health care providers. For this reason, Mr. Williams requested that an amendment be added to the bill. A balloon of the amendment is attached to Mr. Williams testimony. Also, attached to his testimony is a article which describes research done by Dr. Jack Fincham, Dean of the K.U. School of Pharmacy. The K.U. School of Pharmacy has a post-graduate diabetic management certification program for pharmacists.

The Chairperson then called Terri Roberts to the podium. (Attachment #7). Ms Roberts said that she was testifying in place of Robyn Parker ARNP, a family nurse practitioner and certified diabetes educator. Ms. Parker's testimony is attached to Ms Roberts testimony. Ms Roberts would like to see **HB2997** amended. The amendments are outlined in her testimony and a balloon is attached.

The next speaker was Callie Denton. (Attachment #8). She wanted the committee to know that the members of (KAHP) are neutral about this bill. KAHP is in support of the philosophy exemplified by the bill. However, KAHP members are in opposition of **HB2997** inasmuch as it is a mandate. KAHP opposes all mandates.

Ms Denton was asked what the cost per policy holder would be. She said that a fiscal note was done on the Senate side regarding a similar bill and the cost was around $2.00. Representative Wilson wanted to know that since they keep talking about what the long term savings would be on this bill, wouldn't there then be a savings to policy holders. Ms Denton said yes.

The next speaker was Brad Smoot. Mr. Smoot did not have any written testimony because he had not intended to testify. He went over a few areas of the bill and talked about what those changes would mean to the policy holders. B/C B/S would like to have a opportunity to review and comment on the proposed amendments that had been discussed today by the Nurses Association and the Pharmacists association.

The Chairperson then called Bill Sneed to the podium. (Attachment #9). Mr. Sneed represents HIAA. They are in opposition to **HB2997**. HIAA is concerned about the cost of any mandate imposed by the government on the private health insurance market. He said that several people had asked why some insurance companies have this coverage while others do not. The answer is simple. Cost. When individuals or companies are shopping for an insurance company the major factor is cost. He said that if everyone wanted this type of coverage in their policy all the policy's would have it. He said that the insurance companies do respond to the market place. He said that it is because of the market place this coverage is not in all policy's. He feels that if the members of the Insurance Committee feel that everyone in the state of Kansas should have this coverage then the state of Kansas should provide it for them. That way, all of the people will benefit and all of the people will see a reduction in their health care costs. And, if that is not what you really want, then please consider the balloon amendment that is attached to his testimony. He said that balloon is generally what they put in their mandates through out the statutes. And, he suggested that the committee include it in their deliberations. There were no questions.

The final speaker was James P. Schwartz Jr., who spoke in opposition to the bill. Mr. Schwartz essentially spoke from his written testimony. (Attachment #10).

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.

There were no other speakers on this bill. Chairperson Wilson said that he would like to work this bill. The industry needs to see the proposed amendments. He invited anyone to speak to him or Representative Tomlinson and let their feeling on this bill and the proposed amendments be known. From that information the committee can discuss the bill and possibly work it. The hearing was closed on **HB2997** for the day.

Chairperson Wilson said that he would entertain a motion on the four sets of minutes that were handed out at the beginning of the meeting. Representative Stone made a motion to adopt the minutes of February 10, February 11, February 16, and February 25, 1998. The motion was seconded by Representative Burroughs. There was no discussion. The committee voted and the motion passed.

There was no other business. The meeting was adjourned at 3:02 p.m. The next meeting is March 11, 1998.

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.

HOUSE INSURANCE COMMITTEE GUEST LIST

DATE: 3-10-98

NAME	REPRESENTING
Bob Alderson	Ks. Pharmacists Assoc.
Bob Williams	Ks. Pharmacists Assoc
Barbara Woods	KU School of Pharmacy
Callie Hill Denton	KAHP
Julie Hein	ADA / KDA
Steve Kearney	CIGNA
Heather Randall	Whitney Damron PA
Tom Wilder	KID
Terri Roberts	Kansas State Nurses Assoc.
Miranda Raney	KSNA
Bill Sneed	NIAA
Meg Draper	Kansas Medical Society
Betty Hanson	Dietetic Assn of KS
Gary Pedersen	Bayer Corp.
Jim Schwartz	KS Employer Coal. on Health
Jack Hohman	Citizen
Susan Anderson	Hein + Weir
Julie Hellman	ADA
Pat Hohman	citizen

HOUSE INSURANCE COMMITTEE GUEST LIST

DATE: 3-10-98

NAME	REPRESENTING
Marty Cohen	Dietetic Assn of Kansas
Ron Hein - American Diabetes Assoc +	Dietetic Association of Kansas
Brad Smoot	BCBS
Blythe Ridenour	Intern - Rep. Johnson
Natalie Haag	Federico Consulting

HEIN AND WEIR, CHARTERED
ATTORNEYS AT LAW
5845 S.W. 29th Street, Topeka, KS 66614-2462
Telephone: (785) 273-1441
Telefax: (785) 273-9243

Ronald R. Hein
Stephen P. Weir
Susan Baker Anderson

HOUSE INSURANCE COMMITTEE
TESTIMONY RE: HB 2997
Presented by Ronald R. Hein
on behalf of
American Diabetes Association and Dietetic Association of Kansas
March 10, 1998

Mr. Chairman, Members of the Committee:

My name is Ron Hein, and I am legislative counsel for the American Diabetes Association and the Dietetic Association of Kansas.

I appear today in support of HB 2997, which requires insurance companies providing health insurance in Kansas to include within their coverage reimbursement for diabetes self-management supplies and education. The legislation does not require first dollar coverage, and makes the coverage subject to any deductions, co-payments, or medical necessity requirements applicable to other coverages under the policy.

Diabetes is a killer disease affecting 16 million people nationwide, almost half of whom are undiagnosed. Diabetes is the seventh leading cause of death, the leading cause of new blindness, and the leading cause of end-stage renal disease. Diabetes accounts for 50% of lower limb amputations. Diabetics are far more likely to have strokes or heart disease than the general public. Diabetes nationwide accounts for one of every seven healthcare dollars spent costing $138 billion annually.

I have previously delivered to each member of the committee the Social and Financial Report on SB 386 (the companion bill in the Senate) required by Kansas Statutes. If you have had an opportunity to review that report, you have seen clearly that all studies indicate that tight blood sugar control of diabetics, while not a cure, can at the worst delay the onset of complications, and at the best, avoid these complications all together.

The studies clearly indicate that money spent on self-management education and supplies will reduce hospitalizations and overall healthcare costs for diabetics. In 1987, the State of Kansas came to that same conclusion after a study that was ordered by the legislature. Attached to my testimony is an excerpt from then Insurance Commissioner Fletcher Bell's bulletin to all companies authorized to transact accident and health business in the state of Kansas. In that Bulletin, the Commissioner encouraged the insurance companies to cover diabetes self-management education.

