Approved: 1-22-09

Date

MINUTES OF THE SENATE FINANCIAL INSTITUTIONS AND INSURANCE

The meeting was called to order by Chairman Ruth Teichman at 9:30 a.m. on January 15, 2009 in Room 136-N of the Capitol.

All members were present.

Committee staff present:
Beverly Beam, Administrative Assistant
Melissa Calderwood, Kansas Legislative Research
Terri Weber, Kansas Legislative Research
Bruce Wilke, Revisor

Conferees appearing before the committee:
Doug Farmer, Director, State Employee Health Benefits Plan, Kansas Health Policy Authority (Attachment 1)
Linda Sheppard, Director of Accident & Health Division, Kansas Insurance Department (Attachment 2)

Others attending:
See attached list.

Chairman Teichman welcomed the Committee and Staff as well as others in attendance, to the first meeting of the 2009 Legislative Session. The Chair asked the Committee and Staff to introduce themselves.

The Chair presented and discussed the committee rules for the 2009 Session.

Doug Farmer, Director, State Employee Health Benefits Plan, testified on behalf of the Kansas Health Policy Authority. Mr. Farmer gave an overview of the Study on Coverage for Bariatric Surgery. Mr. Farmer stated that prior to Plan Year 2008, all treatment for obesity was excluded from coverage under the State Employee Health Plan. He said Medicaid reimbursed for weight-loss medications but excluded coverage for bariatric surgery. He noted that in 2006, The Health Care Commission considered coverage for bariatric surgery. He said KHPA engaged in Statewide Health Reform initiative in 2007 and 2008 emphasizing prevention and wellness. He said consistent with KHPA initiatives in the area of prevention and wellness, the Health Care Commission decided to cover preventive and non-invasive obesity treatments for 2008 under the State Employee Health Plan.

Mr. Farmer continued that the Health Care Commission review of bariatric surgery in 2006 found that preventive, non-invasive treatment was not covered; that there was a relatively high incidence of complications and even death; that morbidity and mortality vary considerably with experience of surgeon and hospital; that there were no centers of excellence in Kansas and that long-term cost-effectiveness was not yet demonstrated.

Mr. Farmer said, based on the 2006 Commission review, the Kansas Health Policy Authority recommendations for the State Employee Health Plan were to educate consumers on available options for promoting wellness and addressing weight problems; to review state employee health plans for 2008 to examine possible expansion in preventive benefits; to review HealthQuest to consider initiatives in physician-supervised weight management, behavior modification, healthy eating and exercise. Also, he said after the State Employee Health Plan and Medicaid staff review of bariatric surgery they determined to retain exclusion of bariatric surgery.

However, Mr. Farmer said based on new research, it was determined that bariatric surgery does reduce excess body weight by half after two years and reduces total body weight by 16% after ten years, that surgery reduces long-run obesity-related mortality by 50% to 90%, that surgical costs may be recoverable in as little as four to five years, depending upon the patient, that studies compare efficacy of different procedures and that significant risks accompany the surgery, but are lower in accredited and high-volume centers.

Mr. Farmer noted that the estimated cost of coverage for the State Employee Health Plan could be as much as $15 million the first year but costs depend on required pre-conditions.

In conclusion, Mr. Farmer said Kansas Health Policy Authority recognizes that obesity is an epidemic in the U.S. and in Kansas and the increasing individual, employer and societal costs for chronic diseases due to overweight and obesity. He said there is new evidence supporting the long-term value of bariatric surgery which include improved health and longevity, reduced medical costs and improved safety through experience and targeting of services. For those reasons, Mr. Farmer said Kansas Health Policy Authority recommendations are to emphasize the value of preventive care and changes have been made to the State Employee Plan. He said also KHPA will develop recommendations for the Health Care Commission to cover bariatric surgery in the State Employee Health Plan. He said they will use Medicare coverage as a starting point and will work with weight loss and surgical experts to target surgery to those who can benefit the most. He said they will also consider Medicaid coverage, if funding is available. (Attachment 1)

Following brief Q and A with Mr. Farmer, the Chair asked for testimony from Linda Sheppard, Director of Accident and Health Division, Kansas Insurance Department.

Ms. Sheppard testified regarding Health Savings Accounts, High Deductible Health Plans and Section 125 Plans.

First, Ms. Sheppard described a Health Savings Account as a savings product that can be used as an alternative to traditional health insurance which allows you to pay for current health expenses and save for future qualified medical and retiree health expenses on a tax-free basis. She said, however, that in order to take advantage of an HSA, you must also be covered by a high deductible health plan but must not be covered by other health insurance that is not a high deductible health plan. She said a HDHP will cost less than traditional health insurance, so money saved on insurance can be put into the Health Savings Account. She said the money in the HSA is controlled by the owner and decisions regarding how the money is spent are made by the owner, without relying on a third party or a health insurer. She noted that the owner may also decide what types of investments to make with the money in the account, including stocks, bonds, mutual funds and certificates of deposit.

Ms. Sheppard then described a High Deductible Health Plan. She said to open an HSA you must also have a High Deductible Health Plan. She noted that a HDHP is sometimes referred to as a catastrophic health insurance plan. She said it is less expensive health insurance with a high deductible, which means it doesn't cover the first several thousand dollars of health care expenses you incur, but will generally cover your expenses once the deductible is met. The intent, she noted, is that the funds in the HSA will help pay for the expenses your HDHP does not.

In describing the Section 125 Cafeteria Plan, Ms. Sheppard stated that this plan is also referred to as flexible benefit plan or Section 125 Plan. She said these are employer sponsored benefit plans which allow employees to obtain benefits on a pre-tax basis. She said the primary benefit for employers is a potential savings in payroll taxes.

In conclusion, Ms. Sheppard said although there is abundant information available from the Kansas Insurance Department and through the Internet regarding health savings accounts, high deductible health plans and Section 125 cafeteria plans, many small employers are still unaware of the existence and benefits of such plans. She said although HSA, HDHPs, and Section 125 Plans provide significant benefits to both employers and employees, either the employees or the employer must be willing and able to make the necessary monetary contributions to establish and maintain these plans. (Attachment 2)

There were no questions for Ms. Sheppard.

The next meeting is scheduled for 9:30 a.m., January 20, 2009.

The meeting was adjourned at 10:20 a.m.

FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: 1-15-09

NAME	REPRESENTING
Alex Kotoyantz	P. I. A
Lori Church	KAPCIC
Doug Wareham	KBA
Kerri Spielman	KAIA

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KANSAS HEALTH POLICY AUTHORITY

KANSAS HEALTH POLICY AUTHORITY
REPORT TO
JOINT COMMITTEE ON HEALTH POLICY OVERSIGHT
ON A STUDY OF
COVERAGE OF BARIATRIC SURGERY
IN
THE STATE EMPLOYEES HEALTH PLAN

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FI & I Committee
1-15-09
Attachment 1

Purpose of the Study

The purpose of this study is to analyze the effects of bariatric surgery for the morbidly obese, and to make recommendations for potential state coverage of these procedures as required by SB 511. In collaboration with the Kansas Insurance Department, the Kansas Health Policy Authority examined the impact of extending coverage for bariatric surgery in the State Employee Health Benefits plan, and the affordability of coverage in the public and private sectors. The study includes emerging research evidence of the positive health impacts and risks for the morbidly obese, qualifications for the patients and the surgeons that determine when bariatric surgery is appropriate or necessary, and a cost analysis.

