Approved: Feb. 23 1998
Date

MINUTES OF THE Senate Committee on Financial Institutions and Insurance.

The meeting was called to order by Chairperson Don Steffes at 9:00 a.m. on February 16, 1998 in Room 529-S of the Capitol.

All members were present except:

Committee staff present: Dr. William Wolff, Legislative Research Department
Fred Carman, Revisor of Statutes
Nikki Feuerborn, Committee Secretary

Conferees appearing before the committee: Commissioner of Consumer Credit Bill Caton
Callie Jill Denton, Kansas Association of Health Plans
Bruce Witt, Preferred health Systems, Inc., Wichita
Brad Smoot, BC/BS
Bill Sneed, HIAA
Terry Leatherman, KCCI
Kevin Davis, American Family Insurance
Jim Schwartz, KECH

Others attending: See attached list

Senator Becker moved that the minutes of the February 10 and 12 meetings be approved as presented. Motion was seconded by Senator Feleciano. Motion carried.

Action on SB 470 - Maximum finance charge on certain consumer credit sales

Commissioner Caton explained that this bill would put back into the statutes the legality of using a precalculated precomputed contract for credit sales. This was the method used until 1993 when the Legislature changed the method for computing interest. A rebate section has been added which would require any rebate returned to the customer for early payment be figured on an actuarial basis.

Senator Corbin moved to report the bill favorably and Senator Becker seconded the motion. Motion carried.

Continued hearing on SB 509 - Durable medical equipment

Senator Steffes reminded the Committee that there were eleven insurance mandate bills in the House and Senate at this time. The hearing was continued by asking the opponents to speak on the bill.

Callie Jill Denton, Kansas Association of Health Plans, stated that the bill goes beyond what the traditional understanding of what durable medical equipment health insurance should cover: a) must be primarily and customarily used to serve a medical purpose; b) can withstand repeated use; and c) could normally be rented and used by successive patients (Attachment 1). This bill asked that such things as personal computers, whirlpools, and highly specialized and customized equipment, which are normally not considered under the definition of durable medical equipment be included in the definition. Could this list ultimately contain such items as home remodeling costs, ramps, vans, etc.? The cost for insuring such items would be prohibitive. A one percent increase in health insurance would lead to 400,000-500,000 persons dropping their health insurance. Ms. Denton said that helping Kansans with physical challenges is a community concern and the cost should not be inflicted on the 50% of the population that are enrolled in fully insured private health plans.

Bruce Witt, Preferred Health Systems, Inc., of Wichita, informed the Committee that if this policy goes into effect, other coverages for such things as mamograms, immunizations, etc. will have to be reduced (Attachment 2). If the intent of the bill was to only expand the dollar limit while permitting the narrower definition of DME that most insurers currently use, then perhaps meaningful dialogue could begin.

Brad Smoot, BC/BS, stated that anything that increases the cost will lower the number of persons served (Attachment 3). The biggest problem with the bill is the definition of durable medical equipment. BC/BS uses exclusions rather than caps in limiting the coverage of DME. This bill would not allow an insurance company to exclude things. This bill would ultimately ask society to redefine what exactly is health insurance. Is it for preventive care, hospitalization, emergency room coverage, and other medical reasons, or is its purpose to put people back into the community? Mandates do not affect ERISA plans, Medicare, Medicaid, federal or state employee health insurance plans, and those that are self-insured. This mandate would hit small group coverage which means only 30-35% of the population would be paying for DME coverage. It summarizes that either the insureds pay or the taxpayers pay. Approximately 100,000 Americans lose coverage for each one percent increase in insurance costs.

Bill Sneed, HIAA, stated that policies are available for coverage of durable medical equipment rather than expecting the public to pay for this coverage (Attachment 4).

Terry Leatherman, KCCI, stated this would be similar to a tax increase for 30-40% of the population (Attachment 5).

Kevin Davis, American Family Insurance, said he was interested in seeing the development of a cost benefit analysis (Attachment 6). He first recommends that a narrow definition of durable medical equipment be required.

Senator Steffes suggested that this might be included with the other proposed mandates for study in an Interim Committee.

Continued Hearing on SB 386 - Diabetes Coverage

Callie Jill Denton, Kansas Association of Health Plans, reported they were neutral but did review problems with the bill which included: a) qualifications for diabetic educators; b) changing the effective date so companies would have time to comply with the mandate (Attachment 7). Their members already provide education service for diabetics.

Brad Smoot, BC/BS, also stated their neutral status but did present some suggested amendments including (Attachment 8):

1. Mandated coverage for supplies. This could impact policies which do not have an out patient prescription drug component. Would this include such household items as alcohol, cotton balls?

2. Qualifications for those who teach diabetic education. Require only ADA programs.

3. Preservation of the role of the primary care physician.

Bill Sneed, HIAA, stated they would support the bill if a method could be devleoped that would include all self-insured plans to comply (Attachment 9).

Jim Schwartz, KECH, stated his organization has 76 employer plans which are mostly seelf-funded (Attachment 10). He stressed the need for uniformity of policies so persons did not find out after the fact they were not covered for certain items. He reminded the Committee of the Oregon plan in which they first laid out every possibility of coverage and then narrowed the scope by prioritizing coverage according to need, risks, costs of each mandate. They realized they could not provide every service for every enrollee. Mr. Schwartz also suggested adopting health insurance purchasing cooperatives which would serve as mini-regulators.

Kevin Davis, American Family, pointed out that their main objection to the plan was that the issuance of another mandate would not affect self-funded plans (Attachment 11).

The meeting was adjourned at 10:00 a.m. The next meeting is scheduled for February 17, 1998.

SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: 2/16/98

NAME	REPRESENTING
Gabrielle Denton	KAHP
Kevin Davis	Am. Family
John Federico	Humana
Bob Anderson	KPhA
Scott Knoer	KPhA
Linda Hall	Assistive Technology for Kansans
MaryEllen O'Brien Wright	Assis. Tech. for Kansans
Preston Barton	KEDD
Marty Glenn	Dietetic Assn of Kansas
Betty J. Hanson	Dietetic Assn of KS
[illegible]	Intern Sen. Ingoon
John Robert	Kearny Law Offic
[illegible]	
Susan Anderson	KS. Diabetics associations
Brad Smoot	BC/BS
Bill Sneed	HIAA
JEFFREY	SOUTHEAST KANSAS INDIPENDANT LIVING
Bill Caton	Consumer Credit
BUD GRANT	KCCI

SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: 2-16-98

NAME	REPRESENTING
Sharon Huffman	KCDC
Ron Hein	American Diabetes Assoc/Dietetic Assoc of Kansas
George Barbee	KAFS

Kansas Association of Health Plans

Testimony before the
Senate Financial Institutions and Insurance Committee
The Honorable Don Steffes, Chairman
Hearings on SB 509
February 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.

The Kansas Association of Health Plans opposes SB 509 because of the enormous cost increase it would impose on purchasers of health insurance. Nationally, it is recognized that for every one percent of premium increase between 200,000 to 400,000 people lose their private health insurance. The State of Kansas has a great interest in encouraging as many people as possible to get insured and stay insured. The KAHP is skeptical of SB 509 or any similar initiative that would lead to or encourage disenrollment from private health insurance.

Currently, most health plans provide coverage for up to $1,000 annually per individual for durable medical equipment. Covered equipment includes: hemodialysis equipment, iron lungs, wheelchairs operated by hand, and hospital beds that are hand operated. When medically needed, plans generally cover electric wheelchairs or beds, but in such cases limit payment to the amount normally available for non-electric equipment. The current benefit structure is designed to balance the ordinary health care needs of most people who utilize durable medical equipment with the very important need to keep private insurance premiums affordable.

SB 509 goes beyond the traditional understanding of what should be covered by health insurance, i.e. that which is primarily and customarily used to serve a medical purpose, can withstand repeated use, and could normally be rented and used by successive patients (HCFA's definition of durable medical equipment). As described in SB 509, covered durable medical equipment would include "equipment" not currently contemplated by existing health insurance programs, such as personal computers for those with learning disabilities and speech impairments, whirlpools for those with arthritis, and any number of similar examples which go beyond the bounds of current insurance benefits. Most people do not have health needs that require such equipment nor would they be willing to purchase health insurance that covers such equipment when they understand the increased premium cost associated with such coverage.

It is not the position of KAHP that persons in need of assistive technology be forced to do without or to live at less than their fullest potential. However, there are community, state and federal resources that provide many types of devices on a six month loan, such as Easter Seals. In addition there is federal law that requires that each state have programs for children

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with special health care needs. Helping Kansans with physical challenges is a community concern, the cost of which should not be imposed solely on the 50% of Kansans that are enrolled in fully insured private health plans.

The Kansas Association of Health Plans respectfully requests that SB 509 not be passed.

Sincerely,

Callie J Denton

Callie Jill Denton
Executive Director

Callie Jill Denton
Executive Director
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MEMORANDUM

1998
LEGISLATIVE FISCAL NOTE REQUEST

TO: Mary Ellen Wright

FROM: Richard Huncker, CIE
Accident and Health Supervisor
Kansas Insurance Department

Douglas Jones
Accident and Health Policy Examiner
Kansas Insurance Department

RE: Proposed Legislation for Durable Medical Equipment (DME)

CC: Tom Wilder
Director of Government and Public Affairs Division
Kansas Insurance Department

DATE: January 21, 1998

This memorandum is to provide you with information you requested in regards to the proposed legislation.

When asking insurance companies about the proposed financial impact of this bill, we asked that they compute the premium impact, if any, for policies with first dollar coverage, and with deductible options of $500 and $1,000 with 80/20 co-payment for: individual coverage, individual and spouse coverage, individual and child(ren) coverage, and individual, spouse, and child(ren) coverage.

Blue Cross and Blue Shield of Kansas City reported that the proposed legislation has the potential of adding several dollars to the cost of first-dollar programs, and a few dollars to the deductible and coinsurance plans. At this time, Blue Cross and Blue Shield could not provide a dollar value to the impact of the proposed legislation. Also, they stated that they currently have strict limits on Durable Medical Equipment for all of their business.

Blue Cross and Blue Shield of Kansas provided information in regards to the proposed legislation. Due to time constraints, Blue Cross and Blue Shield has selected only some of the situation that might be applicable. In the estimates they have attempted to use average equipment costs with limited diagnosis in each situation. Therefore, Blue Cross and Blue Shield reports that this information does not represent all of the potential costs and the costs may be understated.

Blue Cross and Blue Shield of Kansas

CONDITION	% OF POP.	DESCRIPTION OF DME	ESTIMATED COST Per Unit	Per Person	PMPM*
Learning Disabled	0.96%	Personal Computer w/ software	$5,000	$48.00	$4.00
Speech Impaired (Under age 22)	0.45%	Personal Computer w/ Speech Simulator	$6,000	$27.00	$2.25
Asthma	5.66%	Air Filtration Unit	$1,000	$56.60	$4.72
Arthritis	6.81%	Whirlpool/Jacuzzi	$3,000	$204.30	$17.02
Psoriasis	0.90%	Phototherapy	$2,750	$24.75	$2.06

*Per Person Costs Spread Over 12 Months.

Total for above conditions per person spread over 12 months $30.05
Assume Blue Cross and Blue Shield only pays 80% of these costs $24.04
Total Monthly Cost of $24.04 Per Person Covered to Per Contract:

Insured Only $29.54
Ins./Child(ren) $56.42
Ins./Spouse $63.50
Ins./Sp./Children $90.38

Blue Cross and Blue Shield of Kansas has indicated that these rates which are only part of the estimated total additional costs would result in an increase to annual claims expense for their underwritten contracts (under age 65) of more than $79 million.

Preferred Plus of Kansas has provided information on the financial impact of the proposed legislation.

PREMIUM IMPACT

	80/20 co-pay, $500 deductible	80/20 co-pay, $1,000 deductible
Individual	$0.98	$0.86
Individual and spouse	$2.22	$1.94
Individual and child(ren)	$1.82	$1.59
Individual, spouse, and child(ren)	$2.86	$2.50

Preferred Plus of Kansas has indicated that since they only offer HMO plans with 100% coinsurance without deductibles, their actual impact would be 25% to 40% higher than the values presented above.

