Approved:Feb.3, 2004

MINUTES OF THE SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

The meeting was called to order by Chairperson Ruth Teichman at 9:30 a.m. on January 21, 2004 in Room 234-N of the Capitol.

All members were present except:
Senator David Adkins- absent
Senator Mark Buhler- excused

Committee staff present:
Bill Wolff, Legislative Research
Terri Muchmore, Legislative Research
Ken Wilke, Office of the Revisor of Statutes
Nancy Shaughnessy, Committee Secretary

Conferees appearing before the committee:

Others attending:
See Attached List.

Bill Introduction by Doug Wareham, Kansas Agribusiness Retailers Association regarding liens on personal property.(Attachment 1)

Senator Barnett made a motion to accept the bill as introduced, seconded by Senator Steineger. The motion was carried.

Review,(Attachment2) by Dr. Bill Wolff, of Interim Committee on Insurance and the General Review of all Mandated Insurance Coverage.The Committee Conclusions and Recommendations include:

- No need for change, at this time, on current statutory mandates
- The legislature does not enact proposed legislation mandating coverage for contraceptives
- No recommendations regarding mandating coverage for clinical cancer trails and common therapies utilized in early intervention of developmental disabilities

The meeting adjourned at 10:05 a.m.

The next meeting is scheduled for Thursday January 22, 2004

FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE
COMMITTEE GUEST LIST

DATE: Wed. JAN 21, 2004

PLEASE PRINT

NAME	REPRESENTING
Ron Gaches	KS Financial Services Assn.
Bill Sneed	KAHP - NIAA
Jamie Lowe	KID
Jerry Wells	KID
H Boom	Not a dem
Kami Ann Lower	KAHP
Larry Magill	KAIA
David Harrison	Ks Insur Assns
Rebecca Wempe	"
Kevin Davis	Am Family
Gwendolyn Cargnel	ACS

Date: January 21, 2004

To: Senate Financial Institutions & Insurance Committee

From: Kansas Agribusiness Retailers Association

Re: Bill Introduction Request

For more information please contact Doug Wareham at (785) 234-0463.

Kansas Statute No. 58-244

58-244

Chapter 58.--PERSONAL AND REAL PROPERTY
Article 2.--LIENS ON PERSONAL PROPERTY

58-244. Same; when perfected; priority of lien not perfected; duties of filing offices; fees. (a) To be perfected, the lien must have attached and the supplier entitled to the lien must have filed a lien-notification statement in the form provided for in K.S.A. 58-242, and amendments thereto, accompanied by the form prescribed by K.S.A. 2003 Supp. 84-9-521(a), and amendments thereto, which must indicate in box 10 of the form that the lien is filed in accordance with this section, with the appropriate filing office under K.S.A. 2003 Supp. 84-9-501 and amendments thereto within ~~20~~ 60 days after the last date that agricultural production input was furnished. A lien-notification statement filed pursuant to this section shall include the date which notice was mailed to the lender and a statement signed by the supplier indicating that the lender did not respond to the lien-notification statement.

(b) Subject to the provisions of subsection (d) of K.S.A. 58-242, and amendments thereto, a lien that is not perfected shall be entitled to the same priority as an unperfected security interest as determined by part 3 of article 9 of the uniform commercial code and amendments thereto.

(c) The filing officer shall file, index, amend, maintain, remove and destroy the lien-notification statement in the same manner as a financing statement filed under part 5 of article 9 of the uniform commercial code and amendments thereto. The filing officer shall charge the same filing and information retrieval fees and credit the amounts in the same manner as financing statements filed under part 5 of article 9 of the uniform commercial code and amendments thereto.

History: L. 1985, ch. 4, § 4; L. 2002, ch. 159, § 2; May 23.

Senate F I & I Committee
Meeting Date: Jan 21 2004
Attachment No.: 1

Special Committee on Insurance

General Review of All Mandated Insurance Coverage

Conclusions and Recommendations

The Committee reviewed current statutory mandates and sees no need for change at this time. The Committee held hearings on proposals from the 2003 Session to mandate coverage for contraceptives, clinical cancer trials, and common therapies utilized in early intervention of developmental disabilities. The Committee: recommends that the Legislature not enact proposed legislation mandating coverage for contraceptives; has no recommendation regarding proposed legislation mandating coverage for clinical cancer trials; and makes no recommendation regarding mandating coverage for common therapies utilized in early intervention of developmental disabilities. The Committee has no recommendation on the proposed hair prostheses mandate.

