Approved: Robert Tomlinson
Date April 30, 1999

MINUTES OF THE HOUSE COMMITTEE ON INSURANCE.

The meeting was called to order by Chairperson Bob Tomlinson at 3:30 p.m. on March 9, 1999 in Room 527-S of the Capitol.

All members were present except:	Committee Present
Committee staff present:	Bill Wolff, Research Ken Wilke, Revisor Mary Best, Secretary
Conferees appearing before the committee:	John Pepperdine, American Cancer Society Diane Koger Paul Davis-Kansas Department of Insurance Kevin Robertson-Kansas Dental Association Paul Kittle-D.D.S. Josie Torrez-Kansas Council on Developmental Disabilities
Others attending:	See Attached Guest List

Due to the difficulty in locating the video equipment, it was decided to open public hearings with:

SB 14: Health insurance; reconstructive breast surgery

Chairman Tomlinson informed the committee this is a part of federal requirements that we have this, and began the public testimony with Mr. John Pepperdine, Manager of Government Relations for the American Cancer Society. Mr. Pepperdine gave Proponent Testimony and a copy of his written testimony is (Attachment #1) attached hereto and incorporated into the Minutes by reference. He informed the committee "to date, only 29 states have passed similar laws requiring health plans that cover mastectomies provide for coverage of reconstructive surgery after a mastectomy". He also informed the committee not all health insurance plans or coverage are subjected to the scrutiny of the law. A new law "Women's Health and Cancer Rights Act,"covers plans state laws do not cover, thus securing services for all women in all states (covering those who have no laws addressing the problem or very weak laws). The American Cancer Society feels this bill should be passed to strengthen the current federal laws and more clearly define the laws we do currently have. Mr. Pepperdine also presented written testimony for Diane Bender Koger, a breast cancer survivor. Her Proponent Testimony is (Attachment #2) attached hereto and incorporated into the Minutes by reference. There were no questions from the committee.

Mr. Paul Davis, Kansas Insurance Department, gave Proponent Testimony to the committee. A copy of the testimony is (Attachment #3) attached hereto and incorporated into the Minutes by reference. Mr. Davis stated the Insurance Department is in support of the bill also. His statement included information on reconstruction "to produce a symmetrical appearance."

Questions were asked by Representatives Boston, Jenkins, Showalter, and Chairman Tomlinson.

With no further testimony or discussion the hearing on this bill was closed.

Public hearing were then opened on **SB 3.**

SB 3: Providing coverage for general anesthesia and medical care facility charges for certain dental care.

Mr. Paul Kittle, Jr., D.D.S., gave Proponent Testimony to the committee. A written copy and colored photographs are (Attachment #4) attached hereto and incorporated into the Minutes by reference. As the video projector was unable to be secured, Dr. Kittle used the attached colored photos for his presentation explaining to the committee why is necessary to have legislation to prevent insurance companies from denying coverage to children they are insuring, thus denying them the care and treatment they need. It was also stated the inability of the insurance companies to cooperate in insuring the dental care to be performed under general anesthesia in the operating room. Many parents who think their child is covered by their private insurance company are "being denied medical benefits that otherwise would be payable simply because it is dental procedures that have to be done in the operating room (and not ear tubes or tonsils)." It is for this reason they come before the committee for support of this bill.

Questions were asked by Rep. Showalter.

Josie Torrez, Kansas Council On Developmental Disabilities, gave Proponent Testimony to the committee. A copy of the written testimony is (Attachment #5) attached hereto and incorporated into the Minutes by reference. Mrs. Torrez concurred with the previous testimony offered and asked for support of the bill. There were no questions asked

Mr. Kevin Roberston, Kansas Dental Association, gave Proponent Testimony to the committee. A copy of the written testimony is (Attachment #6) attached hereto and incorporated into the Minutes by reference. Mr. Robertson also agreed with the previous testimony and continued on to explain the Senate amendments to the bill. There were no questions.

With no further discussions or testimony, the hearing on the bill was closed.

The committee was then instructed to turn to **HB 2066:Proof of insurance prior to motor vehicle registration.**

The Chair called the committee's attention to the balloon which would restore the bill to what the committee meant it to be. This will remove the faulty committee report and restore it to the form it was thought to be when it was sent out. Page 2, grammatical comma's were added, they were not a part of the original bill, they are technical in nature of corrections. The bill was then moved to committee. **Representative Kirk made a motion to accept the balloon..(inaudible)... discussion regarding page 5 which is a correction to the mistake in the committee report.** The mistake is the actual wording on page 5 and the balloon is correct. Further discussion by Rep. Boston. Language on page 6, are the original language of the laws, concerning the fees of $25.& $75. It was noted the Insurance Commissioner had indicated a raise at one time to $250. & $750. It was felt some raise was necessary but not to that extent. This balloon restores the bill to where is was originally thought to be. Back to the motion **seconded by Rep. Burroughs, vote taken and motion passes.**

The Chairman moves the committee back to the bill. Rep. Jenkins has a question regarding the balloon, page 1, line 35, offering a change to the word "affidavit" to "certification" so that it would again be easier for people to produce this information with out a notary. The second change request was to line 29, of the last page, regarding time for notification to the public of the changes in the law. It would also give time for Y2k to take effect. **Rep. Jenkins made the motion to offer these two changes as amendments to the bill. The motion was seconded by Rep. Showalter. Call for discussion. Rep. Boston brought forth the grammatical change from "a affidavit" to "an affidavit". Rep. Jenkins corrected her motion, and Rep. Showalter seconded the change. Vote was taken, vote was unanimous. The Chair recognized Rep. Phelps.** Chairman Tomlinson and Rep. Phelps discussed the changes to pages 2 to 5. Page 5, line 16 brought back the original model to $300., Rep. Phelps amendment with the Commissioner indicated $300., and the Commissioners original language was $500. The discussion continued in regard to the restoring the meaning back to current law.

