Approved: March 3, 2009
Date

MINUTES OF THE HOUSE INSURANCE COMMITTEE

The meeting was called to order by Chairman Clark Shultz at 3:30 p.m. on February 26, 2009, in Room 784 of the Docking State Office Building.

All members were present except:
Representative Burroughs - Excused.

Committee staff present:
Bruce Kinzie, Office of the Revisor of Statutes
Melissa Calderwood, Kansas Legislative Research Department
Cindy Lash, Kansas Legislative Research Department
Sue Fowler, Committee Assistant

Conferees appearing before the committee:
Amy Campbell, Consumer Mental Health Coalition
Bill Sneed, America's Health Insurance Plans
Maralee Carpenter, Kansas Association of Health Plans
Rachelle Colombo, KS Chamber
Michelle Sweeney, Association of Community Mental Health Centers of Kansas
Rick Cagan, National Association of Mental Health (NAMI-KS)
Brad Smoot, Blue Cross Blue Shield of Kansas and Blue Cross Blue Shield of Kansas City
Dan Murray, National Federation of Independent Business (NFIB)

Others attending:
See attached list.

Staff review of health insurance mandates currently in law:

Melissa Calderwood, Kansas Legislative Research Department, (Attachment 1), presented an overview of the L-2 Kansas Health Insurance Mandates currently in law.

Public input concerning health insurance mandates currently in law:

Brad Smoot, Blue Cross Blue Shield of Kansas and Blue Cross Blue Shield of Kansas City, (Attachment 2), discussed the health insurance mandates.
Amy Campbell, Consumer Mental Health Coalition, (Attachment 3), commented on the Committee's review of insurance mandates.
Michelle Sweeney, Association of Community Mental Health Centers of Kansas, (Attachment 4), presented information on insurance coverage for mental health treatment in Kansas.
Rick Cagan, National Association of Mental Health (NAMI-KS), (Attachment 5), expressed strong and absolute support for maintaining the mental health mandate for companies providing health insurance to Kansans.
Bill Sneed, America's Health Insurance Plans, (Attachment 6), provided written testimony regarding their client's position relative to state-imposed mandates on health insurance products.
Maralee Carpenter, Kansas Association of Health Plans, (Attachment 7), provided written testimony to provide comments about health insurance mandates.
Rachelle Colombo, KS Chamber, (Attachment 8), provided written testimony on the subject of health insurance mandates and the impact to the overall cost of health care.
Dan Murray, National Federation of Independent Business (NFIB), (Attachment 9), provided written testimony concerning health insurance mandates currently in law.
Representative Nile Dillmore, Ranking Minority Leader, House Insurance Committee, (Attachment 10), handed out information on the cost for the Kansas State Employee Health Plan of various providers and benefits that are mandated by Kansas Statute.

Representative Grant moved without objection to pass the February 17, 2009 committee minutes as written.

The next meeting is scheduled for March 3, 2009.

The meeting was adjourned at 4:50 p.m.

House Insurance Committee
Guest Sign In Sheet
Thursday, February 26, 2009

Name	Representing
Michelle Butler	Capitol Strategies
Kari Presley	Kearney & Associates
Sarah Tidwell	KSNA
Jamel Jones	UHG
Alex Kotoyantz	P.I.A.
Bruce Linn	PHS
Julie Holmes	KID
Suzanne Cleveland	KHI
Barbara Wickelson	KID
Kristin Black	Federico Consulting
John Beetz	KID
Amy Campbell	KMHC
Shelli Lewis	Aetna
Dave Heinis	ACS
Anne Spiess	American Cancer Society
Kerri Spielman	KAIA
Larry Magill	KAIA
Dan Murray	NFIB
Mabel Carpenter	KAHP
D Moyer	KHA
David Hanson	Ks Insur Assns

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Financial Institutions and Insurance

L-2 Kansas Health Insurance Mandates

Background

Since 1973, the Kansas Legislature has added new statutes to insurance law that 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). In more recent years, laws have been enacted to guarantee a right or protection be extended to the patient (patient protection mandates). A table outlining Kansas mandates is included in a later discussion of provider and benefit mandates.

Provider Mandates. The first mandates enacted in Kansas were on behalf of health care providers. In 1973, optometrists, dentists, chiropractors, and podiatrists sought and secured legislation directing insurers to pay for services the providers performed if those services would have been paid for by an insurance company if they had been performed by a practitioner of the healing arts (medical doctors and doctors of osteopathy). In 1974, psychologists sought and received approval of reimbursement for their services on the same basis. In that same year, the Legislature extended the scope of mandated coverages to all policies renewed or issued in Kansas by or for an individual who resides in or is employed in this state (extraterritoriality). Licensed special social workers obtained a mandate in 1982. Advanced nurse practitioners received recognition for reimbursement for services in 1990. In a 1994 mandate, pharmacists gained inclusion in the emerging pharmacy network approach to providing pharmacy services to insured persons.

Benefit Mandates. The first benefit mandate was passed by the 1974 Legislature, through enactment of a bill to require coverage for newborn children. The newborn coverage mandate has been amended to include adopted children and immunizations, as well as a mandatory offer of coverage for the expenses of a birth mother in an adoption. The Legislature began its first review into coverage for alcoholism, drug abuse, and nervous and mental conditions in 1977. The law enacted that year required insurers to make an affirmative offer of such coverage which could be rejected only in writing. This mandate also has been broadened over time, first by becoming a mandated benefit and then as a benefit with minimum dollar amounts of coverage specified by law.

In 1988, mammograms and pap smears were mandated as cancer patients and various cancer interest groups requested mandatory coverage by health insurers. In 1998, male cancer patients and the cancer interest groups sought and received similar mandated coverage for prostate cancer screening. After a number of attempts over the course of more than a decade, supporters of coverage for diabetes were successful in securing mandatory coverage for certain equipment used in the treatment of the disease, as well as for educational costs associated with self-management training.

Table A - Provider and Benefit Mandates				
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	1999
			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

*Off-label use of prescription drugs is limited by allowing for use of a prescription drug (used in cancer treatment) that has not been approved by the federal Food and Drug Administration for that covered indication if the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

Legislative Review

Kansas law (KSA 40-2249a) requires the Legislature to review all state mandated health insurance coverage periodically. The Legislature typically reviews the mandates as amendments rather than reviewing all of the mandates at one time. The provider mandates have been in place, for the most part, longer than the benefit mandates and typically have not been the focus of legislative review. The mandate that has received a great deal of review is the alcohol, drug abuse, and mental illness mandate. A number of interim studies have been conducted on modifying the mandate, with the latest change allowing for mental health parity for certain brain diseases. The Legislature has considered a number of proposed mandates and enacted law to address some of the proposed modifications.

KSA 40-2248 requires the person or organization seeking a mandated coverage for specific health services, specific diseases, or certain providers of health care services as part of individual, group, or blanket health insurance policies, to submit to the legislative committees that would be assigned to review the proposal an impact report that assesses both the social and financial effects of the proposed mandated coverage. The law also requires the Insurance Commissioner to cooperate with, assist, and provide information to any person or organization required to submit an impact report. The social and financial impacts to be addressed in the impact report are outlined in KSA 40-2249. Social impact factors include:

- The extent to which the treatment or service generally is utilized by a significant portion of the population;
- The extent to which such insurance coverage is already generally available;
- If coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment;
- The level of public demand for the treatment or service;
- The level of public demand for individual or group insurance coverage of the treatment or service;
- The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts; and
- The impact of indirect costs (costs other than premiums and administrative costs) on the question of the costs and benefits of coverage.

The financial impact requirements include the extent to which the proposal would increase or decrease the cost of the treatment or service; the extent to which the proposed coverage might increase the use of the treatment or service; the extent to which the mandated treatment or service might serve as an alternative for a more expensive treatment or service; the extent to which insurance coverage of the health care service or provider can reasonably be expected to increase or decrease the insurance premium and administrative expenses of the policyholders; and the impact of proposed coverage on the total cost of health care.

State Employee Health Benefit Plan Study. KSA 40-2249a, enacted by the 1999 Legislature, provides, in addition to the impact report requirements, that any new mandated health insurance coverage approved by the Legislature is to apply only to the state health care benefits program for a period of at least one year beginning with the first anniversary date of implementation of the mandate following its approval by the Legislature. On or before March 1, after the one-year period has been applied, the State Employee Health Care Commission is to report to the President of the Senate and the Speaker of the House of Representatives the impact the new mandate has had on the state health care benefits program, including data on the utilization and costs of the mandated coverage. The report also is to include a recommendation whether such mandated coverage should be continued by the Legislature to apply to the state health care benefits program or whether additional utilization and cost data are required.

Recent Interim Study

1998 Interim. During the 1998 Session, mandated coverages for prostate cancer screening and diabetes education were enacted. Additional legislation proposing new mandates also was introduced during the 1997-98 biennium but was assigned to the Special Committee on Financial Institutions and Insurance, a 1998 interim study committee. In addition to the cost estimates provided by those requesting consideration for mandate proposals, the Committee requested impact statements on premiums for the mandates from the Kansas Department of Health and Environment, as the statistical agent for the Kansas Insurance Department, using the data in the Kansas Health Insurance Information System (KHIIS). The provisions of the bills for proposed mandates were used by the actuary to determine the impact.

In its final report to the 1999 Legislature, the Committee recommended: that coverage for reconstructive breast surgery and coverage for certain oral dental procedures (for young children and certain persons who are severely disabled or have medical or behavioral problems) be mandated by the 1999 Legislature; that point-of-service issues 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–were not recommended. The Committee also recommended any new mandate enacted after the effective date of any enactment by the 1999 Legislature (KSA 40-2249a) be applied first to state employees under the state employee health benefit plan prior to being applied to the public health insurance marketplace.

2003 Interim. The 2003 Special Committee on Insurance also reviewed existing mandates, hearing from both opponents and proponents, reaching a consensus that there was no need to change existing mandates.

The Committee also reviewed proposed mandated coverages from the 2003 Session for contraceptives, cancer clinical trials, and common therapies utilized in early intervention of developmental disabilities. A hearing was scheduled to allow for the review of a hair prostheses bill; however, the scheduled conferee cancelled the presentation, and the Committee gave no further consideration to the topic.

In its final report to the 2004 Legislature, the interim Committee recommended that, as new mandates are proposed in the future, those proposing the mandates 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.

2008 Interim. The 2008 Legislature directed the Kansas Health Policy Authority (KHPA), in collaboration with the Insurance Commissioner, to conduct a study on the impact of extending coverage for bariatric surgery in the State Employee Health Benefit Program. Additionally, the KHPA was directed to conduct a more general study on the issues associated with bariatric surgery for the morbidly obese including: emerging research evidence of the positive health impact (of the surgery) for the morbidly obese; qualifications of the patients and surgeons when the surgery is appropriate or necessary; and cost analysis with insurance and Medicaid reimbursement. KHPA is required to submit a reporting on its findings to the Joint Committee on Health Policy Oversight on or before November 1, 2008 (2008 HB 2672).

The Legislative Coordinating Council assigned the 2008 Interim Special Committee on Insurance the topic to study requiring that colon cancer screening be included in health insurance policies. The Committee is to review the benefits of colon cancer screening and the American Cancer Society's guidelines for such screening (see 2008 SB 218 for proposed legislation).

See Table B for a summary of mandated coverages proposed during the 2007 - 2008 Biennium.

Table B - Proposed Mandated Coverages

Provider Mandates	Bill	Benefit Mandates	Bill
Certain BSRB licensees (clinical prof. counselors, marriage and family therapists, clinical psychotherapists) Psychologist/Social Workers (related to above bills)	HB 2505 HB 2601* HB 2696 HB 2313	Ambulance Services	SB 299
		Assignment of Benefits	SB 175
		Autism Treatment	SB 398
		Cancer Clinical Trials, Patient Services	SB 629
		Colon Cancer Screenings	SB 218 Sub. for HB 2601
		Dependent Age, Increase	SB 117 SB 243 SB 540
		Hearing Aids	HB 2125
		Infertility	HB 2413
		Mental Health	SB 380 HB 2351
		Morbid Obesity, diagnosis and treatment**	HB 2864
		Telemedicine	HB 2065

*Sub. for HB 2601 (HCOW version) proposed assistance by the Kansas Health Policy Authority to proponents of proposed mandated coverages. The HCOW version also included colon cancer screenings.

Mandates in Kansas and Other States

The Kansas Legislature has enacted eight provider mandates and 14 mandates to provide certain benefits or to cover certain health conditions. In contrast, as of 2005, Maryland had more than 52 mandates and California had 46 mandates in place. Other states, including Connecticut, Florida, and Minnesota, also had more than 40 mandates in place. Using this comparison of state mandates, Kansas is closer to its neighbors in having 25 and 36 mandates. (Note: the number of Kansas mandates, outlined in a December 2005 Blue Cross and Blue Shield Association comparison report of state mandates, varies

from the figures provided above by rating Kansas with 15 provider mandates and 15 benefit mandates. The increase is due to interpretation of state laws and definitions assumed for mandated coverages.)

Mandates adopted by Kansas correspond with what most other states and the District of Columbia have enacted, as indicated Table C. The table also includes benefit mandates that were most recently considered by the Legislature.

Table C - Comparison of State Mandates*				
Provider Mandates	States		Benefit Mandates	States
Chiropractors	47		Alcohol Treatment	45
Dentists	42		Drug Abuse Treatment	33
Optometrists	46		Mammography Screening	50
Nurse Practitioners	33		Mental Health (Parity)	33
Podiatrists	38		Minimum Maternity Stays	51
Social Workers	**28**		Prostate Cancer Screening	27
Marriage Therapists	**16**		Diabetes Supplies and Education	47
Professional Counselors	**18**		Emergency Services	45
			Breast Reconstruction	51
			Hair Prostheses (Wigs)	6
			Contraceptives	25
			Dental Anesthesia	27
			Bone Density Screening	15
			Clinical Trials	**18**
			Ambulance Transportation	**9**
			Colorectal Screening	**24**
			Hearing Aids	**7**
			Infertility Treatment	**14**
			Telemedicine	**5**

Source: State Mandated Benefits and Providers, Blue Cross and Blue Shield Association, December 2005

*Highlighted provider and benefit mandates are under current review (representative of legislation introduced during the 2008 Biennium).

For more information, please contact:

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Kansas Health Insurance Mandates

Provider Mandates	Number of States*	Est. Cost %**
Optometrists	46	1-3
Dentists	42	3-5
Chiropractors	47	1-3
Podiatrists	38	<1
Psychologists	43	1-3
Social Workers	28	1-3
Advanced Registered Nurse Practitioners	32	<1
Pharmacists	5	<1

Benefit Mandates	Number of States*	Est. Cost %**
Newborn and Adopted Children	51(N); 43(A)	1-3(N); <1 (A)
Alcoholism	44	1-3
Drug Abuse	33	<1
Nervous and Mental Conditions	26	1-3
Mammograms and Pap Smears	50(M)/29(P)	<1/<1
Immunizations	35(Well Child Care)	1-3
Maternity Stays	51	<1
Prostate Screening	31	<1
Diabetes Supplies and Education	47	<1
Reconstructive Breast Surgery	51	<1
Dental Care in a Medical Facility	29	<1
Off-Label Use of Prescription Drugs	36	<1
Osteoporosis Diagnosis, Treatment, and Management	16	<1
Mental Health Parity for Certain Brain Conditions	39	5-10

*Data taken from "State Mandated Benefits and Providers," Blue Cross and Blue Shield Association, December 2008. (Pharmacist data from CAHI report)

**The cost assessments – the cost-range estimate if the mandate were added to a policy that did not include the coverage – provided by the Council for Affordable Health Insurance, "Health Insurance Mandates in the States 2008".

ployee or 50% of the total amount paid by the employer during the taxable year. In the fourth year, the credit shall be equal to 50% of the lesser of $35 per month per employee or 50% of the total amount paid by the employer during the taxable year. In the fifth year, the credit shall be equal to 25% of the lesser of $35 per month per employee or 50% of the total amount paid by the employer during the taxable year. For the sixth and subsequent years, no credit shall be allowed.

(c) If the credit allowed by this section is claimed, the amount of any deduction allowable under the Kansas income tax act for expenses described in this section shall be reduced by the dollar amount of the credit. The election to claim the credit shall be made at the time of filing the tax return in accordance with law. If the credit allowed by this section exceeds the taxes imposed under the Kansas income tax act for the taxable year, that portion of the credit which exceeds those taxes shall be refunded to the taxpayer.

(d) Any amount of expenses paid by an employer under this act shall not be included as income to the employee for purposes of the Kansas income tax act. If such expenses have been included in federal taxable income of the employee, the amount included shall be subtracted in arriving at state taxable income under the Kansas income tax act.

(e) This section shall apply to all taxable years commencing after December 31, 1999.

History: L. 1990, ch. 157, § 8; L. 1999, ch. 110, § 4; July 1.

Law Review and Bar Journal References:

"1999 Legislative Wrap Up," Ron Smith, 68 J.K.B.A. No. 7, 16 (1999).

40-2247. Same; exemption from insurance premium tax. No premium tax shall be due or payable on a health benefit plan established under this act.

History: L. 1990, ch. 157, § 9; July 1.