Proposed Legislation: None

Background

The Special Committee on Insurance was charged to review all state mandated health insurance coverage in order to meet the statutory requirement for a periodic review of such mandates (KSA 40-2249a). Additionally, the Committee held hearings on certain bills carried over from the 2003 Session dealing with mandated coverages for contraceptives, cancer clinical trials, and hair prostheses. Also added to the study was mandated coverage for common therapies utilized in early intervention and treatment of developmental disabilities.

Committee Activities

Review of existing mandates

At the outset of the interim study, staff reviewed with the Committee the existing mandates in Kansas law. It was noted that since the early 1970s, the Kansas Legislature has added new statutes to insurance law which mandate that certain health care providers be paid for services rendered (provider mandates), and pay for certain prescribed types of coverage or benefit (benefit mandates). Most recently, laws have been enacted to guarantee that some right or protection be extended to the patient (patient protection mandates). The latter category may not be considered as a legislative mandate in the same sense as provider and benefit mandates.

Periodically, the Legislature has reviewed these mandates, although more individually as amendments have been proposed to them than reviewing all of them at one time. The provider mandates have been in place for the longest periods of time and have not been, for the most part, the focus of legislative review. Perhaps the mandate that most often attracted legislative attention has been the alcoholism, drug abuse, and mental illness mandate. Over the years, legislative interim studies have been conducted and proposals made to modify this mandate with the latest change carving out mental health "parity" for certain brain diseases. In addition to the mental health mandate, the Legislature has considered several proposed mandates and enacted statutes to address some of the proposals.

1998 Interim Study. In the 1998 Session, mandated coverage for prostate cancer screening and diabetes education were enacted. Several additional bills proposing new mandates, however, were introduced during the 1997-98 biennium but assigned to a study committee in the 1998 interim.

In its final report to the 1999 Legislature, the Committee recommended: that coverage for reconstructive breast surgery and coverage for certain oral dental procedures be mandated by the 1999 Legislature; that the point of service issue should be studied further, perhaps by the House Committee on Insurance early in the 1999 Session; and that 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—also were not recommended. Finally, the Committee recommended that any new mandate enacted after the effective date of any enactment of the 1999 Legislature be applied first to state employees under the state employee benefit plan before being applied to the public health insurance marketplace.

The Cost of Mandates. Throughout the course of the 1998 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 statement on premiums 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 (HB 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 (HB 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 (SB 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 payments 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 (SB 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 (SB 663). Premium costs for families in the 20-40 age group would increase $6,280,000 (about 1 percent per year).

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

Finally, the interim Committee was made aware throughout the course of its deliberations on health insurance mandates that each

had a separate cost associated with it and, collectively, the total cost of mandates was much greater than the sum of the individual requirements. This awareness of cost was heightened by the testimony of numerous employers who paid a substantial portion of health care costs through premium payments.

State Health Care Benefits Program. Since the state, too, was an employer and payer of substantial dollars in health insurance premiums, the Committee concluded and recommended 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 had, 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.

As enacted by the 1999 Legislature, the bill directs the State Employee Health Care Commission to report to the President of the Senate and to the Speaker of the House of Representatives indicating the impact a new mandate has had on the state health care benefits program, including data on the utilization and costs of the mandated coverage. The law contained no provision for applying the mandate to others in the public marketplace. This law, KSA 40-2249a, also called for the Legislature to periodically review all health insurance coverages mandated by state law.

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. Pharmacists, in a 1994 mandate, gained inclusion in the emerging pharmacy network approach to providing pharmacy services to insured persons.