The Kansas Department of Health and Environment has provided us with an estimate of the premium impact of the proposed legislation. The assumptions used in projecting the data were:

1. An increase in the maximum from $1,000 to $10,000.

2. Claims data form Blue Cross and Blue Shield of Kansas.

3. Assume a payment percentage of 90%.

4. An 85% loss ratio was used to estimate an aggregate impact on premiums.

KDHE estimates that the increase will be .084% or 84 cents per $1,000 of premium. This is approximately $3 per member per year in premium. It was reported that the total Blue Cross and Blue Shield DME payments were $420,690, of which $99,233 were the portion over $1,000. Actual charges for durable medical equipment in excess of $1,000 but less than $10,000 was $345,948. The $99,233 was subtracted from $345,948 leaving $222,044. This amount was then spread over the total claims paid less the $99,233 to arrive at the projected premium impact.

**The differences in cost estimates for Blue Cross and Blue Shield of Kansas are due to the fact that Blue Cross and Blue Shield of Kansas has included examples of DME benefits that were not included in the Kansas Department of Health and Environment's database.

Preferred
Health
Systems

Statement of: Bruce Witt
Preferred Health Systems, Inc.
Wichita, Kansas

To the Senate Financial Institutions and Insurance Committee regarding Senate Bill No. 509.

Preferred Health Systems, Inc. is the parent corporation of Preferred Plus of Kansas, a health maintenance organization, and Preferred Health Systems Insurance Company, a life and health insurance company. Our companies provide group life and health insurance coverage to employer groups located in Kansas, with the primary focus of our business being managed care products such as HMO, PPO, and Point-of-Service plans. As a managed care organization, we have been successful over the last five years in controlling costs, while still delivering high quality health care to our members. The employer groups we cover have experienced low single digit percentage increases in premiums, no increase at all, or in some cases, even decreases in premiums over this time period.

Preferred Health Systems opposes SB 509 because of the cost impact attributed to not only increasing dollar limits of durable medical equipment (DME) to $10,000, but also the extremely broad definition of what could be considered DME. It is our understanding that SB 509 could be interpreted broadly enough to require insurance companies and HMOs to cover items such as eye gaze computers, TTY's, special computer software, hand controls and lift devices for vehicles, ramps, home elevators, home modifications, custom seating devices, entire home air filtration systems, and more. As indicated in the testimony provided by the Kansas Council on Developmental Disabilities on February 11, these items carry an expensive price tag. Notwithstanding the cost of these items, we feel SB 509 contemplates health insurers paying for expenses that are not hospital/ medical care expenses. When health insurers start covering items that are outside the realm of traditional hospital/medical expenses, the cost impact of a mandate such as SB 509 though very difficult to accurately quantify, will undoubtedly be substantial. We would also like to point out when our actuaries first studied the cost impact of this bill, they calculated the benefit change under a tightly managed HMO product where a narrower definition of DME would need prior authorization from a primary care physician, and medical necessity provisions would apply. A subsequent letter (copy attached) has been provided to the Kansas Insurance Department indicating that if the mandate of SB 509 were applied to a fee-for-service type of an arrangement, the cost impact would be more similar to the cost data submitted by Blue Cross and Blue Shield of Kansas.

Our company's opposition to SB 509 should not be construed as indifference to individuals with developmental disabilities. We can certainly sympathize with those who are proponents of this

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bill; in fact, Preferred Health Systems has employees with children who have developmental disabilities requiring expensive specialized care, technology and equipment. However, we do not believe it is appropriate to place the financial burden of purchasing expensive technologies, equipment and home modifications that are not specific hospital/medical expenses on health insurers, and ultimately health insurance consumers in the form of higher premiums. If the intent of SB 509 was to only expand the dollar limit while permitting the narrower definition of DME that most insurers currently use, then we may have a basis for reasonable discussion of a benefit enhancement that could be priced more accurately.

The wording of SB 509 is much broader than that, therefore, Preferred Health Systems respectfully requests that SB 509 not be passed.

Preferred
Health
Systems

VIA FAX

February 13, 1998

Richard Huncker
Supervisor
Accident and Health Division
Kansas Insurance Department

Re: Financial Impact of Proposed DME Legislation (clarification)

Dear Mr. Huncker:

On January 21, 1998, Preferred Plus of Kansas, Inc. (PPK) submitted its' financial impact analysis of proposed DME legislation. After reviewing data provided by other sources, I feel our initial estimate warrants further clarification.

PPK is an HMO with a strong saturation of capitated providers and services subject to a fixed fee schedule. The impact we would experience is mitigated by these factors as well as the active management of health care services by our provider network. Therefore, our estimate is not indicative of the potential impact to Preferred Health Systems Insurance Company (PHSIC), our indemnity carrier, or Kansas' health insurance industry overall.

In PPO, indemnity and some HMO plans, health care providers have little incentive to control utilization or limit unnecessary insurance spending. Since the proposed legislation establishes an exceedingly broad DME definition and no tangible foundation for medical necessity, the market will be poised to exploit this benefit. Many medical conditions such as speech impairment and arthritis could be treated with expensive and highly excessive equipment. In light of this, the diagnosis distribution and cost estimates provided by Blue Cross and Blue Shield of Kansas (BCBSK) are reasonable and representative of expectations.

Please consider this information during the legislative process. I apologize for any initial confusion and welcome the opportunity to discuss the matter in greater detail. I may be reached at (316)268-0383.

Sincerely,

Leo Tokar
Vice President
Underwriting and Actuarial Services

cc: Callie Denton, KAHP
Bruce Witt, PHS
Alida Dodd, PHS

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STATEMENT OF BRAD SMOOT, LEGISLATIVE COUNSEL
BLUE CROSS BLUE SHIELD OF KANSAS
BLUE CROSS BLUE SHIELD OF KANSAS CITY
SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE
REGARDING 1998 SENATE BILL 509
FEBRUARY 16, 1998

Blue Cross Blue Shield of Kansas is a not-for-profit mutual insurance company providing health insurance to more than 700,000 Kansans in 103 counties. Blue Cross Blue Shield of Kansas City is a non profit hospital and medical service corporation serving more than 200,000 Kansans in Johnson and Wyandotte Counties Both Blue Cross and Blue Shield plans generally oppose mandated benefits because they tend to increase the costs of health insurance and thereby decrease the number of Kansas businesses and individuals who can afford coverage. On behalf of thousands of Kansans, who ultimately bear the cost of all insurance mandates, we must respectfully oppose SB 509.

