Approved: _____
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE .

The meeting was called to order by Chairperson Senator Don Steffes at 9:00 a.m. on January 13, 1999 in Room 529 S of the Capitol.

All members were present except:

Committee staff present: Dr. Bill Wolff, Research
Ken Wilke, Office of Revisor
Nikki Feuerborn, Committee Secretary

Conferees appearing before the committee:

Others attending: See Attached

Dr. Bill Wolff, Legislative Research, reviewed the report from the Interim Special Committee on Financial Institutions and Insurance (Attachment 1). He explained the history of provider and benefit mandates and how Kansas compares with other states in numbers and types of mandates. The interim Committee studied all the requested mandates and how they would interact with each other, their necessity, and reported fiscal impact. Present Kansas statutes are in full compliance with the federal mandates. The interim Committee did recommend two new mandates: coverage for breast reconstruction and oral surgery for certain individuals in either a day surgery or hospital operating room setting. The Committee did recommend that any future mandates affect only the State Employees Health Plan for an unspecified length of time to test for necessity and fiscal impact.

During the discussion on mandated coverage for durable medical equipment by the interim Committee, suggestions of spreading the cost of expensive durable equipment throughout all Kansans by offering assistance through the state general fund were made. This problem appears to impact a small number of insurance companies and the small employers who ultimately bear the brunt of this proposed mandate. A more fair solution would be to spread the cost throughout the entire population but a fiscal impact statement would be necessary before any serious discussion could ensue.

Informational meetings on mental health parity and additional mental health coverage for children will be scheduled during the session. Also to be discussed will be the expense of point of service costs due to self-referral. Proposed legislation addressing this and referral outside the network for on going illness or specialty care will be forthcoming. The basic question is whether managed care can exist if self-referrals are allowed and paid at a higher rate.

Senator Becker moved that the minutes of January 12 be approved as presented. The motion was seconded by Senator Clark. Motion carried.

The meeting was adjourned at 10:00 a.m. The next meeting will be held on January 14, 1999.

SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE GUEST LIST

DATE: 1/13

NAME	REPRESENTING
Paul Davis	Kansas Insurance Dept.
Maggie Keating	" "
Marc Hamann	Division of the Budget
Stacey Soldan	Hein & Weir Chtd.
Larrie Ann Brown	KS Assn of Health Plans
Teresa Syffenauer	HIAA
Jim Wood	Via Christi Health System
Linda Hall	Assistive Technology for Kansans
Chuck Stones	KBA
Cyprena Starr	Federico Consulting
Matt Reterm	Prudential
Tom Bell	KHA
Rick Guthrie	Health Midwest
Meg Draper	Ks Medical Society

SPECIAL COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE

VARIOUS HEALTH INSURANCE MANDATES AND THEIR EFFECTS ON INSURERS, HEALTH CARE PROVIDERS AND AFFORDABILITY AND AVAILABILITY OF HEALTH CARE COVERAGE*

CONCLUSIONS AND RECOMMENDATIONS

The Committee recommends that coverage for reconstructive breast surgery and for coverage for certain oral dental procedures be mandated by the 1999 Legislature. The Point of Service issue should be studied further, perhaps by the House Committee on Insurance early in the 1999 Session. The Committee recommends no action be taken to mandate coverage for durable medical equipment or to provide parity for mental illness conditions. Other proposed mandates—maternity benefits, infertility treatments, and certain patient protections—received no recommendation. Any new mandate enacted after the effective date of any enactment of the 1999 Legislature should be applied first to state employees under the state employee benefit plan before being applied to the public health insurance marketplace.

BACKGROUND

For nearly 30 years, legislatures across the country have been petitioned by various individuals, associations, and interest groups to assist them and their constituents with the payment of certain health care costs. At the same time, persons providing services also have sought legislation to ensure payment for the services they provide. In Kansas, the Legislature has responded by enacting 17 mandates for coverage of select treatments, conditions, or diseases and payments to certain providers.

