Approved: February 1, 1999
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 27, 1999 in Room 529 S of the Capitol.

All members were present except: Senator Feleciano, excused for visit to the Pope in St. Louis, MO

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

Conferees appearing before the committee: Kevin Robertson, Kansas Dental Association
Dr. Paul Kittle, Leavenworth
Larrie Ann Brown, Kansas Association of Health Plans
Josie Torrez, KS Council of Developmental Disabilities
Terry Leatherman, KCCI
Dianne Koger, citizen
Linda DeCoursey, Kansas Insurance Department

Others attending: There was no guest list for this date.

Hearing on SB 3 - Providing coverage for general anesthesia and medical care facility charges for certain dental care

Kevin Robertson, Executive Director of the Kansas Dental Association, presented testimony on the bill which would require health insurers to cover the costs of general anesthesia for their insured who require these services for dental care i.e. a child of eight years or under, a person who is severely disabled and has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.(Attachment 1). Also presented was an amendment which would change the age of the child to five years or under but by adding"or" it can cover children of almost any age. The amendments also eliminates the requirement of the disabled person also having a medical or behavioral condition.
S
Dr. Paul Kittle, board-certified pediatric dentist from Leavenworth, informed the Committee that 13 other states have passed such legislation which allows a dentist to treat young children, special needs patients, and those with developmental problems in a hospital operating room if it is deemed medically necessary (Attachment 2). This is usually a last resort for treatment as it is expensive for both the insurance companies and the dentist as he or she must be out of the office. Most insurance companies deny access to hospital operating rooms at this time which is a shock to many parents who assumed they had coverage under their health insurance. Medicaid does cover this cost.

Larrie Ann Brown, Kansas Association of Health Plans, said that although they were usually opposed to mandates, they did support the bill with the Kansas Dental Association amendments (Attachment 3).

Josie Torrez, Kansas Council on Developmental Disabilities, spoke as an advocate for individuals who would benefit greatly from this proposed mandate (Attachment 4)

Terry Leatherman, Kansas Chamber of Commerce, said they oppose any further state coverage mandates to insurance policies (Attachment 5). He stated that a) mandates negatively impact the "endangered species" in today's insurance delivery mechanism–the small employer; b) mandates demonstrate the Legislature's lack of faith in the free enterprise system; and c) mandates remove opportunity to develop market responsive insurance products.

During Committee discussion, it was pointed out that dental insurance companies were excluded from this mandate because they are speciality insurance companies which are excluded from all mandates. The AFLAC language adopted provides for this exclusion. The proposed legislation may cause some confusion for holders of dental policies and a high deductible health policy. It was suggested that such dental care might be paid

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

for out of the $45 million Health Wave funds if the children met the eligibility requirements which requires their families being 200% under the federal poverty level. The state has contributed $12 million of the Health Wave fund. It would take a state appropriation to fund care for those not eligible for Health Wave. This sate money could be used for this dental procedure if it was determined to be medically necessary. Funding would be available through the forthcoming Tobacco Money if the Legislature were to make such a determination. Senator Brownlee requested any further information on this option be made available to Committee members.

Chairman Steffes declared the hearing closed.

Hearing on SB 14 - Reconstructive Breast Surgery

Diane Bender Koger, private citizen, explained to the Committee the horrors of breast cancer, the surgeries involved, and the need for reconstructive surgery for physical and psychological reasons (Attachment 6).

Linda DeCoursey, Kansas Insurance Department, said this bill would codify into Kansas law the provisions of the Women's Health and Cancer Rights Act of 1998 (Attachment 7) The passage of this bill would allow the Kansas Insurance Department to regulate the insurance companies regarding coverage for reconstructive breast surgery.

Terry Leatherman of KCCI spoke against any type of mandate (see testimony for **SB 13**).

Chairman Steffes closed the hearing.

Senator Praeger reported on the Subcommittee on Banking Issues which met on January 26. They will meet again on February 3 to view a proposed bill addressing qualifications for the position of Bank Commissioner, the job description, and composition and purpose (policy making or advisory) of the State Bank Board.

The meeting was adjourned at 10:00 a.m. The next meeting will be on January 28.

Date: January 27, 1999

To: Senate Committee on Financial Institutions and Insurance

From: Kevin Robertson, CAE
Executive Director

RE: Testimony on SB 3

Senator Steffes and members of the Senate Committee on Financial Institutions and 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 has continued into the Session, and we have recently reached further agreement on amendments to the bill that we believe strengthens it by broadening the coverage while at the same time clarifying its administration. The amendments are attached for your review.