Introduction

Obesity in the United States and Kansas

Obesity can be defined as having a very high amount of body fat in relation to lean body mass. Individuals with a Body Mass Index, or BMI, of 30 or higher are normally considered obese. Data from the Behavioral Risk Factor Surveillance Survey show that the incidence of obesity in the United States has been increasing rapidly since 1985[1]. In 2007, the overall rate of obesity in the United States was 25.6%, which included 26.4% of men and 24.8% of women. The percentage of Kansas adults who were obese in 2007 was 26.9.

The health risks of obesity are numerous and severe. Obesity has been linked to a number of chronic diseases[2], including:

- Hypertension (high blood pressure)
- Osteoarthritis (a degeneration of cartilage and its underlying bone within a joint)
- Dyslipidemia (for example, high total cholesterol or high levels of triglycerides)
- Type 2 diabetes
- Coronary heart disease
- Stroke
- Gallbladder disease
- Sleep apnea and respiratory problems
- Some cancers (endometrial, breast, and colon).

Bariatric Surgery and Treatment Options for Obesity

Obesity treatment options can be categorized as either surgical or non-surgical. In the non-surgical category are behavioral treatment, diet modifications and drug treatment. Recently, upon the realization that for morbid obesity (i.e. weighing twice the ideal weight) the non-surgical approaches were largely ineffective, attention has turned to surgical options[3].

Bariatric surgery was first performed at the University of Minnesota in the 1950s. The procedure has since evolved, and in 1991 the National Institutes of Health issued a statement recommending that surgical options or bariatric surgery be considered for patients with morbid obesity[3]. Between 1993 and 2003, the number of surgeries performed increased from 20,000 to more than 120,000 as the procedure was increasingly seen as effective in initiating and maintaining weight loss and reducing comorbidities[3].

Bariatric procedures generally fall into two categories[4]:
1.) Restrictive (gastric banding "lapband", vertical banded gastroplasty) limits an individual's ability to ingest large quantities of food and slows the speed at which food empties from the stomach.
2.) Combination (gastric bypass with Roux-y, Duodenal Switch, or Biliopancreatic Division) procedure combines both restrictive and malabsorptive techniques. This procedure restricts food intake and bypasses the first and second segments of the small intestine. This procedure makes the stomach smaller to restrict food intake and alters digestion (bypasses sections of the small intestine).

The patient will need on-going medical care after the surgery, such as[5,6] nutritional counseling to maintain a healthy diet, physician evaluation, [6]blood work, and continued use of vitamin supplements and minerals due to malabsorption on a life long basis. If the patient loses a significant amount of weight due to the surgery, there is a potential need or request for skin reduction surgery to remove excess skin from areas such as the abdomen, arms, chin, and legs.

The Costs and Benefits of Bariatric Surgery

Cost of Surgery and Return on Investment
According to information provided by KHPA's actuaries, the charges for bariatric surgery in 2005 were over $30,000 per procedure including hospital fees. There is evidence to suggest a relatively short timeframe for return on investment, however. A retrospective case-control study that matched 3,651 bariatric surgery patients with surgery-eligible control subjects and found that, on average, total surgery costs were recovered after 53 months. This number includes a 77 month recovery period for operations performed between 1999 and 2002, and a 49-month recovery period for surgeries performed between 2003 and 2005, reflecting the improvements made during this time to both the cost-effectiveness and quality of the surgery which resulted in fewer complications[7]. Yet the results of this study should be received with prudence. An accompanying editorial[8] published with the aforementioned study in the American Journal of Managed Care cited two major shortcomings of this study: First, the return on investment estimates in the study are driven by rising costs in the matched control group rather than decreased costs from the surgery group. Second, the estimates assume a constant differential in costs between the two groups after 19 months which can only be confirmed or repudiated after the actual cost data becomes available.

Surgical Outcomes, Risks, and Quality
Short-term outcomes: [9]Research pertaining to 136 studies indicates that a significant number of individuals who had bariatric surgery experienced significant improvement, up to and including complete remediation, of four comorbidities of an overweight or obese diagnosis: diabetes, hyperlipidemia, hypertension and obstructive sleep apnea. Other studies have shown that bariatric surgery leads to large improvements in insulin insensitivity for diabetics early after surgery, even before any significant weight loss has occurred.[10]

Intermediate outcomes: [5]Two years after surgery, individuals usually have lost 50% to 60% of their excess body weight with the combination procedure and 40% to 50% with the restrictive

procedure. Some individuals experience a weight gain after 2 years which is estimated at 15% of the maximum weight loss. Weight gain is attributed to lack of remaining on the postoperative diet.

Long-term outcomes: [5,11] The Swedish Obese Subjects study, which assessed the long-run outcomes of bariatric procedures, found an average weight loss of 16% of initial body weight at 10 years. At the end of the ten years, subjects were less likely to have type 2 diabetes, hypertension, high triglycerides, or high levels of uric acid. However, this study consisted of highly motivated self-selected volunteers, so there is reason to doubt that the results apply to a broad-based population such as state employees. In any event, the results suggest that the initial weight loss associated with this class of procedures may dissipate slowly over time from an initial level of about half of their excess body weight.

Other long-term studies have shown variable results. A retrospective cohort study[12] of 9949 patients after Roux-en-Y gastric bypass surgery found a long-term decrease in mortality of 92% for diabetes-related deaths, 60% for cancer-related deaths and 56% for coronary artery disease and over the 18-year study period. However, the rates of death not caused by disease (such as death by accident or suicide) were 58% higher in the surgery group than in the control group.

Outcomes dependent on operative procedure: Two randomized clinical trials enrolling a total of 231 patients compared patient outcomes of a gastric bypass method known as Roux-en-Y with results from vertical banded gastroplasty[13]. Results showed that at 12 and 36 months after surgery patients enrolled in the Roux-en-Y gastric bypass lost substantially more weight than those assigned to vertical banded gastroplasty (42.43 kg versus 34.45kg at 12 months and 39.73 kg versus 30.65 kg at 36 months). Other studies have shown similar outcomes, resulting in the conclusion that Roux-en-Y produces greater weight loss than vertical banded gastroplasty.

Outcomes dependent upon patient characteristics
Postoperative risks:
1. [5]Acute nausea, plugging and vomiting affects approximately one to two thirds of the individuals.
2. [5]Acute gastric dumping (nausea, flushing, bloating, faintness, fatigue, and severe diarrhea) affects 50% to 70% of individuals.
3. [5, 6]Nutritional deficiencies to include anemia, osteoporosis, and metabolic bone disease affects approximately 25%-30% of individuals who undergo this procedure.
4. [6]More than one third develop gallstones.
5. [5]Mortality rate is approximately 1%.

