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Financial Institutions and Insurance

F-2 Kansas Health Insurance Mandates

This article provides an overview of benefit, provider, and other coverage requirements placed on certain health insurance companies in Kansas. Also discussed is the impact of the federal Patient Protection and Affordable Care Act (commonly referred to as the ACA) and recent trends in enacted requirements in Kansas law.

Mandates in Kansas Law

Health insurance mandates in Kansas law apply to:

- Individual health insurance policies issued or renewed in Kansas; and
- Group health insurance policies issued or renewed in Kansas. [*Note:* Individual and group health policies are often referred to as accident and health or accident and sickness insurance policies in Kansas law.] Exceptions are noted below.

Health maintenance organizations (HMOs) are included in the listing of policy issuers.

These mandates do not apply to:

- Self-insured health plans (Employee Retirement Income Security Act of 1974 [ERISA] plans). Self-insured plans are governed by federal laws and are enforced by the U.S. Department of Labor. States cannot regulate these self-insured plans; and
- Supplemental benefit policies. Examples include dental care, vision (eye exams and glasses), and hearing aids.

Since 1973, the Kansas Legislature has added new statutes to insurance law that mandate certain health care providers be paid for services rendered (provider mandates) and be paid for certain prescribed types of coverage or benefit (benefit mandates). The Legislature more recently authorized the study of proposed benefit mandates. (*Note:* See Table A on the next page for a comprehensive list of enacted 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 to require coverage for newborn children. The newborn coverage mandate has been amended to include adopted children and immunizations, as well as a mandatory offer of coverage for the expenses of a birth mother in an adoption. The Legislature began its first review into coverage for alcoholism, drug abuse, and nervous and mental conditions in 1977. The law enacted that year required insurers to make an affirmative offer of such coverage, which could be rejected only in writing.

This mandate also has been broadened over time, first by becoming a mandated benefit and then as a benefit with minimum dollar amounts of coverage specified by law. In 1988, mammograms and pap smears were mandated as cancer patients and various cancer interest groups requested mandatory coverage by health insurers. In 1998, male cancer patients and cancer interest groups sought and received similar mandated coverage for prostate cancer screening. After several attempts, 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
Kansas 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
Pharmacists	1994	Maternity Stays	1996
Advanced Practice Registered Nurses	1995	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
		Autism Spectrum Disorder	2014

* 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 (FDA) 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 periodically review all state mandated health insurance coverage. 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 an impact report that assesses both the social and financial effects of the proposed mandated coverage to the legislative committees assigned to review the proposal. The law also requires the Commissioner of 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 is generally 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 persons being unable to obtain necessary health care treatment;
- 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 (other than premiums and administrative costs) on the question of the costs and benefits of coverage.

The financial impact factors include the extent to which the proposal would change 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 Plan Study. KSA 40-2249a provides, in addition to the impact report requirements, that any new mandated health insurance coverage approved by the Legislature would only apply to the state health care benefits program (State Employee Health Plan [SEHP]) for a period of at least one year beginning with the first anniversary date of implementation of the mandate following its approval. On or before March 1, after this one-year period has been applied, the 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 SEHP, including data on the utilization and costs of the mandated coverage. The report also is to include a recommendation of whether the mandated coverage should be continued by the Legislature to apply to the SEHP or whether additional utilization and cost data are required.

Recent Review and Legislative Trends

Table B on page 5 illustrates recent legislation and enacted law with coverage requirements and related provisions placed on health insurance companies in Kansas.

2009 Session—Mandates Review

Kansas legislative review (KSA 40-2249a). The Senate Committee on Financial Institutions

and Insurance and the House Committee on Insurance received briefings during the regular session from committee staff on the current and recently considered health insurance mandates. Testimony was also received from interested parties.

2010 Session—An Emerging Trend: the Study Directive

The study before the law. The Legislature's review and response to health insurance mandates has recently included a new direction: the study before the mandate is considered and passed by the Legislature. As prescribed by the 1999 statute, a mandate is to be passed by the Legislature, applied to the SEHP for at least one year, and then a recommendation is made about continuation in the SEHP or statewide (KSA 40-2249a). Legislation in 2008 (HB 2672) directed the Kansas Health Policy Authority (KHPA) to conduct a study on the impact of extending coverage for bariatric surgery in the SEHP (corresponding mandate legislation in 2008: SB 511, HB 2864). No legislation requiring treatment for morbid obesity (bariatric surgery) was introduced during the 2009-2010 Biennium.