40-2248. Mandated health benefits; impact report to be submitted prior to legislative consideration. Prior to the legislature's consideration of any bill that mandates health insurance coverage for specific health services, specific diseases, or for certain providers of health care services as part of individual, group or blanket health insurance policies, the person or organization which seeks sponsorship of such proposal shall submit to the legislative committees to which the proposal is assigned an impact report that assesses both the social and financial effects of the proposed mandated coverage. For purposes of this act, mandated health insurance coverage shall include mandated optional benefits. It shall be the duty of the commissioner of insurance to cooperate with, assist and provide information to any person or organization required to submit an impact report under the provisions of this act.

History: L. 1990, ch. 162, § 1; July 1.

40-2249. Same; contents. The report required under K.S.A. 40-2248 for assessing the impact of a proposed mandate of health coverage shall include at the minimum and to the extent that information is available, the following:

(a) The social impact, including:

(1) The extent to which the treatment or service is generally utilized by a significant portion of the population;

(2) the extent to which such insurance coverage is already generally available;

(3) if coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatment;

(4) if the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment;

(5) the level of public demand for the treatment or service;

(6) the level of public demand for individual or group insurance coverage of the treatment or service;

(7) the level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts; and

(8) the impact of indirect costs which are costs other than premiums and administrative costs, on the question of the costs and benefits of coverage.

(b) The financial impact, including:

(1) The extent to which insurance coverage of the kind proposed would increase or decrease the cost of the treatment or service;

(2) the extent to which the proposed coverage might increase the use of the treatment or service;

(3) the extent to which the mandated treatment or service might serve as an alternative for more expensive treatment or service;

(4) the extent to which insurance coverage of the health care service or provider can be reasonably expected to increase or decrease the insur-

9
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ance premium and administrative expenses of policyholders; and

(5) the impact of this coverage on the total cost of health care.

History: L. 1990, ch. 162, § 2; July 1.

40-2249a. Same; state employee group pilot project for new mandated health benefits. (a) After July 1, 1999, in addition to the requirements of K.S.A. 40-2248 and 40-2249, and amendments thereto, any new mandated health insurance coverage for specific health services, specific diseases or for certain providers of health care services approved by the legislature shall apply only to the state health care benefits program, K.S.A. 75-6501, *et seq.*, and amendments thereto, for a period of at least one year beginning with the first anniversary date of the state health care benefits program subsequent to approval of the mandate by the legislature. On or before March 1, after the one year period for which the mandate has been applied, the Kansas state employees health care commission shall submit to the president of the senate and to the speaker of the house of representatives, a report indicating the impact such mandated coverage has had on the state health care benefits program, including data on the utilization and costs of such mandated coverage. Such report shall also include a recommendation whether such mandated coverage should continue for the state health care benefits program or whether additional utilization and cost data is required.

(b) The legislature shall periodically review all health insurance coverages mandated by state law.

History: L. 1999, ch. 162, § 5; July 1.

40-2250. Insurance coverage to include reimbursement for services performed by advanced registered nurse practitioners. (a) Notwithstanding any provision of an individual or group policy or contract for health and accident insurance delivered within the state, whenever such policy or contract shall provide for reimbursement for any services within the lawful scope of practice of an advanced registered nurse practitioner within the state of Kansas, the insured, or any other person covered by the policy or contract, shall be allowed and entitled to reimbursement for such service irrespective of whether it was provided or performed by a duly licensed physician or an advanced registered nurse practitioner.

(b) Notwithstanding the provisions of subsection (a), reimbursement shall be mandated with respect to services performed by an advanced registered nurse practitioner in Douglas, Johnson, Leavenworth, Sedgwick, Shawnee or Wyandotte counties.

(c) The provisions of subsection (b) shall expire on July 1, 1998.

History: L. 1990, ch. 162, § 3; L. 1993, ch. 137, § 1; July 1.

40-2251. Statistical plan for recording and reporting premiums and loss and expense experience by accident and health insurers; compilation and dissemination; secretary of health and environment to serve as statistical agent; assessments; penalties for failure to report. (a) The commissioner of insurance shall develop or approve statistical plans which shall be used by each insurer in the recording and reporting of its premium, accident and sickness insurance loss and expense experience, in order that the experience of all insurers may be made available at least annually in such form and detail as may be necessary to aid the commissioner and other interested parties in determining whether rates and rating systems utilized by insurance companies, mutual nonprofit hospital and medical service corporations, health maintenance organizations and other entities designated by the commissioner produce premiums and subscriber charges for accident and sickness insurance coverage on Kansas residents, employers and employees that are reasonable in relation to the benefits provided and to identify any accident and sickness insurance benefits or provisions that may be unduly influencing the cost. Such plans may also provide for the recording and reporting of expense experience items which are specifically applicable to the state. In promulgating such plans, the commissioner shall give due consideration to the rating systems, classification criteria and insurance and subscriber plans on file with the commissioner and, in order that such plans may be as uniform as is practicable among the several states, to the form of the plans and rating systems in other states.

(b) The secretary of health and environment, as administrator of the health care database, pursuant to K.S.A. 2000 Supp. 65-6804, and amendments thereto, shall serve as the statistical agent for the purpose of gathering, receiving and compiling the data required by the statistical plan or

10
1-18

Kansas Health Insurance Mandates

This addendum to the *2009 Legislator Briefing Book* article on Kansas Health Insurance Mandates includes a description of each provider and benefit mandate and the accompanying statutory language.

Providers

Optometrists, Dentists, Podiatrists

The following statute provides that whenever any accident & health policy coverage for any service within the lawful scope of practice of any practitioner licensed under the Healing Arts Act (MDs, Osteopaths, and chiropractors), reimbursement shall not be denied when such services are performed by an optometrist, dentist, or podiatrist acting within the lawful scope of their licenses.

40-2,100. Insurance coverage to include reimbursement or indemnity for services performed by optometrist, dentist or podiatrist

Notwithstanding any provision of any individual, group or blanket policy of accident and sickness, medical or surgical expense insurance coverage or any provision of a policy, contract, plan or agreement for medical service, issued on or after the effective date of this act, whenever such policy, contract, plan or agreement provides for reimbursement or indemnity for any service which is within the lawful scope of practice of any practitioner licensed under the healing arts act of this state, reimbursement or indemnification under such policy contract, plan or agreement shall not be denied when such services are performed by an optometrist, dentist or podiatrist acting within the lawful scope of their license.

Laws 1973, ch. 194, § 1.

Practitioners of the Healing Arts, Scope of Practice

Pursuant to the following statute, whenever any accident & health policy provides reimbursement for any service within the lawful scope of practice of any practitioner licensed under the Healing Arts Act, reimbursement shall not be denied when such service is rendered by any licensed practitioner practicing within the lawful scope of their practice.

40-2,101. No policies, contracts or agreements for medical service shall deny reimbursement or indemnification for any service within scope of practice licensed under Kansas healing arts act

Notwithstanding any provision of any individual, group or blanket policy of accident and sickness, medical or surgical expense insurance coverage or any provision of a policy, contract, plan or agreement for medical service, issued on or after the effective date of this act, whenever such policy, contract, plan or agreement provides for reimbursement or indemnity for any service which is within the lawful scope of practice of any practitioner licensed under the Kansas healing arts act, reimbursement or indemnification under such policy contract, plan or agreement shall not be denied when such service is rendered by any such licensed practitioner within the lawful scope of his license.

Laws 1973, ch. 195, § 1.

Application of Statutes

Pursuant to the following statute, the requirements of the listed statutes shall apply to all insurance policies, subscriber contracts or certificates of insurance delivered, renewed or issue 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 (extraterritoriality).

40-2,103. Application of designated statutes

The requirements of K.S.A. 40-2,100, 40-2,101, 40-2,102, 40-2,104, 40-2,105, 40-2,114, 40-2,160, 40-2,165 through 40-2,170, inclusive, 40-2250, K.S.A. 40-2,105a and 40-2,105b, 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.

Laws 1974, ch. 190, § 5; Laws 1984, ch. 168, § 1; Laws 1989, ch. 133, § 1; Laws 1990, ch. 162, § 4; Laws 1991, ch. 129, § 1; Laws 1996, ch. 96, § 2; Laws 1999, ch. 128, § 5; Laws 1999, ch. 162, § 3; Laws 2001, ch. 178, § 4.

Psychologists

The following statute provides that whenever any accident & health policy provides reimbursement for any service within the lawful scope of practice of a licensed psychologist, an insured shall be allowed and entitled to reimbursement for such service regardless of whether the service was provided by a duly licensed physician or duly licensed psychologist.

40-2,104. Insurance coverage to include reimbursement for services performed by licensed psychologist

Notwithstanding any provision of an individual or group policy or contract of health and accident

insurance, delivered within the state whenever such policy or contract shall provide for reimbursement for any service within the lawful scope of practice of a duly licensed psychologist within the state of Kansas, the insured, or any other person covered by the policy or contract shall be allowed and entitled to reimbursement for such service irrespective of whether it was provided or performed by a duly licensed physician or a duly licensed psychologist.

Laws 1974, ch. 189, § 1; Laws 1986, ch. 299, § 7.

Social Workers

Pursuant to the following statute, whenever an accident & health policy provides reimbursement for any service within the lawful scope of practice of a duly licensed specialist social worker, the insured shall be allowed and entitled to reimbursement for such service, unless the coverage in the plan is in existence on or before March 15, 1989, is refused in writing by the policyholder prior to March 15, 1989.

40-2,114. Insurance coverage to include reimbursement for services performed by licensed specialist social worker

Notwithstanding any provision of an individual or group policy or contract of health and accident insurance, delivered within the state, whenever such policy or contract shall provide for reimbursement for any service within the lawful scope of practice of a duly licensed specialist social worker authorized to engage in private, independent practice under subsection (a) of K.S.A. 75-5353 and amendments thereto within the state of Kansas, the insured, or any other person covered by the policy or contract shall be allowed and entitled to reimbursement for such service, unless subject coverage in those insurance plans in existence on or before March 15, 1989, is refused in writing by the policyholder prior to March 15, 1989, irrespective of whether it was provided or performed by a duly licensed physician or a duly licensed specialist social worker authorized to engage in private, independent practice under subsection (a) of K.S.A. 75-5353 and amendments thereto.

Laws 1982, ch. 204, § 1; Laws 1989, ch. 133, § 2.

ARNPs

The following statute provides that the provisions of individual and group health insurance policies cannot grant any preference or discriminate between an Advanced Registered Nurse Practitioner or a duly licensed physician for any service within the lawful practice of an ARNP regardless of whether it was provided or performed by either of these providers.

40-2250. Insurance coverage to include reimbursement for services performed by advanced registered nurse practitioners

(a) Notwithstanding any provision of an individual or group policy or contract for health and accident insurance delivered within the state, whenever such policy or contract shall provide for reimbursement for any services within the lawful scope of practice of an advanced registered nurse practitioner within the state of Kansas, the insured, or any other person covered by the policy or contract, shall be allowed and entitled to reimbursement for such service irrespective of whether it was provided or performed by a duly licensed physician or an advanced registered nurse practitioner.

(b) Notwithstanding the provisions of subsection (a), reimbursement shall be mandated with respect to services performed by an advanced registered nurse practitioner in Douglas, Johnson, Leavenworth, Sedgwick, Shawnee or Wyandotte counties.

(c) The provisions of subsection (b) shall expire on July 1, 1998.

Laws 1990, ch. 162, § 3; Laws 1993, ch. 137, § 1.

Pharmacists

The following statute provides that health benefit plans offered by an insurance company, by a nonprofit medical and hospital service corporation, by an HMO, by a PPO, by an individual practice association, or by any similar mechanism are required to provide written notice to the Insurance Commissioner of its intent to create a pharmacy network. This network must permit participation of at least one Kansas pharmacy in each county in which the group health benefit plan has participating employees with no less than one pharmacy within 30 miles of a plan physician in any county designated as underserved nor more than 10 miles in any other county.

40-2,153. Insurance coverage to allow choice of pharmacy providers

(a) Every policy, contract, plan or agreement delivered to any group in this state which provides benefits or services, or both, for hospital and medical services that is offered by an accident and health insurance company or by a health maintenance organization as defined in K.S.A. 40-3202 and amendments thereto, except when the health maintenance organization owns and operates its own pharmacies and such health maintenance organization is in operation on the effective date of this act, by a preferred provider organization or by an individual practice association or by a similar mechanism shall provide for written notice to the commissioner of insurance of the creation of a pharmacy network not less than 90 days prior to the effective date of any contract for pharmacy services. All notices shall identify a contact person or office of such plan, the address of such person or office and the geographic area to be served by such contract. The commissioner of insurance shall cause to be published in the Kansas register on a weekly basis a copy of all notices received by the commissioner in the preceding week.

(b) If such policy, contract, plan or agreement provides or contracts for the services of a pharmacy

network, such policy, contract, plan or agreement shall permit participation of at least one pharmacy for each Kansas county in which that plan has participating employers or physicians. In no event shall a plan have less than one pharmacy within 30 miles of a plan physician or employer in a Kansas county designated pursuant to K.S.A. 76-375 and amendments thereto as an underserved area and within 10 miles in any other county. The provisions of this subsection shall apply only if the plan has a written offer to participate in the pharmacy network from a registered pharmacy located in such Kansas county under the same terms and conditions of the policy, contract, plan or agreement as those offered to any other provider of pharmacy services.

(c) No such policy, contract, plan or agreement, except as permitted in this subsection, shall permit or mandate any difference in coverage for or impose any different conditions, including copayment fees, whether the prescription benefits are provided through direct contact with a pharmacy or by use of an out-of-state mail order pharmacy so long as the provider selected is a participant in the plan involved. The limitations of this subsection shall not apply to any pharmacy services owned and operated by an accident and health insurance company, its commonly owned affiliate or subsidiary, health maintenance organization, individual practice association or other similar mechanism.

(d) Any provision in an accident and health insurance policy, contract, plan or agreement offered in this state which violates the provisions of this section is void.

(e) Nothing in this section shall apply to any policy, plan, contract or agreement operating pursuant to the federal employee retirement income security act of 1974 (ERISA).

(f) The department of insurance shall enforce the provisions of this section with regard to any policy, contract, plan or agreement issued under authority of chapter 40 of the Kansas Statutes Annotated.

Laws 1994, ch. 253, § 1; Laws 1997, ch. 8, § 7.

Benefits and Conditions

Newborn and Adopted Children (incl. immunizations)

Pursuant to this statute, a hospital and medical expenses insurance policy is required to cover the birth of a newborn child of the insured from the moment of birth when coverage has been issued on a family basis, a newborn child adopted by the insured from the moment of birth if a petition for adoption is filed within 31 days of birth, and an adopted child from the date the petition for adoption is filed. Further, the statute required all individual and group hospital and medical expense insurance policies to offer an option whereby the insurance benefits shall include delivery expenses at birth of the birth mother of a child adopted within 90

days of birth of such child by the insured. This benefit is subject to the same limitations contained in the policy and would only apply when the policy has been issued on a family basis. The offer of an option regarding delivery and expense must be made to the insured and to the individual subscriber in the case of a group health insurance policy.

40-2,102. Coverage for newly born and adopted children; coverage for immunizations; notification of birth or adoption; mandatory option to cover delivery expenses of birth mother of adopted child

(a)(1) All individual and group health insurance policies providing coverage on an expense incurred basis, individual and group service or indemnity type contracts issued by a profit or nonprofit corporation and all contracts issued by health maintenance organizations organized or authorized to transact business in this state which provides coverage for a family member of the enrollee, insured or subscriber shall, as to such family members' coverage, also provide that the health insurance benefits applicable for children shall be payable with respect to a: (A) Newly born child of the enrollee, insured or subscriber from the moment of birth; (B) newly born child adopted by the enrollee, insured or subscriber from the moment of birth if a petition for adoption as provided in K.S.A. 59-2128 and amendments thereto was filed within 31 days of the birth of the child; or (C) child adopted by the enrollee, insured or subscriber from the date the petition for adoption as provided in K.S.A. 59-2128 and amendments thereto was filed or (D) child placed in enrollee, insured or subscriber's home by a child placement agency as defined by K.S.A. 65-503 and amendments thereto, for the purpose of adoption from the date of placement as certified by the enrollee, insured or subscriber. In no case shall the time from the date of placement to the date the petition for adoption as provided in K.S.A. 59-2128 and amendments thereto was filed exceed 280 days.

(2) The coverage for newly born children shall consist of: (A) Coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities; and (B) routine and necessary immunizations for all newly born children of the insured or subscriber. For purposes of this paragraph "routine and necessary immunizations" shall consist of at least five doses of vaccine against diphtheria, pertussis, tetanus; at least four doses of vaccine against polio and Haemophilus B (Hib); and three doses of vaccine against Hepatitis B; two doses of vaccine against measles, mumps and rubella; one dose of vaccine against varicella and such other vaccines and dosages as may be prescribed by the secretary of health and environment. The required benefits shall apply to immunizations administered to each newly born child from birth to 72 months of age and shall not be subject to any deductible, copayment or coinsurance requirements.

(3) If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child or the filing of the petition for adoption or certification that a child has been placed in the home for adoption as defined by subsection (a)(1)(D) and payment of the required premium or fees must be

furnished to the health maintenance organization, insurer or nonprofit service or indemnity corporation within 31 days after the date of birth or the filing of the petition for adoption or certification that a child has been placed in the home for adoption as defined by subsection (a)(1)(D) in order to have the coverage continue beyond such 31-day period.