Additional surgery:
1. [6, 14] Surgical reversal as medically necessary due to complications from the original surgery, such as obstruction or stricture.
2. [14]A previous bariatric surgical procedure may be revised or converted to another procedure due to lack of weight loss when medically necessary.

Variable quality: There are potentially significant risks associated with bariatric surgery and these risks can vary substantially across providers. Because of these risks, Medicare has

determined that it will only pay for bariatric surgery when performed at a facility they deem to be a Center of Excellence. When undergoing such a procedure as bariatric surgery, the patient should be in the hands of a skilled surgeon to ensure quality of care. [15]To qualify as an American Society for Bariatric Surgery Center of Excellence, the Center must be able to document to the Surgical Surgery Review Corporation the following:

1) Provide evidence as to resources (e.g. equipment, supplies, training of surgeons, and consultant services) available to perform surgery;
2) Excellent short and long term outcomes;
3) The center is required to have 125 bariatric cases per year or the surgeon must have 50 cases per year/125 lifetime cases.

Kansas now has three facilities that meet the coverage criteria for CMS. These centers are:

- Minimally Invasive Surgery Hospital in Lenexa
- Shawnee Mission Medical Center in Shawnee Mission
- St. Francis Health Center in Topeka.

Health Insurance Coverage of Bariatric Surgery

Medicare Coverage

Medicare announced in November of 2005 that it would begin covering bariatric surgery for beneficiaries under age 65 for open and laparoscopic Roux-en-Y gastric bypass and adjustable gastric banding. Coverage was only available under certain clinical circumstances and for facilities meeting Medicare's evidence-based standards for bariatric surgery[16]. This coverage was extended to all beneficiaries (including those over 65) in 2006[17].

Medicaid Coverage

Medicaid coverage of bariatric surgery varies by state, but the vast majority of state Medicaid programs (45 of 51) cover bariatric surgery in some capacity[18]. The six states that currently do not cover bariatric surgery are:

- Kansas
- Kentucky
- Mississippi
- Montana
- New Jersey
- Texas.

Additionally, several states exclude coverage under certain conditions. The following table compares obesity treatment coverage in all 50 states and the District of Columbia.

State Medicaid Coverage and Treatment Standards for Adults with Obesity[18]				
State	State provides specific guidance for treatment of obesity	State covers and pays for nutritional assessment and consultation	State covers and pays for drug therapy for the treatment of obesity	State covers and pays for bariatric surgery
Alabama	N	SE	SE	+[1]
Alaska	N	+P	SE	+*
Arizona	N	+	N	+
Arkansas	N	N	N	+*
California	N	SE	N	+*
Colorado	N	SE	+*	+[2]
Connecticut	N	SE	N	+
Delaware	N	+*	+*	+*
D.C.	N	N	N	+*
Florida	N	SE	N	+C
Georgia	G	+	SE	+*
Hawaii	N	SE	N	+*
Idaho	N	+C	N	+C
Illinois	N	SE	N	+[3]
Indiana	N	+	+	+
Iowa	N	+	+*	+*
Kansas	N	SE	+	SE
Kentucky	N	+	N	SE
Louisiana	N	+	+	+
Maine	N	+	N	+*
Maryland	N	N	N	+*
Massachusetts	N	N	N	+[4]
Michigan	N	+P	N	+C
Minnesota	N	+	+*	+*
Mississippi	N	+	+*	SE
Missouri	N	+C	N	+[5]
Montana	N	SE	N	SE[6]
Nebraska	N	SE	N	+[7]
Nevada	N	+	N	+[8]
New Hampshire	N	SE	N	+[9]
New Jersey	N	SE	N	SE
New Mexico	N	SE	N	+*
New York	N	N	N	+[10]
North Carolina	N	+	N	+*[11]
North Dakota	N	+L	N	+*
Ohio	N	SE	SE	+*
Oklahoma	N	+	SE	+12
Oregon	N	+P	N	+*
Pennsylvania	N	+	N	+*

State Medicaid Coverage and Treatment Standards for Adults with Obesity[18]				
Rhode Island	N	+	N	+*
South Carolina	N	+C	+*	+
South Dakota	N	SE	N	+[13]
Tennessee	N	SE	N	+[14]
Texas	N	SE	N	SE
Utah	N	SE	N	+*
Vermont	G[15]	+	N	+*
Virginia	N	+P	+*	+*
Washington	N	+P	SE	+
West Virginia	N	SE	N	+*
Wisconsin	N	+L	+*	+
Wyoming	N	SE	SE	+[3]

Symbol	Meaning
N	State manual provides no guidance or does not mention specific service or treatment
G	State manual provides detailed guidance for treating adult obesity
SE	Specified service is specifically excluded
+	State covers and reimburses for specified service
*	Prior authorization required
P	Services provided as part of prenatal care only
C	Services only considered if comorbid condition exist
L	Services are specifically limited in some way

1. Alabama will not cover Gastric Bypass for patients with a history of a previous Gastric Bypass procedure.
2. Colorado does not reimburse for CPT code 43845.
3. Illinois and Wyoming approve gastric bypass on a case-by-case basis.
4. Massachusetts will not cover CPT codes 43842, 48343, or 43845.
5. Missouri will not cover SPT codes 43770, 43771, 43772, 43773, or 43774.
6. Montana has no CPT codes for obesity surgery in its fee schedule nor does it mention obesity in its provider manual.
7. Nebraska excludes lleal bypass and intestinal surgery and will not cover other surgeries when the sole diagnosis is obesity.
8. Nevada excludes intestinal bypass and gastric balloon.
9. New Hampshire does not cover CPT codes 43645 or 43845.
10. New York does not cover CPT code 43845.
11. North Carolina does not cover investigational procedures including jejunoileal bypass, biliopancreatic bypass, gastric wrapping, gastric banding, jejunocolostomy, and mini-gastric bypass.
12. Oklahoma does not include CPT codes 43842 or 43843 in its fee schedule.
13. South Dakota does not cover CPT codes 43644, 43645, 43770, 43771, 43772, 43773, 43774, 43845, or 43848.
14. Coverage offered through TennCare, Tennessee's managed care program. It is unclear if this service is covered through traditional fee for service Medicaid.
15. Vermont does not include obesity treatment language in its provider manual. However, the state offers an extensive adult obesity toolkit at their website: http://healthvermont.gov/.

Bariatric surgery is also covered by a few private health plans, although coverage varies by plan type and location.

Cost to State Employee Health Benefit Plan

During the 2008 Kansas Legislative Session, KHPA prepared an estimate of the cost to include bariatric surgery in the State Employee Health Plan (SEHP). We estimated the surgical costs for 2008 to be $12,750,000. This amount would have covered 425 such surgeries without any limitations on such surgeries (unlike Medicare and other private insurance). For 2010, our estimate is increased to $14,598,000 to account for a 4.5% annual pricing trend and an increased number of utilizers.