Revisor Wilke offered to explain the changes to the committee. Page 5, line 16, the $200. figure would increase to $300., and on line 21 after "class A misdemeanor" additional language would be inserted "and shall be subject to a dine of not less than $800. and no more than $2500." He then explained what this would do as far as the courts and judges were concerned. This would be subsequent offenses within 3 years. Line 14 thru18 refer to the first offense. Another portion of the Amendment affects K.S.A. Supp. 40-3118 (b). On page 8, line 2, the language " and shall be subject to a fine of not less than $300. nor more than $1000." would be inserted after the word "misdemeanor." There was discussion of jail time with a class B misdemeanor. Line 18, page 5, of the balloon inserts " months". Rep. Boston then asked the relevancy of all of this if this was all self-insurers. Researcher Wolff explained 40-3104 would cover all insured not just self-insurers. This is set out in subsection (g) of 40-3104.

The Chair brought the committee back to the motion on the floor and asked for a second. Rep. Kirk seconded the motion. Questions now were to be confined to the structure of the motion itself. This would help them to understand what they were discussing, then the committee would discuss the merits of the motion. Rep. Jenkins and Phelps discussed the Commissioners requests and why they were made. **Rep. Vining made a sub motion to send the bill out as amended marked favorable for passage. The Chair cautioned the committee the motion would also include the amended language by Rep. Jenkins. Discussion of the merits of the motion took place.** Discussions were started by Rep. Hummerickhouse., Kirk, Vining. The committee moved back to the **Phelps motion which would amend the language on page 5, line 16, to increase the amount from $200. to $300., Line 21They would insert "and shall be subject to a fine not less than $800. and not more than $2500", after the words "A misdemeanor". The third change would be to page 8, line 2, after the word misdemeanor insert "and shall be subject to a fine not less than $300. nor more than $1000." Discussion was called for content only. The Chair recognized Rep. Boston, Rep. McCreary for discussion. Rep McCreary made a sub motion to table the bill, the vote was split and Chair voted with the noes taking the vote.** There was more discussion, with Rep. Hummerickhouse on the language on page 8 to raise the amount to $300. and also to amend the bill in three places as per Rep. Phelps motion. **A vote was taken on Rep. Phelps motion, ayes carried, motion passed. Rep. Grant made the motion to pass out with no recommendations, Rep. Cox seconded, Rep. Toelkes made a sub motion to pass out marked favorable for passage. Discussion. Vote taken on sub motion, motion fails. Back to Rep. Grants motion, Rep. Boston made a sub motion to table the bill. Motion passes.**

Committee approved all Minutes for February. Meeting adjourned. Next meeting is March 11, 1999

Many of the above minutes were taken from notes as the tapes were inaudible.

AMERICAN CANCER SOCIETY® Hope. Progress. Answers.

March 9, 1999

Written testimony by John Pepperdine
Manager of Government Relations

SUPPORT OF SENATE BILL 14 UNDER REVIEW BY THE HOUSE INSURANCE COMMITTEE

Thank you for allowing me to speak. My name is John Pepperdine and I am Manager of Government Relations for the American Cancer Society. Representing over 270,000 volunteers and supporters in Kansas, I am here to support Senate Bill 14.

In the closing minutes of the 105th Congress last October, federal lawmakers passed a critical breast cancer measure -- a provision that requires all health plans that cover mastectomies to provide breast cancer reconstruction for mastectomy patients, including coverage of prosthetic devices and reconstruction for restoring symmetry.

To date, only 29 states have passed similar laws requiring health plans that cover mastectomies provide for coverage of reconstructive surgery after a mastectomy. However, not all health plans are subject to state law. This new law, known as the *"Women's Health and Cancer Rights Act,"* covers those plans not currently covered by state law, and sets a minimum standard securing this service for all women in all states -- including those with weaker state laws, and those without any laws on this at all.

Although the law went into effect October 21,1998, it is a somewhat complicated and complex measure, therefore this spring the Department of Labor (DOL) is expected to provide a clear definition of how the new law is to be implemented and how insurance companies are expected to comply. Some of the questions the DOL will be addressing include whether the law is retroactive, for example, what happens to women who had a mastectomy, but did not have breast cancer reconstructive surgery at that time. Can they benefit from the new law? Are there any time constraints or limitations for the coverage? This question pertains to women who at the time of their mastectomy do not want to make the decision as to when to follow-up with reconstructive surgery -- do they have only a small window of opportunity for coverage? Does the law cover reconstruction for women who elect to have lumpectomies or medical procedures for breast cancer? We expect the DOL will come up with definitions and clarify what types of procedures are to be covered under this bill.

Why should you pass **SB 14?** Aside from the written testimony of Ms. Koger, **SB 14** should be passed to strengthen the current federal law and define more clearly what the federal government has yet to define.

Thank you for your time.

HEARTLAND DIVISION, INC.
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House Commerce Ins.
Attachment #1
March 9, 1999

Breast Reconstruction Law: What it means?