(4) The contract issued by a health maintenance organization may provide that the benefits required pursuant to this subsection shall be covered benefits only if the services are rendered by a provider who is designated by and affiliated with the health maintenance organization.

(b)(1) All individual and group health insurance policies providing coverage on an expense incurred basis, individual and group service or indemnity type contracts issued by a profit or nonprofit corporation and all contracts issued by health maintenance organizations organized or authorized to transact business in this state which provides coverage for a family member of the enrollee, insured or subscriber, as to such family members' coverage, shall also offer an option whereby the health insurance benefits shall include delivery and obstetrical expenses at birth of the birth mother of a child adopted within 90 days of birth of such child by the enrollee, insured or subscriber subject to the same limitations contained in such policy or contract applicable to the enrollee, insured or subscriber. Such offer of an option regarding such delivery and obstetrical expense shall be made to the enrollee of a health maintenance organization and to the insured and, to the individual subscribers in the case of a group health insurance policy.

(2) Contracts issued by a health maintenance organization may provide that the benefits required pursuant to paragraph (1) of this subsection, shall be covered benefits only if the services are rendered by a provider who is designated by and affiliated with the health maintenance organization.

Laws 1974, ch. 190, § 4; Laws 1990, ch. 145, § 35; Laws 1995, ch. 183, § 1; Laws 1997, ch. 95, § 1.

Alcoholism, Drug Abuse, Nervous or Mental Conditions

Pursuant to the following statute, hospital and medical expense policies are required to provide not less than 30 days coverage per year when the insured is confined in a medical care facility for treatment of alcoholism, drug abuse, or nervous or mental conditions. When outpatient care is needed for such conditions, the policy must cover 100 percent of the first $100, 80 percent of the next $100, and 50 percent of the next $1,640 in any year and limited to not less than $7,500 in such person's lifetime. (This law also applies to HMOs).

40-2,105. Insurance coverage for services rendered in treatment of alcoholism, drug abuse or nervous or mental conditions; applicability or nonapplicability of section

(a) On or after the effective date of this act, every insurer which issues any individual or group policy of accident and sickness insurance providing medical, surgical or hospital expense coverage for other than specific diseases or accidents only and which provides for reimbursement or indemnity for services rendered to a person covered by such policy in a medical care facility, must provide for reimbursement or indemnity under such individual policy or under such group policy, except as provided in subsection (d), which shall be limited to not less than 30 days per year when such person is confined for treatment of alcoholism, drug abuse or nervous or mental conditions in a medical care facility licensed under the provisions of K.S.A. 65-429 and amendments thereto, a treatment facility for alcoholics licensed under the provisions of K.S.A. 65-4014 and amendments thereto, a treatment facility for drug abusers licensed under the provisions of K.S.A. 65-4605 and amendments thereto, a community mental health center or clinic licensed under the provisions of K.S.A. 75-3307b and amendments thereto or a psychiatric hospital licensed under the provisions of K.S.A. 75-3307b and amendments thereto. Such individual policy or such group policy shall also provide for reimbursement or indemnity, except as provided in subsection (d), of the costs of treatment of such person for alcoholism, drug abuse and nervous or mental conditions, limited to not less than 100% of the first $100, 80% of the next $100 and 50% of the next $1,640 in any year and limited to not less than $7,500 in such person's lifetime, in the facilities enumerated when confinement is not necessary for the treatment or by a physician licensed or psychologist licensed to practice under the laws of the state of Kansas.

(b) For the purposes of this section "nervous or mental conditions" means disorders specified in the diagnostic and statistical manual of mental disorders, fourth edition, (DSM-IV, 1994) of the American psychiatric association but shall not include conditions:

(1) Not attributable to a mental disorder that are a focus of attention or treatment (DSM-IV, 1994); and

(2) defined as a mental illness in K.S.A. 40-2,105a and amendments thereto.

(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.

(d) There shall be no coverage under the provisions of this section for any assessment against any person required by a diversion agreement or by order of a court to attend an alcohol and drug safety action program certified pursuant to K.S.A. 8-1008 and amendments thereto or for evaluations and diagnostic tests ordered or requested in connection with criminal actions, divorce, child custody or child visitation proceedings.

(e) 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.

(f) The provisions of this section shall be applicable to the Kansas state employees health care benefits program developed and provided by the Kansas state employees health care commission.

(g) The outpatient coverage provisions of this section shall not apply to a high deductible health plan as defined in federal law if such plan is purchased in connection with a medical or health savings account pursuant to that federal law, regardless of the effective date of the insurance policy. After the amount of eligible deductible expenses have been paid by the insured, the outpatient costs of treatment of the insured for alcoholism, drug abuse and nervous or mental conditions shall be paid on the same level they are provided for a medical condition, subject to the yearly and lifetime maximums provided in subsection (a).

Laws 1977, ch. 161, § 1; Laws 1978, ch. 166, § 1; Laws 1986, ch. 299, § 8; Laws 1986, ch. 174, § 1; Laws 1996, ch. 170, § 1; Laws 1997, ch. 190, § 15; Laws 1998, ch. 174, § 1; Laws 2001, ch. 178, § 5; Laws 2004, ch. 128, § 2.

Kansas Mental Health Parity Act

Pursuant to the following statutes, insurance coverage is required to be provided for the treatment of certain mental illnesses on and after January 1, 2002.

40-2,105a. Kansas mental health parity act; insurance coverage for services rendered in the treatment of certain mental illnesses

(a)(1) Any 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. Except as provided in paragraph (2), such coverage shall be subject to the same deductibles, coinsurance and other limitations as apply to other covered services.

(2) The coverage required by paragraph (1) shall include annual coverage for both 45 days of in-patient care for mental illness and for 45 visits for out-patient care for mental illness.

(b) Notwithstanding the provisions of K.S.A. 40-2249a, and amendments thereto, the state insurance department shall deliver to the president of the senate and to the speaker of the house of representatives on or before January 1, 2003, a report indicating the impact of providing mental illness benefits required by this act. Such report shall include information regarding access to and

usage of such services and the cost of such services.

(c) For the purposes of this section, "mental illness" means the following: Schizophrenia, schizoaffective disorder, schizophreniform disorder, brief reactive psychosis, paranoid or delusional disorder, atypical psychosis, major affective disorders (bipolar and major depression), cyclothymic and dysthymic disorders, obsessive compulsive disorder, panic disorder, pervasive developmental disorder, including autism, attention deficit disorder and attention deficit hyperactive 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.

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

(e) 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.

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

(g) 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. 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.

(h) 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.

(I) There shall be no coverage under this section for evaluations and diagnostic tests ordered or requested in connection with criminal actions, divorce, child custody or child visitation proceedings.

Laws 2001, ch. 178, § 1.

40-2,105b. Same; insurance coverage for psychotherapeutic drugs used for treatment of mental illness

On and after January 1, 2002, any group health insurance policy, nonprofit medical and hospital service corporation contract, fraternal benefit society, health maintenance organization, municipal group funded pool and state employee benefit program which provides coverage for prescription drugs, other than prescription drugs administered in a hospital or physician's office shall provide coverage for psychotherapeutic drugs used for the treatment of mental illness under terms and conditions no less favorable than coverage provided for other prescription drugs.

Laws 2001, ch. 178, § 2.

40-2,105c. Same; exemption

The provisions of K.S.A. 40-2249a, and amendments thereto, shall not apply to this act.

Laws 2001, ch. 178, § 3.

40-2,105d. Citation of act

K.S.A. 40-2,105a, 40-2,105b and 40-2,105c, and amendments thereto, shall be known as the Kansas mental health parity act.

Laws 2001, ch. 178, § 7.

Off-label Use of Prescription Drugs

The following statutes provide that an insurance company, nonprofit health service corporation, nonprofit medical and hospital service corporation or HMO may exclude coverage of a prescription drug for cancer treatment on the grounds that the drug has not been approved by the Federal Food and Drug Administration for that covered indication.

40-2,167. Off-label use of prescription drugs; definitions

As used in K.S.A. 40-2,167 through 40-2,170, and amendments thereto, unless the context clearly indicates otherwise:

(a) "Peer-reviewed medical literature" means a published scientific study in a journal or other publication in which original manuscripts have been published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts, and that has been determined by the international committee of medical journal editors to have met the uniform requirements for manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

(b) "Off-label use of drugs" means prescribing prescription drugs for treatments other than those stated in the labeling approved by the federal food and drug administration.

(c) "Standard reference compendia" means the United States pharmacopeia drug information, the American hospital formulary service drug information or the American Medical Association drug evaluation.

Laws 1999, ch. 128, § 1.

40-2,168. Same; coverage for cancer treatment; exclusion from coverage prohibited

An insurance company, nonprofit health service corporation, nonprofit medical and hospital service corporation or health maintenance organization that provides coverage for prescription drugs may not issue, deliver, execute or renew any health insurance policy or health service contract on an individual, group, blanket, franchise or association basis which excludes coverage of a prescription drug for cancer treatment on the grounds the prescription drug has not been approved by the federal food and drug administration for that covered indication if the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature. The prescribing physician shall submit to the insurer documentation supporting the proposed off-label use or uses if requested by the insurer.
Laws 1999, ch. 128, § 2.

Mammograms and Pap Smears

Pursuant to the following statutes, whenever an accident and health policy providers reimbursement for lab or x-ray services, reimbursements shall not be denied for pap smears or mammogram; however, the same deductibles, coinsurance, and other limitations as applied to other covered services may apply to cover for pap smears and mammogram (coverage for mammograms performed in certified mobile units according to certain guidelines added in 1994).

40-2229. Mammogram and pap smears coverage; policies to which mandated coverage applicable

Except as otherwise provided, this act applies to any individual, group or blanket policy of accident and sickness, medical or surgical expense coverage and any provision of a policy, contract, plan or agreement for medical service including any contract of a health maintenance organization as defined by K.S.A. 40-3202, and amendments thereto, delivered, renewed or issued for delivery on or after the effective date of this act within or outside of this state or used within this state by or for an individual who resides or is employed in this state. The provisions of this act shall not apply to any medicare supplement policy of insurance, as defined by the commissioner of insurance by rule and regulation, any policy of long-term care insurance, as defined by K.S.A. 40-2227, and amendments thereto, any specified disease or specified accident coverage or any accident only coverage as defined by the commissioner of insurance by rule and regulation whether written on a group, blanket or individual basis.

Laws 1988, ch. 158, § 1.

40-2230. Same; when reimbursement or indemnification required; deductibles, coinsurance and other limitations permissible.

Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this act applies, whenever reimbursement or indemnity for laboratory or x-ray services are covered, reimbursement or indemnification shall not be denied for mammograms or pap smears when performed at the direction of a person licensed to practice medicine and surgery by the board of healing arts within the lawful scope of such person's license, including services performed at a mobile facility certified by the federal health care financing administration and performing mammography testing by American cancer society guidelines. A policy, provision, contract, plan or agreement may apply to mammograms or pap smears the same deductibles, coinsurance and other limitations as apply to other covered services.

Laws 1988, ch. 158, § 2; Laws 1994, ch. 141, § 1.

Prostate Cancer Screening

The following statute provides that any individual or group health plan which provides coverage for accident and health services, as well as any nonprofit medical and hospital service corporation, is required to cover at least a prostate specific antigen blood test and a digital rectal examination for all men over 50 and for men over 40 who are symptomatic or in a high risk category.

40-2,164. Coverage for prostate cancer screening

(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 accident and health services and which is delivered, issued for delivery, amended or renewed on or after July 1, 1998, also, shall provide coverage for prostate cancer screening for men 40 years of age or over who are symptomatic or in a high-risk category and for all men 50 years of age or older. The screening shall consist, at a minimum, of a prostate-specific antigen blood test and a digital rectal examination. A policy, provision, contract, plan or agreement may apply to prostate cancer screening the same deductibles, coinsurance and other limitations as apply to other covered services.

(b) 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, any policy of long-term care insurance, as defined by K.S.A. 40- 2227 and amendments thereto, any specified disease or specified accident coverage or any accident only coverage as defined by the commissioner of insurance by rule and regulation, whether written on a group, blanket or individual basis.

Laws 1998, ch. 174, § 30.

Diabetes Supplies and Education

Pursuant to the following statute, individual and group health insurance policies, medical service plans, contracts, nonprofit medical and hospital service corporations, and HMOs must provide coverage for equipment and supplies limited to hypodermic needles and other items used exclusively with diabetes management and for outpatient self-management training and education as ordered by a health care professional legally authorized to prescribe such services and the diabetic is treated at an approved program, by a certified person, or by a licensed dietitian (as to nutritional education).

40-2,163. Coverage for certain expenses relating to care and treatment of diabetes; educational expenses; exceptions

(a) This section shall be known and may be cited as the "diabetes coverage act."

(b) 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 accident and health services and which is delivered, issued for delivery, amended or renewed on or after January 1, 1999, also, shall provide coverage for equipment, and supplies, limited to hypodermic needles and supplies used exclusively with diabetes management and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin using diabetes if prescribed by a health care

professional legally authorized to prescribe such services and supplies under the law. Such coverage shall include coverage for insulin only if such coverage also includes coverage of prescription drugs.

(c) Diabetes outpatient self-management training and education shall be provided by a certified, registered or licensed health care professional with expertise in diabetes. The coverage for outpatient self-management training and education shall be required pursuant to this section only if ordered by a health care professional legally authorized to prescribe such services and the diabetic (1) is treated at a program approved by the American diabetes association; (2) is treated by a person certified by the national certification board for diabetes educators; or (3) is, as to nutritional education, treated by a licensed dietitian pursuant to a treatment plan authorized by such healthcare professional.

(d)(1) The benefits provided in this act shall be subject to the same annual deductible or co-insurance and the same requirement of medical necessity established for all other covered benefits within a given policy. In the case of a policy requiring that services be provided by or upon referral from a primary care physician, the benefits provided by this act shall be subject to such requirement.

(2) Private third party payors may not reduce or eliminate coverage due to the requirements of this act.

(3) Enforcement of the provisions of this act shall be performed by the commissioner of insurance.

(e) The provisions of this act shall not apply to any medicare supplement policy of insurance, as defined by the commissioner of insurance by rule and regulation, any policy of long-term care insurance, as defined by K.S.A. 40- 2227, and amendments thereto, any specified disease or specified accident coverage or any accident only coverage as defined by the commissioner of insurance by rule and regulation, whether written on a group, blanket, or individual basis.

Laws 1998, ch. 174, § 28.

Dental Care in a Medical Care Facility

The following statute provides that any individual or group health insurance policy, health plan or HMO which provides coverage for accident and health services is required to provide coverage for general anesthesia administered in a medical care facility for dental care to children five year of age and under, a

severely disabled person, or a person with medical or behavioral conditions that require hospitalization or general anesthesia for dental care.

40-2,165. Coverage of general anesthesia in conjunction with dental care for certain individuals

(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 accident and health services and which is delivered, issued for delivery, amended or renewed on or after July 1, 1999, also, shall provide coverage for the administration of general anesthesia and medical care facility charges for dental care provided to the following covered persons:

(1) A child five years of age and under; or

(2) a person who is severely disabled; or

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

(b) A policy, provision, contract, plan or agreement may:

(1) Apply to the covered procedures under this section the same deductibles, coinsurance, network requirements and other limitations, including but not limited to medical necessity determinations, as apply to other covered services;

(2) require prior authorization for hospitalization for the covered procedures under this section in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

(c) The provisions of this section shall not apply to any policy or certificate providing coverage for any specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care, as defined by K.S.A. 40-2227, and amendments thereto, medicare supplement, as defined by the commissioner of insurance by rules and regulations, vision care or other limited-benefit supplemental insurance, nor 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.

(d) Nothing herein shall be construed to require any individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, fraternal benefit society or health maintenance organization to provide benefits for any dental procedures.

(e) The provisions of this section shall apply to the state health care benefits program and municipal self-funded pools.

(f) As used in this section "medical care facility" shall have the meaning ascribed to the term in K.S.A. 65-425, and amendments thereto.

Laws 1999, ch. 162, § 1.

Reconstructive Breast Surgery

The following statute provides that any individual or group health insurance policy, health plan, or HMO which provides medical and surgical benefits with respect to mastectomy is required to cover reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction on the other breast to produce a symmetrical appearance, and prostheses and physical complications in all stages of the mastectomy.

40-2,166. Coverage of reconstructive breast surgery

(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 accident and health services and which is delivered, issued for delivery, amended or renewed on or after July 1, 1999, and which provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

(1) Reconstruction of the breast on which the mastectomy has been performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) prostheses and physical complications in all stages of mastectomy, including lymphedemas.

Such coverage shall be provided in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage.

(b) Each 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 accident and health services which provides medical and surgical benefits with respect to a mastectomy shall provide written notice, as currently required, to all enrollees, insureds or subscribers regarding the coverage required by this section.

(c) No 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 accident and health services which provides medical and surgical benefits with respect to a mastectomy shall:

(1) Deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section; and

(2) penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives (monetary or otherwise) to an attending provider, to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

(d) 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. 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.

Laws 1999, ch. 162, § 2.