These estimates are based on crude population-based estimates of the prevalence of obesity in the state employee population, since no direct measures are available. In addition, the estimates represent an upper bound since they presume the application of only the minimal, Medicare-based criteria to coverage of the surgery. Other insurers and several state Medicaid programs target surgeries at a smaller population of those who would benefit most. Gross expenditures for bariatric surgery under the state employee plan would depend upon the eligibility criteria selected by the Health Care Commission, and could thus be less than the estimates above.

In addition, new research supports the identification of offset savings to the health plan due to the ongoing health improvements of those who have had the surgery. Research summarized above indicates full payback of surgical costs in as little as four years. These savings would be more likely if the surgery were targeted at a smaller group, where the health risks of obesity and the likelihood of successful post-operative compliance with ongoing treatment are highest. A key offset to the documented savings from surgery-related health improvements is the fact that employees who receive SEHP-covered bariatric surgery will leave the plan at some point in the future (at retirement, if not sooner), taking their improved health and offset savings with them. It is also possible that the prospect of receiving bariatric surgery could attract employees into state service, and that some of those employees might leave state service sooner than might otherwise occur.

Taking all of these factors into account introduces many uncertainties into estimates of the overall financial impact of bariatric coverage in the state employee health plan. Financial models of these net impacts suggest that bariatric surgery would increase state employee health expenditures in the first two to three years as the high up-front costs of surgery are incurred for all currently-eligible employees who wish to take advantage. Surgical costs would decline in future years as utilization fell to include only those newly eligible due to increasing weight, new employment, etc. Offset savings due to improved health would grow steadily for several years as the cumulative number of employees with the surgery – and who would otherwise be incurring higher obesity-related health care costs – would increases. Annual net costs would likely to savings in as few as three or four years. Cumulative costs would turn to long run total savings within about 10-12 years. Cumulative savings in the second decade of coverage could reach into the tens of millions of dollars based on the promising research results that have become available in the two years. The assumptions underlying these estimates need to be reviewed by medical care experts before taking any action, but suggest that a modest short-term

investment in bariatric surgery would result in substantial long-run improvement in the health of covered employees and the financing of state employee health benefits.

Eligibility Criteria in Public and Private Health Plans

[19]Medicare

In order for a bariatric surgery to be covered by Medicare, Medicare requires the patient to have a Body Mass Index equal to or greater than 35 (e.g. 200 lbs. for a 5'5" person). The individual must also have at least one of the following associated diseases: Hypertension, Type II diabetes, degenerative joint disease involving the lower back, hips, knees, ankles, or feet, gastroesophageal reflux, sleep apnea, obesity hypoventilation syndrome, female sexual hormone dysfunction including the syndrome of polycystic ovaries, amenorrhea, hirsutism, or (Stein-Leventhal syndrome), urinary incontinence or pseudotumor cerebrii.

Prior to being considered as a candidate for surgery, the patient must undergo prerequisite treatment, including: Dietary education and evaluation, pharmacological management and a psychological evaluation. The patient must also agree to post-operative care that includes medical/surgical management, dietary counseling and planning, and psychological counseling where it is medically necessary.

[14]Cigna

In order for bariatric surgery to be covered, Cigna requires the patient to have the following conditions:
The patient's BMI must be 40 or greater for at least one year *or* a BMI of between 35 and 39.9 for at least one year with one or more co-morbidities (type 2 diabetes, hypertension, hyperlipidemia, coronary artery disease, or sleep apnea) that have failed to respond to nonsurgical treatment methods. Additionally, the patient must be at least 18 years of age and/or have obtained full skeletal growth, have documented participation and compliance in a weight-loss program for at least 6 months (again, participation must have occurred within the last one to two years) and a medical, psychological and nutritional evaluation.

[20]Minnesota Medicaid

The Minnesota Medicaid program has different coverage criteria for adult and adolescent surgery candidates. For adults, the patient must either have a BMI of 40 or higher *or* a BMI of 35-40 with one or more comorbidities (severe cardiac disease, type 2 diabetes, obstructive sleep apneas and other respiratory disease, pseudo-tumor cerebri, gastroesophageal reflux disease, hypertension, hyperlipidemia, or severe joint or disc disease that interferes with daily functioning). The BMI level must have persisted for at least two years before the operation.

For adolescents, the patient must either have (1) a BMI of 40 or higher with one or more comorbidities, including type 2 diabetes, obstructive sleep apnea, pseudotumor cerebri, or severe or complicated hypertension, *or* (2) a BMI of 50 or higher with one or more comorbidities including hypertension, dyslipidemias, nonalcoholic steatohepatitis, venous stasis disease, significant impairment in activities of daily living (ADL), intertriginous soft-tissue infections, stress urinary incontinence, gastroesophageal reflux disease, arthropathies in weight-bearing

joints, or obesity-related psychosocial distress. The recipient must have attained physiologic maturity as measured by reaching Tanner stage IV development and 95% of adult height.

For both adults and adolescents, the patient must have made at least one serious medically supervised attempt of at least six months' duration to lose weight in the past. The patient is also required to provide a written statement of their current eating habits and complete a full medical and psychiatric examination prior to surgery. Minnesota Medicaid is unique in requiring a signed statement by the patient detailing the patient's commitment to lose weight, expectations of the surgical outcomes, willingness to make permanent lifestyle changes and participate in a long-term postoperative care plan. A similar statement of support is required from the custodial parent or guardian for all adolescent patients.

Recommendations

Given the demonstrated safety and efficacy of the procedures, which improve the quality of life, reduce long-run costs, and reduce mortality, KHPA plans to develop recommendations for the HCC that will provide limited coverage of bariatric surgery in the SEHP. Recommendations will be based on the input of medical professional to identify specific coverage criteria that will result in the targeting of this surgery to those who can benefit most, thereby improving health outcomes and reducing costs to the State.

The criteria may begin with the criteria adopted for coverage within Medicare, which require performance of the surgery at a Center for Excellence, and failure at other weight-reduction methods, along with a signed commitment by the patient to follow through with all after-care recommendations. KHPA will plan to seek counsel from those with expertise in weight loss and bariatric surgery to develop initial coverage criteria to be recommended to the Health Care Commission (HCC), the governing body with direct responsibility for determining SEHP benefits. Future consideration of coverage within Medicaid will depend upon the availability of state funds for the initial investment phase of coverage.

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STUDY OF IMPACT OF EXTENDING COVERAGE FOR BARIATRIC SURGERY IN THE SMALL BUSINESS EMPLOYER GROUP AND THE HIGH RISK POOL

Kansas Insurance Department

October 31, 2008

PREFACE

House Bill No. 2672

HB 2672 was an act concerning the Kansas health policy authority that amended K.S.A. 38-2006, 39-968 and 65-435a, repealing the existing sections; and also repealed K.S.A. 46-2507.