In addition, Sub. for HB 2075 (2009) would have directed the KHPA to study the impact of providing coverage for colorectal cancer screening in the SEHP, the affordability of the coverage in the small business employer group, and the state high risk pool (corresponding legislation in 2009: SB 288, introduced as HB 2075).

During the 2010 Session, the House Committee on Insurance considered the reimbursement of services provided by certain Behavioral Sciences Regulatory Board licensees (SB 104; HB 2088 and HB 2546). The House Committee recommended a study by KHPA on the topic of requiring this reimbursement. The study design would have included determining the impact that coverage has had on the SEHP, providing data on utilization of such professionals for direct reimbursement for services provided, and comparing the amount of premiums charged by insurance companies that provide reimbursement for these provider services to the amounts of premiums charged by insurers that do not provide direct reimbursement. Under SB 388, KHPA would also have been required to conduct an analysis to determine if proactive mental health treatment results in reduced expenditures for future mental and physical health care services. SB 388 died in Conference Committee. The study requirement was also included as a proviso to the Omnibus appropriations bill; the proviso was vetoed by the Governor and the veto was sustained.

Autism benefit and oral anticancer medications study and law. The 2010 Legislature considered mandating coverage for certain services associated with the treatment of Autism Spectrum Disorder (ASD). Senate Sub. for HB 2160 required the Health Care Commission, which administers the SEHP, to provide for the coverage of services for the diagnosis and treatment of ASD in any covered individual whose age was less than 19 years during Plan Year 2011. The services provided and limitations on benefits also were prescribed. The Health Care Commission was required to submit on or before March 1, 2012, a report to the Senate President and the House Speaker that included information (*e.g.*, cost impact utilization) pertaining to the mandated ASD benefit coverage provided during the 2011 Plan Year. The Legislature was permitted to consider in the next session following the receipt of the report whether to require the coverage for ASD to be included in any individual or group health insurance policy, medical service plan, HMO, or other contract that provided for accident and health services and was delivered, issued for delivery, amended, or renewed on or after July 1, 2013.

Senate Sub. for HB 2160 also required all individual or group health insurance policies or contracts (including the municipal group-funded pool and the SEHP) that provide coverage for prescription drugs, on and after July 1, 2011, to provide coverage for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected cancer medications that are covered as medical benefits. The Health Care Commission, pursuant to KSA 40-2249a, was required to submit a report to the Senate President and the

House Speaker that indicated the impact the provisions for orally administered anticancer medications had on the SEHP, including data on the utilization and costs of such coverage. The report was required to include a recommendation on whether the coverage should continue for the SEHP or whether additional utilization and cost data was required. The report was required to be provided to the legislative representatives on or before March 1, 2011.

Table B
Kansas Provider and Benefit Mandates

Legislation	Proposed Mandate	Mandate Type	Action Status
2009 SB 12/ HB 2387; 2010 SB 554	Autism, coverage of	Benefit	See Senate Sub. for HB 2160 (study only).
2009 SB 195; 2010 SB 390	Anticancer medications, orally-administered; genetic testing (introduced version, SB 390)	Benefit	See Senate Sub. for HB 2160 (study only).
2009 SB 288; Sub. for HB 2075	Colorectal cancer screening	Benefit (substitute bill contained a study only)	Referred to Senate Committee on Financial Institutions and Insurance. Died in Committee (SB 288); Substitute bill passed. Re-referred to House Committee on Insurance; no action taken by 2010 Legislature.
2009 SB 104/ HB 2088; 2010 HB 2546	Clinical professional counselors, therapists, psychotherapists	Provider	Hearings held (SB 104, HB 2546); bills died in committee.
2009 HB 2344	Dietary formulas	Benefit	Hearing held; died in House Committee on Health and Human Services.
2009 SB 49/ SB 181/ HB 2244/ HB 2231	Mental health, substance abuse	Benefit	See HB 2214 (modifies existing Mental Health Parity Act/ mandate)
2009 HB 2329	Procedures, implants approved by the FDA	Benefit	Died in Committee.
2010 HB 2424	Telemedicine, payment for (telecommunications services)	Benefit	Jointly referred, later separately referred. Died in Committee.
2011 SB 226; HB 2216; HB 2764	Autism Spectrum Disorder, coverage of	Benefit	SB 226 and HB 2216 died in Committee. HB 2764 passed the House; died in Senate Committee. *The bills exempted the proposed mandate from the test track requirements (study).
2011 HB 2228	Hearing aids, coverage of	Benefit	Died in Committee.
2013 SB 175, HB 2317, HB 2395; 2014 HB 2704; HB 2759; HB 2744	Autism Spectrum Disorder, coverage of	Benefit	See HB 2744 (benefit mandate).
2014 HB 2690	Telemedicine mental health services, coverage of	Benefit	Died in Committee.
2015 SB 303	Autism Spectrum Disorder, coverage of	Benefit	See HB 2352 (modified existing mandate).
2017 SB 165	Abuse-deterrent opioid analgesic drug products; emergency opioid antagonists	Benefit	Hearing held. Died in Committee.
2017 HB 2103	Amino acid-based elemental formula	Benefit	Hearing held. Study requested.