Osteoporosis Diagnosis, Treatment, and Management

40-2,166a. Coverage for osteoporosis

(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, municipal group-funded pool and the state employee health care benefits plan which provides coverage for hospital, medical and surgical services, other than medicare supplement or accident-only policies which are delivered, issued for delivery, amended or renewed on or after July 1, 2001, shall include coverage for services related to diagnosis, treatment and management of osteoporosis when such services are provided by a person licensed to practice medicine and surgery in this state, for individuals with a condition or medical history for which bone mass measurement is medically necessary for such individual. Such policy, provision, contract, plan or agreement may apply to such services the same deductibles, coinsurance and other limitations as apply to other covered services.

(b) 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. 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.

Laws 2001, ch. 198, § 2.

Maternity Stay

Pursuant to the following statute, all individual and group health insurance policies, individual and group indemnity type contracts issued by profit or not-for-profit corporations, and all contracts issued by HMOs which provided coverage for maternity services are required to include benefits for child birth for at least 48 hours of inpatient care following a vaginal delivery and at least 96 hours of inpatient care following a caesarian delivery.

40-2,160. Coverage for minimum inpatient care following birth of child

(a) As used in this section:

(1) "Health plan" means any insurer or corporation which issues individual and group health insurance policies providing coverage on an expense-incurred basis, individual and group service or indemnity-type contracts issued by a profit or nonprofit corporation and all contracts issued by health maintenance organizations organized or authorized to transact business in this state;

(2) "attending physician" means the person licensed to practice medicine and surgery who is responsible for the care provided to the mother or newborn.

(b) Any health plan which provides coverage for maternity services, including benefits for childbirth, shall provide coverage for at least 48 hours of inpatient care following a vaginal delivery and at least 96 hours of inpatient care following delivery by caesarean section for a mother and newly born child in a medical care facility.

(c) Any decision to shorten the length of inpatient stay to less than that provided under subsection (b) shall be made by the attending physician. No health plan may terminate the service of, penalize or otherwise provide financial disincentives in response to any attending physician who orders care consistent with the provisions of this section.

(d) Notwithstanding the provisions of subsection (b), any health plan which provides coverage for postdelivery care provided to a mother and newly born child in the home, shall not be required to provide coverage of inpatient care under subsection (b), unless such inpatient care is determined to be medically necessary by the attending physician.

(e) All health plans shall provide written notice, as currently required, to all enrollees, insureds or subscribers regarding the coverage required by this section.

Laws 1996, ch. 96, § 1.

Consumer/Patient

The following statutes dictate additional requirements for Kansas health insurance policies, including uniform policy provisions and the Patient Protection Act.

KSA 40-2209. Group sickness and accident insurance; eligibility for coverage; open enrollment; late enrollment; special enrollment; preexisting conditions; exclusions; renewal or continuation of benefits, exceptions; factors for eligibility; participation requirements designed for groups through negotiations; provisions required in policies; disability income policies with benefits integrated with social security; continued coverage and converted policies, conditions required; excluding or restricting coverage because medicaid benefits available, prohibited; penalties

(a)(1) Group sickness and accident insurance is declared to be that form of sickness and accident insurance covering groups of persons, with or without one or more members of their families or one or more dependents. Except at the option of the employee or member and except employees or members enrolling in a group policy after the close of an open enrollment opportunity, no individual employee or member of an insured group and no individual dependent or family member may be excluded from eligibility or coverage under a policy providing hospital, medical or surgical expense benefits both with respect to policies issued or renewed within this state and with respect to policies issued or renewed outside this state covering persons residing in this state. For purposes of this section, an open enrollment opportunity shall be deemed to be a period no less favorable than a period beginning on the employee's or member's date of initial eligibility and ending 31 days thereafter.

(2) An eligible employee, member or dependent who requests enrollment following the open enrollment opportunity or any special enrollment period for dependents as specified in subsection (3) shall be considered a late enrollee. An accident and sickness insurer may exclude a late enrollee, except during an open enrollment period. However, an eligible employee, member or dependent shall not be considered a late enrollee if:

(A) The individual:

(I) Was covered under another group policy which provided hospital, medical or surgical expense benefits or was covered under section 607(1) of the employee retirement income security act of 1974 (ERISA) at the time the individual was eligible to enroll;

(ii) states in writing, at the time of the open enrollment period, that coverage under another group policy which provided hospital, medical or surgical expense benefits was the reason for declining enrollment, but only if the group policyholder or the accident and sickness insurer required such a written statement and provided the individual with notice of the requirement for a written statement and the consequences of such written statement;

(iii) has lost coverage under another group policy providing hospital, medical or surgical expense benefits or under section 607(1) of the employee retirement income security act of 1974 (ERISA) as a result of the termination of employment, reduction in the number of hours of employment, termination of employer contributions toward such coverage, the termination of the other policy's coverage, death of a spouse or divorce or legal separation or was under a COBRA continuation provision and the coverage under such provision was exhausted; and

(iv) requests enrollment within 30 days after the termination of coverage under the other policy; or

(B) a court has ordered coverage to be provided for a spouse or minor child under a covered employee's or member's policy.

(3)(A) If an accident and sickness insurer issues a group policy providing hospital, medical or surgical expenses and makes coverage available to a dependent of an eligible employee or member and such dependent becomes a dependent of the employee or member through marriage, birth, adoption or placement for adoption, then such group policy shall provide for a dependent special enrollment period as described in subsection (3)(B) of this section during which the dependent may be enrolled under the policy and in the case of the birth or adoption of a child, the spouse of an eligible employee or member may be enrolled if otherwise eligible for coverage.

(B) A dependent special enrollment period under this subsection shall be a period of not less than 30 days and shall begin on the later of (I) the date such dependent coverage is made available, or (ii) the date of the marriage, birth or adoption or placement for adoption.

(C) If an eligible employee or member seeks to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective: (I) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received; (ii) in the case of the birth of a dependent, as of the date of such birth; or (iii) in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(4)(A) No group policy providing hospital, medical or surgical expense benefits issued or renewed within this state or issued or renewed outside this state covering residents within this state shall limit or exclude benefits for specific conditions existing at or prior to the effective date of coverage thereunder. Such policy may impose a preexisting conditions exclusion, not to exceed 90 days following the date of enrollment for benefits for conditions whether mental or physical, regardless of the cause of the condition for which medical advice, diagnosis, care or treatment was recommended or received in the 90 days prior to the effective date of enrollment. Any preexisting conditions exclusion shall run concurrently with any waiting period.

(B) Such policy may impose a waiting period after full-time employment starts before an employee is first eligible to enroll in any applicable group policy.

(C) A health maintenance organization which offers such policy which does not impose any preexisting conditions exclusion may impose an affiliation period for such coverage, provided that: (I) such application period is applied uniformly without regard to any health status related factors and (ii) such affiliation period does not exceed two months. The affiliation period shall run concurrently with any waiting period under the plan.

(D) A health maintenance organization may use alternative methods from those described in this subsection to address adverse selection if approved by the commissioner.

(E) For the purposes of this section, the term "preexisting conditions exclusion" shall mean, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date.

(F) For the purposes of this section, the term "date of enrollment" means the date the individual is enrolled under the group policy or, if earlier, the first day of the waiting period for such enrollment.

(G) For the purposes of this section, the term "waiting period" means with respect to a group policy the period which must pass before the individual is eligible to be covered for benefits under the terms of the policy.

(5) Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to such information.

(6) A group policy providing hospital, medical or surgical expense benefits may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(7) A group policy providing hospital, medical or surgical expense benefits may not impose any preexisting condition waiting period in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of a 30-day period beginning on the date of the adoption or placement for adoption, is covered by a policy specified in subsection (a). This subsection shall not apply to coverage before the date of such adoption or placement for adoption.

(8) Such policy shall waive such a preexisting conditions exclusion to the extent the employee or member or individual dependent or family member was covered by (A) a group or individual sickness and accident policy, (B) coverage under section 607(1) of the employees retirement income security act of 1974 (ERISA), [FN1] (C) a group specified in K.S.A. 40-2222 and amendments thereto, (D) part A or part B of title XVIII of the social security act, [FN2] (E) title XIX of the social security act, [FN3] other than coverage consisting solely of benefits under section 1928, [FN4] (F) a state children's health insurance program established pursuant to title XXI of the social security act, [FN5] (G) chapter 55 of title 10 United States code, [FN6] (H) a medical care program of the Indian health service or of a tribal organization, (I) the Kansas uninsurable health plan act pursuant to K.S.A. 40-2217 et seq. and amendments thereto or a similar health benefits risk pool of another state, (J) a health plan offered under chapter 89 of title 5, United States code, (K) a health

benefit plan under section 5(e) of the peace corps act (22 U.S.C. 2504(e), or (L) a group subject to K.S.A. 12-2616 et seq. and amendments thereto which provided hospital, medical and surgical expense benefits within 63 days prior to the effective date of coverage with no gap in coverage. A group policy shall credit the periods of prior coverage specified in subsection (a)(7) without regard to the specific benefits covered during the period of prior coverage. Any period that the employee or member is in a waiting period for any coverage under a group health plan or is in an affiliation period shall not be taken into account in determining the continuous period under this subsection.

(b)(1) An accident and sickness insurer which offers group policies providing hospital, medical or surgical expense benefits shall provide a certification as described in subsection (b)(2): (A) At the time an eligible employee, member or dependent ceases to be covered under such policy or otherwise becomes covered under a COBRA continuation provision; (B) in the case of an eligible employee, member or dependent being covered under a COBRA continuation provision, at the time such eligible employee, member or dependent ceases to be covered under a COBRA continuation provision; and (C) on the request on behalf of such eligible employee, member or dependent made not later than 24 months after the date of the cessation of the coverage described in subsection (b)(1)(A) or (b)(1)(B), whichever is later.

(2) The certification described in this subsection is a written certification of (A) the period of coverage under a policy specified in subsection (a) and any coverage under such COBRA continuation provision, and (B) any waiting period imposed with respect to the eligible employee, member or dependent for any coverage under such policy.

(c) Any group policy may impose participation requirements, define full-time employees or members and otherwise be designed for the group as a whole through negotiations between the group sponsor and the insurer to the extent such design is not contrary to or inconsistent with this act.

(d)(1) An accident and sickness insurer offering a group policy providing hospital, medical or surgical expense benefits must renew or continue in force such coverage at the option of the policyholder or certificateholder except as provided in paragraph (2) below.

(2) An accident and sickness insurer may nonrenew or discontinue coverage under a group policy providing hospital, medical or surgical expense benefits based only on one or more of the following circumstances:

(A) If the policyholder or certificateholder has failed to pay any premium or contributions in accordance with the terms of the group policy providing hospital, medical or surgical expense benefits or the accident and sickness insurer has not received timely premium payments;

(B) if the policyholder or certificateholder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of such coverage;

(C) if the policyholder or certificateholder has failed to comply with a material plan provision relating to employer contribution or group participation rules;

(D) if the accident and sickness insurer is ceasing to offer coverage in such group market in accordance with subsections (d)(3) or (d)(4);

(E) in the case of accident and sickness insurer that offers coverage under a policy providing hospital, medical or surgical expense benefits through an enrollment area, there is no longer any eligible employee, member or dependent in connection with such policy who lives, resides or works in the medical service enrollment area of the accident and sickness insurer or in the area for which the accident and sickness insurer is authorized to do business; or

(F) in the case of a group policy providing hospital, medical or surgical expense benefits which is offered through an association or trust pursuant to subsections (f)(3) or (f)(5), the membership of the employer in such association or trust ceases but only if such coverage is terminated uniformly without regard to any health status related factor relating to any eligible employee, member or dependent.

(3) In any case in which an accident and sickness insurer which offers a group policy providing hospital, medical or surgical expense benefits decides to discontinue offering such type of group policy, such coverage may be discontinued only if:

(A) The accident and sickness insurer notifies all policyholders and certificateholders and all eligible employees or members of such discontinuation at least 90 days prior to the date of the discontinuation of such coverage;

(B) the accident and sickness insurer offers to each policyholder who is provided such group policy providing hospital, medical or surgical expense benefits which is being discontinued the option to purchase any other group policy providing hospital, medical or surgical expense benefits currently being offered by such accident and sickness insurer; and

(C) in exercising the option to discontinue coverage and in offering the option of coverage under subparagraph (B), the accident and sickness insurer acts uniformly without regard to the claims experience of those policyholders or certificateholders or any health status related factors relating to any eligible employee, member or dependent covered by such group policy or new employees or members who may become eligible for such coverage.

(4) If the accident and sickness insurer elects to discontinue offering group policies providing hospital, medical or surgical expense benefits or group coverage to a small employer pursuant to K.S.A. 40-2209f and amendments thereto, such coverage may be discontinued only if:

(A) The accident and sickness insurer provides notice to the insurance commissioner, to all policyholders or certificateholders and to all eligible employees and members covered by such group policy providing hospital, medical or surgical expense benefits at least 180 days prior to the date of the discontinuation of such coverage;

(B) all group policies providing hospital, medical or surgical expense benefits offered by such accident and sickness insurer are discontinued and coverage under such policies are not renewed; and

(C) the accident and sickness insurer may not provide for the issuance of any group policies providing hospital, medical or surgical expense benefits in the discontinued market during a five year period beginning on the date of the discontinuation of the last such group policy which is nonrenewed.

(e) An accident and sickness insurer offering a group policy providing hospital, medical or surgical expense benefits may not establish rules for eligibility (including continued eligibility) of any employee, member or dependent to enroll under the terms of the group policy based on any of the following factors in relation to the eligible employee, member or dependent: (A) Health status, (B) medical condition, including both physical and mental illness, (C) claims experience, (D) receipt of health care, (E) medical history, (F) genetic information, (G) evidence of insurability, including conditions arising out of acts of domestic violence, or (H) disability. This subsection shall not be construed to require a policy providing hospital, medical or surgical expense benefits to provide particular benefits other than those provided under the terms of such group policy or to prevent a group policy providing hospital, medical or surgical expense benefits from establishing limitations or restrictions on the amount, level, extent or nature of the benefits or coverage for similarly situated individuals enrolled under the group policy.

(f) Group accident and health insurance may be offered to a group under the following basis:

(1) Under a policy issued to an employer or trustees of a fund established by an employer, who is the policyholder, insuring at least two employees of such employer, for the benefit of persons other than the employer. The term "employees" shall include the officers, managers, employees and retired employees of the employer, the partners, if the employer is a partnership, the proprietor, if the employer is an individual proprietorship, the officers, managers and employees and retired employees of subsidiary or affiliated corporations of a corporation employer, and the individual proprietors, partners, employees and retired employees of individuals and firms, the business of which and of the insured employer is under common control through stock ownership contract, or otherwise. The policy may provide that the term "employees" may include the trustees or their employees, or both, if their duties are principally connected with such trusteeship. A policy issued to insure the employees of a public body may provide that the term "employees" shall include elected or appointed officials.

(2) Under a policy issued to a labor union which shall have a constitution and bylaws insuring at least 25 members of such union.

(3) Under a policy issued to the trustees of a fund established by two or more employers or business associations or by one or more labor unions or by one or more employers and one or more labor unions, which trustees shall be the policyholder, to insure employees of the employers or members of the union or members of the association for the benefit of persons other than the employers or the unions or the associations. The term "employees" shall include the officers, managers, employees and retired employees of the employer and the individual proprietor or partners if the employer is an individual proprietor or partnership. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship.

(4) A policy issued to a creditor, who shall be deemed the policyholder, to insure debtors of the creditor, subject to the following requirements: (a) The debtors eligible for insurance under the policy shall be all of the debtors of the creditor whose indebtedness is repayable in installments, or all of any class or classes determined by conditions pertaining to the indebtedness or to the purchase giving rise to the indebtedness. (b) The premium for the policy shall be paid by the policyholder, either from the creditor's funds or from charges collected from the insured debtors, or from both.

(5) A policy issued to an association which has been organized and is maintained for the purposes other than that of obtaining insurance, insuring at least 25 members, employees, or employees of members of the association for the benefit of persons other than the association or its officers. The term "employees" shall include retired employees. The premiums for the policies shall be paid by the policyholder, either wholly from association funds, or funds contributed by the members of such association or by employees of such members or any combination thereof.

(6) Under a policy issued to any other type of group which the commissioner of insurance may find is properly subject to the issuance of a group sickness and accident policy or contract.

(g) Each such policy shall contain in substance: (1) A provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties, and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or the insured's beneficiary.

(2) A provision setting forth the conditions under which an individual's coverage terminates under the policy, including the age, if any, to which an individual's coverage under the policy shall be limited, or, the age, if any, at which any additional limitations or restrictions are placed upon an individual's coverage under the policy.

(3) Provisions setting forth the notice of claim, proofs of loss and claim forms, physical examination and autopsy, time of payment of claims, to whom benefits are payable, payment of claims, change of beneficiary, and legal action requirements. Such provisions shall not be less favorable to the individual insured or the insured's beneficiary than those corresponding policy provisions required to be contained in individual accident and sickness policies.

(4) A provision that the insurer will furnish to the policyholder, for the delivery to each employee or member of the insured group, an individual certificate approved by the commissioner of insurance setting forth in summary form a statement of the essential features of the insurance coverage of such employee or member, the procedure to be followed in making claim under the policy and to whom benefits are payable. Such certificate shall also contain a summary of those provisions required under paragraphs (2) and (3) of this subsection (g) in addition to the other essential features of the insurance coverage. If dependents are included in the coverage, only one certificate need be issued for each family unit.

(h) No group disability income policy which integrates benefits with social security benefits, shall provide that the amount of any disability benefit actually being paid to the disabled person shall be reduced by changes

in the level of social security benefits resulting either from changes in the social security law or due to cost of living adjustments which become effective after the first day for which disability benefits become payable.

