Approved: 2-4-09

Date

MINUTES OF THE SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

The meeting was called to order by Chairman Ruth Teichman at 9:30 a.m. on January 20, 2009, in Room 136-N of the Capitol.

All members were present.

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

Conferees appearing before the committee:
Melissa Calderwood, Research Department (Attachment 1)
John Meetz, Kansas Insurance Department
Bob Alderson, National Association of Public Insurance Adjusters
Bill Sneed, America's Health Insurance Plans (Attachment 2)
Others attending:
See attached list.

Chairman Teichman called the meeting to order.

Bill Introductions

John Meetz, Legislative Liaison, Kansas Insurance Department, introduced two bills, the first pertaining to risk-based capital requirements, establishing a trend test calculation.

The second bill is the mental health parity provision as a result of federal legislation that was included in the seven billion dollar economic stimulus package at the federal level. It allowed for substance abuse provisions and the federal mandate. It also retracted the yearly sunset provision. We would like to introduce a bill that sinks up the Kansas law with those federal changes.

Senator Steineger moved introduction of both bills. Senator Taddiken seconded. Motion passed.

Bob Alderson, Lobbyist, National Association of Public Insurance Adjustors, requested introduction by the committee of a bill to license public insurance adjusters. Mr. Alderson explained that a public insurance adjustor handles third party claims only. He said if you have a claim against your insurance company and you are having difficulty in determining the value of your claim, a public insurance adjustor can be retained.

Senator Holland moved introduction of the bill. Senator Steineger seconded. Motion passed.

Overview of Health Insurance Mandates

Melissa Calderwood, Principal Analyst, Research Department, gave an overview of Kansas Health Insurance Mandates. Ms. Calderwood said Kansas law requires the Legislature to periodically review all state mandated health insurance coverage. She noted that the Legislature typically reviews the mandates as amendments rather than reviewing all of the mandates at one time. She said 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, she noted, that has received a lot of review is the alcohol, drug abuse, and mental illness mandate. Further, she said 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, she said.

She continued, stating that Kansas law 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.

Further, Ms. Calderwood stated that the law enacted by the Legislature in 1999 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. She said 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.

Ms. Calderwood stated that the 2008 Legislature directed the Kansas Health Policy Authority, 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, she said 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 was required to submit a report on its findings to the Joint Committee on Health Policy Oversight on or before November 1, 2008.

In closing, Ms. Calderwood said the Kansas Legislature has enacted eight provider mandates, 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. She noted that using this comparison of state mandates, Kansas is closer to its neighbors in having 25 to 36 mandates. She said mandates adopted by Kansas correspond with what most other states and the District of Columbia have enacted. (Attachment 1)

Comments on Health Insurance Mandates

Bill Sneed, Legislative Counsel, America's Health Insurance Plans, testified in opposition to legislation imposing benefit and/or provider mandates on health insurance plans, stating the mandates could be costly and have unintended consequences for consumers. Mr. Sneed said 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.

Further, Mr. Sneed stated that while overall savings to society are often invoked in support of mandates, legislators must consider the cost of such mandates to consumers. He said while one may believe they are expanding coverage for their constituents through mandates, America's Health Insurance Plans believe 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 they do want, he said. (Attachment 2)

The next meeting is scheduled for January 22, 2009.

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

FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST
DATE: 1-20-09

NAME	REPRESENTING
John Meeh	KID
Bill Sneed	ANIP
BOB ALDERSON	NAPIA
JEFF GLENDENING	KS CHAMBER
RACHELLE COLWELL	"
Suzanne Cleveland	KHI
Lori Church	KAPCIC
Todd Fiander	Ks. Optometric Assoc.
Gby Westerlund	KNASW
Liz Matzberger-Clark	KASB
Amy Campbell	KMHC
Mallee Carpenter	KAHP
Sandra Braden	Gaches, Braden

Melissa Calderwood,
Principal Analyst
785-296-3181
MelissaC@klrd.state.ks.us

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.

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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:

Melissa Calderwood, Principal Analyst
MelissaC@klrd.state.ks.us

Emalene Correll, Research Associate
EmaleneC@klrd.state.ks.us

Kansas Legislative Research Department
300 SW 10th Ave., Room 010-West, Statehouse
Topeka, Kansas 66612
Phone: (785) 296-3181
Fax: (785) 296-3824

Polsinelli

Shalton | Flanigan | Suelthaus PC

Memorandum

TO: THE HONORABLE RUTH TEICHMAN, CHAIR
SENATE INSURANCE COMMITTEE

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

RE: STATE HEALTH MANDATE LAWS

DATE: JANUARY 20, 2009

Madam Chair, 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.

555 Kansas Avenue, Suite 101
Topeka, KS 66603-3443
Telephone: (785) 233-1446
Facsimile: (785) 223-1939

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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:kjb