One of the issues considered by the Legislature was the medical and societal epidemic of obesity and the potential for higher mortality rates for individuals with obesity and the economic impact on medical expenses. In New Section 1 of HB 2672 the Legislature requested that the Kansas health policy authority conduct a study on the topic of bariatric surgery and a study on the impact of extending insurance coverage for bariatric surgery. **In conducting the study on the impact of extending insurance coverage for bariatric surgery, the authority was directed to collaborate with the commissioner of insurance ("Commissioner") with regard to the affordability of coverage in the small business employer group and the high risk pool.**

Study Process

The Commissioner's study process incorporated the following six activities:

1. A survey of the 25 insurers licensed to sell small group coverage in Kansas.

2. Review and analysis of the responses provided by 13 insurers, including costs, potential economic impact on premiums, and related comments.

3. A request for benefits and cost information from the third party administrator and utilization review organization for the Kansas Health Insurance Association (the Kansas high risk pool) regarding coverage for bariatric surgery provided to its members.

4. A request for input from the consulting actuary for KHIA regarding the impact of costs for bariatric surgery on premiums.

5. Review and analysis of the benefits and cost information provided by KHIA's third party administrator, utilization review organization, and consulting actuary.

6. Internet research to obtain national data regarding costs and risk of complications for bariatric surgery.

PART I - AFFORDABILITY OF COVERAGE IN THE SMALL GROUP MARKET

Introduction

The Commissioner conducted a survey of all 25 insurance companies currently licensed to sell small group coverage in Kansas by posing the following question: "What would be the impact on premiums if coverage for bariatric surgery was provided in the small group market?

The Commissioner received complete responses from 13 insurers, all of whom expressed reservations about providing a definitive response to the question in the absence of specific information regarding the specific amount and type of benefits to be provided and the criteria or factors to be used to determine the medical necessity for bariatric surgery services. In addition, they were reluctant to attempt to calculate the possible economic impact on premiums with no reliable data to suggest the number and type of procedures that might be requested by their insureds. The insurers who provided incomplete responses expressed an inability to provide a meaningful or accurate answer to the question posed in the absence of such information. Those insurers who provided complete responses stated that the economic impact on premiums would likely increase dramatically if the demand for costly bariatric surgery procedures and services became significant once coverage was provided.

Demand

All insurers confirmed that coverage for bariatric surgery is currently not provided in the small group market but is available to large groups and self-funded employers. They indicated they receive very few requests for or inquiries about bariatric surgery from their insureds, which may be due, at least in part, to the general knowledge among insureds that weight loss benefits are generally excluded from coverage. However, the insurers also acknowledged they receive frequent inquiries from their contracting providers regarding the possibility of coverage for bariatric surgery. Under these circumstances it would be difficult to project the level of demand for bariatric surgery services if coverage were made available to small groups.

Cost of Treatment

The insurers indicated a cost of $10,000 to $25,000 for bariatric surgery, depending on the type of procedure performed and associated costs, with a lower cost for procedures such as gastric banding (LAP-BAND) and higher costs for more invasive procedures such as gastric bypass. In data submitted to the Kansas Health Insurance Information System (KHIIS) by all insurers, for calendar years 2002 through 2007, 143 patients received insurance benefits for bariatric surgery during this six year period for total provider charges of approximately $6.5 million, including surgical fees, anesthesiologist charges and associated hospital fees, and actual benefits paid in the amount of $2.3 million. The average provider charge per patient was $45,428 with an average benefit payment of $16,371. The costs reported in response to the

Commissioner's survey and the KHIIS cost data do not include any costs related to any subsequent treatment or care required due to complications following bariatric surgery.

A study released by the U.S. Department of Health & Human Services in 2006 reported that four of every 10 obesity surgery patients experience complications within 6 months following surgery, including dumping syndrome, which includes vomiting, reflux, and diarrhea, anastomosis complications (resulting from the joining of the intestine and stomach), such as leaks or strictures, abdominal hernias, infections, and pneumonia. The study reported medical care spending for patients experiencing complications averaged $36,542, including their initial hospital stay, while spending for patients without complications averaged $25,337. For patients requiring hospital readmittance due to complications, costs averaged $65,031.[20]

Impact on Premiums

The 13 insurers who responded estimated an increase in premiums in the range of 1/2% to 8%, for an average of 3.07% for the group. However, as stated above, the insurers indicated that these percentages could prove to be inadequate based on the demand for bariatric surgery services and the incidence of complications and their related costs. These estimates appear to be consistent with the 1% to 3% impacts experienced by the four states that currently mandate coverage for morbid obesity treatment.[20]

PART II - KANSAS HEALTH INSURANCE ASSOCIATION (KHIA) (KANSAS HIGH RISK POOL)

The Kansas Health Insurance Association

The Kansas Health Insurance Association is a nonprofit legal entity created by the Kansas Legislature pursuant to the Kansas uninsurable health insurance plan act of 1992, K.S.A. 40-2117, *et seq.* Under its plan of operation KHIA provides health care benefits for Kansas residents who are unable to purchase health insurance or obtain coverage for an existing medical condition, who have exhausted their health insurance benefits, who have been quoted insurance rates more than the KHIA rate, or otherwise qualify under the federal Health Insurance Portability and Accountability Act (HIPAA).

As of August 31, 2008 KHIA had 1,907 members in 11 plans, with deductibles ranging from $500 to $10,000 per year. KHIA provides comprehensive benefits comparable to those offered in the commercial individual market, including prevention services, inpatient hospital care, maternity, emergency room, mental health/substance abuse, home health care, and prescription drug benefits, with an individual lifetime maximum benefit of $2,000,000. For plan year 2007 KHIA paid benefits totaling $18.7 million.

Coverage for Bariatric Surgery

Under the standard benefit provisions of the KHIA policy, the "treatment of obesity" is excluded from coverage unless the treatment is determined to be "Medically Necessary" by KHIA's utilization review organization ("URO"). The term "Medically Necessary" is defined in the policy as

> a service or supply that:
>
> (a) is appropriate and consistent with the diagnosis in accordance with generally accepted standards of medical practice as determined by a Utilization Review Organization;
>
> (b) is not considered Experimental or Investigative;
>
> (c) could not have been omitted without adversely affecting the Insured person's condition or quality of medical care; and
>
> (d) is the most appropriate supply or level of service that can be provided on a cost effective basis.