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, especially as it relates to children.

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

Senate Financial Institutions & Insurance

Date 1/27/99

Attachment # 1

Session of 1999

SENATE BILL No. 3

By Special Committee on Financial Institutions and Insurance

12-15

9 AN ACT relating to accident and health insurance; providing coverage
10 for general anesthesia and medical care facility charges for certain
11 dental care; amending K.S.A. 1998 Supp. 40-2,103 and 40-19c09 and
12 repealing the existing sections; also repealing K.S.A. 1998 Supp. 40-
13 1909.
14
15 *Be it enacted by the Legislature of the State of Kansas:*
16 New Section 1. (a) Any individual or group health insurance policy,
17 medical service plan, contract, hospital service corporation contract, hos-
18 pital and medical service corporation contract, fraternal benefit society
19 or health maintenance organization which provides coverage for accident
20 and health services and which is delivered, issued for delivery, amended
21 or renewed on or after July 1, 1999, also, shall provide coverage for the
22 administration of general anesthesia and medical care facility charges for
23 dental care provided to the following covered persons:
24 (1) A child ~~eight~~ years of age and under; or
25 (2) a person who is severely disabled; ~~and~~
26 (3) such person has a medical or behavioral condition which requires
27 hospitalization or general anesthesia when dental care is provided.
28 (b) A policy, provision, contract, plan or agreement may:
29 (1) Apply to the covered procedures under this section the same de-
30 ductibles, coinsurance, and other limitations, as apply to other covered
31 services;
32 (2) require prior authorization for hospitalization for the covered pro-
33 cedures under this section in the same manner that prior authorization
34 is required for hospitalization for other covered diseases or conditions.
35 (c) The provisions of this section shall not apply to any policy or cer-
36 tificate providing coverage for any specified disease, specified accident or
37 accident-only coverage, credit, dental, disability income, hospital indem-
38 nity, long-term care, as defined by K.S.A. 40-2227, and amendments
39 thereto, medicare supplement, as defined by the commissioner of insur-
40 ance by rules and regulations, vision care or other limited-benefit sup-
41 plemental insurance, nor any coverage issued as a supplement to liability
42 insurance, workers' compensation or similar insurance, automobile med-
43 ical-payment insurance, or any insurance under which benefits

[five

[or

[,network requirements

[,including but not limited to
medical necessity determinations,

1-2

Testimony of Dr. Paul E Kittle, Jr.

Senator Steffes, Honorable ladies and gentlemen...

Good morning. 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 morning. 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 child or a patient with defined special needs. Thirteen states

Senate Financial Institutions & Insurance

Date 1/27/99

Attachment # 2

(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. 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 (that I did not bring this morning) 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 policyholder $0.97 extra per year to provide this care to the children who needed it. 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)

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. Please do what is right for Kansas kids. Please pass this enabling legislation.

Thank you for your time and consideration.

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

27 JAN 99

Cindy Suozzo
Children's Dentistry
Fax # (913) 651-3559
Cindy:

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 the dental charges not being covered by either the dental or the medical.

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

Sincerely,

04/06/98 MON 14:18 TEL 3366056406

UNICARE — FAX TRANSMISSION

SENT TO	: Cindy	FROM	: Denise
LOCATION	: Childrens Dentistry	LOCATION	: Greensboro Client Service Center
DATE	: 4/6/98	PHONE/FAX	: (910)665-1888 (910)605-6406
FAX	(913) 651-8559	TOTAL PAGES:	2

RE:

your request for confirmation in writing

Thanks
Denise

Attachment 1

An Independent Licensee
of the Blue Cross and
Blue Shield Association

1133 SW Topeka Boulevard
Topeka, Kansas 66629-0001

Local Corporate Phone # -
(785) 291-7000

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

Benefit Plan

Jacksonville, FL 32232-5118
1-800-410-7778

Dr. Kittle M.D.
309 S 2nd Street
Leavenworth, KS 66048

DATE: April 13, 1998
SSN:
ENROLLEE:
PATIENT:
OPTION: Standard

RE: **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 .