On October 21, 1998 the Women's Health and Cancer Rights Act (the Women's Health Act) was signed into law. The Act was part of a large funding bill called the Omnibus Appropriations Act of 1998 [H.R. 4328] and contained important new protections for breast cancer patients who elect breast reconstruction with a mastectomy.

The following information is intended to provide general guidance on frequently asked questions about the Women's Health Act provisions that amend ERISA.

WHAT PROTECTIONS ARE COVERED UNDER THE NEW FEDERAL LAW?
The provision requires all health plans to provide for coverage of prosthetic devices or reconstructive surgery after a mastectomy, including restoring symmetry and addressing physical complications (including lymphedemas), so long as those plan cover mastectomy. The new federal law sets a federal floor so that all women will benefit from breast reconstruction following mastectomy, even if she lives in a State with no current mandates

I have been diagnosed with breast cancer and plan to have a mastectomy. How will the Women's Health Act affect my benefits?
Under the Women's Health Act, group health plans, insurance companies and health maintenance organizations (HMOs) offering mastectomy coverage must also provide coverage for reconstructive surgery as determined by consultation between the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Will the Women's Health Act require all group plans, insurance companies, and HMOs to provide reconstructive Surgery benefits?
All group health plans, and their insurance companies or HMOs, that provide coverage for medical and surgical benefits with respect to a mastectomy are subject to the requirements of the Women's Health Act.

Under the Women's Health Act, may group health plans, insurance plans, insurance companies or HMOs impose deductibles or coinsurance requirements for reconstructive surgery in connection with a mastectomy?
Yes, but only if the deductibles and coinsurance are consistent with those established for other benefits under the plan or coverage.

When do these requirements take effect?
The reconstructive surgery requirements apply to group health plans for plan years beginning on or after October 21, 1998. To find out when your plan year begins, check your Summary Plan Description (SPD) or contact your plan administrator. These requirements also apply to individual health insurance policies offered, sold, issued, renewed, in effect, or operated on or after October 21, 1998.

DIANE BENDER KOGER

January 26, 1999

My name is Diane Bender Koger and I was asked to speak to you again today about the relevance of insurance coverage for breast reconstruction following breast cancer treatment.

Five years ago, at the age of 34, I was diagnosed with Breast Cancer. After two lumpectomies that were unsuccessful, I was advised to have a total mastectomy. You see, although my cancer was ductal "in-situ" or in place, which means it has not metastasized and traveled, it was only treatable by removal. With removal, the survival rate is nearly 100%.

Because of abnormal cell growth in the opposite breast, and the fact I did not want to go through another surgery, I chose to have both breasts, removed. At this point, my concern was saving my life and returning to health, not whether I had breasts or not.

I was content with my decision. I would either wear prosthesis or not, it was no big deal. I just never wanted another surgery.

I felt that I could deal with the inconvenience of clothing not fitting; never wearing lingerie or a regular bathing suit, but, as the years went by, the daily reminder that I was disfigured began to wear on me. Every morning I had to put prosthesis in my bra and every evening take them out.

So, 2 ½ years after my mastectomies I made the decision to have reconstructive surgery. This was not a decision made lightly. I learned that to have the reconstruction that was best for me was a huge commitment. I would need two surgeries, and after I was healed I would have an in office surgery to construct the nipples, then later tattooing. The entire process would go on for more than 9 months.

I was fortunate that my insurance covered this procedure and there was no time limit on the decision. I was not rushed to make a decision that I had not researched and I was able to make a complete physical and mental recovery from the mastectomies, before proceeding with reconstruction.

House Commerce
Attachment # 2
March 9, 1999
2-1

7154 SW WATTLING COURT ❊ TOPEKA KS 66614-4649 ❊ 785-478-4238

I believe that if women have the option to undergo reconstructive surgery they will be more likely to seek early detection and treatment.

I want to thank you for your time and consideration. I would be happy to answer any questions that you may have, today or at a later date.

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

March 9, 1999

TO: House Insurance Committee

FROM: Paul T. Davis, Assistant Director for Governmental Affairs

RE: Senate Bill 14 – Reconstructive Breast Surgery

Mr. Chairman and members of the committee:

I am appearing today in support of Senate Bill 14 which codifies provisions of the Women's Health and Cancer Rights Act of 1998 into Kansas law. This bill requires that insurance companies and health plans provide coverage for reconstruction of a breast on which a mastectomy has been performed. It also requires coverage for reconstruction of the other breast, if a mastectomy has only been performed on one breast, to produce a symmetrical appearance. Additionally, the bill requires coverage for prostheses. Insurance companies and health plans offering these benefits may not deny an insured eligibility to enroll or to renew coverage, and they may not penalize, reduce or limit the reimbursement of an attending provider who provides such care.

In 1997, Commissioner Sebelius testified in support of a bill that included several provisions of Senate Bill 14. The topic of a breast reconstruction mandate was again considered during this past summer and received a favorable recommendation by the Special Committee on Financial Institutions and Insurance. Without the federal mandate, this bill would only affect approximately 25% of Kansans with health insurance. However, the federal mandate allows all Kansans to have access to breast reconstruction coverage.

With breast cancer striking one (1) out of nine (9) women in the United States, this is a significant health issue for Kansas. It is a step forward for cancer survivors in Kansas to have breast reconstruction surgery available to help with the healing process.

Thank you for your consideration of Senate Bill 14, and we ask your favorable passage of the bill.