Utilization Review Organization Determination Process

When a health care provider seeks pre-certification for a bariatric surgery procedure for the KHIA member/patient, such as gastric bypass or gastric banding, the provider is required to submit the following information to the URO for a determination of medical necessity:

- Medical records from the previous six months, relating to the patient evaluation and treatment to date, including diagnostic lab work (must include glucose and thyroid studies). The testing done should have been performed within the previous six months.
- A detailed history that includes co-morbidities.
- A psychosocial/psychiatric evaluation that documents patient understanding of the procedures and needed follow-up care
- The surgical approach and any additional procedures requested, including post-operative needs such as nutritional and psychological support, and weight, exercise and diet monitoring
- Documented current height, weight and BMI
- Six months of documented exercise regimen (including dates and results)
- Six months of physical - dietician monitored diet program (including dates and results)

- Physician verification that patient is a minimum of 100 pounds above the weight indicated by Federal guidelines

In addition to reviewing the information provided above, the URO also considers the following factors in making a determination of medical necessity[20]:

- Patient has a BMI of 40 or greater
- Patient has a BMI of 35 or greater and a clinically serious condition exists (e.g., obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy, musculoskeletal dysfunction)
- Patient's failure to lose weight significantly or regaining of weight despite compliance with a multidisciplinary nonsurgical program, including low- or very low-calorie diet, supervised exercise, behavior modification, and support, with possible medication
- No specifically correctable cause for obesity (e.g., an endocrine disorder)
- Full growth
- Patient is receiving treatment in a surgical program experienced in obesity surgery, characterized by surgeons experienced with gastric bypass and a multidisciplinary approach, including all of the following:
  - Preoperative medical consultation and approval
  - Preoperative psychiatric consultation and approval
  - Nutritional, exercise, and psychological counseling

Financial Impact

From January 1, 2005 through September 30, 2008 (almost four plan years), KHIA paid benefits for bariatric surgery, including both gastric bypass and gastric banding (LAP-BAND) for nine members at a total cost of $95,508.34, for surgical fees, hospital fees, and anesthesia, for an average of $10,612 per procedure. The range of costs for these nine patients was $2,897 to $41,130, with the difference in range attributable to whether the patient underwent the a less expensive procedure, such as lap-banding, or the more invasive gastric bypass procedure and whether the patient had other health conditions which required additional treatment or care at the time of the bariatric procedure. These figures reflect the amount paid after the application of patient deductibles, co-insurance, and the negotiated discount with the provider. The actual amount charged by the providers for these procedures was $233,095, for an average charge of $25,899. The range for those charged amounts was $8,454 to $114,073. These figures do not reflect any subsequent costs incurred for these patients in the weeks and months following their bariatric surgery due to complications.

KHIA's consulting actuary indicated that given the limited number of bariatric surgery procedures covered by KHIA over the past four plan years, there has been no significant impact on member premiums. However, if the criteria and documentation required to determine medical necessity for these procedures were relaxed or reduced KHIA might be expected to

experience increased costs, and resulting increases in premiums, due to greater numbers of procedures being approved and performed.

PART III - REINSURANCE ISSUES

Information regarding reinsurance coverage for high medical costs experienced by small groups has been previously provided to the Legislature in conjunction with other studies and requests for information.[20] However, the types of reinsurance previously described - prospective (before costs occur) or retrospective (after costs occur) - and the financing of the cost of such reinsurance, either by small group insurers paying for the cost of reinsurance through premiums or assessments or the state paying all or some portion of the cost as a subsidy to the small group insurance market through the use of state general funds, or other taxes could be used to cover the costs for bariatric surgery.

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KANSAS HEALTH POLICY AUTHORITY

Financial Institutions and Insurance: SB 511 – Study on Coverage for Bariatric Surgery

January 15, 2009

Doug Farmer
Director, State Employee Health Benefits Plan
Kansas Health Policy Authority

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KANSAS HEALTH POLICY AUTHORITY

Overview

- History
- State Employee study 2006
- New research
- Estimated impact of coverage
- Summary
- Staff recommendations for bariatric surgery

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History

- Prior to Plan Year 2008, all treatment for obesity was excluded from coverage under the State Employee Health Plan (SEHP)
- Medicaid reimbursed for weight-loss medications but excluded coverage for bariatric surgery
- The Health Care Commission (HCC) considered coverage for bariatric surgery in 2006
- KHPA engaged in Statewide Health Reform initiative in 2007 and 2008 emphasizing prevention and wellness
- Consistent with KHPA initiatives in the area of prevention and wellness, HCC decided to cover preventive and non-invasive obesity treatments for 2008 under SEHP

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Health Care Commission Review of Bariatric Surgery in 2006

- Findings:
  - Preventive, non-invasive treatment was not covered
  - Relatively high incidence of complications and even death
  - Morbidity and mortality vary considerably with experience of surgeon and hospital
  - No Centers of Excellence in Kansas
  - Long-term cost-effectiveness not yet demonstrated

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Health Care Commission Review of Bariatric Surgery in 2006

- KHPA Staff Recommendations for State Employee Health Plan (SEHP):
  - Educate consumers on available options for promoting wellness and addressing weight problems
  - Review SEHP plans for 2008 to examine possible expansion in preventive benefits
  - Review HealthQuest program to consider initiatives in the following areas:
    - Physician-supervised weight management
    - Behavior modification
    - Healthy eating
    - Exercise
  - SEHP and Medicaid Staff review of bariatric surgery exclusion
    - Retain exclusion of bariatric surgery

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State Employee Health Plan Changes in 2008

- Provide coverage for non-surgical treatment of obesity
- Expanded coverage for consultation with a dietitian
  - Coverage not limited to diabetics
- Added coverage for prescription weight loss medications

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HealthQuest for 2008

- Healthy Lifestyle Programs Includes:
  - Healthy eating and weight management information
  - Health coaches to provide ongoing support
  - Teleclass: Healthy Weight
  - Online class and tools

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New Developments

- Kansas now has two Centers of Excellence for bariatric surgery as designated by the American Society for Bariatric Surgery
- Centers for Medicare & Medicaid Services (CMS) has 3 certified centers in Kansas to provide bariatric services to Medicare beneficiaries
  - Limited geographic area
- Continued increase in prevalence of bariatric surgery
- Explosion in research
  - Emerging evidence of the positive health impact for the extremely obese
  - Continued advancement in procedures and knowledge of quality indicators
- Widespread, but proscribed, coverage by Medicaid

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New Research

- Surgery reduces excess body weight by half after two years, and reduces total body weight by 16% after ten years
- Surgery reduces long-run obesity-related mortality by 50%-90%
- Surgical costs may be recoverable in as little as 4-5 years, depending upon the patient
- Studies compare efficacy of different procedures
- Significant risks accompany the surgery, but are lower in accredited and high-volume centers

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Estimated Financial Impact

- Estimated cost of coverage for the State Employee Health Plan:
  - As much as $15 Million in first year
  - Costs depend on required pre-conditions
- Long run net savings to the state
- Additional costs of coverage in Medicaid

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Medicaid

- Continues to provide reimbursement for prescription weight-loss medications with prior authorization
- Provides for reimbursement for medical nutrition therapy for children under the KanBeHealthy program

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Summary

- Recognized Problem
  - Obesity is epidemic in the U.S. and in Kansas
  - Increasing individual, employer, and societal costs for chronic diseases due to overweight and obesity
- New evidence supporting long run value of bariatric surgery
  - Improved health and longevity
  - Reduced medical costs
  - Improved safety through experience and targeting of services