Benefit Mandate. 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-man-

agement 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
			Reconstructive Breast Surgery	1998
			Dental Care in a Medical Facility	1999
			Off-Label Use of Prescription Drugs	1999
			Osteoporosis Diagnosis, Treatment, and Management	2001
			Mental Health Parity for Certain Brain Conditions	2001

Kansas and Other States Actions

The Kansas Legislature has enacted eight provider mandates and 14 mandates to provide certain benefits or to cover certain conditions. In contrast, Maryland has more than 45 mandates and Florida has 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	44		Alcohol Treatment	44
Dentists	36		Drug Abuse	32
Optometrists	38		Mammograms	50
Psychologists	42		Mental Health	36
Nurse Practitioners	26		Maternity Stays	51
Podiatrists	31		ProKSAe Screening	26
Social Workers	26		Diabetes	47
			Emergency Services	43
			Breast Reconstruction	51
			Hair Prostheses (Wigs)	5
			Contraceptives	20
			Dental Care	23
			Bone Density (Osteoporosis)	11
			Clinical Trials	15

* Data taken from "State Mandated Benefits and Providers," Blue Cross and Blue Shield Association, December 2001.

Prior to the Legislature's consideration of any bill that mandates health insurance coverage for specific services or diseases, or for certain providers of services, the person or organization making the proposal is required by statute to present an impact report to the legislative committee assigned the proposal which assesses both the social and financial effects of the proposed mandated coverage.

Having reviewed the statutory mandates, the Committee heard the comments of those most affected, the insurance industry, the business community, and consumers of the health care required to b e provided. Conferees for the industry included representatives of Blue Cross and Blue Shield of Kansas, and Coventry Health Care. Written comments were received from a representative of the Health Insurance Association of America and from the state director of the National Federation of Independent Business.

Generally, insurance industry representatives discussed the negative effects on small employers. They pointed out that this group is especially affected by increased costs associated with every mandate. Increasing costs drive employers out of the health insurance marketplace, thereby dropping health insurance coverage for their employees. Further, they noted that state mandates only affect a fraction of all Kansans as governmental coverage and self-insured groups are exempt from the mandates. A final comment from the industry reminded the Committee that there is a very fine line between what is medical necessity and what care is provided to improve quality of life. Mandates move today's insurance products further and further away from the original concept of insurance, they said.

Consumers provided coverage under the mandates, specifically those receiving benefits for cancer and mental health conditions, were represented by the American Cancer Society, the Kansas Mental Health Coalition, NAMI Kansas, Keys For Networking, and the Association of Community Mental Health Centers of Kansas.

Those advocating for continued coverage for cancer screenings and breast reconstruction stressed that existing mandates provide preventive screenings. The screenings have increased survival rates for patients, improved the patient's quality of life, and affected in a positive way health care costs by decreasing treatment needs.

The conferees urging continued mandatory coverage for mental health conditions noted that, instead of considering repeal of mandates pertaining to mental health, Kansas still has not established parity between physical health care and mental health care. They agreed that recent legislation mandating coverage for certain organic brain conditions has improved private insurance coverage for those conditions. However, they suggested that insuring mental illness in an equal manner as physical illness will bring the state one step closer to reducing the stigma associated with mental illness. The end result will be to encourage appropriate and effective treatment.

Conclusions and Recommendations. After reviewing the existing mandates and hearing those opposed to mandates and those in support of them, it was the consensus of the Committee that there is no need for changing existing mandates at this time. The Committee does recommend that as new mandates are proposed in the future, those proposing the mandates should be required to meet the current law requiring impact studies to be completed and presented to the Legislature before consideration is given to the issue.

Coverage for Contraceptives

Proponents for insurance coverage for prescription contraceptives included representatives of the Kansas State Nurses Association, the Kansas Public Health Association, The League of Women Voters, and the Kansas Foundation of Business and Professional Women. Written testimony was provided by

a representative of the Kansas section of the American College of Obstetricians and Gynecologists.

Representative Paul Davis, sponsor of legislation to mandate coverage for contraceptives, discussed the need for contraceptive fairness and parity for women. He added that the cost data provided demonstrated that any premium increase collected as a result of the mandate would be minimal (one percent or less) as most insurance companies, already provide the coverage. He pointed out, as did other conferees, that the use of contraceptives can have a positive impact on the health of women and on the cost of insurance paid for by employers. The representative speaking for the Kansas League of Women Voters quoted a study showing that an unintended pregnancy may cost an employer 15 to 17 percent more than providing coverage for contraceptives.