(i) A group policy of insurance delivered or issued for delivery or renewed which provides hospital, surgical or major medical expense insurance, or any combination of these coverages, on an expense incurred basis, shall provide that an employee or member or such employee's or member's covered dependents whose insurance under the group policy has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy or under any group policy providing similar benefits which it replaces for at least three months immediately prior to termination, shall be entitled to have such coverage nonetheless continued under the group policy for a period of 18 months and have issued to the employee or member or such employee's or member's covered dependents by the insurer, at the end of such eighteen-month period of continuation, a policy of health insurance which conforms to the applicable requirements specified in this subsection. This requirement shall not apply to a group policy which provides benefits for specific diseases or for accidental injuries only or a group policy issued to an employer subject to the continuation and conversion obligations set forth at title I, subtitle B, part 6 of the employee retirement income security act of 1974 or at title XXII of the public health service act, as each act was in effect on January 1, 1987 to the extent federal law provides the employee or member or such employee's or member's covered dependents with equal or greater continuation or conversion rights; or an employee or member or such employee's or member's covered dependents shall not be entitled to have such coverage continued or a converted policy issued to the employee or member or such employee's or member's covered dependents if termination of the insurance under the group policy occurred because:

(1) The employee or member or such employee's or member's covered dependents failed to pay any required contribution after receiving reasonable notice of such required contribution from the insurer in accordance with rules and regulations adopted by the commissioner of insurance; (2) any discontinued group coverage was replaced by similar group coverage within 31 days; (3) the employee or member is or could be covered by medicare (title XVIII of the United States social security act as added by the social security amendments of 1965 or as later amended or superseded); (4) the employee or member is or could be covered to the same extent by any other insured or lawful self-insured arrangement which provides expense incurred hospital, surgical or medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination; or (5) coverage for the employee or member, or any covered dependent thereof, was terminated for cause as permitted by the group policy or certificate of coverage approved by the commissioner. In the event the group policy is terminated and not replaced the insurer may issue an individual policy or certificate in lieu of a conversion policy or the continuation of group coverage required herein if the individual policy or certificate provides substantially similar coverage for the same or less premium as the group policy. In any event, the employee or member shall have the option to be issued a conversion policy which meets the requirements set forth in this subsection in lieu of the right to continue group coverage.

(j) The continued coverage and the issuance of a converted policy shall be subject to the following conditions:

(1) Written application for the converted policy shall be made and the first premium paid to the insurer not later than 31 days after termination of coverage under the group policy or not later than 31 days after notice is received pursuant to paragraph 20 of this subsection.

(2) The converted policy shall be issued without evidence of insurability.

(3) The employer shall give the employee and such employee's covered dependents reasonable notice of the right to continuation of coverage. The terminated employee or member shall pay to the employer the premium for the eighteen-month continuation of coverage and such premium shall be the same as that applicable to members or employees remaining in the group. Failure to pay such premium shall terminate coverage under the group policy at the end of the period for which the premium has been paid. The premium rate charged for converted policies issued subsequent to the period of continued coverage shall be such that can be expected to produce an anticipated loss ratio of not less than 80% based upon conversion, morbidity and reasonable assumptions for expected trends in medical care costs. In the event the group policy is terminated and is not replaced, converted policies may be issued at self-sustaining rates that are not unreasonable in relation to the coverage provided based on conversion, morbidity and reasonable assumptions for expected trends in medical care costs. The frequency of premium payment shall be the frequency customarily required by the insurer for the policy form and plan selected, provided that the insurer shall not require premium payments less frequently than quarterly.

(4) The effective date of the converted policy shall be the day following the termination of insurance under the group policy.

(5) The converted policy shall cover the employee or member and the employee's or member's dependents who were covered by the group policy on the date of termination of insurance. At the option of the insurer, a separate converted policy may be issued to cover any dependent.

(6) The insurer shall not be required to issue a converted policy covering any person if such person is or could be covered by medicare (title XVIII of the United States social security act as added by the social security amendments of 1965 or as later amended or superseded). Furthermore, the insurer shall not be required to issue a converted policy covering any person if:

(A)(I) Such person is covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program, or

(ii) such person is eligible for similar benefits (whether or not covered therefor) under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis, or

(iii) similar benefits are provided for or available to such person, pursuant to or in accordance with the requirements of any state or federal law, and

(B) the benefits provided under the sources referred to in clause (A)(I) above for such person or benefits provided or available under the sources referred to in clauses (A)(ii) and (A)(iii) above for such person, together with the benefits provided by the converted policy, would result in over-insurance according to the insurer's standards. The insurer's standards must bear some reasonable relationship to actual health care costs in the area in which the insured lives at the time of conversion and must be filed with the

commissioner of insurance prior to their use in denying coverage.

(7) A converted policy may include a provision whereby the insurer may request information in advance of any premium due date of such policy of any person covered as to whether:

(A) Such person is covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program;

(B) such person is covered for similar benefits under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or

(C) similar benefits are provided for or available to such person, pursuant to or in accordance with the requirements of any state or federal law.

(8) The converted policy may provide that the insurer may refuse to renew the policy and the coverage of any person insured for the following reasons only:

(A) Either the benefits provided under the sources referred to in clauses (A)(i) and (A)(ii) of paragraph 6 for such person or benefits provided or available under the sources referred to in clause (A)(iii) of paragraph 6 for such person, together with the benefits provided by the converted policy, would result in over-insurance according to the insurer's standards on file with the commissioner of insurance, or the converted policyholder fails to provide the requested information;

(B) fraud or material misrepresentation in applying for any benefits under the converted policy; or

(C) other reasons approved by the commissioner of insurance.

(9) An insurer shall not be required to issue a converted policy which provides coverage and benefits in excess of those provided under the group policy from which conversion is made.

(10) If the converted policy provides that any hospital, surgical or medical benefits payable may be reduced by the amount of any such benefits payable under the group policy after the termination of the individual's insurance or the converted policy includes provisions so that during the first policy year the benefits payable under the converted policy, together with the benefits payable under the group policy, shall not exceed those that would have been payable had the individual's insurance under the group policy remained in force and effect, the converted policy shall provide credit for deductibles, copayments and other conditions satisfied under the group policy.

(11) Subject to the provisions and conditions of this act, if the group insurance policy from which conversion

is made insures the employee or member for major medical expense insurance, the employee or member shall be entitled to obtain a converted policy providing catastrophic or major medical coverage under a plan meeting the following requirements:

(A) A maximum benefit at least equal to either, at the option of the insurer, paragraphs (i) or (ii) below:

(i) The smaller of the following amounts:

The maximum benefit provided under the group policy or a maximum payment of $250,000 per covered person for all covered medical expenses incurred during the covered person's lifetime.

(ii) The smaller of the following amounts:

The maximum benefit provided under the group policy or a maximum payment of $250,000 for each unrelated injury or sickness.

(B) Payment of benefits at the rate of 80% of covered medical expenses which are in excess of the deductible, until 20% of such expenses in a benefit period reaches $1,000, after which benefits will be paid at the rate of 100% during the remainder of such benefit period. Payment of benefits for outpatient treatment of mental illness, if provided in the converted policy, may be at a lesser rate but not less than 50%.

(C) A deductible for each benefit period which, at the option of the insurer, shall be (I) the sum of the benefits deductible and $100, or (ii) the corresponding deductible in the group policy. The term "benefits deductible," as used herein, means the value of any benefits provided on an expense incurred basis which are provided with respect to covered medical expenses by any other hospital, surgical, or medical insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan, or any other plan or program whether on an insured or uninsured basis, or in accordance with the requirements of any state or federal law and, if pursuant to the conditions of paragraph (13), the converted policy provides both basic hospital or surgical coverage and major medical coverage, the value of such basic benefits.

If the maximum benefit is determined by clause (A)(ii) of this paragraph, the insurer may require that the deductible be satisfied during a period of not less than three months if the deductible is $100 or less, and not less than six months if the deductible exceeds $100.

(D) The benefit period shall be each calendar year when the maximum benefit is determined by clause (A)(I) of this paragraph or 24 months when the maximum benefit is determined by clause (A)(ii) of this paragraph.

(E) The term "covered medical expenses," as used above, shall include at least, in the case of hospital

room and board charges 80% of the average semiprivate room and board rate for the hospital in which the individual is confined and twice such amount for charges in an intensive care unit. Any surgical schedule shall be consistent with those customarily offered by the insurer under group or individual health insurance policies and must provide at least a $1,200 maximum benefit.

(12) The conversion privilege required by this act shall, if the group insurance policy insures the employee or member for basic hospital or surgical expense insurance as well as major medical expense insurance, make available the plans of benefits set forth in paragraph 11. At the option of the insurer, such plans of benefits may be provided under one policy.

The insurer may also, in lieu of the plans of benefits set forth in paragraph (11), provide a policy of comprehensive medical expense benefits without first dollar coverage. The policy shall conform to the requirements of paragraph (11). An insurer electing to provide such a policy shall make available a low deductible option, not to exceed $100, a high deductible option between $500 and $1,000, and a third deductible option midway between the high and low deductible options.

(13) The insurer, at its option, may also offer alternative plans for group health conversion in addition to those required by this act.

(14) In the event coverage would be continued under the group policy on an employee following the employee's retirement prior to the time the employee is or could be covered by medicare, the employee may elect, in lieu of such continuation of group insurance, to have the same conversion rights as would apply had such person's insurance terminated at retirement by reason of termination of employment or membership.

(15) The converted policy may provide for reduction of coverage on any person upon such person's eligibility for coverage under medicare (title XVIII of the United States social security act as added by the social security amendments of 1965 or as later amended or superseded) or under any other state or federal law providing for benefits similar to those provided by the converted policy.

(16) Subject to the conditions set forth above, the continuation and conversion privileges shall also be available:

(A) To the surviving spouse, if any, at the death of the employee or member, with respect to the spouse and such children whose coverage under the group policy terminates by reason of such death, otherwise to each surviving child whose coverage under the group policy terminates by reason of such death, or, if the group policy provides for continuation of dependents' coverage following the employee's or member's death, at the end of such continuation;

(B) to the spouse of the employee or member upon termination of coverage of the spouse, while the employee or member remains insured under the group policy, by reason of ceasing to be a qualified family member under the group policy, with respect to the spouse and such children whose coverage under the group policy terminates at the same time; or

(C) to a child solely with respect to such child upon termination of such coverage by reason of ceasing to be a qualified family member under the group policy, if a conversion privilege is not otherwise provided above with respect to such termination.

(17) The insurer may elect to provide group insurance coverage which complies with this act in lieu of the issuance of a converted individual policy.

(18) A notification of the conversion privilege shall be included in each certificate of coverage.

(19) A converted policy which is delivered outside this state must be on a form which could be delivered in such other jurisdiction as a converted policy had the group policy been issued in that jurisdiction.

(20) The insurer shall give the employee or member and such employee's or member's covered dependents: (A) Reasonable notice of the right to convert at least once during the eighteen-month continuation period; or (B) for persons covered under 29 U.S.C. 1161 et seq., notice of the right to a conversion policy required by this subsection (d) shall be given at least 30 days prior to the end of the continuation period provided by 29 U.S.C. 1161 et seq. or from the date the employer ceases to provide any similar group health plan to any employee. Such notices shall be provided in accordance with rules and regulations adopted by the commissioner of insurance.

(k)(1) No policy issued by an insurer to which this section applies shall contain a provision which excludes, limits or otherwise restricts coverage because medicaid benefits as permitted by title XIX of the social security act of 1965 are or may be available for the same accident or illness.

(2) Violation of this subsection shall be subject to the penalties prescribed by K.S.A. 40-2407 and 40-2411, and amendments thereto.

(l) The commissioner is hereby authorized to adopt such rules and regulations as may be necessary to carry out the provisions of this section.
Laws 1951, ch. 296, § 9; Laws 1965, ch. 306, § 1; Laws 1967, ch. 273, § 1; Laws 1977, ch. 162, § 1; Laws 1978, ch. 181, § 1; Laws 1980, ch. 138, § 1; Laws 1981, ch. 195, § 1; Laws 1984, ch. 172, § 4; Laws 1987, ch. 169, § 2; Laws 1988, ch. 160, § 1; Laws 1991, ch. 134, § 1; Laws 1992, ch. 196, § 2; Laws 1993, ch. 132, § 7; Laws 1994, ch. 81, § 1; Laws 1994, ch. 355, § 3; Laws 1996, ch. 182, § 6; Laws 1997, ch. 190, § 1; Laws 1998, ch. 174, § 5; Laws 1999, ch. 15, § 1; Laws 2004, ch. 159, § 11; Laws 2008, ch. 164, § 5, eff. July 1, 2008.

KSA 40-3209. Certificates of coverage, contracts and other marketing documents, contents, form, filing; continuation and conversion requirements; enrollee not liable to provider for amount owed; application of 40-2209 and 40-2215

(a) All forms of group and individual certificates of coverage and contracts issued by the organization to enrollees or other marketing documents purporting to describe the organization's health care services shall contain as a minimum:

(1) A complete description of the health care services and other benefits to which the enrollee is entitled;

(2) The locations of all facilities, the hours of operation and the services which are provided in each facility in the case of individual practice associations or medical staff and group practices, and, in all other cases, a list of providers by specialty with a list of addresses and telephone numbers;

(3) the financial responsibilities of the enrollee and the amount of any deductible, copayment or coinsurance required;

(4) all exclusions and limitations on services or any other benefits to be provided including any deductible or copayment feature and all restrictions relating to pre-existing conditions;

(5) all criteria by which an enrollee may be disenrolled or denied reenrollment;

(6) service priorities in case of epidemic, or other emergency conditions affecting demand for medical services;

(7) in the case of a health maintenance organization, a provision that an enrollee or a covered dependent of an enrollee whose coverage under a health maintenance organization group contract has been terminated for any reason but who remains in the service area and who has been continuously covered by the health maintenance organization or under any group policy providing similar benefits which it replaces for at least three months immediately prior to termination shall be entitled to obtain a converted contract or have such coverage continued under the group contract for a period of 18 months following which such enrollee or dependent shall be entitled to obtain a converted contract in accordance with the provisions of this section. The employer shall give the employee and such employee's dependents reasonable notice of the right to continuation of coverage. The terminated employee shall pay the employer the premium for the continuation of coverage and such premium shall be the same as that applicable to members or employees remaining in the group. The converted contract shall provide coverage at least equal to the conversion coverage options generally available from insurers or mutual nonprofit hospital and medical service corporations in the service area at the applicable premium cost. The group enrollee or enrollees shall be solely responsible for paying the premiums for the alternative coverage. The frequency of premium payment shall be the frequency customarily required by the health maintenance organization, mutual nonprofit hospital and medical service corporation or insurer for the policy form and plan selected, except that the insurer, mutual nonprofit hospital and medical service corporation or health maintenance organization shall require premium payments at least quarterly. The coverage shall be available to all enrollees of any group without medical underwriting. The requirement imposed by this subsection shall not apply to a contract which provides benefits for specific diseases or for accidental injuries only, nor shall it apply to any employee or member or such employee's or member's covered dependents when:

(A) Such person was terminated for cause as permitted by the group contract approved by the commissioner;

(B) any discontinued group coverage was replaced by similar group coverage within 31 days; or

(C) the employee or member is or could be covered by any other insured or noninsured arrangement which provides expense incurred hospital, surgical or medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination. Written application for the converted contract shall be made and the first premium paid not later than 31 days after termination of the group coverage or receipt of notice of conversion rights from the health maintenance organization, whichever is later, and shall become effective the day following the termination of coverage under the group contract. The health maintenance organization shall give the employee or member and such employee's or member's covered dependents reasonable notice of the right to convert at least once within 30 days of termination of coverage under the group contract. The group contract and certificates may include provisions necessary to identify or obtain identification of persons and notification of events that would activate the notice requirements and conversion rights created by this section but such requirements and rights shall not be invalidated by failure of persons other than the employee or member entitled to conversion to comply with any such provisions. In addition, the converted contract shall be subject to the provisions contained in paragraphs (2), (4), (5), (6), (7), (8), (9), (13), (14), (15), (16), (17) and (19) of subsection (j) of K.S.A. 40-2209, and amendments thereto;

(8)(A) group contracts shall contain a provision extending payment of such benefits until discharged or for a period not less than 31 days following the expiration date of the contract, whichever is earlier, for covered enrollees and dependents confined in a hospital on the date of termination;

(B) a provision that coverage under any subsequent replacement contract that is intended to afford continuous coverage will commence immediately following expiration of any prior contract with respect to covered services not provided pursuant to subparagraph (8)(A); and

(9) an individual contract shall provide for a 10-day period for the enrollee to examine and return the contract and have the premium refunded, but if services were received by the enrollee during the 10-day period, and the enrollee returns the contract to receive a refund of the premium paid, the enrollee must pay for such services.