House Comm on Ins
Attachment # 3
March 9, 1999

420 SW 9th Street
Topeka, Kansas 66612-1678

785 296-3071
Fax 785 296-2283

Consumer Assistance Hotline
1 800 432-2484 (Toll Free)

Testimony of Dr. Paul E Kittle, Jr.

Representative Tomlinson, Honorable ladies and gentlemen...

Good afternoon. My name is Dr. Paul Kittle and I am a specialist in children's dentistry from Leavenworth. By way of background, I am a retired U.S. Army full Colonel. I practiced 20 years of children's dentistry in the Army and was privileged to be the Director of the Army's Postgraduate Residency Program in Pediatric Dentistry for 4 years. I am one of only 1100 Board Certified Pediatric dentists in the United States, 1 of only 7 here in Kansas. Most recently, I completed a 3 year term as a national Trustee for my professional organization, the American Academy of Pediatric Dentistry. I am very involved in being an advocate for children, with much of my research and national lecturing being on behavior management, sedation and operating room care for children, and especially the detection and reporting of child abuse/neglect.

I am here today to ask for your consideration in writing enabling legislation that specifically will prevent health insurance companies, doing business in Kansas, from denying coverage to the children they insure, who, because of their young age, the amount of care they require, and/or their inability to cooperate, require their dental care to be performed under general anesthesia in the operating room.

The facts of the matter are that, routinely, in Kansas today, insured children and their parents, who believe they have the health needs of their family covered by their private insurance company, are being denied medical benefits that otherwise would be payable simply because it is dental procedures that have to be done in the operating room (and not ear tubes or tonsils). Is this a problem that requires you help? I adamantly believe so and will try to educate you to the facts this afternoon. I have given you a packet of information. Following a copy of my remarks, on attachments marked 1,2,3,4, you will find copies of 4 recent letters written to me and or a parent denying insurance coverage for their child's dental needs to be done in the operating room solely because the treatment concerns teeth. If it were ear tubes, eyelids, nose or sinus difficulties, anything else on the head, then, it would have been approved. This is unfair to the parent. This is wrong! And most importantly, this is bad for the child!!

Kansas is not alone in facing this dilemma. Great strides, however, are being made in state legislatures across the nation because IT IS THE RIGHT THING TO DO FOR KIDS. In 1995, Minnesota enacted the first legislation in this country requiring medical insurance companies already covering a family's health insurance needs, to also cover the costs for general anesthesia and related hospital items, when dental treatment is required on a young

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child or a patient with defined special needs. Thirteen states (Minnesota-1995, Texas and Tennessee-1996, Wisconsin and Louisiana-1997, Colorado, Maryland, Florida, Missouri, New Hampshire, New Jersey, Oklahoma, and California-1998) have now passed legislation requiring that medical insurance companies cannot exclude treatment of early infant dental caries and routine dental care for special needs patients. I have included a copy of the Missouri legislation for your review (attachment 5).

Please allow me to educate you to the problem:

The problem concerns young children and special needs patients (like those with Down Syndrome, etc.) who have extensive dental cavities that must be treated for them to grow and function in a healthy manner and to be without pain. Have you ever had a toothache? How bad is the pain? The difference is you could take yourself to your dentist, you could cooperate for treatment (hopefully [and if you couldn't or it was hard for you, is it because of something that happened to you as a child?]) and you could be free from debilitating pain when the treatment was done. Hopefully you did not have a negative experience with your treatment and could return for routine preventive care so that nothing like this would develop again. This is NOT what is happening to the children we are speaking of.

HERE ARE THE RELEVANT DENTAL PROBLEMS THAT THE DENTIST MUST FACE:

1) the <u>age</u> of the child needing dental care
2) the <u>extent</u> of dental care required
3) the special needs patient

To expand:

1) TREATMENT
Some young children are put to bed or down for a nap with a bottle. If this bottle contains anything other than water or, if the child is allowed to sleep in the bed with the mother and allowed to nurse all night, then the teeth are exposed to a sugary solution for an extended period of time. What often follows is that the teeth are severely attacked by bacteria in the mouth which convert the sugar to acids thereby dissolving the teeth. Alternatively, or additionally, some young children are given sugary snacks and drinks whenever they ask for them and frequently they are not brought to the dentist until tremendous problems have developed. This leads to severe dental cavities which, if left untreated, can progress to very severe infections. (SLIDES) The biggest problem is the age of the child. It is often not possible to reason with the young child. They are simply too uncooperative, too fearful or too anxious and will not allow the any dental work to be accomplished in the dental office without a tremendous struggle. This presents a real problem because you now have a child with severe cavities who can't be treated with ordinary means. So, when a parent brings me a two,

or three, or four year old, with all these tremendous problems you have seen, what options do I have?

I can say to the mother 'Alright mom, here is what I can do for you':

Treatment options:

do nothing - what happens?
postpone the care - what happens?
restrain them ("tie them down") - what happens?
sedate them - how? what happens, what is the success rate?
Are there dangers?
general anesthesia - what happens?
*The Problem = denial of coverage

2) PREVENTION

Trying to anticipate what you might ask, my next thought would be to dentists testifying in favor of this legislation, then why don't you [the dentist] prevent this from happening? And I want you to know that we (the dental profession) go to great ends to try to prevent this from happening. Many of us go to prenatal classes monthly to educate parents what to do and what not to do. I show slides similiar to those I brought this afternoon to try to emphasize to the expecting parents the severity of the conditions and how to prevent them from happening? But many parents don't attend these classes. So, we visit schools, we go to PTA meetings. We try to prevent the problem.