The insurance industry in Kansas has responded to some extent, and coverage is far more prevalent today than it was in 1987. However, unfortunately, some companies still do not fully cover these services. It is for those companies that SB 386 is intended.

House Insurance
Attachment #1-1
3-10-98

House Insurance Committee
ADA/DAK Testimony HB 2997
March 10, 1998

When SB 386 was heard in the Senate, some issues were raised by Blue Cross/Blue Shield and the Kansas Association of Health Plans. I have worked with Brad Smoot and Callie Denton on those bill drafting issues, and HB 2997 as drafted includes the language that we came to agreement on, and Blue Cross/Blue Shield and Kansas Association of Health Plans are now neutral on the bill.

We would urge the committee to pass HB 2997 so that the citizens of Kansas can enjoy the same rights to coverage of this type as is afforded the citizens of 23 other states, and the beneficiaries of those insurance policies that do fully cover those services in this state.

Thank you very much for permitting me to testify, and I will be happy to yield to questions.

House Insurance Committee
ADA/DAK Testimony HB 2997
March 10, 1998

Excerpt from Insurance Commissioner's Bulletin 1987-9:

"Based on the findings of the Ad Hoc Committee, there is evidence from a number of studies that appears to demonstrate a clear and convincing association between patient education and a reduction in hospitalizations which result in cost savings. From the limited number of companies offering coverage for out-patient diabetes education programs, the Committee believes the health insurance industry in Kansas is not taking full advantage of the potential savings available as a result of diabetes education program benefits. Conversely, the Kansas insuring public is not receiving the economic benefits and health enhancements because of the unenlightened design of most health insurance policies.

"At this time, the Ad Hoc Committee does not recommend requiring or mandating coverage for diabetes self-management education programs. However, in view of the substantial savings potential, the Committee recommended that the Kansas Insurance Department inform insurers issuing medical expense health insurance contracts in Kansas of the Committee's findings and encourage insurers to include benefits for in-patient and out-patient diabetes self-management education.

"The Kansas Insurance Department fully supports the Committee's recommendations. It is the department's belief that by adding benefits for properly administered diabetes education programs which meet nationally recognized standards, the health insurance industry will be providing a meaningful benefit which will, in turn, have a significant impact on the claim costs associated with providing coverage for people who have diabetes.

"It is anticipated that this department will be requested to report the progress of insurers in providing these benefits to a subsequent session of the Kansas Legislature, perhaps as early as 1989. With the cooperation of the health insurance industry the possibility of a legislative enactment requiring coverage for diabetes self-management education programs will be greatly minimized."

Preferred Medical Associates

Crow-Tretbar

848 N. St. Francis
Wichita, KS 67214

Tel: 316 261-3100
Fax: 316-261-3105

Endocrinology
James K. Speed, MD
James A. Mack, MD

Gastroenterology
Alonso Galvan, MD
James A. Whitaker, MD

Internal Medicine
Ray F. Fisher, MD
Joaquin G. Santos, Jr., MD
Mitchell A. Morgan, MD
Thomas C. Reals, MD
Carlene D. Klassen, MD

Neurology
Richard W. Murrow, MD
Bart A. Grelinger, MD
Ty L. Schwertfeger, MD

Pulmonary
Richard W. Spann, MD
Richard A. Claiborne, MD
Guy M. Grabau, MD
Brian M. Gross, MD

Rheumatology
James D. Anderson, MD
Timothy S. Shaver, MD

February 9, 1998

To Whom It May Concern:

I am an endocrinologist in Wichita, and I have become aware of some proposed legislation regarding the funding of supplies and education for diabetic patients. This is a vitally important issue, and I would like to take a few moments to tell you why.

Diabetes mellitus is a chronic, potentially debilitating disease. Its adequate management is complex and requires, first of all, adequate supplies. Diabetic patients must be able to monitor their own blood glucose levels in the same manner that a motorist driving down the highway must be able to see where he or she is on the road at any given time. This, in turn, requires a home blood glucose meter and testing strips, both of which (and particularly the latter, over time) may be quite expensive.

Adequate monitoring alone, however, is not sufficient for appropriate care if the patient does not know how to respond to the measured blood glucose levels. Therefore, appropriate education is vital in the behavioral and cognitive areas to allow each diabetic patient to maximize blood glucose control.

Why is this important? A landmark study, the Diabetes Control and Complications Trial, clearly showed that in type 1 diabetic patients, control of blood glucose levels as close to normal as possible resulted in a dramatic decrease in the rates of debilitating and expensive complications such as eye, kidney, and nerve damage. These findings are generally believed to apply to type 2 patients as well.

With respect to proposed legislation regarding these issues, I am concerned that an error of short-sightedness may prevail. Certainly, diabetic supplies and education are expensive, but I would view this as a "front-loaded" expense. I firmly believe, and studies have shown, that downstream expenses such as those associated with the complications referred to above will be decreased significantly by adequate initial expenditures. As a society, we are, in effect, shooting ourselves in the foot if we do not supply the necessary funds for diabetic patients to manage their disease effectively.

A Member of Via Christi Health System

In a perhaps overworked but nevertheless appropriate analogy, diabetes management may be thought of as a war, where the enemy consists of not only acute complications (such as hypoglycemia and diabetic ketoacidosis) but also chronic, delayed complications such as coronary artery disease and the other organ problems mentioned above. In this scheme, physicians are the generals who plot strategy and deploy various elements of the armamentarium (medications, behavioral strategies, and cognitive training) at appropriate times in the evolution of the battle. Patients, on the other hand, are the infantry who are "in the trenches", making decisions on a daily basis that affect their ultimate safety and health in a way that is every bit as real as that of a soldier who is faced with difficult decisions in the course of battle. The main difference, of course, is that the effects and consequences of a patient's decisions are delayed, in many cases, 10-20 years after decisions are made. Just as we would think it absurd as a society to send soldiers into battle without, firstly, appropriate battle gear and, secondly, the combat training necessary for their survival, I believe we would be equally foolish to send diabetic patients into the fray without the supplies and skills to do daily battle with their disease.

As this legislation is considered, I urge you to consider the importance of empowering patients to take control of their disease, as this is clearly the most humane and the most effective strategy for management of this disease.

Thank you for your consideration of these thoughts.

