# HOUSE BILL No. 2549

AN ACT concerning insurance; pertaining to HIPAA compliance; pertaining to the state children's health insurance program; pertaining to the use of an insured's social security number on any policy card issued by an insurer; amending K.S.A. 2003 Supp. 38-2001, 40-2258 and 40-4623 and repealing the existing sections.

*Be it enacted by the Legislature of the State of Kansas:*

Section 1. K.S.A. 2003 Supp. 40-2258 is hereby amended to read as follows: 40-2258. (a) An accident and sickness insurer which offers coverage through a group policy providing hospital, medical or surgical expense benefits pursuant to K.S.A. 40-2209 and amendments thereto which includes mental health benefits shall be subject to the following requirements:

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

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

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

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

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

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

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

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

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

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

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

(g) As used in this section:

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

such benefits under the policy with respect to an eligible employee, member or dependent;

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

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

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

(h) This section shall be effective for group policies providing hospital, medical or surgical expense benefits which are entered into or renewed after January 1, 1998. This section shall not apply to benefits for services furnished on or after December 31, ~~2003~~ *2004*.

(i) The commissioner is hereby authorized to adopt such rules and regulations as may be necessary to carry out the provisions of this section.

Sec. 2. K.S.A. 2003 Supp. 38-2001 is hereby amended to read as follows: 38-2001. (a) The secretary of social and rehabilitation services shall develop and submit a plan consistent with federal guidelines established under section 4901 of public law 105-33 (42 U.S.C. 1397aa *et seq.*; title XXI).

(b) The plan developed under subsection (a) shall be a capitated managed care plan covering Kansas children from zero to 19 years which:

(1) Contains benefit levels at least equal to those for the early and periodic screening, diagnosis and treatment program;

(2) provides for presumptive eligibility for children where applicable;

(3) provides continuous eligibility for 12 months once a formal determination is made that a child is eligible subject to subsection (e);

(4) has performance based contracting with measurable outcomes indicating age appropriate utilization of plan services to include, but not limited to, such measurable services as immunizations, vision, hearing and dental exams, emergency room utilization, annual physical exams and asthma;

(5) shall use the same prior authorization standards and requirements as used for health care services under medicaid to further the goal of seamlessness of coverage between the two programs; and

(6) will provide targeted low-income children, as defined under section 4901 of public law 105-33 (42 U.S.C. 1397aa, *et seq.*), coverage subject to appropriations.

(c) The secretary is authorized to contract with entities authorized to transact health insurance business in this state to implement the health insurance coverage plan pursuant to subsection (a) providing for several plan options to enrollees which are coordinated with federal and state child health care programs, except that when contracting to provide managed mental health care services the secretary shall assure that contracted entities demonstrate the ability to provide a full array of mental health services in accordance with the early and periodic screening, diagnosis and treatment plan. The secretary shall not develop a request for proposal process which excludes community mental health centers from the opportunity to bid for managed mental health care services.

(d) When developing and implementing the plan in subsection (a), the secretary to the extent authorized by law:

(1) Shall include provisions that encourage contracting insurers to utilize and coordinate with existing community health care institutions and providers;

(2) may work with public health care providers and other community resources to provide educational programs promoting healthy lifestyles and appropriate use of the plan's health services;

(3) shall plan for outreach and maximum enrollment of eligible children through cooperation with local health departments, schools, child care facilities and other community institutions and providers;

(4) shall provide for a simplified enrollment plan;

(5) shall provide cost sharing as allowed by law;

(6) shall not count the caring program for children, the Kansas health insurance association plan or any charity health care plan as insurance under subsection (e)(1); ~~and~~

(7) may provide for payment of health insurance premiums, including contributions to a medical savings account if applicable, if it is determined cost effective, taking into account the number of children to be served and the benefits to be provided*; and*

*(8) may provide that prescription drugs, transportation services and dental services are purchased outside of the capitated managed care plan to improve the efficiency, accessibility and effectiveness of the program.*

(e) A child shall not be eligible for coverage and shall lose coverage under the plan developed under subsection (a) of K.S.A. 38-2001, and amendments thereto, if such child's family has not paid the enrollee's applicable share of any premium due.