Provider Mandates

The first mandates enacted in Kansas were on behalf of health care providers and are referred to as provider mandates. In 1973, optometrists, dentists, chiropractors, and podiatrists sought and secured legislation directing insurers to pay for services they performed, if those same services would be paid for by an insurer if performed by a practitioner of the healing arts (medical doctors (MDs) and doctors of osteopathy (DOs)). In the following year psychologists successfully petitioned for reimbursement for their services on the same basis. In that same year, the Legislature extended the scope of mandates to all policies renewed or issued in this state by or for an individual who resides or is employed in this state (extraterritoriality). Social workers sought and obtained their mandate in 1982. Advanced registered nurse practitioners were recognized for reimbursement in 1990. And pharmacists, in a 1994 mandate, gained inclusion in the emerging pharmacy network approach to providing pharmacy services to insured persons.

Senate Financial Institutions & Insurance

Date 1/13

Attachment # 1

* S B. 83, S B. 14, and H B. 2005, accompanies this report.

Benefit Mandates

The first benefit mandate was passed by the Legislature in 1974, with enactment of a bill to require coverage for newborn children. That mandate has been amended over the years to include adopted children and immunizations, as well as a mandatory offer of coverage for the expenses of a birth mother in an adoptive situation. In 1977, the Legislature took its first foray into coverage for alcoholism, drug abuse, and nervous and mental conditions. The new law enacted that year required insurers to make an affirmative offer of such coverage which could only be rejected in writing. This mandate, too, has been broadened over the years, first to become a mandated benefit and then a benefit with minimum dollar amounts of coverage specified in the law.

Mammograms and pap smears were the next benefits to be mandated as cancer patients and various cancer interest groups appealed for mandatory coverage by health insurers. The year was 1988. In 1998, male cancer patients and the cancer interest groups sought and received "reciprocity" for coverage of prostate cancer. Finally, after repeated attempts over the course of more than a decade, supporters of coverage for diabetes were successful in securing coverage for certain items of equipment used in the treatment of the disease, as well as for educational costs associated with self-management training.

Provider Mandates	Year		Benefit Mandates	Year
Optometrists	1973		Newborn and Adopted Children	1974
Dentists	1973		Alcoholism	1977
Chiropractors	1973		Drug Abuse	1977
Podiatrists	1973		Nervous and Mental Conditions	1977
Psychologists	1974		Mammograms and Pap Smears	1988
Social Workers	1982		Immunizations	1995
Advanced Registered Nurse Practitioners	1990		Maternity Stays	1996
Pharmacists	1994		Prostate Screening	1998
			Diabetes Supplies and Education	1998

Kansas and Other State Actions

The Kansas Legislature has enacted eight provider mandates and nine mandates to provide certain benefits or cover certain conditions. In contrast, Maryland and Florida have in place more than 30 mandates. Minnesota, California, Connecticut, and Arkansas each have more than 25 mandates on their statute books. Using the number of mandates as a basis for comparison, Kansas is closer to its neighbors which have enacted mandates numbering in the mid to higher teens. The mandates Kansas has adopted also correspond with what most other states have enacted as indicated in the following table.

Provider Mandate	States*		Benefit Mandate	States*
Chiropractors	43		Alcohol Treatment	43
Dentists	34		Drug Abuse	31
Optometrists	37		Mammograms	47
Psychologists	41		Mental Health	32
Nurse Practitioners	21		Maternity Stays	51
			Prostate Screening	16
			Diabetes	27

* Data taken from "State Mandated Benefits and Providers," Blue Cross and Blue Shield Association, December 1997 and 1998 Health Policy Tracking Service, National Conference of State Legislatures (NCSL), May 1998. (Data are compiled by these groups and reflect what is reported to them. The data have not been independently verified and the classification of state laws and the definition of what constitutes a mandate is generally open to interpretation.)

Recent Trends

With the advent of managed care, the issue of mandates has taken on a new dimension. Now, the interests of consumer patients come more into play in legislative considerations and enactments both in state and federal legislative arenas. While enactment of provider and benefit mandates continues, patient protection bills are being introduced across the country and at the federal level. NCSL health policy tracking data shows that at least 17 states enacted comprehensive consumer rights and patient protection laws in 1997. At least four more states followed suit in 1998. Several other legislatures have the topic on their agendas. Kansas was one of that number in 1997, when the Patient Protection Act passed. The law identified the types of requirements the Legislature thought important for Kansas patients and upon which providers those mandates should be placed.