Sincerely,

James A. Mack, M.D.
JAM/cs
r 2/9/98 & t 2/9/98

2-2
3-10-98

Testimony-House Bill 2997
House Insurance Committee
March 10, 1998
Marty Glenn M.S.,R.D,.L.D.-Legislative Co-Chair DAK

I represent the 750 dietitian's in Kansas in asking for your support of SB 2997. I along with many other dietitian's treat diabetics everyday and see first hand why this is such an important issue. I want to begin with some alarming statistics that show how devastating this disease can be:

- -diabetes accounts for one in seven Kansas HealthCare dollars
- -151,000 have diabetes
- -it is the leading cause of blindness in people ages 25-74
- -it accounts for 50% of lower limb amputations
- -are 2-4 times more likely to have heart disease & 5 times more likely to have a stroke
- -diabetes accounts for 1/3 of all cases of kidney failure
- -diabetics are 1.5 times more likely to be hospitalized
- -one Kansan dies every 4 hours from the disease

What this data doesn't take into account is the problems diabetes creates that are difficult to quantify but every bit as costly. I've interviewed allot of diabetics and they all tell me the same thing: that until they gained control of their blood sugars they felt sluggish, fatigued, unable to think as clearly, and un-ambitious. They were much less productive on their jobs, and often absent employees. So you can see that managing diabetes can not only save health insurers money, it will benefit employers in Kansas, through more productive workers, with a better attitude, and less sick days.

I also urge that you take action on this bill during this session and not postpone it for the interim. I think the issue has been thoroughly analyzed, further analysis will only reinforce what we're telling you today and what former Insurance Commissioner Fletcher Bell wrote in a memo 11 years ago, "that the health insurance industry is not taking full advantage of the potential savings available as a result of diabetes education program benefits. Conversely, the Kansas insured public is not receiving the economic benefits and health enhancements because of the unenlightened design of most health insurance policies".

I realize mandate issues are difficult, but there are occasions when mandates aren't such a bad resolution. This legislation can be a win-win situation for all involved as I do not know of any chronic disease in which people who suffer from it, are so responsible for its management, day in and day out. And by self-managing their disease simultaneously save health insurers significant amounts of money by reducing costly complications of the disease.

In closing, I urge you to follow the lead of 23 other states and support the diabetes coverage act and not see it as just another health insurance mandate that will drive up insurance rates. Thank you for the opportunity to testify.

House Insurance
Attachment #3
3-10-98

My name is Patricia Hohman. I am a Registred Nurse with a Masters Degree in Nursing and I am a Certified Diabetes Educator. I feel fortunate to be standing here before you on my own two legs and looking at you through healthy eyes. I have been a diabetic for 21 years and never had diabetic teaching. I graduated from nursing school 10 years ago and during my nursing education I learned the basics of managing diabetes. In 1992 I became employed as a diabetes educator and in 1995 sat for and passed the CDE exam.

Most patients are not as lucky as I have been. Had I not decided to become a nurse I am sure I would not be healthy today. Within the last 2 years, 3 patients I knew died who were Type 1 diabetics, and had been diabetic fewer years than I have.

The first was 34 when I began working with him.. His diabetes was diagnosed at the age of 16, but he never had any follow up education or support after the initial diagnosis. He was unable to work, and did not have health insurance. He had a medical card with limited benefits. I supplied him with insulin and test strips as often as I could. Part of his foot was amputated, his kidneys had failed and he was on dialysis. He had had laser surgery to correct the damage caused from retinopathy. He lost the vision in one eye and had limited vision in the opposite eye. He died at home, presumably of a heart attack at the age of 36.

Another Type 1 diabetic died after having diabetes for 15 years. She was in the hospital more times than I can remember with Diabetic Keto Acidosis. Although I did not work with her in the capacity of a CDE, I took care of her many times as a staff nurse. Her repeated hospitalizations may have been prevented but, she never had the education and support that was necessary to manager her diabetes. She was on dialysis and died of congestive heart failure at the age of 36.

The third individual struggled to live a normal life in spite of her diabetes. She wanted to work because it made her feel good about herself and gave some structure to her life. She started selling Tupperware. She was forced to stop because the income threatened her Medical Card which she needed badly to cover her medical expenses. She had never had any formal diabetic education. What she knew she had picked up along the way through some reliable and some unreliable sources. The diabetes had caused the amputation of her left leg , and her kidneys were failing. She died of a systemic infection that the physicians were unable to cure even with very powerful antibiotics. Unfortunately she died at the age of 48 with low self esteem and low self worth.

Everyone knows that there is no cure for diabetes. Education is our best hope for helping diabetics understand how to manage their disease and the consequences of not managing their disease. Unfortunately, most insurance companies do not provide benefits for education. Even if diabetics have the knowledge to manage their disease they still need the tools and support to do so. I feel that if the individuals I discussed had had access to education and supplies at the onset of their diabetes, they would be here today just as I am to tell their stories.

Because I have access to the latest research and information I am able to manage my diabetes and keep myself healthy and free of complications. I recently purchased an insulin pump at a cost of more than $4,000.00. Fortunately, I was able to afford the insulin pump since it is not a service covered by my health insurance. I am only one of the 81,000 voices of people in the State of Kansas with diabetes. Not everyone may be as lucky as I. Please support House Bill No. 2997.

House Insurance
Attachment #4
3-10-98

H.B. 2997 Diabetes Reimbursement Bill

My name is Julie Hellman. I am a registered professional nurse and a certified diabetes educator. I am a professional member of the American Diabetes Association, a member of the Endocrine Nurses Society, the American Association of Diabetes Educators and a charter member of the Lipid Nurse Task Force. As a clinical nurse and diabetes educator, I help people with diabetes manage their care and teach self-management skills on a daily basis. I have worked in this area since 1983. I am employed in a private practice setting and work with three physicians who are specialists in diabetes and endocrinology. I am submitting my testimony in support of H.B. 2997 on behalf of the American Diabetes Association.

Diabetes is a devastating disease. The number of people with diabetes in the United States has tripled since 1960. There are now 16 million Americans with diabetes. According to the National Institutes of Health, the nation now spends $138 billion per year on diabetes and diabetes related complications. That is an increase of 50% in the last five years. Diabetes is the leading cause of blindness in adults aged 25-64; it is the leading cause of end-stage kidney disease; it is a major contributor to heart disease and stroke. Diabetes is also a silent disease: half of the sixteen million people estimated to have diabetes do not yet know it. Often Type 2 diabetes is not diagnosed until some of the more serious complications leads the person to seek medical care. Poorly controlled diabetes can be a major contributor to absenteeism in the workplace and decreased performance due to fatigue and altered mental function. Only preventive treatment can improve the quality of life for the person with diabetes and substantially reduce the long term health care costs. According to the December 1995 issue of Practical Diabetology, it is estimated that through better management of diabetes:

- diabetes-related blindness could be reduced by 90%.
- diabetes-related kidney disease requiring dialysis could be reduced by 50%.
- diabetes-related complications and amputations could be reduced by 50%.

There is no cure for diabetes. Diabetes can be treated; however, the person who has diabetes is the one who is responsible for carrying out the treatment. This condition is one in which the person with diabetes needs to know how to manage the disease. This management is at least in part based upon blood glucose levels tested by the patient using a home glucose monitor or strips. The person with diabetes must have the tools to perform the testing and the knowledge in order to incorporate this information into their day to day plan of care.

