Approved: _____
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by Chairperson Senator Don Steffes at 1:00 p.m. on March 24, 2000 in Room 526-S of the Capitol.

All members were present except:

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

Conferees appearing before the committee: Linda DeCoursey, Kansas Insurance Department
Jerry Slaughter, Kansas Medical Society
Terry Bernatis, State Employees Health Plan

Others attending: No attendance kept

Continued Hearing on SB 547--Providing coverage for certain mental health conditions
Continued Discussion on SB 160–Eliminating discrimination in the coverage of specific mental illnesses

Committee members were given copies of past testimony from Larrie Ann Lower, Kansas Association of Health Plans (Attachment 1) and an explanation of fiscal impact from Terry Bernatis, Kansas Employees Health Plan Administrator (Attachment 2).

Senator Steffes explained the three options open to the Committee regarding mental health parity:

- **SB 160**–Would mandate mental health parity in all private health care insurance policies as well as in the State Employees Health Care Plan.
- **SB 547**–Would allow test tracking mental health parity for employees not currently covered under the State Employees Health Plan and would apply to the private sector on January 1, 2002.
- **SB 547–(With amendments from the Kansas Association of Health Plans)** Would allow test tracking mental health parity for employees not currently covered under the State Employees Health Plan for at least one year beginning January 1, 2001. The amendments as suggested by Ms. Lower in the first balloon would require that the HMO portion of the state employees health plan be restructured to match the mandated benefits in the bill. After March 1, 2002, the Legislature would review the cost and make its decision regarding continuation of the coverage for both state employees and the private sector or whether more data are required.

Senator Barone moved to amend **SB 547** by deleting "specific" from compulsive behavior disorders and make the mandate effective upon the private sector after January 2002 without action of the Legislature. The motion was seconded by Senator Biggs. Motion did not carry.

Senator Praeger moved that the first balloon amendment as presented by the Kansas Association of Health Plans (as explained above) be accepted and by deleting "specific" from compulsive behavior disorders be adopted. Motion was seconded by Senator Becker. Motion carried.

Hearing on SB 663–Gynecological care; authorizing such care under certain circumstances without visiting a primary care physician

Linda DeCoursey, Kansas Insurance Department, testified that recent research has provided information that 60% of women preferred a gynecologist for basic gynecology care over 13% who preferred their own PCP (Attachment 3). Forty states have enacted OB/GYN access laws which give women direct access to OB/GYNs or other women's health providers for their annual visit. This legislation would promote primary and preventive health care. No fiscal note would be involved in the passage of the proposal.

Committee members pointed out that some medical care providers such as OB's may be reluctant to be

considered the primary care physician and would rather practice in their own specialty area only. This bill would provide access only and not demand that they provide services outside their arena.

Jerry Slaughter, Kansas Medical Society, agreed with the comments from the Kansas Insurance Department.

Terry Bernatis, Kansas Employees State Health Plan, stated that this is already a requirement of HMO's in the state health plan. She questioned whether this would have to be test tracked in the Plan. During discussion it was determined that this was an access issue, not a mandate.

Written testimony was received from The Women's Health Group, P.A. supporting the bill (Attachment 4).

Senator Feleciano moved to adopt the language in **SB 663**, exempting it from test tracking in the State Employees Health Plan, and place the language in **SB 547.** Motion was seconded by Senator Praeger. Motion carried.

The Committee discussed the wisdom of placing the mental health parity proposal and access to OB/GYN as a primary care provider proposal in the same bill. Would the fiscal note as presented by Ms. Bernatis regarding test tracking mental health parity in the State Health Plan sink the whole bill? Is there enough interest and demand for mental health parity to force the passage of the proposed bill? It was pointed out that the bill would be conferenceable if it passed the Senate floor.

Senator Brownlee moved to amend **SB 663** by striking lines 20-25 in the bill. Motion was seconded by Senator Clark. Motion failed.

Senator Feleciano moved to pass the bill out favorably as amended. Motion was seconded by Senator Praeger. Motion carried. A dissenting vote was cast by Senator Brownlee.

The next meeting is scheduled for March 28, 2000.

Kansas Association of Health Plans

Testimony before the
Senate Financial Institutions and Insurance Committee
The Honorable Don Steffes, Chairman
Hearings on SB 547
March 21, 2000

Good morning Chairman Steffes and members of the committee. Thank you for allowing me to appear before you today. I am Larrie Ann Lower, 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. Members of the KAHP serve most of the Kansans who are insured by an HMO.