If the family pays all of the delinquent premiums owed during the year, such child will again be eligible for coverage for the remaining months of the continuous eligibility period.

(f) The plan developed under section 4901 of public law 105-33 (42 U.S.C. 1397aa *et seq.*, and amendments thereto) is not an entitlement program. The availability of the plan benefits shall be subject to funds appropriated. The secretary shall not utilize waiting lists, but shall monitor costs of the program and make necessary adjustments to stay within the program's appropriations.

New Sec. 3. On and after July 1, 2006: (a) No insurance company, including health maintenance organizations, offering any type of accident and sickness policy covering individuals residing in this state shall print or encode an insured's social security number on or into the insured's policy card.

(b) Any distinguishing identifier assigned to the insured's policy card shall be a combination of numbers or letters or both, which is unique to the insured.

(c) An insured's distinguishing identifier assigned to such insured's policy card shall not, in any way, be based on or depend on the insured's social security number.

New Sec. 4. On and after July 1, 2006: (a) No insurance company, including health maintenance organizations, offering any type of coverage for prescription drugs or devices covering individuals residing in this state shall print or encode an insured's social security number on or into the insured's policy card.

(b) Any distinguishing identifier assigned to the insured's policy card shall be a combination of numbers or letters or both, which is unique to the insured.

(c) An insured's distinguishing identifier assigned to such insured's policy card shall not, in any way, be based on or depend on the insured's social security number.

New Sec. 5. If a federal law takes effect requiring the United States department of health and human services to establish a national unique patient health identifier program, any person or entity that complies with such federal law shall be deemed to be in compliance with the provisions of sections 5 and 6, and amendments thereto, and K.S.A. 2003 Supp. 40-4623, and amendments thereto.

Sec. 6. K.S.A. 2003 Supp. 40-4623 is hereby amended to read as follows: 40-4623. (a) A health benefit plan that provides coverage for prescription drugs or devices and issues a card for claims processing and an administrator of any such plan, including, but not limited to, a pharmacy benefits manager and a third-party administrator shall issue a card containing uniform prescription drug information to each person entitled to such card under the health benefit plan. If required for claims adjudication, the uniform prescription drug information card shall specifically identify and display the following information:

(1) ANSI-BIN number;

(2) processor control number or group number or both;

(3) card issuer identifier;

(4) prescription claims processor, if different from card issuer;

(5) cardholder identification number;

(6) cardholder or insured name;

(7) claims submission names and addresses; and

(8) help desk telephone numbers.

(b) A uniform prescription drug information card shall be issued by a health benefit plan to each person entitled to such card under the health benefit plan upon enrollment and reissued upon any change in such person's coverage that affects one or more mandatory data elements contained on the card.

(c) Notwithstanding the foregoing provision, any health benefit plan or administrator of such plan may utilize, in lieu of such card, electronic technology which contains all of the information required for claims adjudication, as long as such electronic technology is provided by the health benefit plan or administrator of such plan to the pharmacies which will adjudicate the prescription drug claims.

*(d) On and after July 1, 2006: (1) No cardholder's social security number shall be printed or encoded on or into any card issued under this section.*

*(2) Any cardholder identification number or other distinguishing identifier assigned to the card issued to a cardholder shall be a combination of numbers or letters or both, which is unique to the cardholder.*

*(3) A cardholder's identification number or other distinguishing identifier assigned to such insured's policy card shall not, in any way, be based on or depend on the cardholder's social security number.*

Sec. 7. K.S.A. 2003 Supp. 38-2001, 40-2258 and 40-4623 are hereby repealed.

Sec. 8. This act shall take effect and be in force from and after its publication in the statute book.

I hereby certify that the above BILL originated in the HOUSE, and passed that body

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HOUSE adopted
Conference Committee Report _____

_____
*Speaker of the House.*

_____
*Chief Clerk of the House.*

Passed the SENATE
as amended _____

SENATE adopted
Conference Committee Report _____

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*President of the Senate.*

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*Secretary of the Senate.*

APPROVED _____

_____
*Governor.*