(b) No health maintenance organization or medicare provider organization authorized under this act shall contract with any provider under provisions which require enrollees to guarantee payment, other than copayments and deductibles, to such provider in the event of nonpayment by the health maintenance organization or medicare provider organization for any services which have been performed under contracts between such enrollees and the health maintenance organization or medicare provider organization. Further, any contract between a health maintenance organization or medicare provider organization and a provider shall provide that if the health maintenance organization or medicare provider organization fails to pay for covered health care services as set forth in the contract between the health maintenance organization or medicare provider organization and its enrollee, the enrollee or covered dependents shall not be liable to any provider for any amounts owed by the health maintenance organization or medicare provider organization. If there is no written contract between the health maintenance organization or medicare provider organization

and the provider or if the written contract fails to include the above provision, the enrollee and dependents are not liable to any provider for any amounts owed by the health maintenance organization or medicare provider organization. Any action by a provider to collect or attempt to collect from a subscriber or enrollee any sum owed by the health maintenance organization to a provider shall be deemed to be an unconscionable act within the meaning of K. S.A. 50-627 and amendments thereto.

(c) No group or individual certificate of coverage or contract form or amendment to an approved certificate of coverage or contract form shall be issued unless it is filed with the commissioner. Such contract form or amendment shall become effective within 30 days of such filing unless the commissioner finds that such contract form or amendment does not comply with the requirements of this section.

(d) Every contract shall include a clear and understandable description of the health maintenance organization's or medicare provider organization's method for resolving enrollee grievances.

(e) The provisions of subsections (A), (B), (C), (D) and (E) of K.S.A. 40- 2209 and 40-2215 and amendments thereto shall apply to all contracts issued under this section, and the provisions of such sections shall apply to health maintenance organizations.

(f) In lieu of any of the requirements of subsection (a), the commissioner may accept certificates of coverage issued by a medicare provider organization in conformity with requirements imposed by any appropriate federal regulatory agency.

Laws 1974, ch. 181, § 9; Laws 1988, ch. 163, § 1; Laws 1990, ch. 172, § 1; Laws 1991, ch. 137, § 1; Laws 1991, ch. 134, § 10; Laws 1992, ch. 196, § 3; Laws 1993, ch. 231, § 3; Laws 1996, ch. 169, § 9; Laws 1997, ch. 190, § 4; Laws 1998, ch. 174, § 18; Laws 2000, ch. 147, § 38; Laws 2006, ch. 124, § 9; Laws 2008, ch. 164, § 7, eff. July 1, 2008.

KSA 40-2254. Group accident and sickness insurance; extension of payment of benefits

Every issuer of a group policy and certificate of accident and sickness insurance providing inpatient hospital, medical-surgical benefits issued or renewed within this state or issued or renewed outside this state covering residents within this state shall:

(a) Include in its contracts a provision extending payment of such benefits until discharged or for a period not less than 31 days following the expiration date of the policy, whichever is earlier, for covered insureds confined in a hospital on the date of termination;

(b) not fail to enroll in a replacement group policy, contract or certificate without any gap in coverage any individual who is confined to a hospital or otherwise disabled at the time such individual's prior group policy, contract or certificate terminates;

(c) provide that payment of benefits under any subsequent replacement policy, contract or certificate that is intended to afford continuous coverage will commence immediately following expiration of any prior policy, contract or certificate.

Laws 1993, ch. 231, § 1; Laws 2001, ch. 40, § 1.

KSA 40-2258. Group policies; aggregate lifetime limit; exceptions; definitions

(a) An accident and sickness insurer which offers coverage through a group policy providing hospital, medical or surgical expense benefits pursuant to K.S.A. 40-2209 and amendments thereto which includes mental health benefits shall be subject to the following requirements:

(1) If the policy does not include an aggregate lifetime limit on substantially all hospital, medical and surgical expense benefits, the policy may not impose any aggregate lifetime limit on mental health benefits;

(2) if the policy includes an aggregate lifetime limit on substantially all hospital, medical and surgical expense benefits the plan shall either: (A) Apply the applicable lifetime limit both to the hospital, medical and surgical expense benefits to which it otherwise would apply and to mental health benefits and not distinguished in the application of such limit between such hospital, medical and surgical expense benefits and mental health benefits; or (B) not include any aggregate lifetime limit on mental health benefits that is less than the applicable lifetime limit on hospital, medical and surgical expense benefits;

(3) if the policy does not include an annual limit on substantially all hospital, medical and surgical expense benefits, the plan or coverage may not impose any annual limit on mental health benefits; and

(4) if the policy includes an annual limit on substantially all hospital, medical and surgical expense benefits the policy shall either: (A) Apply the applicable annual limit both to hospital, medical and surgical expense benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such hospital, medical and surgical expense benefits and mental health benefits; or (B) not include any annual limit on mental health benefits that is less than the applicable annual limit.

(b) If the group policy providing hospital, medical or surgical expense benefits is not otherwise covered by subsection (a) and either does not apply a lifetime or annual benefit or applies different lifetime or annual benefits to different categories of hospital, medical and surgical expense benefits, the commissioner may adopt rules and regulations under which subsections (a)(2) and (a)(4) are applied to such policies with respect to mental health benefits by substituting for the applicable lifetime or annual limits an average limit that is computed taking into account the weighted average of the lifetime or annual limits applicable to such categories.

(c) Nothing in this section shall be construed as either:

(1) Requiring an accident and sickness policy to offer mental health benefits except as otherwise required by K.S.A. 40-2,105 and amendments thereto; or

(2) affecting any terms and conditions of a policy which does include mental health benefits including provisions regarding cost sharing, limits on the number of visits or days of coverage, requirements relating to medical necessity, requirements relating to the amount, duration or scope of mental health benefits under the plan or coverage, except as specifically provided in subsection (a).

(d) This section shall not apply to any group accident and health insurance policy which is sold to a small employer as defined in K.S.A. 40-2209 and amendments thereto.

(e) This section shall not apply with respect to a group policy providing hospital, medical or surgical expense benefits if the application of this section will result in an increase in the cost under the plan of at least 1%.

(f) In the case of a group policy providing hospital, medical or surgical expense benefits that offers an eligible employee, member or dependent two or more benefit package options under the policy, subsections (a) and (b) shall be applied separately with respect to each such option.

(g) As used in this section:

(1) "Aggregate lifetime limit" means, with respect to benefits under a group policy providing hospital, medical or surgical expense benefits, a dollar limitation on the total amount that may be paid with respect to such benefits under the policy with respect to an eligible employee, member or dependent;

(2) "annual limit" means, with respect to benefits under a group policy providing hospital, medical or surgical expense benefits, a dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the policy with respect to an eligible employee, member or dependent;

(3) "hospital, medical or surgical expense benefits" means benefits with respect to hospital, medical or surgical services, as defined under the terms of the policy, but does not include mental health benefits;

(4) "mental health benefits" means benefits with respect to mental health services, as defined under the terms of the policy, but does not include benefits with respect to treatment of substance abuse or chemical dependency.

(h) This section shall be effective for group policies providing hospital, medical or surgical expense benefits which are entered into or renewed after January 1, 1998. This section shall not apply to benefits for services furnished on or after December 31, 2008.

(I) The commissioner is hereby authorized to adopt such rules and regulations as may be necessary to carry

out the provisions of this section.

Laws 1997, ch. 190, § 13; Laws 2002, ch. 158, § 19; Laws 2003, ch. 88, § 1; Laws 2004, ch. 157, § 1; Laws 2005, ch. 163, § 11; Laws 2006, ch. 123, § 1; Laws 2007, ch. 25, § 1, eff. July 1, 2007; Laws 2008, ch. 13, § 1, eff. July 1, 2008.

KSA 40-2259. Genetic screening or testing; prohibiting the use of; exceptions

(a) As used in this section, "genetic screening or testing" means a laboratory test of a person's genes or chromosomes for abnormalities, defects or deficiencies, including carrier status, that are linked to physical or mental disorders or impairments, or that indicate a susceptibility to illness, disease or other disorders, whether physical or mental, which test is a direct test for abnormalities, defects or deficiencies, and not an indirect manifestation of genetic disorders.

(b) An insurance company, health maintenance organization, nonprofit medical and hospital, dental, optometric or pharmacy corporations, or a group subject to K.S.A. 12-2616 et seq., and amendments thereto, shall not:

(1) Require or request directly or indirectly any individual or a member of the individual's family to obtain a genetic test;

(2) require or request directly or indirectly any individual to reveal whether the individual or a member of the individual's family has obtained a genetic test or the results of the test, if obtained by the individual or a member of the individual's family;

(3) condition the provision of insurance coverage or health care benefits on whether an individual or a member of the individual's family has obtained a genetic test or the results of the test, if obtained by the individual or a member of the individual's family; or

(4) consider in the determination of rates or any other aspect of insurance coverage or health care benefits provided to an individual whether an individual or a member of the individual's family has obtained a genetic test or the results of the test, if obtained by the individual or a member of the individual's family.

(c) Subsection (b) does not apply to an insurer writing life insurance, disability income insurance or long-term care insurance coverage.

(d) An insurer writing life insurance, disability income insurance or long-term care insurance coverage that obtains information under paragraphs (1) or (2) of subsection (b), shall not:

(1) Use the information contrary to paragraphs (3) or (4) of subsection (b) in writing a type of insurance

coverage other than life for the individual or a member of the individual's family; or

(2) provide for rates or any other aspect of coverage that is not reasonably related to the risk involved.

Laws 1997, ch. 190, § 14.

KSA 40-4602. Same; definitions

As used in this act:

(a) "Emergency medical condition" means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

(b) "Emergency services" means ambulance services and health care items and services furnished or required to evaluate and treat an emergency medical condition, as directed or ordered by a physician.

(c) "Health benefit plan" means any hospital or medical expense policy, health, hospital or medical service corporation contract, a plan provided by a municipal group-funded pool, a policy or agreement entered into by a health insurer or a health maintenance organization contract offered by an employer or any certificate issued under any such policies, contracts or plans. "Health benefit plan" does not include policies or certificates covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, specified disease, vision care, coverage issued as a supplement to liability insurance, insurance arising out of a workers compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(d) "Health insurer" means any insurance company, nonprofit medical and hospital service corporation, municipal group-funded pool, fraternal benefit society, health maintenance organization, or any other entity which offers a health benefit plan subject to the Kansas Statutes Annotated.

(e) "Insured" means a person who is covered by a health benefit plan.

(f) "Participating provider" means a provider who, under a contract with the health insurer or with its contractor or subcontractor, has agreed to provide one or more health care services to insureds with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health insurer.

(g) "Provider" means a physician, hospital or other person which is licensed, accredited or certified to

perform specified health care services.

(h) "Provider network" means those participating providers who have entered into a contract or agreement with a health insurer to provide items or health care services to individuals covered by a health benefit plan offered by such health insurer.

(I) "Physician" means a person licensed by the state board of healing arts to practice medicine and surgery.

Laws 1997, ch. 190, § 17.

KSA 40-4603. Same; emergency services, prohibitions on health care plan; prior authorization after condition stabilized; post evaluation or post stabilization services

(a) A health benefit plan shall not deny coverage for emergency services if the symptoms presented by an insured and recorded by the attending provider indicate that an emergency medical condition exists, or for emergency services necessary to provide an insured with a medical examination and stabilizing treatment, regardless of whether prior authorization was obtained to provide those services.

(b) If a participating provider or other authorized representative of a health insurer authorizes emergency services, the health insurer shall not subsequently rescind or modify that authorization after the provider renders the authorized care in good faith and pursuant to the authorization except for:

(1) Payments made as a result of misrepresentation, fraud, omission or clerical error; and

(2) copayment, coinsurance or deductible amounts that are the responsibility of the insured.

(c) Once an insured is stabilized pursuant to subsection (a), a health benefit plan may require as a condition of further coverage that a hospital emergency facility shall promptly contact the health insurer for prior authorization for continuing treatment, specialty consultations, transfer arrangements or other medically necessary and appropriate care for an insured.

(d) Coverage of emergency services shall be subject to applicable copayments, coinsurance and deductibles.

(e) For required post evaluation or post stabilization services immediately following treatment of an emergency medical condition, a health insurer shall provide access to an authorized representative 24 hours a day, seven days a week.

Laws 1997, ch. 190, § 18.

KSA 40-4604. Same; medically appropriate health care information; advocating on behalf of insured

No health insurer shall prohibit or restrict any participating provider from discussing with or disclosing to any insured or other individual any medically appropriate health care information that such provider deems appropriate regarding the nature of treatment options, the risks or alternatives thereto, the process used or the decision made by such insurer to approve or deny health care services, the availability of alternate therapies, consultations, or tests, or from advocating on behalf of the insured within the utilization review or grievance processes established by the health insurer.

Laws 1997, ch. 190, § 19.

KSA 40-4605. Same; arrangements which serve as inducement to reduce or limit delivery of medically necessary services prohibited; capitation payments or other risk sharing provisions not considered inducements

No health insurer shall offer or operate a compensation arrangement between such health insurer or its agents and a participating provider that may directly or indirectly serve as an inducement to reduce or limit the delivery of medically necessary services with respect to an insured in any health benefit plan offered by such health insurer. Compensation arrangements which involve capitation payments or other risk sharing provisions shall not be considered inducements.

Laws 1997, ch. 190, § 20.

KSA 40-4606. Same; health insurer required to inform in writing current and prospective insureds of availability of certain information

Every health insurer shall inform in writing current and prospective insureds that the following information shall be available upon request:

(a) A complete description of the health care services, items and other benefits to which the insured is entitled in the particular health benefit plan which is covering or being offered to such person;

(b) a description of any limitations, exceptions or exclusions to coverage in the health benefit plan, including prior authorization policies, restricted drug formularies or other provisions which restrict access to covered services or items by the insured;

(c) a listing of the health benefit plan's participating providers, their business addresses and telephone numbers, the availability of those providers, and any limitations on an insured's choice of provider;

(d) notification in advance of any changes in the health benefit plan which either reduces the coverage or benefits, or increases the cost, to such person; and

(e) a description of the grievance and appeal procedures available under the health benefit plan and an insured's rights regarding termination, disenrollment, nonrenewal or cancelation of coverage.

Laws 1997, ch. 190, § 21.

KSA 40-4607. Same; provider network required to be sufficient to ensure covered services accessible without unreasonable delay; determination of sufficiency of provider network; plan to provide for referral of insured to specialists under certain conditions; exceptions to requirements

(a) A health insurer providing a health benefit plan shall maintain a provider network that is sufficient in numbers and types of providers to assure that all covered services to an insured will be accessible without unreasonable delay. Sufficiency of the provider network shall be determined in accordance with the requirements of this section, and may be established by reference to any reasonable criteria used by the health insurer, including but not limited to: provider-insured ratios by specialty; primary care provider-insured ratios; geographic accessibility; waiting times for appointments with participating providers; hours of operation; and the availability of technological and specialty services to serve the needs of insureds requiring technologically advanced or specialty care.

(b) A health insurer shall have a plan by which an insured with a life-threatening, chronic, degenerative or disabling condition or disease, which requires specialized medical care over a prolonged period of time, may receive a referral to a specialist with expertise in treating such disease or condition who shall be responsible for and capable of providing and coordinating the insured's specialty care.

(c) Nothing in this section shall require a health insurer to provide benefits not otherwise covered by the terms of the health benefits plan.

(d) A provider network shall not be determined to be insufficient for failure to contract with any provider unwilling to contract under the same terms and conditions, including reimbursement levels, as such health insurer offers to other similarly situated health care providers.

Laws 1997, ch. 190, § 22.

KSA 40-4608. Same; rules and regulations

The commissioner of insurance may adopt rules and regulations as necessary to implement the provisions of the patient protection act.

Laws 1997, ch. 190, § 23.

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Statement of Brad Smoot, Legislative Counsel
Blue Cross Blue Shield of Kansas
Blue Cross Blue Shield of Kansas City
House Insurance Committee
February 26, 2009

Mr. Chair and Members:

On behalf of two independent Blue Plans (BCBSKS & BCBSKC) serving Kansas, I am pleased to appear today to discuss health insurance mandates. BCBSKS is a mutual life insurance company (meaning it is owned by its policyholders) serving approximately 700,000 in 103 counties and BCBSKC is a not-for-profit hospital and medical service corporation serving nearly 300,000 the counties of Johnson and Wyandotte. Other conferees have already provided the committee valuable information on the statutory framework for evaluating and changing health insurance mandates as well as volumes of statistics to assist you in understanding the costs and impact of such mandates. The Kansas statutes regarding health insurance framework provide an orderly and studious methodology for considering the seemingly endless list of mandates proposed each year. The required cost/benefit analysis; "test tracking" of any proposed mandate on the state employees' health care plan and the five year review of existing mandates also reflect the Legislature's respect for the premium payers – those employers, employees and families who must "foot the bill" for the cost of health insurance. Those of us who watch this process appreciate your thoughtful and deliberate approach. Thank you.

I'd like to focus on a handful of fundamental issues that I hope will add some perspective to the discussion: First, is the issue of "What Is Health Insurance?" Attached to my comments is a chart which attempts to illustrate the services, conditions and situations that might be considered as part of health insurance coverage during the continuum of life. In bold type are the items that have historically been accepted as within the scope of insurance coverage and at the bottom in smaller type are other areas which advocates for mandates have advanced. Health insurance coverage is an evolutionary product (e.g. maternity benefits) but it will take a lot of thought and tough decision making to draw the lines on what should be included and what should not.