For several reasons, the KAHP must respectfully oppose SB 547. This bill if enacted in its current form has the potential of creating an unlevel playing field because as you know, self insured plans are exempt from state laws because they are governed by the Federal ERISA law. We also know that a state imposed health insurance mandate affects only a limited amount of Kansans who have health insurance.

In previous hearings on this issue, you have heard that full parity for mental health is estimated to increase premiums by either 3.4% on average or some have said 3.6% or 2-5%. Regardless of the percent increase, the fact is that insurance premiums most likely will increase. According to a Congressional Budget Office report, the CBO estimated that nationwide, for every 1% increase in health insurance costs, 200,000 more individuals are added to the uninsured population. The State of Kansas is generally estimated to be 1% of the population of the United States. This means that for every 1% increase in health insurance costs in Kansas, an estimated 2,000 Kansans become uninsured.

SB 547 has the potential to drive more employers into the self insured plans, drop coverage altogether or reduce other benefits offered. Previously you have also heard testimony on this issue citing a study that states employers will not attempt to avoid parity laws by becoming self-insured. That same study states that employers do not tend to pass on the costs of

parity to employees. However, the authors of the study presented to you in previous hearings on this issue, noted that their estimates do not account for the possibility that employers may respond to parity mandates by -among other things- dropping coverage or reducing other benefits offered to their employees.

Although this bill appears to require that mental health parity first be tested on the state employee's health insurance we would like to point out that this bill does have the potential to drive up health insurance costs for the state. You should also note that the benefits this bill mandates are not exactly the same benefits provided to the state employees who choose to participate in the HMO portion of the state health plan. This bill also lacks any language requiring that the legislature take action based upon the cost impact report presented by the state employees health benefits coordinator, March 1, 2002. The current bill would allow the mandate to automatically be in effect January 1, 2002 on the rest of the policies subject to state imposed mandates, before the legislature even receives the March 1, 2002 cost impact report. Therefore the mandate would be in effect throughout the rest of the state regardless of what the report on the cost impact to the state employees health plan indicates.

In conclusion, this mandate if enacted could increase the cost of the state employees health plan and if then automatically enacted on the rest of the policies in this state subject to state imposed mandates will most likely increase the cost of employers health insurance therefore running the real risk of increasing the number of uninsured in Kansas. The KAHP would request that you not pass this legislation for the reasons stated above.

However, if you feel this is a necessary mandate then we would strongly suggest that this legislation indeed first be subject to the provisions of K.S.A. 1999 Supp. 40-2249a, which you passed last year to determine its potential cost impact and then allow the legislature to determine if the mandate should then be expanded to include the rest of those policies subject to Kansas legislation. I would like to offer two versions of amendments that would accomplish the intent of K.S.A. 1999 Supp. 40-2249a, which was to determine the cost impact of an insurance mandate by testing the mandate first on the largest employer of the state, the state of Kansas, before subjecting the employers of this state to potentially cost rising mandates, that may lead to an increase in the number of uninsured in Kansas.

The first set of amendments would simply require that the mandate be tested on the state employees health insurance plans. The amendments would require that the HMO portion of the state employees health plan be restructured to match the mandated benefits in this bill. At the

end of the testing period, after the cost impact report is presented, the legislature would then decide, based on the cost impact report, whether to pass legislation mandating the benefit on the rest of the state.

The second set of attached amendments creates a second option. This set of amendments requires that the legislature pass a resolution to implement the mandate on the rest of the state after the cost impact is reported. This language is similar to previously enacted legislation: K.S.A. 39-7,117(c).

I will be happy to answer any questions the committee may have.

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Session of 2000

SENATE BILL No. 547

By Committee on Financial Institutions and Insurance

2-2

AN ACT concerning insurance; providing coverage for certain mental health conditions; amending K.S.A. 1999 Supp. 40-2,103 and repealing the existing section.

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

New Section 1. (a) From and after January 1, 2001, the state health benefits program established by K.S.A. 75-6101 *et seq.*, and amendments thereto, shall provide a program of insurance which provides coverage for diagnosis and treatment of mental illnesses under terms and conditions no less extensive than coverage for any other type of health care.

(b) For the purposes of this act, "mental illness" means the following: Schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, specific obsessive compulsive disorder and panic disorder as such terms are defined in the diagnostic and statistical manual of mental disorders, fourth edition, (DSM-IV, 1994) of the American psychiatric association but shall not include conditions not attributable to a mental disorder that are a focus of attention or treatment.