Per page 26 of the 1998 Mailhandlers Benefit Plan (Plan) brochure dental benefits are available under the High Option of the Plan only. 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

P.1

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

Attachment 3

2-8

Secondary

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,

[signature]

Mark Whitaker, M.D.
Medical Director

2° Medicaid Denied

[redacted]

plc

Attachment 4

2-9

MISSOURI LEGISLATION

Section 7. 1. To the extent consistent with the Employee Retirement Income
2 Security Act of 1974 (ERISA), 29 U.S.C. 1001, et seq., this section shall apply to any health
3 insurer as defined in section 376.806, RSMo, any nonprofit health service plan and any
4 health maintenance organization.
5 2. Within forty-five days after receipt of a claim for reimbursement from a person
6 entitled to reimbursement, a health insurer, nonprofit health service plan or health
7 maintenance organization shall pay the claim in accordance with this section or send a
8 notice of receipt and status of the claim that states:
9 (1) That the insurer, nonprofit health service plan or health maintenance
10 organization refuses to reimburse all or part of the claim and the reason for the refusal;
11 or
12 (2) That additional information is necessary to determine if all or part of the claim

13 will be reimbursed and what specific additional information is necessary.
14 3. If an insurer, nonprofit health service plan or health maintenance organization
15 fails to comply with subsection 2 of this section, the insurer, nonprofit health service plan
16 or health maintenance organization shall pay interest on the amount of the claim that
17 remains unpaid forty-five days after the claim is filed at the monthly rate of one percent.
18 The interest paid pursuant to this subsection shall be included in any late reimbursement
19 without the necessity for the person that filed the original claim to make an additional
20 claim for that interest.
21 4. Within ten days after the day on which all additional information is received by
22 an insurer, nonprofit health service plan or health maintenance organization, it shall pay
23 the claim in accordance with this section or send a written notice that:
24 (1) States refusal to reimburse the claim or any part of the claim; and
25 (2) Specifies each reason for denial.
26 An insurer, nonprofit health service plan or health maintenance organization that fails to
27 comply with this subsection shall pay interest on any amount of the claim that remains
28 unpaid at the monthly rate of one percent.
29 5. A provider who is paid interest under this section shall pay the proportionate
30 amount of said interest to the enrollee or insured to the extent and for the time period that
31 the enrollee or insured had paid for the services and for which reimbursement was due to
32 the insured or enrollee.

Attachment 5

Section 8. All individual and group health insurance policies providing coverage on
2 an expense incurred basis, individual and group service or indemnity type contracts issued
3 by a nonprofit corporation, individual and group service contracts issued by a health
4 maintenance organization, all self-insured group arrangements to the extent not preempted
5 by federal law and all managed health care delivery entities of any type or description, that
6 are delivered, issued for delivery, continued or renewed on or after August 28, 1998, shall
7 provide coverage for administration of general anesthesia and hospital charges for dental
8 care provided to the following covered persons:
9 (1).A child under the age of five;
10 (2) A person who is severely disabled; or
11 (3) A person who has a medical or behavioral condition which requires hospitaliza-
12 tion or general anesthesia when dental care is provided.
13 2. Each plan as described in this section must provide coverage for administration
14 of general anesthesia and hospital or office charges for treatment rendered by a dentist,
15 regardless of whether the services are provided in a participating hospital or surgical

16 center or office.
17 3. Nothing in this section shall prevent a health carrier from requiring prior
18 authorization for hospitalization for dental care procedures in the same manner that prior
19 authorization is required for hospitalization for other covered diseases or conditions.
20 4. Nothing in this section shall apply to accident-only, dental only plans or other
21 specified disease, hospital indemnity, medicare supplement or long-term care policies, or
22 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

*** 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 6

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.

2-14
~~2-17~~
~~Attachment 7~~

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.

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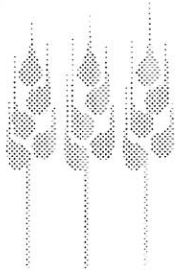
attachment 8



Kansas Association of Health Plans

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Testimony before the
Senate Financial Institutions and Insurance Committee
The Honorable Don Steffes, Chairman
<u>Hearings on SB 3</u>
January 27, 1999

Good Morning Chairman Steffes and members of the committee. Thank you for allowing me to appear before you today. I am Larrie Ann Brown Executive Director of the Kansas Association of Health Plans (KAHP).

The KAHP is a nonprofit association 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 many Kansans.

The KAHP does not generally support the idea of mandating health insurance benefits due to the financial impact a mandate could have on small businesses offering health insurance to their employees. As Insurance Commissioner Kathleen Sebelius stated in her testimony this past summer before the interim committee that studied the various proposed mandates, "new regulations and treatment mandates will have some cost impact on fully insured plans, and may drive more employers out of the market, or into self-insured plans."