As currently drafted, SB 509 would dramatically increase insurance benefits. While $10,000 cap on DME may cause some increase in benefits and a modest rise in premiums for some policyholders, it will have little or no effect on others. At BCBS of Kansas, more than two-thirds of its insured policies have no cap on DME benefits. The real cost driver in SB 509, is the expansion of the types of products which must be covered by insurance.

The broad definition of "durable medical equipment" contained in Section 1(c) encompasses devices which are currently denied by specific contract exclusions. In pricing this bill for the Insurance Department, BCBS of Kansas looked at the following examples: Computers and software for the learning disabled; computers with speech simulators for the speech impaired; air filtration units for asthmatics; whirlpools for arthritis patients or photo therapy equipment for psoriasis sufferers. The impact for their insureds just for these products is estimated to be $24.04 per person per month. This represents a whopping $79 million increase in premium or $1084.56 per year for full family coverage. And this does not take

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into consideration all those other products which haven't been priced or any increase attributable to the $10,000 benefit cap.

Use of specific contract exclusions is a common method of defining benefits. It is complicated, detailed, well-researched and based on the medical purpose and value of particular brands of products. To illustrate, I have submitted a copy of Claims Operating Manual used by BCBS of Kansas for air conditioners and inhalation equipment. The manual makes distinctions between products that serve a medical purpose (e.g., oxygen humidifiers) and those that do not (e.g., ordinary humidifiers). SB 509 requires payment for all such products and none of these distinctions are permitted.

If you are having doubts that this is what the SB 509 says or what its supporters intend, please review the testimony of the Kansas Council on Disabilities. The Council's Executive Director lists DME requests for a cerebral palsy program costing more than $3 million for computers and software; communication devices; van lifts and home modifications, including lifts, ramps and accessible showers. Based on the terms of SB 509, on what basis could an insurer deny payment for a customized van with fork lift or various home modifications for a severely disabled policyholder?

During this Session, there are a dozen health insurance mandates pending with more expected. Such mandates fall hardest on the individual and small employer. Self insured ERISA groups, Medicare, Medicaid, state and federal employee groups and the uninsured, are not subject to state insurance laws. And while each mandate proposed may benefit a particular provider or patient group, each adds some cost to health insurance policies purchased by Kansas businesses and families. Dollars paid out to providers must be paid in by, or on behalf of, those covered. As you know, when insurance costs too much, some Kansans will be denied access to <u>any</u> coverage.

National studies suggest that for every 1% of premium increase 100,000 Americans drop coverage. In Kansas, that would mean about 1,000 Kansans will lose coverage for each 1%. And a GAO report indicates that the percentage of Americans covered by health insurance declined by 9% from 1980 to 1997. With inflation and utilization pushing claims costs higher each year anyway, adding more benefits only exacerbates the problem. Please remember,

Kansans do not go without health insurance because it doesn't cover enough. They go without insurance because it costs too much.

I do not envy you the task of choosing among the several mandates proposed again this year. I know that each one is appealing in its own way. Some bills force you to consider how much your constituents can afford for health coverage while others require you to immerse yourselves in endless medical details. Still others, like this bill, ask you to determine that fine line between the medical needs of the disabled and their needs to access their communities. Insurers with decades of expertise have spent countless hours of research and mountains of paper attempting to make and apply reasonable coverage choices. We wish you luck. And we urge you to give yourselves a chance to look at the entire list of mandates, both current and proposed, so that you may price and prioritize them in deliberate fashion.

AIR CONDITIONERS AND INHALATION

Covered items are eligible under Major Medical, Shared Pay Comprehensive and Blue Select.

NOTE REGARDING BLUE SELECT: Primary Care Physician authorization is required to obtain maximum benefits. If such authorization is NOT received, reimbursement will be at the Self-Referred Level. The maximum benefit for Durable Medical Equipment is $1,000 or $2,500 per patient PER BENEFIT PERIOD. The maximum represents a combination of benefits received as Primary Care Benefits AND Self-Referred Benefits.

A. Humidifiers/Nebulizers

1. Coverage
   a. Humidifiers
      1) Oxygen humidifiers are covered if medical humidifier has been prescribed for use in connection with medically necessary DME for purposes of moisturizing oxygen.
      2) Humidifiers (room or central heating system types) are non-covered, does not serve a medical purpose.
   b. Nebulizers
      1) Nebulizers are covered if the patient's ability to breathe is severely impaired and machine is used daily. The saline solution used in the nebulizer is also covered.
      2) Disposable nebulizers and similar disposable devices are not covered unless they contain prescription medication, in which case they will be allowed.
      3) Nebulizer, with compressor (E0570), will be purchased immediately, without medical review, for patients with a chronic condition such as asthma, chronic bronchitis, or chronic obstructive pulmonary disease.
      4) Ultrasonic Nebulizer (E0575), will require a deluxe/medical necessity waiver form be signed by the patient. The waiver should be attached to the claim form to make the balance the Insured's responsibility. If there is no waiver attached to the claim, the balance will be a contracting provider write-off.
      5) HCPCS Codes - The following are level 2 codes covering accessories used with nebulizers.

         K0168 - Administration set, small volume nonfiltered pneumatic nebulizer, disposable.

         K0169 - Small volume nonfiltered pneumatic nebulizer, disposable.

         K0170 - Administration set, small volume nonfiltered pneumatic nebulizer, non-disposable.

         K0171 - Administration set, small volume filtered pneumatic nebulizer.

         K0172 - Large volume nebulizer, disposable, unfilled, used with aerosol compressor.

         K0173 - Large volume nebulizer, disposable, pre-filled, used with aerosol compressor.

K0174 - Reservoir bottle, non-disposable, used with large volu ultrasonic nebulizer.