Table B
Kansas Provider and Benefit Mandates

Legislation	Proposed Mandate	Mandate Type	Action Status
2017 HB 2119, HB 2255	Dental services	Contract/ Network	Hearing held. Died in Committee.
2017 HB 2021	Hearing aids	Benefit	Hearing held. Died in Committee.
2017 HB 2254; HB 2206; 2018 HB 2674	Telehealth; telemedicine	Benefit	See Senate Sub. for HB 2028.
2018 SB 417; HB 2679	Contraceptives	Benefit	Died in Committee.
2019 SB 163; HB 2124	Contraceptives	Benefit	Died in Committee.
2019 HB 2307; 2020 HB 2633	Dental Services	Contract/ Network. Establishes non-covered dental benefits and plan limitations.	Passed House; Died in Senate Committee. Died in House Committee.
2019 HB 2074	Preexisting Conditions	Contract (Individual market only).	Hearing held. Died in Committee.
2020 SB 401	Hearing Aids	Benefit	Died in Committee.
2020 HB 2556	Prosthetic Devices	Benefit	Died in Committee.

The Health Care Commission opted to continue ASD coverage in the SEHP, as had been required under the 2010 law for Plan Year 2011, for both Plan Year 2012 and Plan Year 2013. In June 2013, the Health Care Commission authorized a permanent ASD benefit. The 2014 Legislature again considered ASD coverage in HB 2744. Following amendments in the House Committee on Insurance and House Committee of the Whole, the bill passed the Senate and was signed into law on April 16, 2014. The bill required, subject to limitations on benefits and services provided, health insurance coverage for the diagnosis and treatment of ASD in children under the age of 12 years and also created the Applied Behavior Analysis (ABA) Licensure Act.

The SEHP updated its benefits coverage for Plan Year 2015 to reflect the changes enacted in HB 2744.

2017-2018 Biennium Study, Special Committee

The House Committee on Insurance held hearings on two benefit mandate bills: HB 2103 (amino acid-based elemental formula) and HB 2021 (hearing aids). No formal committee action was taken during the 2017 Session; however, a SEHP study was requested relating to HB 2103 to provide more information on economic and social impact factors associated with the requirements of KSA 40-2249. Telehealth and telemedicine legislation, including proposed insurance coverage requirements, were assigned to the 2017 Interim Special Committee on Health.

Amino acid-based elemental formula. Following receipt of the SEHP report, the House Committee on Insurance recommended a substitute bill limiting the coverage of formula to the SEHP enrollees for a one-year ("test

track") period in Plan Year 2019 and requiring a report to the 2020 Legislature. These provisions ultimately were enacted in 2018 SB 348. (*Note:* The report, submitted in March 2020, indicates in 2019, the SEHP had 4 members for whom prior authorizations for the formula were submitted. One of the requests met the guidelines for coverage and was approved. This member submitted one claim, for a total allowed amount of $203.80. The SEHP elected to continue the pilot program for the elemental formula for Plan Year 2020.)

Telemedicine. The 2017 Special Committee on Health did not recommend the 2017 legislation (HB 2206 and HB 2254), but did recommend the introduction of comprehensive telemedicine legislation in the 2018 Session.

The Kansas Telemedicine Act (Senate Sub. for HB 2028) provides that coverage for a health care service delivered *via* telemedicine is not mandated if such service is not already covered when delivered by a health care provider and subject to the terms and conditions of the covered individual's health benefits plan.