Many studies have shown the value of diabetes education and self-management training in improving quality of life and decreasing health care costs. Unfortunately, many people with diabetes cannot afford to pay for blood glucose monitoring supplies and diabetes education out-of-pocket. As a result, they are unable to effectively manage their diabetes. The Diabetes Control and Complications Trial (DCCT), the results of which were published in 1993, showed that excellent blood glucose control in persons with diabetes resulted in a 76% decrease in diabetic retinopathy (diabetic eye disease), a 60% reduction in neuropathy (nerve damage), and a 56% reduction in diabetic nephropathy (kidney disease). This study was done in persons with Type 1 diabetes only - it was not designed to study the 90% of the diabetic population that has Type 2 diabetes, but it was believed by the investigators that similar treatment should result in similar benefits for the Type 2 patients.

In June, 1993, I was in the audience at the Scientific Sessions of the American Diabetes Association where the long awaited results of the nine year DCCT study were presented to the medical community for the first time. I believed that the data would support the use of intensified control of diabetes in the United States. We had been providing similar care in our practice since 1981. This form of care has been considered routine in Europe since the early 1970's. I hoped the findings would help us to get on with the monumental task of taking care of our population that had been under-served for so long. Not all were convinced. A physician sitting behind me said, "Yes, but that was not the normal patient population and the care was provided in a university setting. You can't do that in the real world." When our team returned to Kansas, my co-authors and I began the task of compiling the data to prove that - yes, you can do that in the

real world. Our research was published in Diabetes Care in March, 1997. Under the direction of Dr. Richard Hellman, we put together 14 years of data on 780 patients. We showed that we reduced the morbidity (illness rate) and mortality (death rate) in both Type 2 and Type 1 diabetes with an intensified program.

When we speak of an intensified program, we refer to a team of physicians, nurses and dietitians, working together with the patient to educate in diet and self-management skills, provide aggressive cardiovascular screening and risk reduction. Care involved glucose monitoring four times daily and what ever level of medical intervention was required to achieve normalization of blood glucose levels - from diet and exercise alone, to oral medications, to multiple insulin injection or insulin pumps. We were able to achieve a 22% decrease in mortality overall and a 45% decrease in mortality in those who were in the lower risk group at the start of the fourteen year period. We saw similar reductions when we looked specifically at females, minorities, cardiac deaths and renal failure resulting in dialysis or death. There was a striking correlation between patients who developed long term disability from diabetic neuropathy and elevated overall blood glucose control.

We could not provide the care that we give successfully, if our patients were unable to spend the time with us to learn to care for themselves. We could not safely control their blood glucose levels if they were unable to monitor those levels on a day to day basis. We are constantly confronted with the dilemma our patients face when they have no insurance coverage for these essential services and supplies and the burden these out of pocket medical expenses can become. For the woman with gestational diabetes, it can make the difference between a healthy newborn and child born with long term disabilities. For the Type 1 diabetic, it may reduce the incidence of hospitalizations, make a healthy pregnancy possible, preserve their vision, their kidneys or their life. For the Type 2 diabetic, it may mean the difference between seeing their grandchildren grow up or dying of premature cardiovascular complications.

On behalf of the American Diabetes Association, I ask for your support of H.B. 2997. Not only will this bill improve the lives of Kansans with diabetes, it will significantly decrease health care costs. Thank you for the opportunity to speak to this Committee.

THE KANSAS PHARMACISTS ASSOCIATION
1308 SW 10TH AVENUE
TOPEKA, KANSAS 66604-1299
PHONE (785) 232-0439
FAX (785) 232-3764

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

TESTIMONY

HB 2997

House Insurance Committee

Tuesday, March 10, 1998

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 2997.

HB 2997 would require group health insurance policies, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization which provides coverage for accident and health services to provide coverage for equipment, supplies, and outpatient self-management training and education when prescribed by a physician.

Diabetes is a progressive, chronic disease affecting 16 million Americans. There is no cure and its incidence is increasing. According to the new guidelines issued by the American Diabetes Association early diagnosis and treatment can reduce the risk of diabetic complications by as much as 50 to 75 percent. While there is no cure, diabetes can be controlled with the proper treatment. Pharmacists are in a unique position to help patients optimize their drug therapy, including managing the adverse effects of medications. According to a special report by the American Pharmaceutical Association: *Solving Drug Therapy Problems in Patients with Type 2 Diabetes;* "The newer antidiabetes agents affect different mechanisms that underlie diabetes and thus offer varying avenues to controlling hyperglycemia. They also present new challenges to physicians and pharmacists alike in determining the optimum dosage for each patient that will control the disease while minimizing adverse effects." I have attached to my testimony an article

describing research done by Dr. Jack Fincham, Dean of the K.U. School of Pharmacy. His research clearly indicates that pharmacists actively engaged in the education of diabetic patients resulted in a $4,295 per patient savings to the overall health care system.

The K.U. School of Pharmacy provides a 45-hour post-graduate diabetic management certification program for pharmacists. This program focuses on the following: foster improved patient therapy outcomes by encouraging practice behavior that emphasizes drug and treatment monitoring, compliance and education; review of current trends in the diagnosis, treatment and management of diabetics; evaluation of the complications of diabetes related to the diabetic foot, obesity and kidney disease; focus on the relationship of diet, nutrition and medication in the treatment of Type II diabetes; methods to improve sensitivity, understanding, concentration and credibility in communicating with patients; improve documentation of patient/pharmacist interactions by use of the S.O.A.P. method.

For these reasons, KPhA encourages the committee to adopt an amendment which would include the coverage for outpatient self-management training and education when provided by a "licensed pharmacist who has successfully completed a program of diabetes education conducted by the University of Kansas School of Pharmacy."

To effectively control and treat diabetes, the entire health care team needs to participate in the patient's treatment plan. Many states have already moved in this direction and have passed similar legislation (AR, IN, MN, TN, WV, MD, TX). Legislation is pending in eleven other states (CA, DE, IL, LA, MA, NC, NH, NY, PA, VT, NM). It makes no sense to exclude the pharmacy profession, especially when one considers that, in many settings, the pharmacist is the only accessible health care provider.

We encourage your support of our amendment and this bill. Thank you.

An update on management, marketing, and compensation in an evolving marketplace

INSIDE PHARMACIST CARE

JAN/FEB 1998

Published Bimonthly by the National Institute for Pharmacist Care Outcomes

REC'D FEB 17 '98

Kansas Study Shows Diabetes Care Saves Payers Billions

A study funded by NCPA has offered stunning proof that pharmacist care can save health care payers billions—yes, billions—of dollars each year.

The study, headed by University of Kansas School of Pharmacy Dean Jack Fincham and University of California at San Francisco Clinical Professor of Pharmacy Paul Lofholm, focused on how diabetes care improves patient compliance. The result: Cost savings for reduced physician visits, emergency room visits, hospitalizations, and long-term care admissions were estimated at $219,045 for 51 patients over two months.