Current Issues

In Kansas, as in every other state, legislators are asked to confront numerous mandate bills and accompanying advocates and opponents each session. In some instances, the Legislature is literally left to make decisions body part by body part with advocates for each part in active competition for legislative attention with those advocating for another part. In the 1997 and 1998 Legislative Sessions mandates were introduced involving reconstructive breast surgery, osteoporosis, infertility treatment, managed care point of service, managed care patient notification, oral surgery for children, maternity benefits, durable medical equipment, health information privacy, and mental health parity. Judging from activities in other states' legislatures, waiting in the wings for introduction and consideration in Kansas are such issues as payment for contraceptives and off-label drugs, to mention only two outstanding issues.

Appointment of the interim Committee offered the Legislature the rare opportunity to connect all the body parts and look at all the mandates at one time to determine the necessity, the desirability, and the efficacy of enacting any new mandates. Further, the Committee had the opportunity to review the impact any new mandate may have on the ever expanding managed health care marketplace in Kansas.

COMMITTEE ACTIVITIES

The Special Committee on Financial Institutions and Insurance spent one and a half days on hearing each of the mandates currently before the Legislature. One-half day was devoted to hearing opponents of any new mandates. Additional time was spent in Committee discussion sorting out the issues and arriving at conclusions and recommendations.

Durable Medical Equipment. The Committee received testimony from representatives of Assistive Technology For Kansans, Community

Action, Inc., Independence Inc., Tenth Street Medical Inc., Envision, the Kansas Council on Developmental Disabilities, Families Together, Inc., the Statewide Independent Living Council of Kansas, and from the consumers and family members of consumers of durable medical equipment.

Briefly stated, conferees stressed that special medical equipment is essential to persons with disabilities. Such equipment allows the user to lead more normal and productive lives whether the equipment used be a power wheelchair, hearing aids, communicative devices, or handrails for home safety. Advocates for the mandate pointed out that traditional insurance coverage is minimal as compared to the cost of equipment and that an increase in the minimum level of coverage to $10,000 was reasonable.

Point of Service. Conferees on the requirement that point of service be an option in managed care plans included the Kansas Psychological Association, Kansas Optometric Association, Kansas Pharmacists Association, Kansas Association of Osteopathic Medicine, Kansas Chiropractic Association, the Silver Haired Legislature, and two physician specialists in private practice.

In General, proponents on the point of service mandate contended that provider choice is most important to patients, particularly to those patients with longstanding ties to a practitioner. Advocates for the mental health professions, especially certain other special treatment areas, voiced concern that managed care plans and health maintenance organizations (HMOs) imposed on existing provider and patient relationships are disruptive and jeopardizes the care critical to the patient. Some conferees discussed point of service as related to patient protection whereby the patient has the option to stay within a network if satisfied with the care received or step outside the network if dissatisfied with the level of care. The ability to choose, they said, serves to provide some check and balance to the system of managed care.

Mental Illness Parity. Among those appearing in favor of parity treatment for mental illness were representatives of The Alliance on Mental Illness Kansas, Kansas Mental Health Coalition, Kansas Medical Society, Kansas Psychiatric Society, Kansas Psychological Association, the Insurance Commissioner, Association of Community Mental Health Centers of Kansas, Inc., and individual consumers of mental health treatment.

By July 1998, conferees pointed out, at least 17 states had enacted some form of mental health parity legislation. They found it difficult to understand why diseases of the body are readily covered by insurance but diseases of the mind are not. Several proponents addressed the assumption that mandated coverage for mental illness would increase the utilization of such services, inpatient and out-patient, and raise the cost of care. Their data indicate patients tend to get more appropriate care in the proper setting with a reduction in the utilization of other medical services.

Infertility Treatment. Several Kansans, some associated with the Kansas chapter of the national advocacy group RESOLVE, made presentations in support of insurance coverage for infertility treatment.

They noted public advocacy on this subject was difficult given the very personal and private nature of the subject. Generally, the proponents described infertility as a medically recognized disease but one singled out for exclusion by insurers. Legislation requiring insurance coverage for infertility treatment, some said, would end the discriminatory practices of insurers and provide couples with the disease of infertility the opportunity to build a family, an experience most people take for granted.