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Staff Recommendations

- Emphasize value of preventive care
  - Changes have been made to State Employee Plan
  - Recommendations being developed for Medicaid
- Develop recommendation for HCC to cover bariatric surgery in the SEHP
  - Use Medicare coverage as a starting point
  - Work with weight loss and surgical experts to target surgery to those who can benefit most
  - Consider Medicaid coverage if funding is available

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http://www.khpa.ks.gov/

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Kansas Insurance Department
Sandy Praeger, Commissioner of Insurance

HSAs, HDHPs, AND SECTION 125 PLANS

and

INSURER PROGRAMS PROMOTING WELLNESS, HEALTH, AND DISEASE PREVENTION

January 9, 2009

FI&I Committee
1-15-09
Attachment 2

420 SW 9th Street
Topeka, Kansas 66612-1678

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INTRODUCTION

Public Health Studies

In May 2008 the Conference Committee on H. Sub. for SB 81 requested studies on a number of topics initially considered as part of the legislation. On July 9, 2008 the Legislative Coordinating Council (LCC) approved a number of these studies to be conducted by the Kansas Health Policy Authority (KHPA) during the 2008 Interim period, with such studies to be provided to the Joint Committee on Health Policy Oversight on or before November 1, 2008. On August 29, 2008 KHPA confirmed, in a letter addressed to the LCC, that on August 14, 2008 the Joint Committee had approved an extension of the delivery date for the studies to the first day of the 2009 Legislative Session (on or before January 12, 2009). The LCC acknowledged this extension on October 13, 2008 and also approved KHPA's assignment of certain studies to various agencies. The following two studies were assigned to the Kansas Insurance Department:

1. **Study encouragement of HSAs, HDHPs, and Section 125 plans to expand affordable commercial insurance**

2. **Study allowing insurers to provide incentives in return for participation in programs promoting wellness, health, and disease prevention to expand affordable commercial insurance**

HEALTH SAVINGS ACCOUNTS, HIGH DEDUCTIBLE HEALTH PLANS & SECTION 125 PLANS

What is a Health Savings Account?

A health savings account (HSA) is a savings product that can be used as an alternative to traditional health insurance and which allows one to pay for current health expenses and save for future qualified medical and retiree health expenses on a tax-free basis. In order to take advantage of an HSA, you must also be covered by a high deductible health plan (HDHP) but must not be covered by other health insurance that is not an HDHP. In general, an HDHP will cost less than traditional health insurance, so the money saved on insurance can be put into the HSA. The money placed in the HSA is controlled by the owner and decisions regarding how the money is spent are made by the owner, without relying on a third party or a health insurer. The owner may also decide what types of investments to make with the money in the account in order to make it grow, including stocks, bonds, mutual funds, and certificates of deposit.

What is a High Deductible Health Plan?

As stated above, if you want to open an HSA you must also have a high deductible health plan. An HDHP, sometimes referred to as a "catastrophic" health insurance plan, is a less expensive health insurance plan with a high "deductible", which means it doesn't cover the first several thousand dollars of health care expenses you incur but will generally cover your expenses once that deductible is met. The intent is that the funds in the HSA will help pay for the expenses that your HDHP does not cover.

The HDHP policy does not have to be in the name of the owner of the HSA, as long as the HSA owner has coverage under the HDHP policy. This situation might arise in cases where the HSA owner has coverage under an HDHP in his or her spouse's name.

Setting Up an HSA

HSAs can be set up with banks, credit unions, insurance companies, and other approved companies. Employers are also permitted to set up plans for their employees. There are no income limitations that affect HSA eligibility. However, if you do not file a federal income tax return, you may not receive all the tax benefits that HSAs offer.

How Much Does It Cost?

An HSA is not something you purchase but is a savings account, similar to an IRA, into which you can deposit money on a tax-preferred basis. The only additional expense is the cost of purchasing an HDHP, which will cover you should your medical expenses exceed the funds available in your HSA. However, depending on where the HSA is established, there may be additional fees for administration of the account.

For 2008, in order to qualify to open an HSA, you were required to purchase an HDHP with a minimum deductible of $1,100 (for individual-only coverage) or $2,200 (for family

coverage). The annual out-of-pocket expenses, including deductibles and co-payments, could not exceed $5,600 (individual-only coverage) or $11,200 (family coverage). HDHPs are permitted to have first dollar coverage (no deductible) for preventive care but may also apply higher out-of-pocket limits (co-payments and insurance) for non-network services.

Once funds are deposited into an HSA, they can be used to pay for qualified medical expenses tax-free. The funds in the account roll over automatically each year and there is no time limit on using the funds. If your HDHP is cancelled or terminated, the funds in the HSA can still be used to pay for qualified medical expenses tax-free but no additional contributions can be made to the HSA account for the period you are not covered by an HDHP.

Eligibility

As stated above, in order to be eligible for an HSA, an individual must be covered by a qualified HDHP and must not be covered by other health insurance that is not an HDHP. However, certain types of insurance, such as automobile, dental, vision, disability, and long-term care insurance do not jeopardize your eligibility for an HSA. You may also have health insurance coverage for a specific disease or illness, such as cancer, as long as that insurance pays a specific dollar amount when the policy is triggered. Wellness programs offered by your employer are also permitted if they do not pay significant medical benefits.

Individuals are not eligible for an HSA after they have enrolled in Medicare. However, if you had an HSA before you enrolled in Medicare you may keep it and continue to use it but may no longer make contributions to the account. Individuals who have received any health benefits from the Veterans Administration or one of their facilities, including prescription drugs, are also ineligible for an HSA.

HSA Funding

Contributions to HSAs can be made by individuals, their employers, or both. For 2008 the maximum annual HSA contribution was $2,900, for individual only HDHP coverage, and $5,800 for family coverage, regardless of the amount of the HDHP deductible. For 2009, these amounts increase to $3,000 for individual coverage and $5,950 for family coverage. If you are age 55 or older, you may also make additional "catch-up" contributions each year until you enroll in Medicare. For 2008, the catch-up contribution amount is $900 and for 2009 and after the catch-up amount is $1,000.

Contributions may be made to an HSA in a lump sum or in any amounts or frequency desired. However, the account trustee (bank, credit union, insurer, etc.) may have minimum deposit and balance requirements. Contributions made by employers are aggregated with those made by the HSA account holder to determine whether the maximum contribution has been made.

Tax Benefits

Personal contributions to an HSA provide an "above-the-line" deduction, which means the HSA account holder is permitted to reduce his or her taxable income by the amount contributed to the HSA. The account holder is not required to itemize deductions in order to qualify for this tax benefit. If an employer makes a contribution to the HSA, the contribution is not taxable to the employee.

If your employer offers a "salary reduction" plan, also known as a Section 125 plan or cafeteria plan, you may also make contributions to your HSA on a pre-tax basis but may not claim the "above-the-line" deduction for that same contribution.