That comes out to $4,295 per patient; extrapolated to the entire population of diabetes patients each year, the amount saved would total $34.4 billion (see related story, page 3). "This amount would postpone a staggering 37.4 percent of the direct and indirect costs of diabetes per year in the United States," says Fincham.

The number of patients in the study who underwent monthly foot examinations doubled, from 35 percent at the beginning of the study to 70 percent. Self-reported drug regimen compliance rates also jumped from 82 percent to 88 percent over the study period, while patients also saw a 24 percent reduction in glycosylated hemoglobin levels between baseline and the end of the study.

Results from the Health Status Questionnaire—which measures, among other things, health perception, physical functioning, social functioning, and mental health—found that patients' perception of their health "significantly improved," as did physical and social functioning and energy levels.

"Pharmacists deserve to be paid for such interventions that avert the spending of unnecessary health care dollars and markedly improve the quality and consistency of health care in the United States," asserts Fincham.

NCPA Seeks HCFA Definition on Diabetes Providers

NCPA, with several other health care provider groups, wants the Health Care Financing Administration to clarify the definition of a certified diabetes provider in hopes of ensuring that pharmacists get paid for diabetes educational services.

The groups agreed to suggest regulatory language that includes licensed pharmacists, registered nurses, dietitians, physicians, physician assistants, podiatrists, physical therapists, and occupational therapists under the "certified provider" umbrella.

NIPCO Executive Director Kathryn Kuhn met recently with HCFA and representatives of the American Dietetic Association, the American Association of Diabetes Educators, the American Diabetes Association, the National Association of Chain Drug Stores, and the American Pharmaceutical Association. The groups discussed proposed regulatory language for the definition of a certified provider, education criteria, and a care plan that can be used as a basis for billing and payment.

The Balanced Budget Act passed last year by Congress calls for Medicare to pay for diabetes "outpatient self-management training services" and blood-glucose testing strips and monitors.

Pharmacists are becoming front-line providers in treating diabetes because they can effectively identify diabetes patients, educate them, monitor their medication use, monitor blood glucose levels, track outcomes, and refer patients to other providers.

6-3
3-10

INSIDE THIS ISSUE...

2 Pennant Fever
3 Convention Topics
4 Coding Case
6 Quality Check
6 Paid in Full
7 Well Being
7 At Their Service
8 Coding Corner

Session of 1998

HOUSE BILL No. 2997

By Committee on Appropriations

2-26

AN ACT concerning insurance; relating to increased coverage for diabetes; amending K.S.A. 1997 Supp. 40-1909 and 40-19c09 and repealing the existing sections.

Be it enacted by the Legislature of the State of Kansas:

New Section 1. (a) This act shall be known and may be cited as the "diabetes coverage act."

(b) Any individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization which provides coverage for accident and health services and which is delivered, issued for delivery, amended or renewed on or after January 1, 1999, also, shall provide coverage for equipment, and supplies, limited to hypodermic needles and supplies used exclusively with diabetes management and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin using diabetes if prescribed by a health care professional legally authorized to prescribe such items under the law. Such coverage shall include coverage for insulin only if such coverage also includes coverage of prescription drugs.

(c) Diabetes outpatient self-management training and education shall be provided by a certified, registered or licensed health care professional with expertise in diabetes. The coverage for outpatient self-management training and education shall be required pursuant to this section only if the diabetic after consultation and approval by a physician licensed to practice medicine and surgery: (1) is treated at a program approved by the American diabetes association; (2) is treated by a person certified by the national certification board for diabetic educators; ~~or~~ (3) is, as to nutritional education, treated by a licensed dietitian

; or (4) is treated by a licensed pharmacist who has successfully completed a program of diabetes education conducted by the university of Kansas school of pharmacy

(d) (1) The benefits provided in this act shall be subject to the same annual deductible or co-insurance and the same requirement of medical necessity established for all other covered benefits within a given policy. In the case of a policy requiring that services be provided by or upon referral from a primary care physician, the benefits provided by this act

6-4
3-10-98

700 SW Jackson, Suite 601
Topeka, Kansas 66603-3731

785/233-8638 * FAX 785/233-5222
www.nursingworld.org/snas/ks

the Voice of Nursing in Kansas

Debbie Folkerts, A.R.N.P.--C.
President

Terri Roberts, J.D., R.N.
Executive Director

TO: Members of the House Insurance Committee

FROM: Terri Roberts J.D., R.N.
Executive Director

DATE: March 10, 1998

SUBJ: H.B. 2997 Increased Coverage for Diabetes Supplies and Education

The Kansas State Nurses Association is very encouraged that Kansans with diabetes may have the opportunities to self-manage their disease through proper education and supplies provided for as part of H.B. 2997 I insurance coverage. Robyn Parker ARNP, a family nurse practitioner and certified diabetes educator could not be with you today to give her testimony on behalf of the nursing profession, so it is included with this memorandum. She has a passion when she addresses this issue, and that is reflected in her written testimony.

There is one proposed change that we would like to offer to H.B. 2997 that addresses who can prescribe the services addressed by this legislation. Page 1, line 26 uses the term *"prescribed by a health care professional legally authorized to prescribe such items under the law."* to describe the category of provider that will trigger reimbursement for the various services and supplies. For purposes of reimbursing outpatient self-management training and education, **line 34** more narrowly defines who may authorize this service and it is limited to *"after consultation and approval by a physician licensed to practice medicine and surgery."* We are recommending the striking of the language beginning on *line 34* after the word *diabetic. (See Balloon)*

Our rationale for making this request is to permit Advanced Registered Nurse Practitioners and others legally authorized to prescribe such items, to do so and provide insurance coverage in these cases. We believe that the language used in section (b) is sufficient to provide clear direction regarding those authorized to prescribe the services/supplies. In many of the rural communities in Kansas nurse practitioners are providing much needed health care services, in fact they are providing the majority of professional services in the more than 150 rural health clinics in our state.