~~New Sec. 2. (a) Any individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization which provides coverage for mental health benefits and which is delivered, issued for delivery, amended or renewed on or after January 1, 2002, shall include coverage for diagnosis and treatment of mental illnesses under terms and conditions no less extensive than coverage for any other type of health care.~~

~~(b) For the purposes of this act, "mental illness" means the following: Schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, specific obsessive compulsive disorder and panic disorder as such terms are defined in the diagnostic and statistical manual of mental disorders, fourth edition, (DSM-IV, 1994) of the American psychiatric association but shall not include conditions not attributable to a mental disorder that are a focus of attention or treatment.~~

(c) The provisions of this section shall be applicable to health maintenance organizations organized under article 32 of chapter 40 of the Kansas Statutes Annotated

contracting with the state to provide health care benefits

~~(d) The provisions of this section shall not apply to any medicare supplement policy of insurance, as defined by the commissioner of insurance by rule and regulation.~~

~~(e) The provisions of this section shall be applicable to the Kansas state employees health care benefits program and municipal funded pools.~~

~~(f) The provisions of this section shall not apply to any policy or certificate which provides coverage for any specified disease, specified accident or accident only coverage, credit, dental, disability income, hospital indemnity, long term care insurance as defined by K.S.A. 1999 Supp. 40-2227 and amendments thereto, vision care or any other limited supplemental benefit nor to any medicare supplement policy of insurance as defined by the commissioner of insurance by rule and regulation, any coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, automobile medical payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group, blanket or individual basis.~~

~~(g)~~ From and after January 1, ~~2002~~, the provisions of K.S.A. 40-2,105, and amendments thereto, shall not apply to mental illnesses as defined in this act.

New Sec. ~~3.~~ The provisions of this act shall be implemented as required by K.S.A. 1999 Supp. 40-2249a.

Sec. ~~4.~~ K.S.A. 1999 Supp. 40-2,103 is hereby amended to read as follows: 40-2,103. The requirements of K.S.A. 40-2,100, 40-2,101, 40-2,102, 40-2,104, 40-2,105, 40-2,114 and 40-2250, and amendments thereto and K.S.A. 1999 Supp. 40-2,160 and 40-2,165 through 40-2,170 ~~and section~~ 2, and amendments thereto, shall apply to all insurance policies, subscriber contracts or certificates of insurance delivered, renewed or issued for delivery within or outside of this state or used within this state by or for an individual who resides or is employed in this state.

Sec. ~~5.~~ K.S.A. 1999 Supp. 40-2,103 is hereby repealed.

Sec. ~~6.~~ This act shall take effect and be in force from and after its publication in the statute book.

(d)

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Session of 2000

SENATE BILL No. 547

By Committee on Financial Institutions and Insurance

2-2

AN ACT concerning insurance; providing coverage for certain mental health conditions; amending K.S.A. 1999 Supp. 40-2,103 and repealing the existing section.

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New Sec. 2. (a) Any individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization which provides coverage for mental health benefits and which is delivered, issued for delivery, amended or renewed on or after ~~January~~ July 1, 2002, shall include coverage for diagnosis and treatment of mental illnesses under terms and conditions no less extensive than coverage for any other type of health care.

(b) For the purposes of this act, "mental illness" means the following: Schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, specific obsessive compulsive disorder and panic disorder as such terms are defined in the diagnostic and statistical manual of mental disorders, fourth edition, (DSM-IV, 1994) of the American psychiatric association but shall not include conditions not attributable to a mental disorder that are a focus of attention or treatment.

(c) The provisions of this section shall be applicable to health maintenance organizations organized under article 32 of chapter 40 of the Kansas Statutes Annotated.

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(d) The provisions of this section shall not apply to any medicare supplement policy of insurance, as defined by the commissioner of insurance by rule and regulation.

(e) The provisions of this section shall be applicable to the Kansas state employees health care benefits program and municipal funded pools.

(f) The provisions of this section shall not apply to any policy or certificate which provides coverage for any specified disease, specified accident or accident only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance as defined by K.S.A. 1999 Supp. 40-2227 and amendments thereto, vision care or any other limited supplemental benefit nor to any medicare supplement policy of insurance as defined by the commissioner of insurance by rule and regulation, any coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group, blanket or individual basis.

(g) From and after ~~January~~ July 1, 2002, the provisions of K.S.A. 40-2,105, and amendments thereto, shall not apply to mental illnesses as defined in this act.

New Sec. 3. The provisions of this act shall be implemented as required by K.S.A. 1999 Supp. 40-2249a.