3) WHO CAN OPERATE?

I want you to understand that if the procedures are small, or the cavities are not that bad, or if the condition can be observed, then sometimes we can accomplish the treatment in the office. We often try the various options, including sedation, first. Major efforts are made to not take the child to the operating room because it is an involved procedure. If I elect to sedate the child, it may take 3 or 4 sedations to treat the child in the office. That is, presuming, that we can be successful. But sometimes the care is so difficult, the care required is so complex, that it is best done, in our opinion as the experts in dentistry for children, in the operating room. One of our major concerns is to prevent children from having damage done to their developing psyche. In other words, we don't want the child to be terrified of going to the dentist for the rest of their lives. Can any dentist just decide to go to the O.R.? The answer is No. You have to be specially trained and then credentialed by a hospital to perform treatment in the operating room. Dentists must have had an internship or residency to do it; therefore it is primarily pediatric dentists, oral surgeons and a few general dentists who have advance training who utilize the hospital. What about financial incentives? Do we, do I, make a whole bunch of extra money because I take a child to the O.R.? Quite the

contrary, I lose money because instead of treating multiple patients that morning (I see 35-40 children a day), I am treating one or two children in the operating room all day and the office is essentially closed for that time period. However, ethically, morally, there are times when the treatment must be done in the operating room and access to the hospital is being denied by some of the insurance companies.

4) SPECIAL NEEDS PATENTS
There is also another category of patients, both children and adults, who are handicapped/disadvantaged/challenged either mentally, physically or medically (special needs patients) who simply cannot be treated safely in the office. For example, a child or adult with autism, one with cerebral palsy, or one with hemophilia. There are numerous other conditions that fit these categories. These patients sometimes cannot be treated any other way than in the operating room. Their dental care in the operating room is sometimes also being denied.

5) COST
The bottom line on everything these days is cost. How much is it going to cost the insurance companies to allow these needy children to be cared for in the hospital? This is important of course, because it follows that this cost is going to be passed onto the consumer who is insured. I have provided you a copy of the recent study done in Alabama to explore these costs (attachment 6). You will note that it cost each policy holder $0.97 extra per year to provide this care to the children who needed it. (EXPAND) Of special interest is the note on the bottom of the first page of that attachment noting that, in a similar program in Texas, after 2 years of covering anesthesia and hospital costs for children's dental procedures, Blue Cross and Blue Shield had not found it necessary to raise premiums.

Additionally, please note that Alabama has 62 pediatric dentists who will perform the majority of this type of care. Kansas has a shortage of pediatric dentists. We have only 22.

6) MEDICAID
Ironically - our state Medicaid program recognizes the treatment difficulties in attempting to treat these young children with extensive dental problems in the office and <u>already</u> routinely permits dental treatment in the operating room utilizing general anesthesia for children and special needs patients when their conditions warrant it.

7) OTHER
There are several other items in your packet to help in your decision process:

a) a copy of a fact sheet on this issue as prepared by the American Academy of Pediatric Dentistry (attachment 7)
b) a copy of the official document from the American Academy of Pediatric Dentistry Reference Manual that lists the current

indications for performing dental work in the operating room. In other words, the dentist doesn't just decide to go to the operating room. Rather, there are specific indications when the child should be taken. (attachment 8)

c) photos of several children recently seen in my practice who needs their dental care done in the operating room. (attachment 9) Please look at him.

Please do not forget him. He and other Kansas children need your help.

8) CONCLUSION

The bottom line is this. Kansas children whose parents have health insurance are being denied general anesthesia and operating room coverage for dental needs. Thirteen states including our neighbors in Oklahoma, Texas, Missouri and Colorado have already passed legislation requiring this coverage be provided. The Kansas Senate has already passed this bill 39-0. Please pass this enabling legislation on it's own merit.

Please do what is right for Kansas kids.

Thank you for your time and consideration.

Paul Kittle, D.D.S.
309 South Second St
Leavenworth, Ks 66048
913-651-9800

11 MAR 99

4-5
5-16

indy Suozzo
hildren's Dentistry
x # (913) 651-3559
indy

As per our conversation today regarding the [redacted] this plan does not allow for medical charges in conjunction with dental services to be paid under the medical portion of the plan. In particular, this would refer to the hospital and also anesthesia charges that would be billed separately from he dental charges not being covered by either the dental or the medical.

Please let me know if I can be of further assistance.

Sincerely,

[redacted]

04/06/98 MON 14:18 TEL 3366056406 JHHL

UNICARE — FAX TRANSMISSION

SENT TO : Cindy
LOCATION : Childrens Dentistry
DATE : 4/6/98
FAX : (913) 651-8559

FROM : Denise
LOCATION : Greensboro Client Service Center
PHONE/FAX : (910)665-1888 (910)605-6406
TOTAL PAGES: 2

RE:

Your request for confirmation in writing

Thanks

Denise

Attachment 1

4-6
6-16

BlueCross
BlueShield
of Kansas

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Corporate 800 Number
(800) 432-0216

April 16, 1998

PAUL KITTLE
309 S 2ND ST
LEAVENWORTH KS 66048

IDENTIFICATION [redacted]
PATIENT: [redacted]
INQUIRY [redacted]

Dear Mr. Kittle:

This letter is in regard to your predetermination for dental services to be done at St. John's Hospital in Leavenworth. Per the Federal policy hospital services in connection with dental procedures are only covered when a nondental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient. Per the information received these services are not being done for this reason, therefore, they would be considered not covered in a hospital setting.