Self-employed persons are not permitted to contribute to an HSA on a pre-tax basis but may contribute with after-tax dollars and take the above-the-line deduction.

Use of HSA Funds

HSA funds can be used to pay for any "qualified medical expense" for yourself, your spouse, or a dependent, even if the expense is not covered by your HDHP. For example, most health insurance plans do not cover the cost of over-the-counter medicines, but HSA funds can be used for these expenses. As long as HSA funds are used for qualified medical expenses, the money spent is tax-free.

When determining whether an expense qualifies as a "qualified medical expense," HSA account holders can refer to IRS Publication 502, available at the Internal Revenue Service website (www.irs.gov). However, in general, the expense has to primarily be for the prevention or alleviation of a physical defect or illness. If HSA funds are used for other than qualified medical expense, the expenditure will be taxed and, for individuals who are not disabled or over age 65, subject to a 10% tax penalty.

The HSA account holder is responsible for keeping track of contributions made to the account and expenditures. If you have not met your HDHP policy deductible you will be expected to pay for 100% of the amount agreed to be paid by your insurance policy to the physician, either at the time services are provided or when you receive a bill from your physician.

What Are Section 125 Cafeteria Plans?

Section 125 cafeteria plans, also referred to as flexible benefit plans or Section 125 plans, are employer sponsored employee benefit plans that allow employees to obtain benefits on a pre-tax basis. Congress provided for cafeteria plans in 1978 under IRS Code Section 125.

The primary benefit for employers is a potential savings in payroll taxes. For employees, the benefits include income tax savings, increased take-home pay, and increased morale. In general, the administrative costs of establishing and maintaining a Section 125 plan are minimal compared to the potential tax savings.

Premium Only (POP) Section 125 Cafeteria Plans

A premium only plan, also known as a POP, is a popular type of Section 125 plan. A POP plan helps reduce a company's costs by allowing its employees to pay for qualified health care premiums with pre-tax dollars.

POP Benefits

For employers, the benefits include:

- Savings on payroll taxes when employees make pre-tax contributions, which ultimately decrease the amount of taxable pay
- Ability to deduct POP fees as a business expense

For employees, the benefits include:

- Savings on cost of qualified insurance premiums since employee contributions are made with pre-tax dollars
- Increased take-home pay as a result of reduced taxes

How Can Employers Be Encouraged to Use HSAs, HDHPs, and Section 125 Cafeteria Plans?

The Kansas Insurance Department (KID) provides a number of resources for small employers that contain information regarding HSAs. Such information is included in KID's Small Business Packet, which is distributed to small businesses seeking information about the different types of insurance needed for their companies. This information is also provided on KID's public website at www.ksinsurance.org/consumers/hsa.htm. The KID website also provides a regularly updated list of banks that offer HSAs. Periodically Commissioner Praeger has discussed HSAs in articles provided to media throughout the State, which are published in local newspapers. Finally, KID recently completed an insurance Primer that will be available for distribution in early 2009. This Primer contains information about the various types of insurance regulated at both the state and federal level and provides specific information regarding HSAs and tax credits available to employers who make contributions to HSAs on behalf of their employees.

House Substitute for Senate Bill 81, which was passed during the 2007-2008 Legislative Session, included a number of provisions to expand the use of Premium Only Section 125 Plans by Kansas employers. In New Section 1, insurers doing business in Kansas are now required to provide employers with the option of establishing a premium only cafeteria plan and the definition of "health benefit plan" was amended to include Section 125 cafeteria plans. In New Section 2, the Legislature also encouraged employers to "offer the option of paying all or any portion of the health insurance premium or the option of receiving health insurance coverage

through a high deductible health plan and the establishment of a health savings account." Finally, in Section 16 of SB 81, the Legislature authorized the Kansas Health Policy Authority to provide grants to small employers "for the purpose of establishing a cafeteria plan" and directed the Authority to develop and implement a program to ensure that small employers are aware of the grant program and understand the benefits of establishing cafeteria plans.

Recommendation

Although there is abundant information available from the Kansas Insurance Department and through the Internet regarding health savings accounts, high deductible health plans, and Section 125 cafeteria plans, many small employers may still be unaware of the existence and benefits of such plans. Greater promotion in the media or education for small employers regarding the costs and benefits of HSAs, HDHPs, and Section 125 Plans through small business associations or a state-sponsored clearinghouse, like the development program described in SB 81, may result in expanded use of these benefits. However, small employers may still be reluctant to establish such programs for their employees for a number of reasons.

First, small employers, that typically do not have human resource departments or a human resource person on staff, may feel overwhelmed or unprepared to take on the responsibility of establishing and maintaining these types of benefit plans for their employees. In some cases there may be misunderstandings regarding the cost of establishing such programs or concerns regarding the amount of time necessary to administer these programs.

Second, although HSAs, HDHPs, and Section 125 Plans provide significant benefits to both employers and employees, either the employees or the employer must be willing and able to make the necessary monetary contributions to establish and maintain these plans. In the case of HSAs, both the employee and the employer are permitted to make contributions to the employee's HSA, but the contributions needed to provide sufficient funds to cover the deductible of the employee's HDHP, generally in excess of $1,000, may be difficult or impossible for both parties. In these cases, expanded use of such plans might be possible if subsidies were provided to small employers or individuals to reduce the costs associated with HSAs, HDHPs, and Section 125 Cafeteria Plans for their employees.

WELLNESS, HEALTH AND DISEASE PREVENTION PROGRAMS

In general, Kansas insurance law does not prohibit insurers from providing incentives to their insureds for participation in wellness or disease prevention programs and inclusion of such programs in contracts of health insurance issued to Kansas insureds is routinely approved by the Kansas Insurance Department. However, under K.S.A. 40-2404(8)(a), insurers are prohibited from knowingly permitting, offering or making any contract of accident and health insurance that contains any inducement to purchase, discounted premiums, special favor or advantage, or any "valuable consideration or inducement" unless it is "plainly expressed in the insurance contract."

When reviewing and approving contracts of insurance that contain these types of programs, KID's policy examiners review the type of incentives or special benefits that an insurer is proposing to offer to Kansas insureds to determine whether the incentives or special benefits are clearly described in the policy and apply to all insureds in a non-discriminatory fashion. In cases where the policy examiner asks for additional clarification or language to be included in the policy form or an associated rider, insurers regularly modify the contracts to provide the clarity needed to insure that the incentives and benefits are clearly described.

In the past KID has approved wellness and disease prevention programs that include:

- Health risk assessments
- Personalized healthy living action plans
- Healthy weight or weight management programs, including dietitian services
- 24 hour nurse access
- Wellness counseling
- Discounts for fitness club memberships and home exercise equipment
- Complementary "natural" health care services, such as acupuncture, chiropractic care, and massage therapy
- Reduced deductibles and co-payments for preventive care services, such as annual physical, eye, and hearing exams, routine dental visits, flu shots and other vaccinations.