Sec. 4. K.S.A. 1999 Supp. 40-2,103 is hereby amended to read as follows: 40-2,103. The requirements of K.S.A. 40-2,100, 40-2,101, 40-2,102, 40-2,104, 40-2,105, 40-2,114 and 40-2250, and amendments thereto and K.S.A. 1999 Supp. 40-2,160 and 40-2,165 through 40-2,170 *and section 2*, and amendments thereto, shall apply to all insurance policies, subscriber contracts or certificates of insurance delivered, renewed or issued for delivery within or outside of this state or used within this state by or for an individual who resides or is employed in this state.

Sec. 5. K.S.A. 1999 Supp. 40-2,103 is hereby repealed.

Sec. 6. This act shall take effect and be in force from and after its publication in the statute book.

(h) The provisions of this section shall be effective on and after July 1, 2002, by further authorization by a concurrent resolution approved by a majority of all members elected (or appointed) and qualified of each house of the legislature and shall not be effective prior to that date.

1-7

BILL GR...S
Governor

DAN STANLEY
Secretary of Administration

TERRY BERNATIS
Health Benefits Administrator
900 S.W. Jackson, Room 951-S
Landon State Office Building
Topeka, KS 66612-1251
(785) 296-6280
FAX (785) 368-7180

http://da.state.ks.us

DEPARTMENT OF ADMINISTRATION
Kansas State Employees Health Care Commission

March 21, 2000

The Honorable Don Steffes
Room 128-S
The Capitol Building
Topeka, Kansas 66612

Dear Senator Steffes:

As requested, attached is the detailed information of participant and state general fund increases associated with providing mental health parity under the Blue Select and Traditional Plan options of the state of Kansas Health Benefits Plan. Direct Bill participants will see annual cost of coverage increases ranging from $12.48 to $109.80. Active participants will see annual cost of coverage increases ranging from $2.34 to $48.36. Total **participant** cost of coverage increase is **$570,984.58**. The increased employer cost is $807,105.42 with **state general funds** representing **$395,437.56** of the increased amount.

If you need further information, please let me know. We have the ability to provide information in the form and format that is most useful to the committee.

Sincerely,

Terry D. Bernatis

Cc: Dan Stanley
Duane Goossen
Pat Higgins
Financial Institutions and Insurance Committee Members

Mental Health Parity Increase Analysis
Participant and SOK
Prepared: 3/21/00
Department of Administration

Membership Type	Increased Participant Annual Cost	Number of Contract Types	Annual Cost
Direct Bill Participants - Blue Select and Traditional			
Member Only	$39.24	845	$ 33,157.80
Member and Spouse	$78.36	311	$ 24,369.96
Member and Children	$70.56	38	$ 2,681.28
Member and Family	$109.80	35	$ 3,843.00
Medicare Member Only	$12.48	5138	$ 64,122.24
Member, Medicare Spouse, Children	$83.04	5	$ 415.20
Medicare Member and Family	$83.04	21	$ 1,743.84
Medicare Member and Medicare Spouse	$25.08	1982	$ 49,708.56
Medicare Member, Medicare Spouse and Family	$56.40	7	$ 394.80
Medicare Member and Spouse	$51.72	367	$ 18,981.24
Medicare Member and Children	$43.92	17	$ 746.64
Medicare Member and Dependent	$51.72	76	$ 3,930.72
Medicare Member, Medicare Spouse, Medicare Family	$37.68	4	$ 150.72
TOTAL ANNUAL PREMIUM INCREASE			**$ 204,246.00**
Active Employees - Blue Select*			
Employee	$2.34	11753	$ 27,502.02
Employee and Spouse	$28.08	2827	$ 79,382.16
Employee and Children	$23.14	3286	$ 76,038.04
Employee and Family	$48.36	3801	$ 183,816.36
TOTAL ANNUAL PREMIUM INCREASE			**$ 366,738.58**
TOTAL ANNUAL PARTICIPANT PREMIUM INCREASE			**$ 570,984.58**

Annual Plan Cost Increase	$1,378,000.00
Annual Participant Contribution	**$570,984.58**
TOTAL ANNUAL EMPLOYER COST	$807,015.42
ANNUAL STATE GENERAL FUND COST	**$395,437.56**

* Assumes middle income tier - full time ($17,000-$30,000)

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

TO: Senate Committee on Financial Institutions and Insurance

FROM: Linda De Coursey, Director of Government Affairs

RE: SB 663 – Insured Woman's Access to OB/GYN care (without primary care provider referral)

DATE: March 24, 2000

Mr. Chairman and members of the Committee:

Thank you for the opportunity to discuss with you SB 663, which allows the health insurer to permit an insured woman to receive an annual visit to an in-network OB/GYN for routine gynecological care without requiring the insured woman to first visit her primary care provider.