THANK YOU

attachment: Written Testimony Robyn Parker MSN, ARNP

House Insurance
Attachment # 7-1
3-10-98

HOUSE BILL No. 2997

By Committee on Appropriations

2-26

Kansas State Nurses Association
Proposed Amendment to H.B. 2997
March 10, 1998

7-2
3-10-98

9 AN ACT concerning insurance; relating to increased coverage for dia-
10 betes; amending K.S.A. 1997 Supp. 40-1909 and 40-19c09 and re-
11 pealing the existing sections.
12
13 *Be it enacted by the Legislature of the State of Kansas:*
14 New Section 1. (a) This act shall be known and may be cited as the
15 "diabetes coverage act."
16 (b) Any individual or group health insurance policy, medical service
17 plan, contract, hospital service corporation contract, hospital and medical
18 service corporation contract, fraternal benefit society or health mainte-
19 nance organization which provides coverage for accident and health serv-
20 ices and which is delivered, issued for delivery, amended or renewed on
21 or after January 1, 1999, also, shall provide coverage for equipment, and
22 supplies, limited to hypodermic needles and supplies used exclusively
23 with diabetes management and outpatient self-management training and
24 education, including medical nutrition therapy, for the treatment of in-
25 sulin dependent diabetes, insulin-using diabetes, gestational diabetes and
26 noninsulin using diabetes if prescribed by a health care professional le-
27 gally authorized to prescribe such items under the law. Such coverage
28 shall include coverage for insulin only if such coverage also includes cov-
29 erage of prescription drugs.
30 (c) Diabetes outpatient self-management training and education shall
31 be provided by a certified, registered or licensed health care professional
32 with expertise in diabetes. The coverage for outpatient self-management
33 training and education shall be required pursuant to this section only if
34 the diabetic ~~after consultation and approval by a physician licensed to~~
35 ~~practice medicine and surgery:~~ (1) is treated at a program approved by
36 the American diabetes association; (2) is treated by a person certified by
37 the national certification board for diabetic educators; or (3) is, as to
38 nutritional education, treated by a licensed dietitian.
39 (d) (1) The benefits provided in this act shall be subject to the same
40 annual deductible or co-insurance and the same requirement of medical
41 necessity established for all other covered benefits within a given policy.
42 In the case of a policy requiring that services be provided by or upon
43 referral from a primary care physician, the benefits provided by this act

Delete

700 SW Jackson, Suite 601
Topeka, Kansas 66603-3731
Work: 785-233-8638 Fax: 785-233-5222
Cell Phone: 785-249-8215
E-Mail: troberts@echo.sound.net
www.nursingworld.org/snas/ks
Home: 785-354-9303 Fax: 785-354-9317
TERRI ROBERTS, JD, RN
Executive Director

700 SW Jackson, Suite 601
Topeka, Kansas 66603-3731

785/233-8638 * FAX 785/233-5222
www.nursingworld.org/snas/ks
the Voice of Nursing in Kansas

Debbie Folkerts, A.R.N.P.--C.
President

Terri Roberts, J.D., R.N.
Executive Director

FOR MORE INFORMATION CONTACT:
TERRI ROBERTS J.D., R.N.
700 S.W. JACKSON, Suite 601
TOPEKA, KANSAS 66603-3731
(785) 233-8638 FAX (785) 233-5222

H.B. 2997: REIMBURSEMENT FOR DIABETES SUPPLIES AND EDUCATION

(DIABETES COVERAGE ACT)

Chairman Wilson and members of the House Insurance Committee, my name is Robyn Parker. I am a Master's prepared registered professional nurse and family nurse practitioner, clinical nurse specialist, and certified diabetes educator. As a diabetes educator and health care provider, I help persons with diabetes manage their care and teach them self-management skills on a daily basis. I am the chair of the Kansas Delegates for Diabetes Committee of the American Diabetes Association, the State Legislative Coordinator and President-Elect for the Kansas Association of Diabetes Educators, and the Chair of the Advanced Practice Conference Group of the Kansas State Nurses Association. It is on behalf of the Kansas State Nurses Association that I am submitting my testimony in support of H.B. 2997.

Diabetes is a truly devastating disease. The number of people with diabetes in the U.S. has tripled since 1960. There are now 16 million Americans with diabetes. According to the National Institutes of Health, the nation now spends $138 billion per year on diabetes and related complications. That is an incredible increase of 50% in just the last five years, Diabetes is the leading cause of blindness in adults aged 25-64; it is the leading cause of end-stage kidney disease; and it is a major contributor to heart disease and stroke. Unfortunately, diabetes is also a silent disease: half of the sixteen million people estimated to have diabetes do not yet know it. This is quite serious, as undetected diabetes leads to major health problems. Only preventive treatment can improve the quality of life for diabetes patients at substantially reduced health care costs. According to the December 1995 issue of *Practical Diabetology,* it is estimated that through better treatment and management of diabetes:

* the incidence of diabetes-related blindness could be reduced by 90%.
* diabetes-related kidney disease requiring dialysis could be reduced by 50%.
* diabetes-related complications and amputations could be reduced by *50%.*

There is no cure for diabetes. Diabetes can be treated; however, the person who has diabetes is the one who carries out the treatment. This condition is one in which the person with diabetes needs to know how to manage the disease. This management is at least in part based upon blood glucose levels tested by the patient on a daily basis. Obviously, the person with diabetes must have the tools to perform the testing and the knowledge of how to use this information in daily life.

Diabetes self-management education and supplies are essential for successful management of the disease. It has been shown in numerous studies that diabetes education and self-management will decrease diabetes complications, improve quality of life, and decrease health care costs. Unfortunately, many persons with diabetes cannot afford to pay for blood glucose monitoring supplies and diabetes education out-of-pocket. As a result, they are unable to effectively manage their diabetes. The Diabetes Control and Complications Trial, the results of which were published in 1993, showed that excellent blood glucose control in persons with diabetes resulted in a 76% decrease in diabetic retinopathy (diabetic eye disease), a 60% reduction in neuropathy-uropathy (nerve damage), and a 56% reduction in diabetic nephropathy (kidney disease). Although this study was done in per-sons with type I diabetes, other studies are showing similar benefits for persons with type 2 diabetes as well.

In my work as a diabetes educator and nurse practitioner, I frequently see patients who cannot afford to buy test strips for blood glucose monitoring. Last week, one of my patients was starting insulin therapy and needed to test his blood glucose levels two to four times per day during the dose adjustment period. He did have insurance, but it did not cover this necessary part of his treatment. As an inpatient, he was not charged for diabetes education, but he would not have been able to attend diabetes classes as an outpatient because of lack of insurance coverage. Although he had a steady job, he was responsible for caring for his family and did not have the financial resources to pay for $150-$200 per month for diabetes supplies in addition to his basic expenses.

I recently saw another patient, a young woman with type I diabetes for several years, who had an excellent secretarial job. She worked very hard to control her blood glucose levels, but in order to do so she often needs to test her blood glucose levels four to six times per day. Although her insurance plan paid for her insulin and syringes, it did not cover any blood glucose testing supplies, the cost of which amounts to well over $120 per month. While attempting to manage her diabetes well, there were times during the month when she did not test as frequently because she simply did not have the money to purchase the test strips.

I work closely with a perinatology practice and their patients with diabetes. Many insurance companies do not cover medical nutrition therapy for pregnant women with diabetes. In women with gestational diabetes, diet is the cornerstone of management, and the lack of insurance coverage for seeing a registered dietitian sometimes denies these women p roper treatment for their condition. In addition, frequent blood glucose monitoring is crucial for successful management of both pregnant women with preexisting diabetes and with gestational diabetes. Of all the conditions in which proper blood glucose control has been shown to be beneficial, diabetes in pregnancy is the most well supported. In diabetic women with blood glucose levels near normal levels throughout the pregnancy, the risk of complications related to pregnancy are similar to those of nondiabetic women. In

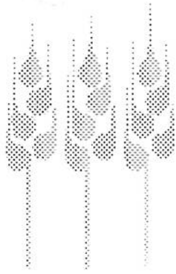
women with poor diabetes control during pregnancy, the morbidity and mortality of both the fetus and the mother are significantly increased.