Reconstructive Breast Surgery. Several women who survived the ordeal of breast cancer made presentations to the Committee. Additionally, a reconstructive breast surgeon graphically demonstrated the end results of breast surgery, explained the various procedures for reconstruction, and highlighted the frequent need to per-

form surgery on the healthy breast to obtain symmetry.

While the advocates for the mandate acknowledged that most companies provide coverage for reconstructing the diseased breast, the issue of coverage arises most frequently over the issue of symmetrical restorations. Through the 1998 sessions of state legislatures, they pointed out, 29 states had adopted coverage for reconstructive surgery and, in at least 20 of those states, the law specifically requires coverage for surgery to establish symmetry. Feeling strongly that insurance coverage should be mandated, proponents expressed some frustration with the legislative process necessary to achieve the mandate but gave assurances that, if legislation did not pass in 1999, "we'll be back."

Coverage for Oral Surgery. The Kansas Dental Association was the primary proponent for such coverage. A board certified pediatric dentist and a dentist in general practice with a large patient base of children testified on the need for certain dental procedures to be performed in an operating room setting.

They indicated that young children with severe dental caries and certain special needs patients, *i.e.*, both children and adults who are disabled either mentally, physically, or medically, are most appropriately treated in an operating room setting with anesthesia and life support systems. While many families with health care coverage believe such treatments to be covered, are surprised to discover that treatment in such a setting is excluded. This exclusion by private insurers, they said, is in contrast to benefits available under the Kansas Medicaid program which recognizes the treatment difficulties and pays for dental care provided in the operating room setting. The dentists noted that at least two states bordering Kansas, Missouri and Oklahoma, and some other states generally require insurance coverage for hospital and anesthesia charges for dental care provided to covered persons who are children under a certain age, severely disabled, or have special medical conditions.

Finally, each proponent spoke to the importance of early positive experiences with a dentist to ensure needed dental care will be sought in the future. Such experiences are not positive for some persons when care is restricted to the dental office.

Maternity Benefits. The Insurance Commissioner had requested a bill be introduced in the 1998 Legislature to require the mandatory offer of maternity benefits. While S.B. 461 was printed and referred to Committee, the Commissioner requested no action be taken as the bill did not address the issue at hand. She indicated that the issue was under review in the Department and if a bill was determined to be needed, a new request would be made in 1999.

Certain Patient Protection Provisions. Senator Karin Brownlee, author of 1998 S.B. 662, explained the patient protection provisions in the measure. She related personal incidents involving her family's encounters with managed care providers relating to the need to have referrals both to specialists and to walk-in health centers. She noted that the "gatekeeper" frequently seemed more like a "gate blocker" and the whole system like a "mother may I" system. She proposed in the bill that referrals be valid for two years, although the senator expressed a willingness to reduce that period to one year thereby accommodating the length of most health care contracts or to a specific episode of illness. The bill also would have allowed an OB/GYN to be the primary care physician; but, again, the senator commented that her intent was to make such a provider available without hurdles, such as referrals, getting in the way of care.

Remarks of the Commissioner

In addition to hearing conferees on the specific mandates, the Insurance Commissioner was invited to address the Committee to share her opinions on the subject of mandates in general. To give some perspective to the issue, the Commissioner reminded the Committee that 75 percent of Kansans covered by health insurance are under federal jurisdiction. That is, they are insured under Employee Retirement Income Security Act (ERISA) plans, Medicare, or

Medicaid. The significance of this fact is that legislative action at the state level can impact no more that one quarter of the insured population. Any mandate enacted affects only those under state jurisdiction.

With the advent of managed care, the Commissioner noted, those insured in larger groups enjoy level or lower costs for health care coverage. Persons covered under small group plans have not shared in the cost benefit associated with managed care. Insureds in both categories, have found managed care to be confining with limited choices to care whether primary or specialized and some concern that when care will be needed, it will not be available or, if available, not covered under the plan. State legislatures and Congress continue to deal with the "backlash" against the managed care concept.