If you have any further questions, please contact Federal Customer Service.

Sincerely,

Karen Ehrhart

KAREN EHRHART
Federal Customer Service Center
Topeka 785-232-3379
Toll Free 1-800-432-0379

276
cc: [redacted]
jb12-03o

Attachment 2

4 1
7 16

PATIENT: [redacted]
OPTION: Standard

TYPE OF SERVICE Surgical Pre-Authorization
PROVIDER OF CARE: Dr. Kittle

Dear Dr. Dr. Kittle:

This letter is in response to your inquiry of April 13, 1998 concerning pre-authorization for surgical anesthesia for dental caries in an outpatient facility for [redacted].

Per page 26 of the 1998 Mailhandlers Benefit Plan (Plan) brochure dental benefits are available under the High Option of the Plan only. [redacted] is covered under our standard option and therefore does not have the dental coverage under the Plan. The Plan does have a benefit for oral and maxillofacial surgery however, procedures that involve the teeth or their supporting structures, such as periodontal membrane, gingiva, and alveolar bone are not considered covered oral surgery.

On page 40 of the 1998 Plan brochure under definitions:

Medically necessary is defined as: *Services, drugs, supplies or equipment provided by a hospital or covered provider of the health care services that the Carrier determines:*

3) are not primarily for the personal comfort or convience of the patient, the family, or the provider.

The fact that a covered provider has prescribed, recommended, or approved a service, supply, drug or equipment does not, in itself, make it medically necessary.

Of course, the decision to proceed with this procedure is between you and your patient's family. We hope you find this information helpful.

Thank you for the opportunity to assist you.

Sincerely,

Paula House

Paula House, RN
Review Coordinator
[redacted]

APR 14 '98 09:00AM CLAIMS ADMIN CORP. MESA OFC

Attachment 3

4-8
8-16

COMMUNITY HEALTH PLAN

April 14, 1998

Paul E. Kittle, D.D.S., P.A.
309 South Second Street
Leavenworth, KS 66048

RE: [redacted] DOB: 3-17-94

Dear Dr. Kittle;

Community Health Plan Health Services Department reviews all requests for appropriateness under the terms of the members benefit plan. After careful review of the information provided, treatment of extensive caries (dental) is not a covered benefit, and, therefore, cannot be approved for payment.

You have the right to request the clinical rationale for this decision, and it will be provided in writing within five (5) working days. You also have the right to appeal this decision. To exercise this right, please contact our Customer Service Department at 271-1247 or 1-800-990-9247 to obtain information on the appeal process.

Based on compliance with (Missouri) (Kansas) legislation, you are entitled to an expedited review under certain circumstances. You also have the right at any time to file a complaint with the Department of Insurance at (if KS: 1-800-432-2484) (if MO: 1-800-726-7390)

We would be pleased to answer any questions you may have by calling our local number, 816-271-1247.

Thank you for your cooperation in this process.

Sincerely,

Mark Whitaker, M.D.
Medical Director

[redacted]

plc

Attachment 4

801 Faraon Street • St. Joseph, Missouri 64501 • 816-271-1247 • FAX:816-271-1248

MISSOURI LEGISLATION

Section 7. 1. To the extent consistent with the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001, et seq., this section shall apply to any health insurer as defined in section 376.806, RSMo, any nonprofit health service plan and any health maintenance organization.

2. Within forty-five days after receipt of a claim for reimbursement from a person entitled to reimbursement, a health insurer, nonprofit health service plan or health maintenance organization shall pay the claim in accordance with this section or send a notice of receipt and status of the claim that states:

(1) That the insurer, nonprofit health service plan or health maintenance organization refuses to reimburse all or part of the claim and the reason for the refusal; or

(2) That additional information is necessary to determine if all or part of the claim

will be reimbursed and what specific additional information is necessary.

3. If an insurer, nonprofit health service plan or health maintenance organization fails to comply with subsection 2 of this section, the insurer, nonprofit health service plan or health maintenance organization shall pay interest on the amount of the claim that remains unpaid forty-five days after the claim is filed at the monthly rate of one percent. The interest paid pursuant to this subsection shall be included in any late reimbursement without the necessity for the person that filed the original claim to make an additional claim for that interest.

4. Within ten days after the day on which all additional information is received by an insurer, nonprofit health service plan or health maintenance organization, it shall pay the claim in accordance with this section or send a written notice that:

(1) States refusal to reimburse the claim or any part of the claim; and

(2) Specifies each reason for denial.

An insurer, nonprofit health service plan or health maintenance organization that fails to comply with this subsection shall pay interest on any amount of the claim that remains unpaid at the monthly rate of one percent.

5. A provider who is paid interest under this section shall pay the proportionate amount of said interest to the enrollee or insured to the extent and for the time period that the enrollee or insured had paid for the services and for which reimbursement was due to the insured or enrollee.

Attachment 5

4-10
10-16

Section 8. All individual and group health insurance policies providing coverage on an expense incurred basis, individual and group service or indemnity type contracts issued by a nonprofit corporation, individual and group service contracts issued by a health maintenance organization, all self-insured group arrangements to the extent not preempted by federal law and all managed health care delivery entities of any type or description, that are delivered, issued for delivery, continued or renewed on or after August 28, 1998, shall provide coverage for administration of general anesthesia and hospital charges for dental care provided to the following covered persons:

(1).A child under the age of five;

(2) A person who is severely disabled; or

(3) A person who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

2. Each plan as described in this section must provide coverage for administration of general anesthesia and hospital or office charges for treatment rendered by a dentist, regardless of whether the services are provided in a participating hospital or surgical

center or office.