K0175 - Corrugated tubing, disposable, used with large volume nebulizer, 100 feet.

K0176 - Corrugated tubing, non-disposable, used with large volume nebulizer, 10 feet.

K0177 - Water collection device, used with large volume nebulizer.

K0178 - Filter, disposable, used with aerosol compressor.

K0179 - Filter, non-disposable, used with aerosol compressor or ultra-sonic generator.

K0180 - Aerosol mask, used with HME nebulizer.

K0181 - Dome and mouthpiece, used with small volume ultrasonic nebulizer.

K0182 - Water, distilled, used with large volume nebulizer 1000 ml.

Q0132 - Dispensing fee for covered drug administered through HME nebulizer (for pharmacies).

6) Aerochamber - (E1399) - Device used to improve the delivery of aerosolized medications - Does not come in combination with any drug. It is used with a variety of metered dose inhalers (MDI's). (Other similar devices include brethancer, insporese (and replacement bags) inhale-aid and ellipse inhaler spacers)

c. The Blue Shield authorization form for Pulmoaides must be completed and submitted.

2. Brand Names -- John Bunn Co.; Devilbiss Health Care; Hudson; Invacare; Maximist; Medimist; Pulmosonic; Puritan-Bennett Corp.; Shuco-Mist; Western Enterprises; Pulmo-Aide

3. HCPCS Codes

E0550 -- Humidifier, durable for extensive supplemental humidification during IPPB treatments or oxygen delivery, E.G., Cascade

E0555 -- Humidifier, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter

E0560 -- Humidifier, durable for supplemental humidification during IPPB treatment or oxygen delivery, E.G., Cascade Jr.

E0565 -- Compressor, air power source for equipment which is not self-contained or cylinder driven

E0570 -- Nebulizer, with compressor, E.G., Devilbliss Pulmo-Aide - Does not require medical review.

E0575 -- Nebulizer, self-contained, ultrasonic

E0580 -- Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter

E0585 -- Nebulizer, with compressor and heater

B. IPPB MACHINES

1. verage - Covered if the patient's ability to breathe is severely impaired. Subject to individual consideration. Documentation must indicate why pulmo-aide and/or other device is not effective. The prescription must document why the patient's ability to breathe is severely impaired.

2. Brand Names -- Bird Products; Puritan-Bennett Corp.

3. HCPCS Codes
   E0500 -- IPPB machines with manual valves, external power source, includes cylinder regulator, built-in nebulization
   E0505 -- IPPB machines with manual valves, electrically driven with internal power source, built-in nebulization
   E0510 -- IPPB machines with automatic valves, external power source includes cylinder regulator, built-in nebulization
   E0515 -- IPPB machines with automatic valves, electrically driven with internal compressor, built-in nebulization

C. Percussor Mechanical Home Model

1. Coverage
   a. Covered when patient or operator has received appropriate training and no one competent to administer manual therapy is available.
   b. The prescription must document that the patient has chronic obstructive lung disease, chronic bronchitis or emphysema.

2. Brand Names --John Bunn Company; General Physiotherapy; Puritan-Bennett Corp.

3. HCPCS Code -- E0480 -- Percussor, electric or pneumatic, home model

D. Room Vaporizers

1. Coverage - Non-covered. Does not serve a medical purpose.
2. Brand Name - DeVilbiss Health Care
3. HCPCS Code - E0605 -- Vaporizer, room type

E. Volume Ventilator, Portable

1. Coverage
   a. Covered if patient has respiratory paralysis and requires a life support device to sustain pulmonary function.
   b. The prescription must document why the device is appropriate for home use without professional or technical supervision.

2. Brand Names -- Aequitron; Bird Products; J. E. Emerson; Lifecare; Puritan-Bennett Corp.

3. HCPCS Codes
   E0450 -- Volume ventilator
   E0451 -- Volume ventilator, portable

F. Examples

1. Air Cleaners/Purifiers - Deny not covered -- Room air cleaners do not serve a medical purpose, these are environmental control devices.

2. Air Conditioners - Deny--does not serve a medical purpose.
3. Bendix Respiratory Support System - Covered if patient's ability to breathe is severely impaired.
4. Bennett IPPB Machine - Covered if patient's ability to breathe is severely impaired.
5. Bird Respirator (IPPB Machine) - Covered if patient's ability to breathe is severely impaired.
6. Cascade Humidifier - Deny--does not serve a medical purpose.
7. Continuous Positive Airway Pressure System (CPAP)
   a. CPAP, E0601, is allowed for moderate to severe sleep apnea only. The sleep study and physician's detailed summarization of the sleep study must accompany billings for CPAP determination, rental, and/or purchase. Indications for CPAP would include significant hypoxemia (less than 87% oxygen saturation or significant daytime somnolence).
   b. Sleep studies must extend over at least a six hour period and should include information with the patient both off and on CPAP so that its effectiveness may be evaluated. The physician's summary report will serve as the certificate of medical necessity (CMN).
   c. If allowed, CPAP should be rented for a three month trial period. At the end of the second month, the attending physician must complete and send in the "Authorization for CPAP or BIPAP Purchase" (form 29-215) which will document efficacy and medical need. If purchase is approved, the first three months rental is applied to the purchase allowance.
   d. BIPAP will be reviewed on a individual consideration basis only. Indications for BIPAP include:
      1) Patients with nocturnal hypoventilation, i.e., hypoventilation secondary to neuromuscular disease, kyphoscoliosis, post-polio syndrome, and amyotrophic lateral sclerosis.
      2) Documented failure of CPAP. If CPAP is not tolerated and a BIPAP is tried, a three month trial period is required to see if it can be tolerated before purchase. If after a month, documentation is received which supports its effectiveness it could be purchased.
      3) The correct codes to use when submitting a claim for a patient who is using a BIPAP Machine are:
         BIPAP S (E0452) - Intermittent assist device with continuous positive airway pressure device
         BIPAP ST (E0453) - Therapeutic ventilator; suitable for use 12 hours or less per day
   e. Information required for review
      - Results of sleep lab studies that were performed to diagnose condition.
      - Evaluation after initiation of unit.
   f. Brand Names - Healthdyne; Respironix
   g. HCPCS Codes
      Y3000 -- CPAP system
      Y3001 -- CPAP mask
      Y3002 -- CPAP NRV value
      Y3003 -- CPAP sander kit
      Y3004 -- CPAP headgear
   h. CPAP Accessories and Devices Codes
      K0183 - Nasal application device, used with CPAP device.
      K0184 - Nasal pillows/seals, replacement for nasal application device, pair.
      K0185 - Headgear, used with CPAP device.
      K0186 - Chin strap, used with CPAP device.