Addressing the issue of mandates, the Commissioner acknowledged that mandates will have some impact on the cost of insurance for those included in the mandate. As a result, some employers may be driven out of the market or into self-insured plans. However, if employers, the purchasers of the coverage, choose coverages for their employees based solely on cost and the coverage does not provide the benefits needed by the beneficiaries, coverage is of limited value. If the cost of the coverage to the employer or employee is unaffordable, then the fact that coverage is available also is of little value.

Confronted with these difficult choices, what are legislators to do. The Commissioner suggested continued work with counterparts at the federal level and in national associations to retain supervisory jurisdiction over insurance at the state level. Further, and specific to the point of mandates, the Commissioner said the Committee and the Legislature need to evaluate each mandate on a cost and benefit basis. If the benefit is cost effective then it is good public policy to enact the mandate. She added that when costs are measured, potential savings also must be weighed. In those instances where the issue is not cost but fairness, *e.g.*, discriminatory on the basis of sex, again good public policy dictates that the issue be debated. Finally, she reminded the members of the importance of continuing the health safety net for that 10 percent of the Kansas population that receives its care from charity and public health clinics, children's programs, and other insurance and governmental programs.

The Cost of Mandates

Throughout the course of the study, proponents offered estimates as to the cost of their special mandate. For the most part, the estimates were based on other states' experiences or professional association judgments and expectations of costs. The Committee believed that decisions on proposed mandates should be based on the best information available. In that regard, the Kansas Department of Health and Environment, Statistical Agent for the Kansas Insurance Department, queried data in the Kansas Health Insurance Information System (KHIIS). The Actuary for KHIIS was asked to prepare an impact on premium statement for the mandates before the Committee. Since each mandate was supported by a bill, the provisions of the bills were used by the Actuary to determine the impact.

- **Breast Reconstruction (H.B. 2297).** Based upon the Kansas mastectomy rate of 3.5 per 10,000 women aged 20-65, the total premium impact on premiums in Kansas would be $900,000 (0.3 percent or 50 cents per year).
- **Mental Health Parity (H.B. 2138).** Dependent upon whether or not long-term care was excluded, the additional premium cost would be $13 million to $32.5 million (1.0+2.5 percent increase per year).

  The Committee did receive testimony summarizing various studies done on the cost of mental health parity which reflect actual cost savings associated with treatment. That is, the expected value of benefits from treatment does normally exceed the expected costs.

- **Durable Medical Equipment (S.B. 509).** With the current definition of durable medical equipment and assuming payments over $1,000 are already made for half the cases, the impact on premiums would be $5,525,000 for the state. Expanding the definition while

making the same assumption of current payment over $1,000, the impact on premiums could be up to $150 million (0.85 percent up to 12 percent increase per year).

- **Point of Service (S.B. 331).** Assuming 40 percent of the plans would be affected, premium costs in Kansas would increase by $76.5 million (about 15 percent increase per year).

- **Infertility Treatment (S.B. 663).** Premium costs for families in the 20-40 age group would increase $6,280,000 (about 1 percent per year).

- **Oral Surgery (H.B. 2800).** The impact of this mandate is too small to be measured. There is no information available from the database.

The Industry Response

Conferees appearing before the Committee in opposition to any new mandate legislation, and in some cases to existing mandates, included the Kansas Chamber of Commerce and Industry, Preferred Health Systems, the National Center for Managed Health Care Administration, Kansas Association of Health Plans, Health Insurance Association of America, and Blue Cross and Blue Shield of Kansas and Blue Cross and Blue Shield of Kansas City. In addition, employers providing health insurance to their employees included Custom Metal Fabricators, Inc., Herington, Kansas; International Cold Storage Co., Inc., Andover, Kansas; Western Resources, Topeka, Kansas; Grandview Products Co., Parsons, Kansas; Bombardier Aerospace (Learjet, Inc.), Wichita, Kansas; and the Kansas Employer Coalition on Health, Inc. A single individual gave testimony specific to the mental health parity proposal, and the President of the Kansas Self-Insurers Association also appeared in opposition to mandates.

In general, whether representing the insurance industry, the managed care industry, or private employers, testimony was unanimous in the rejection of new mandates because they drive up the cost of coverage to the employer and, most likely the employee; they drive employers out of the insurance marketplace and likewise their employees; they drive employers into the unregulated self-insurance market; they impose a one size fits all benefit package on employers and insureds thereby removing the ability to tailor coverage to specific needs; they reduce the ability of small business to compete, especially in world markets; and, in some instances, mandates pervert the meaning and scope of health insurance and substitute for a finding of medical necessity personal, individual lifestyle choices.

