MINUTES

SPECIAL COMMITTEE ON INSURANCE

September 18-19, 2003
Room 514-S—Statehouse

Members Present

Senator Ruth Teichman, Chairperson
Representative Patricia Barbieri-Lightner, Vice Chairperson
Senator David Adkins
Senator Mark Buhler
Representative Mike Burgess
Representative Stan Dreher
Representative Eber Phelps
Representative Scott Schwab
Representative Bonnie Sharp
Representative Judy Showalter

Members Absent

Senator Paul Feleciano

Staff Present

William G. Wolff, Kansas Legislative Research Department
Amy Deckard, Kansas Legislative Research Department
Ken Wilke, Revisor of Statutes Office
Gina Poertner, Committee Secretary

Others Present

Andy Shaw, Kansas Psychiatric Society
Chip Wheelen, Association of Osteopathic Medicine
Charles Bartlett, Department of Social and Rehabilitation Services/AAPS
Jeff Bottenberg, Health Insurance Association of America
Sky Westerland, Kansas National Association of Social Workers
Jennifer Schwartz, Assistive Technology for Kansas
Cheryl Dillard, Coventry Health Care
Christina Collins, Kansas Medical Society

Jayme Stase, Federico Consulting
Janet Lortez, Kansas Insurance Department
Jerry Wells, Kansas Insurance Department
Brad Smoot, Blue Cross Blue Shield of Kansas
John Peterson, Kansas Governmental Consulting
Karen Ford Manza, NAMI Kansas
Larrie Ann Lower, Kansas Association of Health Plans
Bruce Witt, Preferred Health Systems
Larry Magill, Kansas Association of Independent Agents
Beatrice Swoopes, Kansas Catholic Conference
Peggy Galvin, Blue Cross Blue Shield of Kansas City
Ron Seeber, Hein Law Firm
Stuart Little, Association of Community Mental Health Centers
JoAnn Bunten, Kansas Insurance Department
Lisa Jones, KAPS
Bret Wilson, Leukemia and Lymphoma Society
Janna LaCock, Leukemia and Lymphoma Society
Karen Carlin, Leukemia and Lymphoma Society
Elizabeth Kinch, Leukemia and Lymphoma Society
Wendy Benjamin, Leukemia and Lymphoma Society
Harry Bossi, Department of Administration
Mary Spires, Department of Administration
Gwendolyn Cargnel, American Cancer Society
Mike Farmer, Kansas Catholic Conference

September 18
Morning Session

Senator Teichman called the meeting to order at 10:00 a.m. on September 18, 2003, in Room 514-S of the Capitol.

Members were asked by the Chairperson to introduce themselves. Senator Teichman then explained that the charge of the Committee is to review all state mandates of health insurance coverage in order to meet the statutory requirements for the periodic review of such mandates. There are currently 25 mandates and additional proposed mandates that need to be reviewed in order to meet that requirement. The last review of the health insurance mandates was conducted in 1998. She said there are four proposed mandates that the Committee will be taking up in addition to the existing mandates to be reviewed. Financial impact of the mandates also will be considered. She explained that all testimonies will be heard and information will be reviewed, but action probably would not be taken until the fourth day of the Committee.

Dr. Bill Wolff was recognized by the Chairperson. He advised the Committee of changes to the agenda, followed by a review of Kansas health insurance mandates

(Attachment 1). He stated that although mandates have been reviewed over the years, they have not been considered as a whole.

He briefed the members on the 1998 interim study. Various mandates were explained, as well as action, or lack thereof, on the recommendation of the Special Committee on Financial Institutions and Insurance. Several bills which would have enacted mandates were discussed regarding cost, impact, and outcome.

A member asked if mandate testing through the State Employee Health Plan is a formula, criteria, or just what. Dr. Wolff stated that, to date, no new mandate has been enacted that would require testing in the Plan. He added that the statute specifies a time following imposition of the mandate for a report to be made to the Legislature concerning the cost of the mandate.

Brad Smoot, representing Blue Cross Blue Shield of Kansas, was introduced (Attachment 2). He discussed the negative effect of mandates on small employers: that this group is especially affected by the increased cost associated with any mandate. Premium increases, he said, drive employers out of the health insurance marketplace, thereby dropping coverage for their employees. This creates a ripple effect by increasing health care costs due to uninsured parties failing to pay for services.

Mr. Smoot stated that state government mandates only impact a fraction of Kansans. Self insureds and government-funded insureds are exempt from state mandates. He discussed proposed congressional legislation that would allow small employers, association groups, to opt out of various state mandates, which would have a disastrous impact on the remaining regulated insurance market.