K0187 - Tubing, used with CPAP device.
K0188 - Filter, disposable, used with CPAP device.
K0189 - Filter, non-disposable, used with CPAP device.
K0193 - Continuous positive airway pressure device with humidifier.
K0194 - Intermittent assist device with continuous positive airway pressure with humidifier.

8. Dehumidifiers (room or central heating system type) Deny--does not serve a medical purpose.
9. Devilbiss Nebulizer - covered if patient's ability to breathe is severely impaired.
10. Electric Air Cleaners/Purifiers - Deny not covered -- Room air cleaners do not serve a medical purpose, these are environmental control devices.
11. Electrostatic Machines - Deny--does not serve a medical purpose.
12. Fluidic Breathing Assistor - Covered where there is need for an IPPB device but oxygen is not required. There are no medical indications for simultaneous home use of the assistor and an IPPB machine.
13. Hand E Vent - Covered if patient's ability to breathe is severely impaired.
14. Heating And Cooling Plants - Deny--does not serve a medical purpose.
15. Air Purifier - Deny--does not serve a medical purpose.
16. Humidifiers (room or central heating system type) - Deny--does not serve a medical purpose.
17. Inhalators - Covered if patient's ability to breathe is severely impaired.
18. IPPB Machines - Covered if patient's ability to breathe is severely impaired.
19. Iron Lungs - Covered for treatment of neuromuscular disease, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease.
20. Maxi Myst Monaghan Nebulizer - Covered if patient's ability to breathe is severely impaired.
21. Micronaire Environmental Control - Deny--does not serve a medical purpose.
22. Nebulizer - Covered if patient's ability to breathe is severely impaired.
23. Negative Pressure Ventilators - Covered if treatment of neuromuscular disease, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease.
24. Percussion Pac - Covered for mobilizing respiratory tract secretions in patients with chronic obstructive lung disease, chronic bronchitis, or emphysema, when a patient or operator of powered percussor has received appropriate training by a doctor or therapist, and no one competent to administer manual therapy is available.
25. Percussors - Covered for mobilizing respiratory tract secretions in patients with chronic obstructive lung disease, chronic bronchitis, or emphysema, when a patient or operator of powered percussor has received appropriate training by a doctor or therapist, and no one competent to administer manual therapy is available.
26. Portable Room Heaters - Deny--does not serve a medical purpose.
27. Pulmo-Aide - Send to Special Claims for Individual Consideration.
28. Respirator - Send to Special Claims for Individual Consideration. Can be covered if it is determined that the apparatus specified in the claim is medically required and appropriate for home use without technical or professional supervision.
29. Selectronair - Deny--does not serve a medical purpose.

30. Sleep Apnea Respirator

NOTE: One brand name of this type of equipment is "Respironic Sleep Easy Machine".

a. In order for the sleep apnea respirator to be eligible for reimbursement, the patient must have SEVERE obstructive sleep apnea (as opposed to a central nervous system disease). Moderate or mild obstructive disease is not appropriately treated by this equipment.

b. In addition to the respirator, some accessory items would also be eligible for reimbursement. These items include (but are not limited to) headwear, masks, and reservoir bags.

c. Claims for Sleep Apnea Respirators are to be referred to the Medical Utilization Review Department for review and allowance determination.

31. Vaporizers - Deny--does not serve a medical purpose.

MEMORANDUM

TO: Senator Don Steffes, Chair
Senate Financial Institutions and Insurance

FROM: William W. Sneed
Health Insurance Association of America

DATE: February 10, 1998

RE: SB 509

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 SB 386.

SB 509 mandates health insurance coverage of at least $10,000 per individual per year for durable medical equipment.

HIAA is concerned about the cost of any mandate imposed by the government on the private health insurance market. This bill, however, would present an astronomical cost to health insurance companies and their policyholders.

Further, we are extremely concerned with the broad nature of the language describing what is to be covered under SB 509. The bill is crafted to cover any device which supports cognitive or physical functions. This language would potentially encompass a great variety of devices, most of which are extremely expensive. We also

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have a problem with language which suggests that devices other than power equipment must be covered without a physician's prescription.

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.

For these reasons, we urge you to reject SB 509. Please don't hesitate to contact me if you have questions or need further information.

Respectfully submitted,

William W. Sneed

LEGISLATIVE TESTIMONY

Kansas Chamber of Commerce and Industry

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SB 509

February 10, 1998

KANSAS CHAMBER OF COMMERCE AND INDUSTRY

Testimony Before the

Senate Committee on Financial Institutions and Insurance

by

Terry Leatherman
Executive Director
Kansas Industrial Council

Mr. Chairman and members of the Committee:

I am Terry Leatherman, with the Kansas Chamber of Commerce and Industry. Thank you for the opportunity to explain why KCCI has grave concerns about the impact SB 509 would have on the affordability and availability of health insurance in Kansas.

The Kansas Chamber of Commerce and Industry (KCCI) is a statewide organization dedicated to the promotion of economic growth and job creation within Kansas, and to the protection and support of the private competitive enterprise system.

KCCI is comprised of more than 3,000 businesses which includes 200 local and regional chambers of commerce and trade organizations which represent over 161,000 business men and women. The organization represents both large and small employers in Kansas, with 46% of KCCI's members having less than 25 employees, and 77% having less than 100 employees. KCCI receives no government funding.

The KCCI Board of Directors establishes policies through the work of hundreds of the organization's members who make up its various committees. These policies are the guiding principles of the organization and translate into views such as those expressed here.

The goal of SB 509 is laudable. The expenses associated with equipping the physically challenged to participate in major life activity can be staggering to an individual or family. However, to spread these costs through a health insurance mandate raises the specter of higher insurance premiums, prompting KCCI's opposition to SB 509.