That leads us to our second chart, entitled "Where to Draw the Line." On the left of the chart are the existing mandates and to the right of "the line" are those that have been proposed or discussed over the years. Coverages on both sides of the line have some merit and it is entirely understandable that advocates for such coverages would want to spread the cost of certain health care services from their family budget to the larger pool of insureds. But that leads us back to the first chart about what is health insurance; what should be just the ordinary costs of living; what should be borne by government, etc. In

House Insurance
Date: 2-26-09
Attachment # 2

the twenty years that I've been observing this topic, I've never seen anyone advocate to remove an existing mandate or even substitute a new one for an older one. While mental health, drug & alcohol counseling, for example, may be most appropriate as mandated coverage, who would argue that pharmacy, vision or dental might not be just as important. Yet, these three basics to good health are not mandated by law and many insured Kansans don't have such coverage and can't afford it. In short, where the line is drawn today may change but it reflects as much the timing of the mandate proposals as it does a studied prioritizing of what is the optimum health insurance package.

Third on my list is the subject of "who is affected by state mandates?" Only a limited number of Kansans are immediately impacted by state mandate legislation. Only those employer groups (often small businesses) that are insured and those in the non-group (or individual) market are subject to our mandate statutes. Large self insured ERISA exempt groups, government programs such as Medicaid and Medicare as well as the uninsured are simply not within the jurisdiction of state insurance laws. And as a practical matter, those that are affected are among the most vulnerable to price increases. As you know, Kansas does not mandate that employers or individuals carry health insurance. Absent such a universal mandate, costs of premiums may and do drive employers and families to reduce coverage or drop it altogether – a phenomenon we have seen more of in recent years, giving rise to the general concern over the increasing number of uninsured and underinsured Americans.

Finally, the issue of insurance premium costs leads us to the issue of where the money goes. At BCBSKS nearly 90 cents of every dollar goes to pay for services consumed by our policyholders. Simply stated, when a new benefit or provider group is added to the policy my virtue of a state mandate, more money will be paid out and carriers will either have to reduce payments to current providers for existing services, increase co-pays and deductibles or raise premiums. It is this aspect of the mandate issue which is addressed by the statutory requirement to perform a cost benefit analysis and to test track the mandate on the state employees plan. Health care costs and the corresponding premium increases continue to rise due to underfunding of government programs; an aging population; advances in technology and medications; increasing public demand for care and other factors. Consequently, your mandate discussions are often about how much more premiums will increase and will any given mandate be worth the adverse impact on the premium payers.

BCBS plans understand the needs and desires of those who advocate for state mandates. Our employees have the same aliments and health care cost issues that other Kansans have but we also understand that the biggest problem in health insurance today is the rising cost of coverage for many and we are most appreciative that the Kansas Legislature is willing to be careful about adding additional burdens to premium payers across the state. Thank you for considering our views and I would be pleased to respond to questions.

What is Health Insurance?

Birth **Death**

Prenatal & Birth

Acute Episodic Care

Chronic Disease Management

Life Support

Emergency

Health Education

Pain Relief & Management

Life Extension

Life Activities

Safety

Mobility

Infertility

Self-Esteem (Appearance)

Quality of Life

Communication

Productivity

Life Enhancement

Full Potential

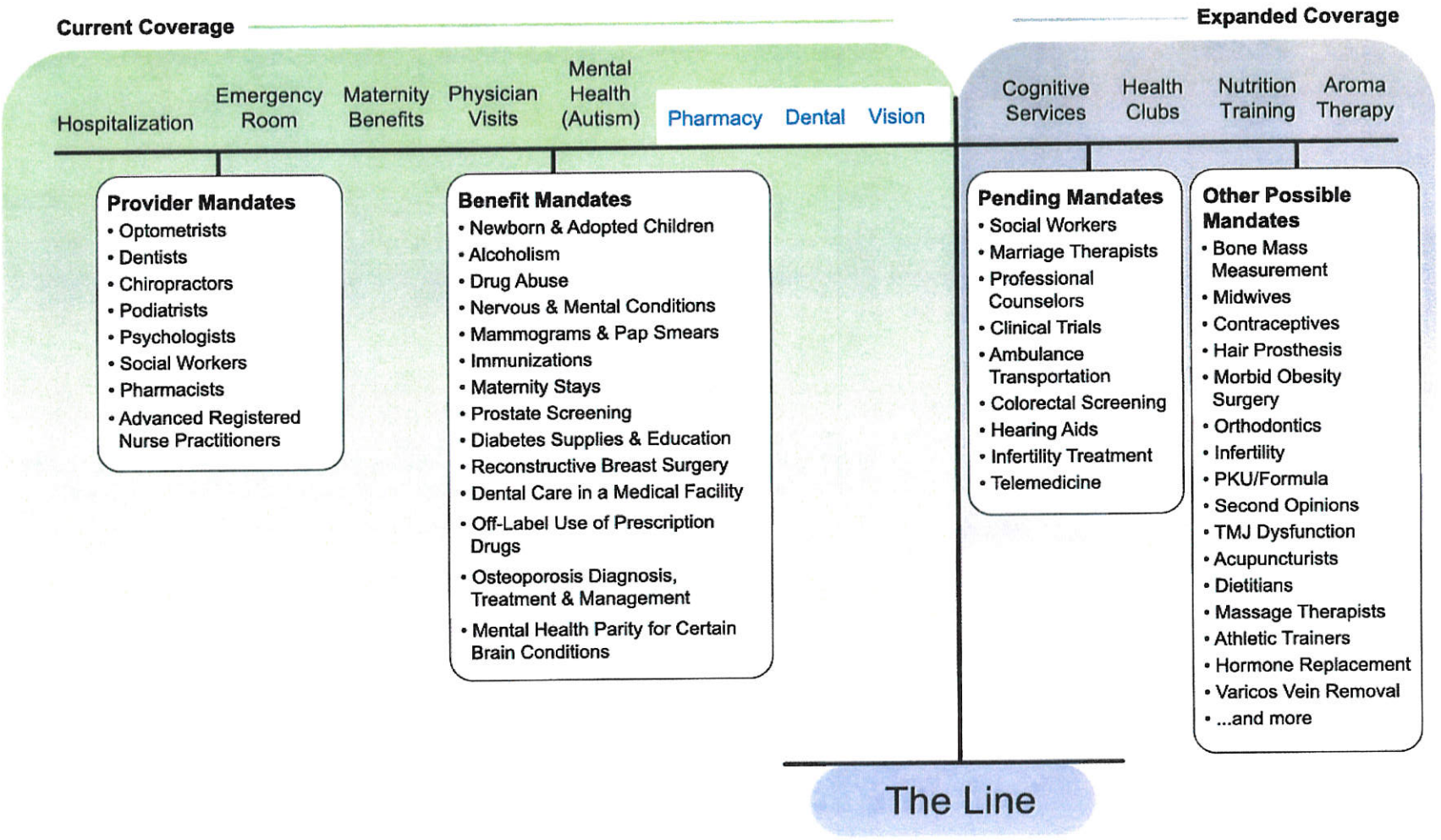
Independent Living

BlueCross BlueShield of Kansas

Information prepared by Blue Cross and Blue Shield of Kansas, October 2007

* An Independent Licensee of the Blue Cross and Blue Shield Association

Where to Draw the Line?



BlueCross BlueShield of Kansas*

Information prepared by Blue Cross and Blue Shield of Kansas, October 2007

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KANSAS MENTAL HEALTH COALITION

An Organization Dedicated to Improving the Lives of Kansans with Mental Illnesses

House Insurance Committee
February 26, 2009
"Review of Insurance Mandates"

Thank you, Chairman Shultz and Members of the Committee, for the opportunity to comment on the Committee's review of insurance mandates.

In 1977, the Kansas Legislature recognized the importance of treating mental illness and required health insurance policies to provide such treatment under a specifically prescribed formula. Stigma against people with mental health issues was prevalent at the time, and without the action of the Legislature, coverage for treatment was nonexistent.

The coverage for "nervous and mental conditions" is described in K.S.A. 40-2,105. It includes very specific coverage specifications for the treatment of mental conditions that are not covered by the 2001 Kansas Mental Health Parity Act. This statute includes annual and lifetime limits that are much more restrictive than those applied to other health conditions, but were considered progressive at that time.

In 2001, the Kansas Legislature amended the statutes to pass the "Kansas mental health parity act", which attempts to provide equal coverage for the diagnosis and treatment of certain mental illnesses. "Equal coverage" requires the same deductibles, coinsurance and other limitations as apply to other covered services.

The goal of "parity" is to provide coverage that is no more and no less than coverage provided for other medical treatment. The passage of the 2001 legislation fell just short of this goal – requiring equal treatment for only a specific list of illnesses and including 45 days inpatient treatment and 45 outpatient visits per year. National comparisons list Kansas as a "Limited Parity" state.

Covering mental health treatment is crucial to maintaining employment and independence and empowering families to care for their children with mental health needs. The actions of the Legislature have had a significant impact on individuals and families who need to access treatment for mental illness. Perhaps the greatest impact has been the improved coverage for families with children who are diagnosed with mental illness. Prior to its implementation, testimony was presented by families who had exhausted their insurance coverage and were forced into serious financial hardship, including one family that was forced to sell their home. Other testimony was received from a young woman who ultimately was able to graduate college once her coverage was no longer limited to treatment lasting only part of the year.

Ultimately, it is an issue of fairness and not one of mandating a specific treatment. Why should a Kansan who is paying the same premiums as another be unable to access needed treatment for their medical condition, simply because it is a brain disorder rather than a cardiac or kidney ailment?

The Kansas Mental Health Coalition is particularly concerned with reports stating Kansas required coverage for certain mental illnesses (K.S.A. 40-2,105a) costs 5% to 10% - "the cost range estimate if the mandate were added to a policy that did not include the coverage".

Kansas has several studies analyzing actual costs of implementation in our state. One was the analysis of the impact of providing coverage in the Kansas State Employees Health Care Plan prior to the passage of the legislation in 2001. The benefits were provided in 1999 in the managed care portions of the Plan, then expanded to the full Plan in 2000. Studies of each implementation, which were used by the Kansas

Legislature in its decision to ultimately pass HB 2033 in 2001, showed that making coverage for those specified serious mental illnesses available on a basis no more restrictive than that for other biologically based illnesses cost less than 1%.

-The increased cost of mental health parity to consumers, employers, and insurers is less than 1% a year. In 1999 and 2000, some argued that covering mental health care would dramatically increase the overall cost of healthcare. That did not turn out to be true. In fact, a study commissioned as part of the 2001 legislation showed that – after implementation - mental health parity increased costs to private health plans in Kansas by less than 1% a year. (Blobaum, G., 2002, Mental health parity experience (audit) – Kansas Insurance Department)

-Full mental health parity has the potential of reducing overall medical costs by 20%. A 1999 study suggests that having full mental health coverage and benefits could reduce the overall cost of health care by as much as 20%. This is referred to as the "cost-offset" data. Every dollar spent on mental health care results in greater cost savings on the medical-surgical side. (Chiles, J.A., et.al. 1999, "The Impact of Psychological Interventions on Medical Cost Offset: A Meta-analytic Review, " Clinical Psychology: Science and Practice, V6, Summer)

The current statutes are due for review and update. In 2005, Governor Sebelius asked the Governor's Mental Health Services Planning Council to create a group to study the implementation of the mental health parity statutes. The resulting report of the Mental Health Parity Task Force was published November 2006 and included several recommendations for improvement to the statutes.

The Coalition urges this Committee to host a presentation of the report of the Task Force in order to learn more about mental health coverage in Kansas and where there is room for improvement.

In 2008, Congress passed a new Federal Parity Act, which makes changes to the way that mental health coverage is regulated for corporations providing insurance under federal regulation. You will be receiving information from the Kansas Insurance Department regarding those amendments. Kansas must update our statutes to comply with the Federal Act and those amendments are contained in Senate Bill 49.

The Kansas Mental Health Coalition supports retaining Kansas statutes that require coverage for mental health treatment. We look forward to bringing you more information as you examine this important area of the law further.

For More Information, Contact:

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c/o Roy W. Menninger MD, Chair
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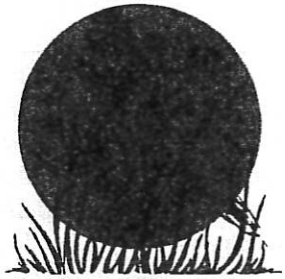
The Kansas Mental Health Coalition is an Organization Dedicated to Improving the Lives of Kansans with Mental Illnesses and Severe Emotional Disorders. KMHC is a coalition of consumer and family advocacy groups, provider associations, direct services providers, pharmaceutical companies and others, all of whom share this common mission. Within the format of monthly roundtable meetings, participants forge a consensus agenda which provides the basis for legislative advocacy efforts each year. This design enables many groups otherwise unable to participate in the policy making process to have a voice in public policy matters that directly affect the lives of their constituencies. The result of this consensus building is greater success for our common goals. Our current membership includes over 40 organizations which get together once a month to discuss issues of common concern and develop consensus.



Association of Community Mental Health Centers of Kansas, Inc
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House Insurance Committee

Testimony on
Insurance Coverage for Mental Health Treatment
in Kansas

February 26, 2009

Presented by:

Michelle Sweeney, Policy Analyst
Association of CMHCs of Kansas, Inc.

Mr. Chairman and members of the Committee, my name is Michelle Sweeney, I am the Policy Analyst for the Association Community Mental Health Centers of Kansas, Inc. The Association represents the 27 licensed Community Mental Health Centers (CMHCs) in Kansas who provide home and community-based, as well as outpatient mental health services in all 105 counties in Kansas, 24-hours a day, seven days a week. In Kansas, CMHCs are the local Mental Health Authorities coordinating the delivery of publicly funded community -based mental health services. The CMHC system is state and county funded and locally administered. Consequently, service delivery decisions are made at the community level, closest to the residents that require mental health treatment. Each CMHC has a defined and discrete geographical service area. With a collective staff of over 4,500 professionals, the CMHCs provide services to Kansans of all ages with a diverse range of presenting problems.

Together, this system of 27 licensed CMHCs form an integral part of the total mental health system in Kansas. As part of licensing regulations, CMHCs are required to provide services to all Kansans needing them, regardless of their ability to pay. This makes the community mental health system the "safety net" for Kansans with mental health needs, collectively serving over 123,000 Kansans with mental illness.

I stand before you today to discuss mental health coverage that is mandated to be provided under group health insurance policies in the state. It is important to note that One in four adults—approximately 57.7 million Americans— experience a mental health disorder in a given year.[1] Per K.S.A. 40-2,103, 40-2,105 and 40-19c09, group health insurance companies who offer coverage in the state must offer a minimum package of mental health services and care—both inpatient and outpatient—to policy holders. The coverage directed under this statute is not truly comparable with the physical health coverage provided by insurers. There are limits on the number of outpatient treatments and inpatient days available to insured members. There are also lifetime doll ar limits on coverage and higher co-payments than physical coverage.

The truth is, when employees are provided treatment for mental and physical illness, the total cost of health care may be decreased for the employer. Case in point is a study of health coverage provided by Bank One, which showed that increased emphasis on mental health benefits (combining low cost-sharing requirements, expanded services, no separate benefit caps, and a sophisticated EAP) can result in lower total health expenditures.[2]
The Community Mental Health Centers serve as the public mental health system in Kansas, and as such, do not serve a large number of privately insured individuals. In fact, only about 8% of reimbursement to the CMCHs is from private group heath insurers. However, we believe that coverage is important for those Kansans who seek mental health treatment. The Kansas Department of Insurance commissioned a study of the costs and outcomes from the implementation of the mental health coverage statute in Kansas in July 2004 for the State Employees Health Plan (SEHP). What they found was that the overall increase to costs for the SEHP was around 1%.[3]

Another important note for the committee is that the State Employees Benefit Plan for 2008 increased coverage for mental health treatment, both inpatient and outpatient, and decreased co -payments. This expansion is beyond the mandate in the statute, and provides state employees with better coverage and more access to mental health care treatment. This shows a realization that coverage for mental health treatment is as important as physical health treatment, and that the cost to provide such coverage has proven to be minimal, as cited above.

The Association supports continued coverage for mental health treatment in g roup health insurance policies in Kansas, since we know that treatment works and recovery is possible for those who have a mental illness.

Thank you for your support of mental health care and treatment for all Kansas, which includes continuation of coverage under group plans. Thank you for allowing me to appear before you today.

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[1] U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services,1999, pp. 408, 409, 411.
[2] Comprehensiv Study of Mental Health Benefits: Bank One at http://mentalhealth.samhsa.gov/_scripts/printpage.aspx?FromPage=http%3A//mentalhealth.samhsa.gov/publications/allpubs/sma01_-3481/SMA01-3481ch8.asp.
[3] KHIS Progress Report, Mental Health Parity, Appendix E, July 2004, Blobaum, Gene, Consulting Actuary.

NAMI Kansas
National Alliance on Mental Illness

House Insurance Committee

February 26, 2009

Presented by:
Rick Cagan
Executive Director

Mr. Chairman and members of the Committee, my name is Rick Cagan. I am the Executive Director of NAMI Kansas, the National Alliance on Mental Illness. NAMI Kansas is a statewide grassroots membership organization dedicated to improving the lives of individuals with mental illness. Our members are the individuals living with mental illnesses as well as the family members who provide care and support.

We wish to express our strong and absolute support for maintaining the mental health mandate for companies providing health insurance to Kansans.

One in four adults experiences a mental health disorder in a given year. One in seventeen lives with a serious mental illness, such as schizophrenia, major depression or bipolar disorder and about one in ten children have a serious mental or emotional disorder.