A recent survey completed in Northern California revealed that of the responses from 5,164 women (age 35 years, plus) over half--56 percent--had seen a gynecologist for the last pelvic examination, only 18 percent had seen their primary care physician for the exam. In that same study, 60 percent of the women stated they preferred a gynecologist for basic gynecology care. Only 13 percent preferred their own PCP.

Yet, many women cannot easily go to an OB/GYN. Women who prefer to go to their OB/GYN, instead of their PCP for their annual pelvic examination, first have to go to their PCP, which means an extra appointment and more time. Why should women be forced to see two doctors when the only need one doctor.

The legislative movement for women to obtain direct access to OB/GYNs began in 1994 when Maryland became the first state to classify an OB/GYN as a primary care physician (PCP), and allow direct access. Since that time 39 other states have enacted OB/GYN direct access laws. While the laws vary, each gives women direct access to OB/GYNs or other women's health providers for their annual visit. Some of the laws

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Fax 785 296-2283

require plans to permit qualified OB/GYNs as primary care physicians; others allow unlimited access, or access for routine gynecological and pregnancy service only, without a referral. I have attached a list of those states passing laws or regulations allowing women direct access to OB/GYNs.

Mr. Chairman and members of the committee, there really isn't a good reason why some women should be forced to see two doctors when they only need one. This is an issue that affects the lives of the female population of Kansas. Women want the option to see a specialist in women's health throughout their lifetime. It's time to put a law on the books to insure Kansas women have access to the best health care available to them. This proposed legislation affords the opportunity to promote primary and preventive health care. I respectfully urge you to favorably pass SB 663 out of committee.

STATE INSURANCE MANDATES FOR OB-GYN PRIMARY CARE/DIRECT ACCESS, 1994-2000

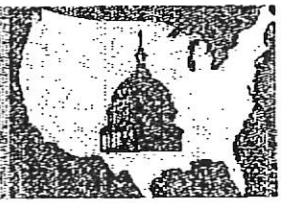
[Current as of February 2000]

STATE LAWS/RULES/REGS (1994-1999) - #40	2000 ACTIONS
Laws: Alabama, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin **Department of Health and/or Insurance Rule:** New Jersey, New Mexico, Vermont, West Virginia **Implementing/Enforcement Regs:** Colorado, New York, Pennsylvania, Texas, Washington	**Pending Bills:** Hawaii, Kansas, Kentucky, Missouri, New Jersey

GENERAL DESCRIPTION AND INTENT OF LAWS/REGS (These are broad categorizations. For actual language, see individual laws, rules, or regulations.)	STATE
PRIMARY CARE *Insurers* must permit eligible ob-gyns to contract as primary care physicians thereby allowing female enrollees to select such an ob-gyn in their insurance plan as their primary care physician. Women do not have direct access unless they select an ob-gyn as their primary care physician.	CA, FL, IN, NE, NJ, UT, WV
DIRECT ACCESS *Insurers* must permit female enrollees to self-refer (i.e., direct access) to a participating ob-gyn in their insurance plan for certain specified obstetric and gynecologic services without a gatekeeper's preapproval or preauthorization. Insurers are not required to permit ob-gyns to contract as primary care physicians.	AR, CA, CO, CT, FL, GA, IL, LA, MD, MI, MN, MO, NV, NH, NY, NC, OH, PA, RI, SC, TN, TX, UT, VA, VT, WA, WV, WI
BOTH PRIMARY CARE AND DIRECT ACCESS *Insurers* must (1) permit eligible ob-gyns to contract as primary care physicians (PCPs) thereby allowing female enrollees to select such an ob-gyn in their insurance plan as their PCP; and also (2) permit female enrollees to self-refer for their obstetric and gynecologic care. This means that women have maximum choice: They can either select an eligible ob-gyn as their PCP or, if they select a non-ob/gyn as their PCP, they can still self-refer to an ob-gyn within their plan without having to go thru a gatekeeper (although services typically are more restricted with the self-referral option). This also means that ob-gyns have maximum choice: They will not lose patient access if they choose not to contract as PCPs because women are permitted to self-refer for their obstetric and gynecologic care.	AL, DE, DC, ID, ME, MS, MT, NM, OR but see also CA, FL, UT and WV above; CA, FL and UT have passed 2 distinct laws; WV has passed a law and a rule
STATE INSURER OPTION *Insurers* have the option under the law of permitting eligible ob-gyns to contract as primary care physicians. This means that ob-gyns may contract as primary care physicians only at the option of individual insurers; and women may select a participating ob-gyn as their primary care physician only at the option of their insurer.	CT, LA*, MD * insurer option applies to HMOs only