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.arge majority of Kansans receive their health insurance coverage through an employer sponsored program. Those employed, but uninsured, Kansans typically work for a small employer who has found the cost of insurance prohibitive. When legislative action pushes the cost of insurance higher, more employers delay offering a health insurance option to workers while others must curb, or cancel, existing policies.

Two more points on SB 509. First, this measure is a tax increase, plain and simple. The cost of durable medical equipment, if SB 509 became law, would become a social cost paid by all insured Kansans through higher premiums. A second and final point involves the role legislators take when approving mandated coverage. Each new mandate creates a new example of legislative interference with the free market development of a consumer product. Instead of permitting insurance companies to develop coverage options which are attractive and affordable, mandates create government's version of what the free market insurance product should look like.

Thank you very much for considering KCCI's concerns regarding SB 509.

February 16, 1998

To: Senator Steffes and the Senate Financial Institutions and Insurance Committee

From: Kevin Davis, AMERICAN FAMILY INSURANCE GROUP

Subject: **Senate Bill 509 –Mandate for Durable Medical Equipment**

American Family sells individual health insurance coverage and only individual coverage. We do not have a group policy and intend to market only to our niche in the individual market who have a particular need for our product. We currently provide coverage for durable medical equipment to the extent provided in our policy, which may in some respects be greater than the mandates required by this bill. While we do not necessarily oppose the coverage mandated by the bill, we must respectfully oppose the mandate of the coverage.

We think that in general, mandates drive up the cost of coverage and restrict the ability of consumer to purchase the product that they desire at a price they can afford. Not all consumers need all coverage's mandated. We believe that the market place and the consumer can best produce the desired product. Some studies have concluded that as many as 25% of all uninsured individuals have been priced out of the market because of mandates. This bill will have a cost to us of providing an endorsement and notification to our customers of the new mandate and the changes in their policy, in addition to any direct costs.

While we do not support any mandates, we believe this mandate and all others requested of the legislature should be considered in a comprehensive fashion to measure the full impact (cost/benefit) on the health insurance policy and the consumer.

KS98.SB509

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Kansas Association of Health Plans

Testimony before the

Senate Financial Institutions and Insurance Committee

The Honorable Don Steffes, Chairman

Hearings on SB 386

February 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.

Currently, most HMOs provide coverage for many of the services and equipment necessary for the treatment of diabetes that are described in SB 386. However, the bill's intent should be clarified. First, it is unclear whether insulin is included in the term "supplies". Most plans that provide prescription drug coverage include insulin, lancets, and chem strips as part of that coverage. The bill should be amended to specify whether coverage of supplies includes insulin and whether plans that do not offer pharmacy benefits or do not include insulin as a pharmacy benefit will be mandated to do so under SB 386.

Second, the effective date of July 1, 1998 will be more difficult for some plans to comply with than others because of the variety of methods that plans use for providing insulin and supplies as part of a benefit package. The effective date should be changed to January 1, 1999 in order to allow plans sufficient time to fully comply.

Third, the bill should specifically identify some standard for licensing or certification for

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those providing self-management training and education. The current wording of the bill is extremely broad and would likely result in a huge variation in the quality of the education being provided. We would suggest requiring that education programs be certified by the American Diabetes Association in order to assure that programs meet consistent quality standards.

Nothwithstanding the above, KAHP supports the philosophy of SB 386. However, KAHP members are in opposition of SB 386 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 SB 386 against the public benefit of having a competitive marketplace for health insurance.

Respectfully,

Callie J Denton

Callie Jill Denton
Executive Director

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**STATEMENT OF BRAD SMOOT, LEGISLATIVE COUNSEL
BLUE CROSS BLUE SHIELD OF KANSAS
BLUE CROSS BLUE SHIELD OF KANSAS CITY
SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE
REGARDING 1998 SENATE BILL 386
FEBRUARY 16, 1998**

Blue Cross and Blue Shield of Kansas is a not-for-profit domestic mutual insurance company providing health insurance to more than 700,000 Kansans in 103 counties. Blue Cross Blue Shield of Kansas City is a non profit hospital and medical service corporation serving more than 200,000 Kansans in Johnson and Wyandotte Counties.

Both Blue Cross Blue Shield plans generally oppose mandated benefits because they tend to increase the costs of health insurance and thereby decrease the number of Kansas businesses and individuals who can afford coverage. We do have somewhat less concern over SB 386, since it appears to mandate coverage which our own insureds already have.

However, SB 386, as currently drafted, has a few critical problems. Attached, are proposed amendments to address each concern. Section 1 (b), line 24, mandates coverage for "supplies." If it is the intent of the bill to mandate coverage for out patient insulin doses, this could have significant impact on policies which do not have an out patient prescription drug component. Currently, BCBS of Kansas pays for insulin if the insured has chosen to pay for out patient pharmacy. In addition, we pay for "supplies" which are of unique to diabetics. It does not seem appropriate or manageable to pay for alcohol, cotton balls or other household items. See attached criteria from Claims Operating Manual for diabetic care.

Section 1(c), lines 30-32, mandates insurance payment for self-management training and education by "certified, registered or licensed" health care professionals "with expertise in diabetes." Currently, BCBS of Kansas pays for such educational programs and considers them to be beneficial. However, reimbursement is

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restricted to educational programs received in a facility approved by the American Diabetes Association (ADA). Education delivered by a professional provider is considered part of the overall service of that provider and is not separately reimbursed. Since the state of Kansas has no certification process for diabetes educators, we would suggest that Subsection (c) be amended to restrict the mandate to only ADA programs. We would not want the ambiguity of this section to create the potential for waste or abuse.

Finally, managed care plans are covered by SB 386. Some rely on primary care physicians (PCP) as a basic feature of patient care and coverage. We have suggested language in Section 1(d)(1), line 35, to preserve the role of the PCP in making necessary educational referrals.

Again, we have reservations about government mandates as we believe the marketplace will respond to consumer demands and that health plans can see the value of educating diabetic patients. But if the Legislature is to act on SB 386, please consider the concerns we have expressed above and the specific amendments we have offered.