2019-2020 Biennium; Amendments to Existing Mandates, Coverage Requirements

In addition to the legislation highlighted in Table B, legislation was introduced to expand existing mandated benefits—breast cancer screening and mental health treatment. SB 464 would have required a health insurer that provides benefits for diagnostic breast cancer examinations to ensure that the cost-sharing requirements and treatment limitations that are applicable to a diagnostic examination are not less favorable than the requirements and limitations that apply to a screening examination for an insured patient. The bill died in Senate Committee.

HB 2459/SB 249 would have amended provisions in the Kansas Mental Health Parity Act previously applying to coverage of mental illness, alcoholism, drug abuse, or other substance use disorders to expand the coverage associated with treatment of mental illness or substance use disorders. Among amendments, the bill would have required insurers to provide coverage without the imposition of prior authorization, concurrent review or retrospective review or other forms of utilization review for the first 14 days of medically necessary inpatient and 180 days of medically necessary outpatient treatment and services provided in-network. The bill would further designate the amendments to this act as "The Kristi L. Bennett Mental Health Parity Act." Following its hearing in the House Committee on Insurance, HB 2459 was assigned to a subcommittee for further review. The bill died in House Committee; SB 249 died in Senate Committee.

ACA Requirements—Essential Health Benefits

The ACA does not directly alter or preempt Kansas or other states' laws that require coverage of specific benefits and provider services. However, the law (Section 1302(b) of the ACA and subject to future federal regulations by the U.S. Department of Health and Human Services [HHS]), directs the Secretary of HHS to determine the "essential health benefits" to be included in the "essential health benefits" package that qualified health plans (QHPs) in the Exchange marketplaces are required to cover (coverage effective beginning in 2014). "Essential health benefits," as defined in Section 1302(b), include the required coverage of at least the following ten general categories:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness and chronic disease management; and
- Pediatric services, including oral and vision care.

Insurance policies are required to cover these benefits in order to be certified and offered in Exchanges. Women's preventive health services were separately defined by federal regulation in August 2011 (*Federal Register*, Vol. 76, No. 149: 46621-46626) and required that "a group K health plan or health insurance issuer must cover certain items and services, without costsharing." Coverages included annual preventive care medical visits and exams, contraceptives (products approved by the FDA), mammograms, and colonoscopies.

Under the ACA, QHPs are not barred from offering additional benefits. However, starting in 2014, if a state law mandates coverage not included in the final HHS "essential benefits" list of coverages, the State must defray any additional costs for those benefits for Exchange enrollees.

Benchmark. HHS issued a bulletin on December 16, 2011, to provide information about the approach the agency plans to take in its rulemaking for defining "essential benefits." The bulletin outlined a "benchmark approach" allowing states the ability to choose from the following benchmark health plans (a benchmark plan would reflect the scope of benefits and services offered by a "typical employer plan"):

- One of the three largest small group health plans in the state by enrollment;
- One of the largest state employee health plans by enrollment;
- One of the three largest federal employee health plans by enrollment; or
- The largest HMO plan offered in the state's commercial market by enrollment.

Should a state not select a benchmark, the default option would become the small group plan with the largest enrollment in the state. In 2010, the Kansas Insurance Department contracted with Milliman, Inc., to analyze plans and related benefits and services available in Kansas. "The Milliman Report" analyzed nine plans, and its findings were included in a September 2012 public hearing on essential benefits and selection of a benchmark for Kansas.

The Commissioner submitted the following recommendations and conclusions to the Governor for consideration of a state essential health benefits benchmark: selection of the largest small group plan, by enrollment (the Blue Cross Blue Shield of Kansas Comprehensive Plan); supplementing the recommended benchmark plan with the required pediatric oral and vision benefits available in the Kansas Children's Health Insurance Program; and anticipation of further guidance from HHS on the definition of "habilitative services" later in fall 2012. No specific recommendation was made by the Commissioner.

Including Kansas, 25 states did not provide a recommendation on a benchmark plan to HHS by the September 30, 2012, deadline; therefore, HHS assigned those states the largest small group plan as the benchmark for 2013-2016 (in August 2015, HHS extended the plans to 2017).

Recent developments. On April 9, 2018, the Centers for Medicare and Medicaid Services finalized its Benefits and Payment Parameters rule for 2019. Among changes prescribed in the rule, beginning in Plan Year 2020, states are given additional flexibility to define their benchmark plan and can update plans on an annual basis. States will also be permitted to maintain their current 2017 benchmark plan without taking any action.

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