3. Nothing in this section shall prevent a health carrier from requiring prior authorization for hospitalization for dental care procedures in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

4. Nothing in this section shall apply to accident-only, dental only plans or other specified disease, hospital indemnity, medicare supplement or long-term care policies, or short term major medical policies of six months or less in duration.

Attachment 5

How much was the cost

Fiscal Estimate

Impact of Hospital Dentistry Legislation on Insurance Claims

Following the lead taken by Oklahoma and Louisiana, the Alabama Society of Pediatric Dentistry formulated a Fiscal Impact of the estimated insurance cost increase per Alabama household with passage of legislation that guarantees medical benefits when dental procedures are provided under general anesthesia. The document (below) was presented to the Alabama state legislature last month. The results are remarkable: to guarantee coverage for dental procedures performed in a hospital setting, insurance costs per Alabama family will increase 97 cents.

ASPD Estimated Impact on Insurance Claims

Approximate total number of claims annually if bill passes	450*
Estimated cost per claim	x $2,150**
Total annual dollar impact on Alabama insurers	$967,500
Total number of Alabama households covered by employer or private insurance	999,648***
Annual cost per household (i.e., policyholder) of all claims	$0.97

Alabama insurers should be able to absorb approximately 97 cents per policyholder in new claims costs without raising premium rates.

How Estimate was Calculated

The Alabama Society of Pediatric Dentistry lists 62 pediatric dentists in Alabama. They treat virtually all the patients who would be affected by this legislation (most general dentists do not have hospital training). Members estimated in a recent survey that approximately 225 such cases were treated in a recent 12-month period (does not include Medicaid eligible patients). Assuming a 100 percent increase in the number of new claims if this bill were to pass, which is an overestimation based on the survey results, this projects to about 450 possible claims being filed annually.

Other States' Experience

Blue Cross/Blue Shield of Texas, after discussions with the Texas Dental Association, began covering anesthesia and hospital services for dental procedures almost two years ago. In the time since, BCBS of Texas has not found it necessary to raise premiums.

* From a 1997 survey of Alabama pediatric dentists (90 percent response rate).

** Rough average (high-end estimate) of hospital and anesthesia charges to insurers for comparable same-day procedures at the most utilized hospitals and outpatient surgical centers in Alabama.

Attachment 6

4-12
12-16

*** Sources: Calculated from figures obtained from the US Department of Commerce (Bureau of the Census), the Alabama State Data Center at the University of Alabama and the Alabama Department of Human Resources.

NOTE: Alabama's percentage of children covered by private insurance or employer health plans (62.4 percent) is remarkably close to the 1995 US Census Bureau national percentage (66.1 percent). All statistics used to formulate Alabama's statement were available through federal resources. For more information, contact ASPD member Richard A. Simpson, 205-758-3341.

Attachment b

4-13
13-16

American Academy of Pediatric Dentistry

Fact Sheet on Issues Relating to Access to Hospital Care

- Denial of medical benefits otherwise payable just because dental procedures are performed is inherently unfair when the justification for general anesthesia is the same regardless of the procedure.

- Denial of medical benefits effectively eliminates the option of general anesthesia for most families. Children and persons with disabilities suffer most. There are no comparable alternatives to general anesthesia for this group. Comparable results and outcomes are not obtained when general anesthesia is denied.

- General anesthesia is the accepted standard of care for this population group. General anesthesia for dental treatment is available under Federal medicaid guidelines, but effectively unavailable for private patients. Care under general anesthesia is supported by the American Dental Association, the American Academy of Pediatric Dentistry, the American Medical Association, the U.S. Department of Health and Human Services and most other professional dental and medical organizations.

- Legislation mandating such benefits under medical insurance policies was enacted in Minnesota in 1995.

- There is little consistency in the insurance industry concerning such benefits. Benefits are often extended to one insured and denied to others insured by the same company and even under the same policy. Policy holders are unlikely to be aware of these exclusions at the time of policy purchase. Aggressive and determined parents are sometimes able to force the payment of benefits that the majority of less well-connected, well-educated or financially well off parents are denied.

- Pediatric Dentists estimate overwhelmingly that parental acceptance of general anesthesia would increase if artificial financial barriers were removed. When over 1500 members of the American Academy of Pediatric Dentistry responded to a 1995 survey, they reported that when general anesthesia was indicated and denied, comparable treatment results could be achieved in less than half their cases. In fully 60% of these cases, patients either received compromised outcomes or were denied treatment altogether.

- This is a problem the insurance community chooses to ignore. They offer no alternatives and no solutions. They find the current situation acceptable and tolerable; we do not. We need legislative remedy.

4+4
14-16

VI. General Anesthesia

Introduction

The use of general anesthesia sometimes is necessary to provide quality dental care for the child. Depending on the patient, this can be done in an ambulatory care setting, a same day surgery center, an out-patient surgery area of a hospital or an in-patient hospital setting with the use of pre- and/or postoperative patient admission to the hospital.

General anesthesia is a controlled state of unconsciousness accompanied by a loss of protective reflexes, including the ability to maintain an airway independently and respond purposefully to physical stimulation or verbal command.