ACOG STATE LEGISLATIVE FACT SHEET

The American College of Obstetricians and Gynecologists • Department of State Legislative & Regulatory Activities
409 12th Street SW • Washington, DC 20024-2188 • (202) 863-2594 • FAX (202) 863-0789



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[January 2000]

Direct Access ...omen's Health Services: State Mandates

STATE	DIRECT ACCESS PERMITTED FOR SPECIFIED SERVICE						
	ALL OB-GYN	JUST OB / JUST GYN	GYN IS LIMITED	ACUTE GYN	FOLLOW-UP CARE	REFERRALS FOR SPECIALTY CARE*	ONE/TWO ANNUAL VISITS
ALABAMA	✓			✓	✓	✓	NOT LIMITED
ALASKA	STATE HAS NO LAW						
ARIZONA	STATE HAS NO LAW						
ARKANSAS	✓			✓	✓		NOT LIMITED
CALIFORNIA	✓			✓	*	*	*
COLORADO	✓			✓	✓		NOT LIMITED
CONNECTICUT	✓			✓	✓		NOT LIMITED
DELAWARE	✓			✓	✓	*	MINIMUM OF 1
DISTRICT OF COLUMBIA	✓			✓	✓		NOT LIMITED
FLORIDA	✓*	*		✓*	✓*		ANNUAL*
GEORGIA	✓			✓	✓	✓	NOT LIMITED
HAWAII	STATE HAS NO LAW						
IDAHO	✓			✓	✓		NOT LIMITED
ILLINOIS	✓						NOT LIMITED
INDIANA	✓						
IOWA	STATE HAS NO LAW						
KANSAS	STATE HAS NO LAW						
KENTUCKY	STATE HAS NO LAW						
LOUISIANA		ALL OB & SOME GYN	✓	✓	w/in 60 days		2 ROUTINE VISITS
MAINE*		JUST GYN*	✓*				ONE*
MARYLAND		JUST GYN		✓	✓		NOT LIMITED
MASSACHUSETTS	STATE HAS NO LAW						
MICHIGAN	*		✓*				NOT LIMITED
MINNESOTA	✓			✓	✓		NOT LIMITED
MISSISSIPPI	✓			✓	✓		NOT LIMITED
MISSOURI							ONE ANNUAL
MONTANA	✓			✓	✓		NOT LIMITED
NEBRASKA	✓			✓	✓		
NEVADA	✓			✓	✓		NOT LIMITED
NEW HAMPSHIRE	✓			✓	✓		ANNUAL
NEW JERSEY	✓*			✓*	✓*		
NEW MEXICO	✓			✓	✓		
NEW YORK	✓			✓	✓		MINIMUM OF 2
NORTH CAROLINA	✓			✓	✓		NOT LIMITED
NORTH DAKOTA	STATE HAS NO LAW						
OHIO	✓			✓	✓		NOT LIMITED
OKLAHOMA	STATE HAS NO LAW						
OREGON	✓*			✓*	✓*		ANNUAL*
PENNSYLVANIA	✓			✓	✓	✓	NOT LIMITED
RHODE ISLAND		JUST GYN	✓				ONE
SOUTH CAROLINA			✓				MINIMUM OF 2
SOUTH DAKOTA	STATE HAS NO LAW						
TENNESSEE							MINIMUM OF 1
TEXAS	✓			✓	✓	✓	NOT LIMITED
UTAH	✓			✓	✓		NOT LIMITED
VERMONT		JUST GYN		✓	✓		MINIMUM OF 2
VIRGINIA		JUST GYN	✓				ONE ANNUAL
WASHINGTON	✓			✓	✓		NOT LIMITED
WEST VIRGINIA	SEE EXPLANATION*						
WISCONSIN	✓			✓	✓		NOT LIMITED
WYOMING	STATE HAS NO LAW						

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS • WOMEN'S HEALTH CARE PHYSICIANS •
DEPARTMENT OF STATE LEGISLATIVE & REGULATORY ACTIVITIES • 202-863-2594

* EXPLANATION – SEE OVER

* EXPLANATION:

Referrals For Specialty Care – Only a very small minority of these laws address the issue of referrals for specialty care and permit the ob-gyn, who is not the women's primary care physician, to refer patients to another specialty provider without PCP or plan pre-approval. Referrals for specialty care has recently been identified by ob-gyns in some states as a major access problem. This seems to be a new and emerging problem. During the first years (1994-1996) of ACOG's legislative campaign for direct access, the major problem was restrictions on access for gyn follow-up and acute care. ACOG has lobbied aggressively (though not always successfully) for a lifting of restrictions on direct access to treatment for gyn conditions. (See the column on Acute Gyn)

CALIFORNIA – Utilization protocols imposed by the insurer may not be more restrictive for ob-gyn services than for other services. Ob-gyns not acting as PCPs must communicate with the patient's PCP about treatment and follow-up care.