Nevertheless the KAHP participated in the negotiating process that took place between the parties involved in writing and amending this bill. We appreciate the efforts that went into the formation of this bill and we support the bill with the proposed balloon amendments.

Thank you again for allowing me to make comments on SB 3 and I will be happy to try and answer any questions the committee may have.

Senate Financial Institutions & Insurance
Date 1/27/99
Attachment # 3

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

January 27, 1999

Testimony in Regard to S.B3
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.

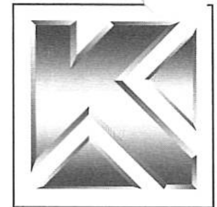
Josie Torrez, Coordinator, Partners in Policymaking
Kansas Council on Developmental Disabilities
Docking State Office Building, Room 141
915 SW Harrison
Topeka, KS 66612-1570

Senate Financial Institutions & Insurance

Date 1/27/99

Attachment # 4

LEGISLATIVE TESTIMONY



Kansas Chamber of Commerce and Industry web: www.kansaschamber.org

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SB 3 & 14 January 26, 1999

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. I am the Executive Director of the Kansas Industrial Council, a division of the Kansas Chamber of Commerce and Industry. Thank you for this opportunity to briefly explain why KCCI opposes further state coverage mandates to insurance policies, as called for in SB 3 and SB 14.

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 47% 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 members who make up its various committees. These policies are organization and translate into views such as those expressed here

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The Kansas Chamber's opposition to these bills is not based on the specific coverage demands of these two bills. They are as justified as mandates imposed last year and in year's past by the Legislature. KCCI's objection is based on the impact mandates, taken as a whole, have on the

s insurance market and that mandates represent government intrusion into private sector initiative.

1) MANDATES NEGATIVELY IMPACT THE "ENDANGERED SPECIES" IN TODAY'S INSURANCE DELIVERY MECHANISM...THE SMALL EMPLOYER

Mandates do not affect Kansans who are insured through state or federal insurance programs or by employer self insurance plans. As a result, mandates are imposed on only roughly one/third of the insured in the state. That one/third is also the segment of the population most challenged to find and retain affordable insurance, the individual policyholder and those insured through small employer plans.

2) MANDATES DEMONSTRATE THE LEGISLATURE'S LACK OF FAITH IN THE FREE ENTERPRISE SYSTEM

A mandate, at its heart, is a government statement that private sector insurance will fail unless the government compels action. Please remember private insurance was born to meet a consumer need.

3) MANDATES REMOVE OPPORTUNITY TO DEVELOP MARKET RESPONSIVE INSURANCE PRODUCTS

There are hundreds of ways to prepare an omelet, just as there are hundreds of ways to design an insurance product. However, as with an omelet, the more a third party specifies the ingredients to be included in an insurance product, the less opportunity there is to cater to the needs of the purchaser.

There is virtually no end to the number of worthwhile benefits that could be mandated. However, there is an end to what many individual policy holders and small businesses can afford. KCCI urges the Committee to keep that in mind during your deliberations on SB 3 and SB 14.

Mr. Chairman, thank you for the opportunity to comment on the bills before you today and to participate in the ongoing debate regarding mandated insurance benefits. I would be happy to attempt to answer any questions.

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.

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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

January 27, 1999

TO: Senate Committee on Financial Institutions and Insurance

FROM: Linda J. De Coursey, Director of Government Affairs

RE: SB 14 – Reconstructive Breast Surgery

Mr. Chairman and members of the committee:

I am appearing today in support of SB 14 which will codify into Kansas law the provisions of the Women's Health and Cancer Rights Act of 1998. Insurance companies must provide benefits for reconstruction of the breast on which a mastectomy has been preformed, also reconstruction of the other breast to produce a symmetrical appearance, and also for prostheses. The insurance companies 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 would have established some of the provisions in SB 14. The issue was again debated and considered during this past legislative interim, and you were just about to make a recommendation for a bill to enact a state mandate for breast reconstruction, and symmetry, when the federal government preempted your announcement. The state mandate would have only affected approximately 25% of Kansans with health insurance.

With breast cancer striking one out of nine women in the United States, this is a significant health issue for Kansas. The federal mandate will apply to all Kansans with health insurance, and in that respect goes much farther than the original proposal. It is a tremendous step forward to cancer survivors in Kansas that insurance coverage will be available to help with the healing process.

Thank you for your consideration of SB 14, and we ask your favorable passage of SB 141`.

Senate Financial Institutions & Insurance

Date 1/27/99

Attachment # 7

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