In 1987, the insurance industry in Kansas was advised by the Insurance Commissioner that they should voluntarily provide coverage for diabetes self-management education and supplies because it reduces health care costs. Although some companies have provided this coverage, not all have done so. Many patients are therefore unable to afford the tools to manage their diabetes. This bill would allow these persons to obtain the supplies and self-management skills necessary, which in turn would decrease hospitalizations and the occurrence and severity of long-term diabetes complications.

The bill on page 1 lines 34 and 35 have language that triggers reimbursement only when outpatient self-management training and education is approved by "a physician licensed to practice medicine and surgery." This language would eliminate reimbursement for ARNP's practicing in the state, many of whom are in the more than 150 rural health clinics. The language in New Section 1 (b) line 26 defines those appropriate for ordering the services as " if prescribed by a health care professional legally authorized to prescribe such items under the law." I recommend deleting the language on lines 34 and 35 that narrowly focus this to physicians only for this service.

On behalf of the KANSAS STATE NURSES ASSOCIATION, I ask for your support of H.B. 2997, the Diabetes Coverage Act. Not only would this bill dramatically improve the lives of Kansans with diabetes, it would significantly decrease health care costs as well. *Thank you* for the opportunity to speak to the Committee on this important issue.

Robyn Parker M.S.N., ARNP
517 Sagebush
Wichita, Kansas 67230
Home (316) 733-8548
Work (316) 689-5530
Diabetes Nurse Educator, Via Christi St. Francis



Kansas Association of Health Plans

Testimony before the

House Insurance Committee
The Honorable Dennis Wilson, Chairman
<u>Hearings on HB 2997</u>

March 10, 1998

The Kansas Association of Health Plans (KAHP) is a nonprofit corporation dedicated to providing the public information on managed care health plans. Members of the KAHP are Kansas licensed health maintenance organizations, preferred provider organizations, and others who support managed care. KAHP members serve over 200,000 Kansans.

Members of the Kansas Association of Health Plans are neutral with regard to HB 2997. KAHP is in support of the philosophy exemplified by HB 2997. Currently, most HMOs provide coverage for much of the services and equipment necessary for the treatment of diabetes and for diabetes management that are described in HB 2997. However, KAHP members are in opposition of HB 2997 inasmuch as it is a mandate. KAHP opposes all mandates because they have the effect of increasing the premium costs of health insurance and therefore reducing access to health care. The better approach would be to empower consumers by expanding competition in the marketplace. Competition to meet the needs of patients and the demands of consumers will improve quality--not mandates.

The Kansas Association of Health Plans requests that policy makers weigh the mandate of HB 2997 against the public benefit of having a competitive marketplace for health insurance.

Respectfully,

Callie J Denton

Callie Jill Denton
Executive Director

Callie Jill Denton
Executive Director
800 SW Jackson, Suite 1120
Topeka, Kansas 66612
785-235-2020
785-235-2121 FAX
callie@cjnetworks.com

House Insurance
Attachment #8
3-10-98

MEMORANDUM

TO: Representative Dennis Wilson, Chair
House Insurance Committee

FROM: William W. Sneed
Health Insurance Association of America

DATE: March 10, 1998

RE: H.B. 2997

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I appear today on behalf of the Health Insurance Association of America ("HIAA"). HIAA is an association of more than 250 health insurance companies doing business in Kansas and nationwide. We appreciate this opportunity to present our testimony in opposition to H.B. 2997.

H.B. 2997 creates the "diabetes coverage act." This Act would mandate coverage for equipment, supplies, and outpatient self-management training and education, including medical nutrition therapy, for the treatment of diabetes, if prescribed by a health care professional.

HIAA is concerned about the cost of any mandate imposed by the government on the private health insurance market. We favor preservation of a system that allows the purchaser of health insurance free choice of which risks to cover from among the various coverages offered by competing insurance carriers. We support the concept of preventative health care benefits as set out in H.B. 2997; however, we believe that the decision to offer such benefits should be left to individual companies in response to competitive market forces.

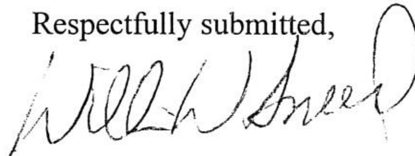
HIAA is also concerned that since the mandate will only affect insurance companies, and not self insurers, the bill may actually force people into programs that will not provide the coverage.

House Insurance
Attachment #9-1
3-10-98

Finally, as you know, any mandate imposed by the Kansas Legislature reaches only so far--self-insured plans are not affected. As well-intentioned as the provisions of this bill may be, the result is that it drives up health insurance costs for some and does not even affect the plans of many. However, if the Committee does work the bill, I have attached an amendment that would make clear the types of policies that this mandate would not affect.

For these reasons, we urge you to reject H.B. 2997. Please don't hesitate to contact me if you have questions or need further information.

Respectfully submitted,



William W. Sneed

9-3

HOUSE BILL No. 2997

By Committee on Appropriations

2-26

9 AN ACT concerning insurance; relating to increased coverage for dia-
10 betes; amending K.S.A. 1997 Supp. 40-1909 and 40-19c09 and re-
11 pealing the existing sections.
12
13 *Be it enacted by the Legislature of the State of Kansas:*
14 New Section 1. (a) This act shall be known and may be cited as the
15 "diabetes coverage act."
16 (b) Any individual or group health insurance policy, medical service
17 plan, contract, hospital service corporation contract, hospital and medical
18 service corporation contract, fraternal benefit society or health mainte-
19 nance organization which provides coverage for accident and health serv-
20 ices and which is delivered, issued for delivery, amended or renewed on
21 or after January 1, 1999, also, shall provide coverage for equipment, and
22 supplies, limited to hypodermic needles and supplies used exclusively
23 with diabetes management and outpatient self-management training and
24 education, including medical nutrition therapy, for the treatment of in-
25 sulin dependent diabetes, insulin-using diabetes, gestational diabetes and
26 noninsulin using diabetes if prescribed by a health care professional le-
27 gally authorized to prescribe such items under the law. Such coverage
28 shall include coverage for insulin only if such coverage also includes cov-
29 erage of prescription drugs.
30 (c) Diabetes outpatient self-management training and education shall
31 be provided by a certified, registered or licensed health care professional
32 with expertise in diabetes. The coverage for outpatient self-management
33 training and education shall be required pursuant to this section only if
34 the diabetic after consultation and approval by a physician licensed to
35 practice medicine and surgery: (1) is treated at a program approved by
36 the American diabetes association; (2) is treated by a person certified by
37 the national certification board for diabetic educators; or (3) is, as to
38 nutritional education, treated by a licensed dietitian.
39 (d) (1) The benefits provided in this act shall be subject to the same
40 annual deductible or co-insurance and the same requirement of medical
41 necessity established for all other covered benefits within a given policy.
42 In the case of a policy requiring that services be provided by or upon
43 referral from a primary care physician, the benefits provided by this act

[Inserted after "services" (line 20):] other than specific diseases or accidents only, hospital confinement indemnity, long term care, Medicare supplement, or high deductible health plans

9-3
3-10-98

shall be subject to such requirement.