DELAWARE – The law specifies that an insurer may require a visit to the primary care physician before the ob-gyn can make a referral to another provider.

FLORIDA _ Florida has passed two laws – a primary care mandate and a self-referral mandate. Under the self-referral law passed in 1999, women may self-refer for an annual visit and any medically necessary follow-up care based on the annual visit. Additionally, the health plan may require that the ob-gyn coordinate the patient's care with her primary care physician.

MAINE – The law allows both self-referral and designation and selection of an ob-gyn as a PCP. However, the services that women have direct access to are more restricted under the self-referral option.

MICHIGAN – Direct access is to routine obstetrical and routine gynecologic services only.

NEW JERSEY – Direct access is permitted only to those ob-gyns and CNMs who have contracted with an HMO to be a primary care physician/provider.

Oregon – A second law passed in 1999 expands self-referral to include all medically necessary follow-up care. (Previously, self-referral was limited to one annual well-woman exam and pregnancy care.) Women selecting a woman's health care provider as their primary care provider (FCP) are allowed direct access for all obstetric and gynecological care.

WEST VIRGINIA – West Virginia has passed both a law and a regulation. The regulation, which governs HMOs only, designates ob-gyns as primary care physicians. Women enrolled in an HMO may choose an ob-gyn as their PCP who will then be responsible for coordinating their care and making referrals to other providers. Direct access under these circumstances is to all ob-gyn care. The law, on the other hand, does not designate ob-gyns as PCPs and allows only limited direct access for women enrolled in HMOs. Thus, for women not choosing an ob-gyn as their PCP, their direct access to an ob-gyn is limited to one annual visit, at minimum, and to prenatal and obstetric care.

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[January 2000]

Direct Access to Women's Health Services: State Mandates

STATE	STATE REQUIRES INSURERS* TO ALLOW WOMEN TO SELF-REFER W/OUT PLAN OR PCP PRE-APPROVAL FOR SPECIFIED OB-GYN SERVICES AS COVERED UNDER THE PLAN	STATE REQUIRES INSURERS* TO ALLOW WOMEN TO CHOOSE A PARTICIPATING OB-GYN IN THEIR PLAN AS THEIR PRIMARY CARE PHYSICIAN (PCP)	OTHER PROTECTIONS FOR WOMEN ENROLLEES		
			ADDITIONAL CO-PAY OR SURCHARGE FOR DIRECT ACCESS PROHIBITED	*NOTICE TO ENROLLEES ABOUT DIRECT ACCESS REQUIRED*	*PLAN MUST HAVE ADEQUATE NO. OF OB-GYN PROVIDERS*
ALABAMA	✓	✓			
ALASKA	STATE HAS NO LAW				
ARIZONA	STATE HAS NO LAW				
ARKANSAS	✓				
CALIFORNIA	✓	✓			
COLORADO	✓				
CONNECTICUT	✓	•			
DELAWARE	✓	✓	✓	✓	✓
DISTRICT OF COLUMBIA	✓	✓			
FLORIDA	✓	✓			
GEORGIA	✓			✓	
HAWAII	STATE HAS NO LAW				
IDAHO	✓	✓			
ILLINOIS	✓			✓	
INDIANA		✓			
IOWA	STATE HAS NO LAW				
KANSAS	STATE HAS NO LAW				
KENTUCKY	STATE HAS NO LAW				
LOUISIANA	✓	AT HMO'S OPTION	NO PENALTIES*		
MAINE	✓	✓			
MARYLAND	✓	AT INSURER'S OPTION			
MASSACHUSETTS	STATE HAS NO LAW				
MICHIGAN	✓			✓	
MINNESOTA	✓				
MISSISSIPPI	✓	✓			
MISSOURI	✓				
MONTANA	✓	✓	✓	✓	✓
NEBRASKA		✓			
NEVADA	✓				
NEW HAMPSHIRE	✓			✓	
NEW JERSEY		✓			✓
NEW MEXICO	✓	✓	✓	✓	✓
NEW YORK	✓			✓	
NORTH CAROLINA	✓			✓	
NORTH DAKOTA	STATE HAS NO LAW				
OHIO	✓		✓		
OKLAHOMA	STATE HAS NO LAW				
OREGON	✓	✓			
PENNSYLVANIA	✓				
RHODE ISLAND	✓				
SOUTH CAROLINA	✓			✓	
SOUTH DAKOTA	STATE HAS NO LAW				
TENNESSEE	✓				
TEXAS	✓		✓	✓	
UTAH		✓	✓	✓	
VERMONT	✓				
VIRGINIA	✓			✓	
WASHINGTON	✓		✓	✓	✓
WEST VIRGINIA	✓	✓	✓	✓	
WISCONSIN	✓		NO PENALTIES*	✓	
WYOMING	STATE HAS NO LAW				