The need to diagnose and treat as well as the safety of the patient, practitioner, and staff should be considered for the use of general anesthesia. The decision to use general anesthesia should take into consideration:

1. Alternative behavior management modalities
2. Patient's dental needs
3. Quality of dental care
4. Patient's emotional development
5. Patient's physical considerations
6. Patient's requiring dental care for whom the use of general anesthesia may protect the developing psyche.

Parental or guardian informed consent must be obtained and should be documented prior to the use of general anesthesia.

The patient's record should include: a. Informed consent, b. Indication for the use of general anesthesia.

Objectives: To provide safe, efficient and effective dental care

Indications:

1. Patients with certain physical, mental, or medically compromising conditions
2. Patients with dental needs for whom local anesthesia is ineffective because of acute infection, anatomic variations, or allergy
3. The extremely uncooperative, fearful, anxious, or uncommunicative child or adolescent with dental needs deemed sufficiently important that dental care cannot be deferred
4. Patients who have sustained extensive orofacial and dental trauma
5. Patients with dental needs who otherwise would not obtain necessary dental care
6. Patients requiring dental care for whom the use of general anesthesia may protect the developing psyche.

Contraindications:

1. A healthy, cooperative patient with minimal dental needs
2. Medical contraindication to general anesthesia.

References:

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Sen Brownlee – Healthware $

Attachment 8

KAHP

KS Chamber Comm + Industry

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Kansas Council on Developmental Disabilities

BILL GRAVES, Governor
TOM ROSE, Chairperson
JANE RHYS, Ph. D., Executive Director

Docking State Off. Bldg., Room 141, 915 Harrison
Topeka, KS 66612-1570
Phone (785) 296-2608, FAX (785) 296-2861

"To ensure the opportunity to make choices regarding participation in society and quality of life for individuals with developmental disabilities"

Senate Financial Institutions & Insurance Committee

March 9, 1999

Testimony in Regard to S.B.3

AN ACT RELATING TO providing coverage for general anesthesia and medical care facility charges for certain dental care.

To ensure the opportunity to make choices regarding participation in society and quality of life for individuals with developmental disabilities.

Mr. Chairman, Members of the Committee, I am appearing today on behalf of the Kansas Council on Developmental Disabilities in support of S.B.3, providing coverage for general anesthesia and medical care facility charges for certain dental care.

The Kansas Council is a federally mandated, federally funded council composed of individuals who are appointed by the Governor, include representatives of the major agencies who provide services for individuals with developmental disabilities, and at least half of the membership is composed of individuals who are persons with developmental disabilities or their immediate relatives. Our mission is to advocate for individuals with developmental disabilities, to see that they have choices in life about where they wish to live, work, and what leisure activities they wish to participate in.

Many times people with disabilities, both adults and children, must be sedated and/or anesthetized for any dental procedure to take place due to many reasons, one of which is involuntary movement of the individual. Often, this is not covered under the person's health insurance; it is an out-of-pocket expense, or it may be covered, but not fully. We therefore, ask for your support of this bill.

Josie Torrez, Coordinator, Partners in Policymaking
Kansas Council on Developmental Disabilities
Docking State Office Building, Room 141
915 SW Harrison
Topeka, KS 66612-1570

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Josie Torrez, Coordinator, Partners in Policymaking
Kansas Council on Developmental Disabilities
Docking State Office Building, Room 141
915 SW Harrison
Topeka, KS 66612-1570

House Comm on Ins
Attachment 4-5
March 9, 1999

KANSAS DENTAL ASSOCIATION

Date: March 9, 1999

To: House Committee on Insurance

From: Kevin Robertson, CAE
Executive Director

RE: Testimony in Support of SB 3

Chairman Tomlinson and members of the House Committee on Insurance, I am Kevin Robertson Executive Director of the Kansas Dental Association. The Kansas Dental Association consists of approximately 1,000 members, representing 80% of Kansas' practicing dentists.

Today I am here to testify in support of SB 3, which would require health insurers to cover the costs of general anesthesia and medical care facilities for their insureds who require these services for dental care. SB 3 is a bill forwarded by the Special Committee on Financial Institutions and Insurance which met throughout the interim. During the interim, the Kansas Dental Association worked in collaboration with the representatives from Blue Cross/Blue Shield of Kansas and Kansas City, the Kansas Association of Health Plans, and Humana Health Care Plans to reach a workable and agreeable compromise on this concept. This collaboration continued into the Session as the Senate amendments to the bill were requested by this same group of entities to strengthen the bill by broadening the coverage, while at the same time clarifying its administration.

I would like to take a minute to clarify the Senate amendments to the bill. As originally drafted, SB 3 contained the word "and" in line 26 which meant that in order to be covered under this bill a person had to be under eight years of age AND have a medical condition requiring hospitalization, or, be both severely disabled AND have a medical condition requiring hospitalization. Under the original language, if you were nine years of age or had a physical condition or illness not considered to be severely disabling, regardless of your medical condition, you were not covered by SB 3. The Senate amendments lowered the age to "five and under," however, by replacing the "and" in line 26 with an "or" the bill was braodened to potentially cover more persons. As amended, a six year old, a nine year old, a person with epilepsy, etc. can receive reimbursement under this bill.

With the permission of the Chair, at this time I would like to turn the podium over to Dr. Paul Kittle, a pediatric dentist from Leavenworth, who would like to address the specific need for SB 3 as it relates to children.

I'll be happy to answer any questions now or following Dr. Kittle's remarks.

5200 Huntoon
Topeka, Kansas 66604-2398
785-272-7360

House Comm on Ins.
Attachment # 6
March 4 1999