(2) Private third party payors may not reduce or eliminate coverage due to the requirements of this act.

(3) Enforcement of the provisions of this act shall be performed by the commissioner of insurance.

Sec. 2. K.S.A. 1997 Supp. 40-1909 is hereby amended to read as follows: 40-1909. (a) Such corporations shall be subject to the provisions of the Kansas general corporation code, articles 60 to 74, inclusive, of chapter 17 of the Kansas Statutes Annotated, applicable to nonprofit corporations, to the provisions of K.S.A. 40-214, 40-215, 40-216, 40-218, 40-219, 40-222, 40-223, 40-224, 40-225, 40-226, 40-229, 40-230, 40-231, 40-235, 40-236, 40-237, 40-247, 40-248, 40-249, 40-250, 40-251, 40-252, 40-254, 40-2,100, 40-2,101, 40-2,102, 40-2,103, 40-2,104, 40-2,105, 40-2,114, 40-2,116, 40-2,117, 40-2a01 to 40-2a19, inclusive, 40-2216 to 40-2221, inclusive, 40-2229, 40-2230, 40-2250, 40-2251, 40-2253, 40-2254, 40-2401 to 40-2421, inclusive, 40-3301 to 40-3313, inclusive, K.S.A. 1997 Supp. 40-2,153, 40-2,154, 40-2,160 ~~and~~, 40-2,161 *and section 1*, and amendments thereto, except as the context otherwise requires, and shall not be subject to any other provisions of the insurance code except as expressly provided in this act.

(b) No policy, agreement, contract or certificate issued by a corporation to which this section applies shall contain a provision which excludes, limits or otherwise restricts coverage because medicaid benefits as permitted by title XIX of the social security act of 1965 are or may be available for the same accident or illness.

(c) Violation of subsection (b) shall be subject to the penalties prescribed by K.S.A. 40-2407 and 40-2411, and amendments thereto.

Sec. 3. K.S.A. 1997 Supp. 40-19c09 is hereby amended to read as follows: 40-19c09. (a) Corporations organized under the nonprofit medical and hospital service corporation act shall be subject to the provisions of the Kansas general corporation code, articles 60 to 74, inclusive, of chapter 17 of the Kansas Statutes Annotated, applicable to nonprofit corporations, to the provisions of K.S.A. 40-214, 40-215, 40-216, 40-218, 40-219, 40-222, 40-223, 40-224, 40-225, 40-226, 40-229, 40-230, 40-231, 40-235, 40-236, 40-237, 40-247, 40-248, 40-249, 40-250, 40-251, 40-252, 40-254, 40-2,100, 40-2,101, 40-2,102, 40-2,103, 40-2,104, 40-2,105, 40-2,116, 40-2,117, 40-2a01 *et seq.*, 40-2111 to 40-2116, inclusive, 40-2215 to 40-2220, inclusive, 40-2221a, 40-2221b, 40-2229, 40-2230, 40-2250, 40-2251, 40-2253, 40-2254, 40-2401 to 40-2421, inclusive, and 40-3301 to 40-3313, inclusive, K.S.A. 1997 Supp. 40-2,153, 40-2,154, 40-2,160 ~~and~~, 40-2,161 *and section 1*, and amendments thereto, except as the context otherwise requires, and shall not be subject to any other provisions of the insurance code except as expressly provided in this act.

(b) No policy, agreement, contract or certificate issued by a corporation to which this section applies shall contain a provision which excludes, limits or otherwise restricts coverage because medicaid benefits as permitted by title XIX of the social security act of 1965 are or may be available for the same accident or illness.

(c) Violation of subsection (b) shall be subject to the penalties prescribed by K.S.A. 40-2407 and 40-2411, and amendments thereto.

Sec. 4. K.S.A. 1997 Supp. 40-1909 and 40-19c09 are hereby repealed.

Sec. 5. This act shall take effect and be in force from and after its publication in the statute book.

Kansas Employer Coalition on Health, Inc.

214 ½ S.W. 7th Street, Suite A • Topeka, Kansas 66603

(785) 233-0351 • FAX (785) 233-0384

Testimony to House Committee on Insurance

on HB 2997

(Expanded Diabetes Coverage)

by James P. Schwartz Jr.
Consulting Director
March 10, 1998

I am Jim Schwartz, director of the Kansas Employer Coalition on Health. The Coalition is currently 76 employers across Kansas, like Sprint, Hallmark, Coleman, and Western Resources, who share concerns about the cost-effectiveness of health care we purchase for nearly 200,000 Kansas employees and dependents.

Recently I tried to explain the current crop of health insurance mandate bills to my 10-year-old daughter, Libby. I explained that a business could offer its employees a policy that covered only cancer. Or only hearts. Or, theoretically, only diabetes. It could offer any combination of such policies. It could even offer nothing, and there are many that do just that because of the high cost of insurance. It's perfectly legal to cover only this organ or that disease or a particular treatment or nothing whatsoever.

But if a group tries to put many coverages together into one broad policy, laws--or would-be laws--say the policy has to be so long and so wide. It has to cover so much treatment for the brain, so much for the bones, and in this case, so much for the pancreas.

Libby found this situation incredible. Did grown-ups really operate this way? To her it was like having a law that says it's legal for parents to not give their kids any allowance, but if the parents did give an allowance, it had to be at least $10.

So, in a voluntary market for health insurance, what is a helpful role for government? It seems to me that key role is to protect consumers from fraud and abuse. If you find that current practices in covering diabetes or any other condition are fraudulent or abusive, then we need you to step in with force of law. But I don't think that's the situation here.

I do, though, have a concern that some insureds don't really know what they're buying when they opt for health insurance, and only later do they find out that what they want isn't covered. You could do something about that situation in interim session.

For example, an interim committee could decide to form a commission to create a benchmark policy. The commission would evaluate current coverage norms, consider cost/benefit evaluations by other states like Oregon, and peg a budgeted cost for the plan. You could then require all carriers to plainly label their policies as meeting the benchmark coverage or not. And if not, clearly label the shortcomings.

That way we could promote reasonable expectations about health coverage. We would have a clear target and "truth in labeling" about products that fell short. But we should never prohibit shortcomings as long as it's permissible for groups to go bare.

Send HB 2997 to interim committee where all the all the possible coverages can be considered at once, prioritized, and weighed against the public's willingness to pay.

House Insurance
Attachment #10
3-10-98