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS • WOMEN'S HEALTH CARE PHYSICIANS •
DEPARTMENT OF STATE LEGISLATIVE & REGULATORY ACTIVITIES • 202-863-2594

*EXPLANATION – SEE OVER

* EXPLANATION:

INSURERS – The term "insurers" is used broadly in this chart to include HMOs, managed care plans, and individual and group indemnity plans. Please be advised that each state varies as to which type of insurance plans its law or regulation applies. Also, in a minority of states, the law or regulation applies additionally to preferred provider organizations (PPOs), the Medicaid program, and/or to the state employees health insurance program.

It is also important to note that, as with *any* state law that regulates insurance -- whether it be these ob-gyn direct access mandates or mandates to cover a particular service, such as the pap smear or mammogram -- state laws do not apply to the so-called ERISA plans; unless, of course, an ERISA plan *voluntarily* chooses to comply with the state mandate. In 1997, which was the fourth year of ACOG's state legislative campaign on this issue, several of the large insurers -- bowing to the successful passage of laws in over half of the states -- voluntarily reversed their restrictive access policies and announced new policies allowing women direct access to their ob-gyn without preauthorization or prior approval from the plan or the primary care physician. Aetna U.S. Healthcare was one of these. Its ob-gyn direct access policy took effect on September 1, 1997.

CONNECTICUT – Ob-gyns may negotiate contracts with insurers to be primary care physicians for women *only* at the insurer's discretion.

LOUISIANA – As applied to preferred provider organizations (PPOs) only, the law specifies that direct access shall be permitted without penalty or denial of benefits.

WISCONSIN – The law specifies that managed care plans may not "penalize or restrict" coverage.

T · H · E
WOMEN'S
HEALTH
GROUP, P.A.

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March 9, 2000

Senator Lana Oleen
State Capitol
Topeka, Ks 66612

Dear Senator Lana Oleen,

Kansas is one of ten States that, as of this date, has not passed Direct Access legislation. Forty states and the District of Columbia have the Direct Access law, which requires all insurers and health plans to allow their female insured clients direct access to Obstetrician-Gynecologists. This has significantly improved women's access to health care in two important ways. It requires insurers and health plans to allow a woman to obtain covered obstetric and gynecologic services from an Ob-Gyn physican without having to secure prior authorization or referral from her primary care physician. It also allows women to receive covered, follow-up obstetric and gynecologic care and/or subsequent referrals without prior approval.

According to a national survey of women and the 'Commonwealth Fund' 1993 survey of women's health, the number of preventive services received by women, is higher for women whose regular Doctor is an Obstetrician-Gynecologist . A January 1998 survey conducted by the Kaiser Family Foundation and Harvard University found that 82% of Americans support legislation requiring health plans to allow a woman to see her Obstetrician-Gynecologist without having to get permission or see another Doctor first. The same survey found that a significant majority of Americans(63%) continue to support requiring access to Obstetrican-Gynecologists even if their health insurance costs would increase. The Congressional Budget Office estimated the cost of direct access and primary care by Obstetrician-Gynecologists as only 0.1% of premiums. In November 1997, the Presidential Advisory Commission on consumer Protection and Quality in the Health Care Industry unanimously adopted a "Consumer Bill of Rights and Responsibilities" that requires health plans to allow women direct access to Ob-Gyn care. The Managed Care and Women's Health Task Force determined that the largest obstacle to a woman obtaining quality care is managed care's requirement that a female enrollee seek a referral from her primary care physician before seeing an Obstetrician-Gynecologist.

Senate Financial Institutions & Insurance
Date 3/24
Attachment
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Clearly there is a mandate for Direct Access as evidenced by the enacted legislation of 40 States and the District of Columbia to date. We feel Kansas should be the 41st State to pass Direct Access legislation and hereby respectfully request that you introduce this legislation and do what you can to ensure that it is passed into law.

Thank you for your timely consideration of this most important issue. Please let us know how we can assist you further in this endeavor.

Sincerely,

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