One conferee representing the insurance industry, said in no uncertain terms that it was time for the Legislature to "just say no" to new mandates. Again, opponents of mandates seemed unanimous in support of the idea that the best way to achieve quality health care at an affordable price is to promote choice and competition in the marketplace, not by burdening the marketplace with government imposed mandates.

Finally, on a subject tangentially related to mandates, the Committee heard from the domestic health insurance industry and a representative of the American Family Life Assurance Company. These conferees suggested that certain policies be specifically and uniformly excluded from all existing and any new mandates that might be enacted. Policies to be excluded would be accident-only, specific disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited benefit supplemental insurance policies.

Conclusions and Recommendations

At its final meeting on health insurance mandates, the Special Committee on Financial Institutions and Insurance reviewed each mandate presented to it in the course of its study.

Reconstructive Breast Surgery. The Committee was aware that just one day prior to its meeting, Congress had enacted this mandate as a part of H.R. 4328, the omnibus consolidated appropriations act for 1999. Title IX of that act

contains the Women's Health and Cancer Rights Act of 1998. The new law applies to all health insurers and plans, including those covered by the Employee Retirement Income Security Act of 1974. Briefly, insurers will be required to cover reconstruction of a breast on which a mastectomy has been performed, surgery and reconstruction on the other breast to produce a symmetrical appearance, and prostheses and physical complications at all stages of the mastectomy, including lymphedemas. Coverage must be in a manner determined in consultation with the attending physician and the patient and may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Notice of coverage must be delivered to insureds not later than January 1, 1999.

The Committee was prepared to address the issue at the state level prior to the federal action; however, since the federal government has determined the scope of the benefit, the Committee agrees with the new law and recommends the introduction and passage of a bill to enact the same provisions into Kansas law.

Oral Surgery. The Committee concludes from its hearing on this issue that certain children and others with medical or behavioral conditions cannot be treated appropriately in the usual dental office setting. Therefore, the Committee recommends introduction and passage of a bill to require insurers to provide coverage for the administration of general anesthesia and medical care facility for dental care provided to a child eight years of age or younger or a person who is severely disabled and who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided. Coverage may require prior authorization and may be subject to the same deductibles, coinsurance, and other limitations as apply to other covered services.

Mental Health Parity and Durable Medical Equipment. The Committee debated extensively the issues contained within mandates for each of the proposals. Specific suggestions for legislative action were considered for each mandate, but by votes of 8 to 5, each of the suggestions failed to receive sufficient support to be recommended for legislative action. It is the Committee's recommendation that no legislation be passed by the 1999 Legislature to enact mandatory parity for mental health coverage or to establish minimum levels of coverage for durable medical equipment.

While no legislation is recommended for mental health parity, the consensus of the Committee is that the topic deserves and should receive further study.

Point of Service. The Committee recommends further investigation of the manner in which referrals, including self-referrals, are made for chronically ill patients to specialists practicing out-of-network from the patient. It is the Committee's belief that the investigation should continue in the House Committee on Insurance early in the 1999 Session of the Legislature.

As for mandates involving infertility, maternity, and certain patient protections, the Committee did not go beyond the early discussions of the topics at the time each was heard. Consequently, the Committee makes no recommendations on these subjects.

Finally, the Committee was made aware throughout the course of its deliberations on health insurance mandates that each has a separate cost associated with it and, collectively, the total cost of mandates is much greater than the sum of the individual requirement. This awareness of cost was heightened by the testimony of numerous employers who pay a substantial portion of health care costs through premium payments. Since the state, too, is an employer and payer of substantial dollars in health insurance premiums, the Committee concludes and recommends a bill that would make new mandates applicable only to the state employee benefit plan. After a sufficient trial period, the state could determine the financial impact the mandate has as well as the benefit derived from the mandate. With cost and benefit data in hand, the state could then decide whether the mandate should be continued for state employees and extended to other persons in

the health insurance marketplace. The trial plan for mandates would begin with any mandate enacted after the effective date of the bill.