Thank you for this opportunity to comment.

SENATE BILL No. 386

By Committee on Ways and Means

3-28

AN ACT concerning insurance; relating to increased coverage for treatment of diabetes; amending K.S.A. 1996 Supp. 40-1909 and 40-19c09 and repealing the existing sections; also repealing K.S.A. 40-1909, as amended by section 110 of chapter 229 of the 1996 Session Laws of Kansas, and K.S.A. 1996 Supp. 40-19c09, as amended by section 113 of chapter 229 of the 1996 Session Laws of Kansas.

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 July 1, 1997, also, shall provide coverage for equipment, supplies 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.

(c) Diabetes outpatient self-management training and education shall be provided ~~by a certified, registered or licensed health care professional with expertise in diabetes~~.

(d) (1) The benefits provided in this act shall be subject to the same annual deductible or co-insurance established for all other covered benefits within a given policy.

(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. 1996 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 cor-

and

limited to hypodermic needles and supplies associated exclusively with diabetes management

through a program approved by the american diabetes association

Such coverage shall include coverage for insulin only if such coverage also includes coverage of prescription drugs.

through a program approved by the american diabetes association

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 shall be subject to such requirement.

8-3

C. DIABETIC CARE

NOTE: Coverage of syringes/hypodermic needles for self-injectable drugs for diagnoses other than diabetes MAY be approved based on Individual Consideration for medical necessity by the Medical Review Utilization Department.

COVERED
acetest/clintest tablets
glucometer supplies
- calibration test strips
- diab tape
- lancets
- sterile saline

hypodermic needles
syringes
testape
diastix (Keto is a brand name)

NOT COVERED
alcohol
autochex
autolet
cotton balls
food scales
stop watch

MEMORANDUM

TO: Senator Don Steffes, Chair
Senate Financial Institutions and Insurance

FROM: William W. Sneed
Health Insurance Association of America

DATE: February 10, 1998

RE: SB 386

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 SB 386.

SB 386 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

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preventative health care benefits as set out in SB 386; 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 with the broad nature of the language describing what is to be covered under SB 386. Terms such as "equipment," "supplies," "training" and "education" are not defined in the bill and could potentially encompass more than even the drafters had intended.

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.

For these reasons, we urge you to reject SB 386. Please don't hesitate to contact me if you have questions or need further information.

Respectfully submitted,

William W. Sneed

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Testimony to Senate Committee on Financial Institutions and Insurance

on SB 509 and SB 386

(Durable Medical Equipment / Diabetes Coverage)

by James P. Schwartz Jr.
Consulting Director
February 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.

Well, here we go again, the cowboys versus the Indians, fighting over that vast frontier of health insurance.

Today the squabble is over medical equipment and diabetes coverage. Other days we'll consider brittle bones, missing breasts, and suspicious prostates for assurances of coverage. All the claimants for inclusion have merit. So do many, many others.

This book is *Gray's Anatomy*. It's the classic text of the human body. Every page details a portion of the incredible human form. I've attached a sticky note to each page where a current or proposed health insurance mandate applies. You'll see we already have quite a few pages taken care of. But what concerns me is all the pages we haven't taken care of. There are over 1200 pages in this book. If we mandate a half dozen body parts a year, it'll take us 200 years to get the whole job done. And that's if medical science doesn't get any more complex.

You may be surprised to hear me say this, but I see one valid argument for mandating specific coverages. We'd all like to eliminate the situation where the policyholder discovers, in the course of treatment...and to her horror, that the fine print excludes the very thing she needs.

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At the same time, though, we can't adopt a policy of covering whatever might yield a marginally better outcome, regardless of cost. We've tried that route, and it led to the world's record for costs, with second place barely in sight.

So what could we do instead? One honorable approach was that taken by Oregon, who formed a commission to lay out all the possible coverages, estimate their incidence, price them, judge their benefit to patients, consider the state's funding capacity, and decide which coverages to include and which ones to leave out. The resulting "rationing list" was an excruciating exercise, but it honorably weighed costs and benefits within an overall budget.

Another honorable approach would be to adopt a system of health insurance purchasing cooperatives for small groups. Those are the groups that are still insured and thus affected by state law. They're also the groups that are more likely to have "holes" in their coverage. Purchasing cooperatives would have to do a mini-Oregon process of cost/benefit analysis, and state government could oversee that process without having to get its hands too dirty. In other words we could use these "private regulators" to bring about a degree of uniformity and rationality in coverage decisions.

But we're not talking about those approaches today. We're talking about pages 241 and 948. We'll never get where we need to go that way. Reject this piecemeal approach and bills that use it.

February 16, 1998

To: Senator Steffes and the Senate Financial Institutions and Insurance Committee

From: Kevin Davis, AMERICAN FAMILY INSURANCE GROUP

Subject: **Senate Bill 386 –Mandated Coverage for Diabetes**

American Family sells individual health insurance coverage and only individual coverage. That is, we do not have a group policy and we intend to provide a product to those individuals in a unique niche who have a particular need for our product. Most of our business is with self employed individuals or those people working for smaller employers who cannot afford to provide group health benefits. We currently provide coverage for diabetes to the extent defined in our policy. Depending on the interpretation of the mandates required in the bill, it could provide for additional or new coverage under our policy. While we do not necessarily oppose the coverage mandated by the bill, we must respectfully oppose the mandate of the coverage.

We think that in general, mandates drive up the cost of coverage and restrict the ability of the consumer to purchase the product that they desire at a price they can afford. Not all consumers need all coverage's mandated. We believe that the market place and the consumer can best produce the desired product. Some studies have concluded that as many as 25% of all uninsured individuals have been priced out of the market because of mandates. This bill will have a cost to us of providing for any additional coverage, which admittedly could, in part perhaps, be offset by reduced future expenditures for treatment of the disease. These costs are speculative and not quantifiable at this point. Administrative costs incurred would be for an endorsement and notification to our customers of the new mandate and the changes in their policy.

While we do not support any mandates, we believe this mandate and all others should be considered in a comprehensive fashion to measure the full impact (cost/benefit) on the health insurance policy and the consumer.

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