Fewer than one-third of adults and half of children with a diagnosable mental disorder receive any mental health services in a given year. In the U.S., the annual economic, indirect cost of mental illnesses is estimated to be $79 billion. Most of that amount reflects the loss of productivity as a result of illnesses.

Individuals with serious mental illness face an increased risk of having chronic medical conditions. Adults with serious mental illness die 25 years younger than other Americans, largely due to treatable medical conditions. Suicide is the eleventh leading cause of death and the third leading cause of death for ages 10 to 24 years. More than 90 percent of those who die by suicide have a diagnosable mental disorder.

Male veterans are twice as likely to die by suicide as compared with their civilian peers in the general US population. Twenty-four percent of state prisoners and 21 percent of local jail prisoners have a recent history of a mental health disorder.

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Seventy percent of youth in juvenile justice systems have at least one mental disorder with at least 20 percent experiencing significant functional impairment from a serious mental illness. Over 50 percent of students with a mental disorder age 14 and older drop out of high school—the highest dropout rate of any disability group.

For these and other reasons, we must maintain a basic requirement that treatment for mental illness be a part of the health care coverage offered to policyholders. To do otherwise would be to compromise the health and well-being of a large segment of our population.

Thank you for the opportunity to be a part of this review process. We look forward to a continuing dialogue with members of the committee on the broader questions related to ensuring parity in the treatment of mental illnesses as outlined in HB 2231.

Polsinelli Shughart PC

Memorandum

TO: THE HONORABLE CLARK SCHULTZ, CHAIR
HOUSE INSURANCE COMMITTEE

FROM: WILLIAM W. SNEED, LEGISLATIVE COUNSEL
AMERICA'S HEALTH INSURANCE PLANS

RE: STATE HEALTH MANDATE LAWS

DATE: FEBRUARY 26, 2009

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I am Legislative Counsel for America's Health Insurance Plans ("AHIP"). AHIP is a trade association representing nearly 1,300 member companies providing health insurance coverage to more than two million Americans. Our member companies offer medical expense insurance, long-term care insurance, disability income insurance, dental insurance, supplemental insurance, stop-loss insurance and reinsurance to consumers, employers and public purchasers. Please accept this memorandum regarding my client's position relative to state-imposed mandates on health insurance products.

AHIP opposes legislation imposing benefit and/or provider mandates on health insurance plans, which could be costly and have unintended consequences for consumers. AHIP supports policies that spur innovation in cost savings and efficiency, which in turn allow health insurance plans to provide affordable health care coverage and improve services to their insured customers. However, our member companies recognize the impetus for enacting mandate legislation, and our Board has issued their support for the following principles.

1. Mandates must promote evidence-based medicine. Mandates often have a direct and negative impact on quality since they require adherence to procedures and practices that may not be optimally appropriate or effective. When a state passes a mandate, the mandate remains static and does not reflect changes in the practice of medicine, new medical terminology, or other medical advances or knowledge that make the mandate obsolete or even harmful to patients. Mandates, should they be enacted, must promote evidence-based medicine.

2. Mandates must be properly evaluated. Independent advisory commissions should be established to proactively evaluate the impact of mandates and to ensure that they will result in improved care and value. The commission's findings also should inform public program coverage and decision-making processes to promote consistent application of evidence-based standards in Medicare, Medicaid and other public programs.

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3. Mandates should not limit customer choice. Health insurance plans must have the flexibility to design benefits and services specific to their insured customers' needs. Mandates must not limit the broad array of innovative and efficient products health insurance plans have available to employers and individuals, including mandate-free policies. Mandates misallocate resources by requiring consumers, or their employers, to spend available funds on benefits that they otherwise not purchase. This makes it harder for consumers to obtain the benefits they do want. Mandates that are not evidence-based only increase this occurrence.

4. Mandates should not increase costs and limit access. Studies show that improving health care quality and patient safety through the adoption of evidence-based medicine into everyday clinical practice would result in health care cost savings. Mandates drive up health care costs for consumers and employers and take out of the system money and other resources that could be better used to provide uninsured Americans with access to health care coverage.

Attached to this testimony are several research documents that we contend would be helpful as the Legislature reviews any type of proposed mandate. In summary, the documents are:

1. An article by John R. Graham, Director, Health Care Studies, Pacific Research Institute, titled "The Doubt of the Benefit: Why State Benefit Mandates are a Poor Prescription for Health Insurance."

2. A major article by John R. Graham titled "From Heart Transplants to Hairpieces: The Questionable Benefits of State Benefit Mandates for Health Insurance."

3. A document by the Council for Affordable Health Insurance titled "Health Insurance Mandates in the States 2008" by Victoria Craig Bunce, Director of Research and Policy, and J.P. Wieske, Director of State Affairs.

4. A memorandum from the Council for Affordable Health Insurance titled "Trends in State Mandate Benefits" dated May, 2008.

5. Mandate benefit definition memorandum by the Council for Affordable Health Insurance dated January, 2008.

6. A 50-state mandate report prepared by my client, America's Health Insurance Plans, as of August 26, 2008.

While overall savings to society are often invoked in support of mandates, we believe legislators must consider the cost of such mandates to consumers. While one may believe they are expanding coverage for their constituents through mandates, America's Health Insurance Plans believes mandates can harm consumers by driving up health insurance costs and ultimately contributing to the growing number of Americans who cannot afford to purchase coverage. Mandates misallocate resources by requiring consumers or their employers to spend available funds on benefits that they would otherwise not purchase. This makes it harder for consumers to obtain the benefits that they do want.

We appreciate the opportunity to present this material and would be happy to answer any questions.

Respectfully submitted,

William W. Sneed

WWS:pmk

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February 26, 2009

Mandate Review
Before the House Insurance Committee
Marlee Carpenter, Executive Director

Chairman Shultz and members of the Committee;

I am Marlee Carpenter, 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 other entities that are associated with managed care. KAHP members serve the majority of Kansans enrolled in private health insurance. KAHP members also serve the Kansans enrolled in HealthWave and Medicaid managed care. We appreciate the opportunity to provide comments to this committee.

The KAHP is dedicated to providing low costs health insurance to Kansas citizens. We are committed to working with the Kansas Legislature, the Kansas Health Policy Authority and the Kansas business community on ways to reduce health insurance costs in Kansas.

KAHP is here today to provide comments about health insurance mandates. Historically, a health insurance mandate was enacted to force health insurance companies to cover a service or type of provider that companies have refused to cover. Many of the health insurance mandates that have been offered over the last few years are services currently covered by health plans in Kansas.

There is much debate around the cost of health insurance mandates. While actuaries, insurers, and health economists agree that virtually all mandates increase the cost of health insurance, the magnitude of their effects has been subject to debate. The Council for Afforadable Health Insurance estimates that mandated benefits currently increases the cost of basic health coverage from a little less than 20% to more than 50%, depending on the state and its mandates. In Kansas, for every 1% increase in medical insurance premium costs, approximately 2,500 Kansans lose all medical insurance coverage due to their employer dropping all medical coverage due to costs.

Every health insurance mandate is brought to the legislature with good intention, but as additional mandates have been enacted, health insurance companies have become limited in the types of lower costs plans they can offer. Mandates place additional requirements upon health insurance companies in Kansas and limit their ability to offer innovative and low cost health insurance products.

The KAHP requests that as you look at newly proposed health insurance mandates that you consider the impact they will have on the health insurance market and ability to offer cost effective insurance products to Kansas citizens.

Thank you for your time and I will be happy to answer any questions.

House Insurance
Date: 2-26-09
Attachment # 7

Legislative Testimony

achieve more

Review of Mandates

February 26, 2009

House Insurance Committee

Rachelle Colombo, Senior Director of Legislative Affairs

Chairman Shultz, members of the Committee:

The Kansas Chamber, with headquarters in Topeka, is the leading statewide pro-business advocacy group moving Kansas towards becoming the best state in America to do business. The Chamber represents small, medium and large employers all across Kansas.

We appreciate the opportunity to provide input on the subject of health insurance mandates and the impact to the overall cost of health care. Managing health care costs remains one of the top three issues affecting profitability as identified by Kansas CEOs surveyed in the Chamber's annual CEO poll.

The Kansas Chamber supports meaningful health care reform aimed at lowering the overall cost of health care so it is more affordable for employers. Because of the increased cost they often induce, the Chamber generally opposes health care mandates and supports efforts to reduce the number of cost-increasing mandates insurers are required to provide in policies.

The Chamber's Annual Competitiveness Index is a nationwide comparison of nearly eighty economic indicators compiled to gauge Kansas's comparative business climate. This year's ACI found that Kansas improved from ranking 20th to 18th in health care cost competitiveness because our number of mandates remained constant while other states increased their mandates.

It is widely accepted that mandates increase the cost of health care but forecasting the impact of individual mandates on health care premiums before they have been enacted is difficult to determine. The specific cost of new mandates in one state is hard to extract for a number of reasons.

First, no state has zero mandatory benefits so we do not have an opposite controlled group for purposes of comparison and analysis. Second, there are national studies aimed at determining the impact of mandates on overall cost but these studies use broad averages of the number of benefits required to determine a per mandate cost.

In one such study, the Pacific Research Institute for Public Policy, a privately funded, non-profit, free market think tank found that each health insurance mandate increases the premium of a health policy by about 0.5 percent. However, because of the wide variance of definition and implementation of "mandate" from state to state, this number is truly a rough average and not a clear indicator of the cost per mandate.

According to the Council for Affordable Health Insurance mandates may currently have as much as a 12 percent impact on premium cost in Kansas. Here again, this data was derived from national data and may not accurately reflect exceptions in state mandate policy.

THE KANSAS CHAMBER

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Though the federal mental health parody is mandated in each state, prevalence and utilization varies from state to state, resulting in different pricing and making the average unreliable. Additionally, the cost of each mandated benefit will vary dependent upon the targeted patient. There are more people who benefit from a mental health mandate for example than from a breast reconstruction mandate for obvious reasons.

Actuaries within the insurance industry in Kansas who are more familiar with the specific stipulations and cost of mandates required have estimated the overall impact of mandates on premiums to be between twelve and seventeen percent. **Yet even a minimal increase in premium price makes health care less affordable and results in a growing number of uninsured.**

In the study previously referenced, the Pacific Research Institute found that if the cost of insurance premiums rises by 1 percent, the number of uninsured people increases by 0.5 percent. Here again, the importance of reducing the number of mandates and containing the growth of health care costs is demonstrated.

Although predicting the exact impact of new mandates on premiums before they are required on the market is unreliable, the cost impact of mandates **can** be accurately measured.

The best tool for determining the cost impact of mandates is the State Employee Health Benefit Plan Study as enacted in KSA 40-2249a. This statute stipulates that any new mandated health insurance coverage approved by the Legislature must apply onto the state health care benefits program for one year. This provides a controlled sample where the true cost of implementing a mandate can be determined.

The value of this statute can be seen in light of suggested mandates that are currently being considered. For instance, a growing number of our population is impacted by autism. In light of this fact, mandating coverage for autism prevention and treatment seems reasonable. However, determining the cost impact of such a proposed mandates which provides coverage for therapies and treatments unapproved by federal government regulatory agencies proves even more difficult to determine. If these mandates are not first implemented on a controlled sample, such as the State Employee Health Benefit Plan as prescribed in statute, there is no way to determine their cost other than by educated guesstimate.

Another good tool for determining the cost of mandates is the financial impact requirements outlined in KSA 40-2248. This statute essentially requires a cost benefit analysis to be conducted before implementation of a new mandate. Here again, when therapies and coverage are untested in a controlled sample, this impact report is at best, an informed guesstimate computed by insurers.

Before employers are burdened with increasing premium costs fattened by mandates and forced to shoulder the cost of an even heftier health care bill, we should study the financial and physical impact of new mandates on the market and the health of individuals. The state employee health benefit plan study provides an ideal environment and produces the clearest results on the financial impact of mandates on the overall cost of health care.

The Kansas Chamber and its members believe that before we impose higher premiums on employers additional mandates should meet the financial impact requirements laid out in statute so that their cost can be accurately determined.

Thank you for the opportunity to offer these comments today.

NFIB
The Voice of Small Business®

House Insurance Committee
Daniel S. Murray: State Director, NFIB-Kansas
Comments on Health-Insurance Mandates
February 26, 2009

NFIB-KS advocates free-market reforms that allow small-business owners to decide which benefits they can and cannot afford to offer.

Mr. Chair, Members of the Committee: My name is Dan Murray and I am the State Director of the National Federation of Independent Business-Kansas. NFIB-KS is the leading small business association representing small and independent businesses. A nonprofit, nonpartisan organization founded in 1943, NFIB-KS represents the consensus views of its 4,000 members in Kansas. Thank you for the opportunity to comment on health-insurance mandates-an issue that is extremely important to our members.

Small business owners want to and do offer healthcare plans that cover a wide variety of benefits such as preventive care and cancer screenings. Providing these types of benefits is important to the productivity of NFIB members and their employees. However, NFIB continues to be greatly concerned by government imposed mandates that discourage consumer control and innovative health plan design.

While mandates make small business health insurance more comprehensive, they also make it more expensive. Mandates require insurers to pay for care consumers may have previously funded out of their own pockets, thereby raising the price of premium to cover the increased claims the insurer anticipates to take place as a result of the mandate.

In some markets, mandated benefits increase the cost of health insurance by as much as 45 percent. Mandating benefits is like requiring auto insurance to not only cover collisions and auto damage but to also pay for new tires, engine tune ups and oil changes. Imagine what an auto insurance policy would cost if that were the case!

Mandates, regardless of the form they take or how well intentioned, drive up the cost of health insurance, especially in the small 2-50 employee market. NFIB-KS wants small business to have affordable benefit packages that can be tailored to their workforce needs. When contemplating proposed health-insurance mandates, we urge you to consider the impact on small business. Thank you for the opportunity to comment.

National Federation of Independent Business – KANSAS
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Cost to the Kansas State Employee Health Plan
of Various Providers and Benefits That are Mandated by Kansas Statute

Period Claims Incurred: 10/1/2007 to 9/30/2008

Provider Mandates (1)	Health Service Expense as a percent of total SEHBP benefit spending
Optometrists (a)	0.90%
Dentists (b)	0.01%
Chiropractors (c)	1.44%
Podiatrists (d)	0.27%
Psychologists (e)	0.36%
Social Workers (f)	0.26%
Advance Registered Nurse Practitioners (g)	0.05%
Pharmacists (h)	0.05%

Benefit Mandates (2)	Health Service Expense as a percent of total SEHBP benefit spending
Newborn & Adopted Children (i)	0.17%
Alcoholism (j)	0.14%
Drug Abuse (k)	0.06%
Nervous and Mental Conditions (l)	0.17%
Mammograms and Pap Smears (m)	1.08%
Immunizations (n)	0.28%
Maternity Stays (o)	0.67%
Prostate Screenings (p)	0.14%
Diabetes Supplies and Education (q)	0.12%
Reconstructive Breast Surgery (r)	0.26%
Dental Care in a medical facility (s)	U
Off- Label Use of Prescription Drugs (t)	U
Osteoporosis Diagnosis, Treatment, and Management (u)	0.05%
Mental Health Parity for Certain Brain Conditions (v)	0.93%

1. Kansas mandates that these providers be included in any Health Insurance plan regulated by the State.

2. Kansas mandates that these services be included in any Health Insurance plan regulated by the State.

U - Unknown since we do capture the information

a This is the percent of total spending paid to optometrists, as listed in the provider field in Thomson Reuters Database.
b This is the percent of total spending paid to dentists for providing medical services, as listed in the provider that provided a medical service field in Thomson Reuters Database.
c This is the percent of total spending paid to chiropractors, as listed in the provider field in Thomson Reuters Database.
d This is the percent of total spending paid to Podiatrists, as listed in the provider field in Thomson Reuters Database.
e This is the percent of total spending paid to Psychologists, as listed in the provider field in Thomson Reuters Database.
f This is the percent of total spending paid to Social Workers, as provided by the our Health Carriers.
g This is the percent of total spending paid to Advance Registered Nurses, as listed in the provider field in Thomson Reuters Database.
h This is the percent of total spending paid to Pharmacists, as listed in the provider field in Thomson Reuters Database.
i This is the percent of total spending paid for PKU testing , including Assay Thyroid, Assay PKU, and Immunoassay
j Alcohol Detoxification Unspecified, Alcohol Dependency
k Dug withdrawal, Opioid Dependency, Cocaine Dependency, Amphetamine Dependency, Cannabis Dependency, Combined Drug Dependency
l Neurobehavioral Status Exam, Neuropsych Testing, Development Testing
m Mammogram Screening, Pap Smear
n Dtap Vaccine, Chicken Pox, DT Vaccine, Rubella, Polio Virus, Pneumococcal Vaccine, Diptheria
o Cesarean Delivery, VBAC Delivery, Obstetrical care
p Assay of PSA
q Glucose Blood Test, Glucose Monitoring, Medical nutrition group
r Breast reconstruction, Partial Mastectomy, breast reduction, removal of breast implant, removal of implant material
s Neither the KHPA nor its vendors captures this data.
y Neither the KHPA nor its vendors captures this data.
u US Bone Density measure, Bone Mineral
v Paranoid, Depression, Bipolar

Data provided to Kansas Legislative Research Department
on February 9, 2009 by the Kansas Health Policy Authority.