The actuary for the Center for Health and Environmental Statistics of the Kansas Department of Health and Environment reported that, based upon a review of Kansas specific insurance data, the cost of a mandate for contraceptive coverage would be an average premium increase roughly equal to .6 percent.

The Executive Director of the Kansas Catholic Conference spoke against a mandate. He said the Legislature should not mandate coverage for contraceptives and other devices when many Kansans do not have basic health care coverage. He added that those opposed to the use of contraceptives should not be required to pay for such coverage or to provide such coverage for employees.

Insurance industry opponents argued that, while one percent seems like a small increase in premiums, it converts to $22 million in increased premiums. Also, opponents saw no need for the legislation since proponents admitted that nearly all companies doing business in Kansas already provide the coverage.

Conclusions and Recommendations. Some members of the Committee thought that the proponents had met all the legislative requirements for consideration of their issue, and, therefore, at the least, the appropriate standing committees of the Legislature should continue consideration of the issue. The majority of the Committee, however, concluded and recommended that the Legislature in the 2004 Session take no action to mandate coverage for contraceptive.

Cancer Clinical Trials

The Leukemia and Lymphoma Society of Kansas, the American Cancer Society, an oncologist, and private citizens spoke as proponents for a health insurance mandate to require insurers to pay for routine costs associated with clinical trials. They noted that, while the sponsors of the trial are responsible for many of the costs associated with the trial, sponsors do not pay for other costs associated with the care of the patient; specifically, those costs that would ordinarily be incurred in the treatment of the disease whether or not the patient was involved in a trial. Proponents noted that Medicare pays such costs and the private insurance companies should be required to pay as well.

One citizen spoke of his family's ordeal in attempting to get not one but two insurance companies to pay those routine costs. He admitted that in the end, and after several confrontations with the companies, the insurers did pay for much of the care for which they otherwise would have paid. However, he stressed that those payments did not cover many other out-of-pocket expenses.

Again, insurance industry representatives pointed out that in the instance cited, insurance companies did pay for the routine and medically necessary costs associated with the clinical trial. They contended that no need had been demonstrated for the proposed mandate.

Conclusions and Recommendations. After reviewing the testimony, the Committee was evenly divided over whether or not action should be taken by the 2004 Legislature to mandate coverage for cancer clinical trials. Therefore, the Committee has no recommendation on this topic.

Common Therapies Utilized in Early Intervention of Developmental Disabilities

Representatives of the Coordinating Council on Early Childhood Developmental Disabilities proposed that insurance companies be required to pay for those common therapies that can be utilized in early intervention and treatment of person, especially young children, with developmental disabilities. Proponents explained that parents of children with disabilities are reluctant to use available insurance coverage early in treatment for fear of exhausting coverage long before the need for coverage is ended. Insurers, they said, should exempt early intervention diagnosis and treatment from a lifetime cap placed on a health policy or plan.

Additionally, proponents said health plans require providers to be accredited by their companies in order to get reimbursed for their services. The cost of the accreditation discourages many providers from being accredited and, therefore, families have to pay the costs of therapy.

Insurance industry representatives spoke strongly against the proposed mandate. They noted that all insurers have benefit caps on coverage. The proponents suggestion that the cap be removed would be unique to the industry. Further, opponents said no evidence had been presented to show that the coverage is not already being provided. The testimony of the proponents, the opponents pointed out, clearly indicated that parents were reluctant to use coverage available to them and providers were apparently unwilling to be accredited so that they could be paid insurers for their services.

Conclusions and Recommendations. After discussion, the Committee recommended that no consideration be given on the proposed mandate until such time as the proponents provide specific information about what they are asking to be enacted.

Hair Prostheses

The Special Committee scheduled a hearing on the hair prostheses bill carried over from the 2003 Session. However, the scheduled conferee cancelled the presentation and the Committee withdrew any further considerations of the topic.

Conclusions and Recommendations. The Special Committee makes no recommendation on this topic.

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