A personal account was given by a member in which certain expenses could have been avoided during a particular treatment regimen. Mr. Smoot mentioned that educational efforts to assist patients in asking the right questions of their health care professionals can be instrumental in helping to control health care costs.

The next speaker introduced was Cheryl Dillard, of Coventry Health Care (Attachment 3). She illustrated the fine line between medical necessity and improved quality of life as it relates to the role of insurance in today's world. She commented that we are moving further away from the original concept of health insurance with each mandate.

Members received written testimony from Kevin Wregge, of the Health Insurance Association of America (Attachment 4), and from Hal Hudson, State Director of the national Federation of Independent Business (Attachment 5).

Afternoon Session

The afternoon session was called to order by Senator Teichman at 1:30 p.m. The Chairperson introduced Gwendolyn Cargnel of the American Cancer Society (ACS)

(Attachment 6). Ms. Cargnel stated ACS's support of mandates regarding preventive screenings and their effect on increased survival rates and improvement of the patient's quality of life. Prevention efforts such as these save health care costs long term by decreasing treatment needs, she pointed out.

Roy Menninger, M.D., speaking for the Kansas Mental Health Coalition was recognized by the Chairperson (Attachment 7). He discussed private health insurance for mental illness and that Kansas statutes do not establish mental health parity, although Sub. for HB 2033 in 2001 did improve private insurance coverage for certain mental illnesses. By insuring mental illness in an equal manner as physical illness, we come one step closer to reducing the stigma associated with mental illness, which, in turn, encourages appropriate and effective treatment. Asked to point out some of the elements that were left out of the mental health parity bill, he reviewed the points bulleted in Attachment 7.

Next to speak was Karen Ford Manza, Executive Director of NAMI Kansas (Attachment 8). Ms. Manza informed the Committee of the consequences of untreated mental illness. She commented on the mental health parity bill of 2001 and gave an overview of Vermont's mental health parity law.

A member asked how many inpatient days were covered by insurance under the current law. Ms. Manza stated that a total of 45 days per year are covered.

The Chairperson recognized Sarah Adams, Director of Information Services of Keys For Networking (Attachment 9). She discussed the limits for coverage of her personal policy stating that although 45 days of outpatient care are allowed, this is limited further by a maximum benefit of $1,000 per year. For a psychiatrist charging $200 per visit, this provides only five visits per year. She further stated that in cases where in-home therapy or attendant care are medically prescribed, these services are not covered for the diagnosis of mental illness.

A member asked if there are any services provided by county mental health associations, such as family services, or some type of coordinated effort to fill in the gap. Ms. Adams stated she was unaware of available mental health services of this type.

Stuart Little, from the Association of Community Mental Health Centers of Kansas, Inc., was introduced (Attachment 10). He addressed the requirement to provide services to all Kansans, regardless of their ability to pay. He touched on community-based services, the status of parity in Kansas, and the economic benefit of mental health parity.

The Chairperson opened the floor for discussion on the topic of existing health care mandates. A member asked Dr. Menninger about statistics on children with ADD/ADHD in the United States, as compared to other countries. Dr. Menninger stated that sometimes difficult children are labeled when the disorder is not actual. It was also asked if these labels are applied excessively in order for schools to receive economic benefits. Dr. Menninger stated that increased sensitivity leads to an increase of cases discovered and that there is benefit in catching the disorders early. Over treatment is better than under treatment, he said.

To the question regarding adoption and benefits to the birth mother, it was stated that a maternity rider to the policy would cover this and that policies vary as to the coverage.

A member stated he is interested in exploring any dichotomy that might exist between benefit packages that are available under government-sponsored plans, such as Medicaid, Medicare, and Healthwave, and to what extent those plans differ from what is commercially available. He wondered to what extent state action, short of imposing mandates, can create incentives within the private sector. Dr. Wolff noted the current work of the Health Insurance Issues Working Group along the lines of these questions.

It was asked if there are any states considering lifestyle mandates, such as those addressing alcohol and tobacco use, and if there are any states decreasing coverage for health issues secondary to these causes. There is no awareness of other states doing this.

A member asked about the difference between a small and large group in actual numbers. Almost all states differentiate between small and large groups, those numbers being typically 2-50 defining a small group, and 50 and above defining a larger group. A few states may have higher numbers defining these groups. Colorado is the only state that defines a small group as one.

To the question of whether we have ever mandated insurance coverage that was later repealed, dropped, or eliminated, Dr. Wolff stated that he is unaware of any that were repealed. He stated that some started out more minimally than they exist now.

It was asked what the effect would be if every mandate were "wiped off the board" right now. Dr. Wolff gave an example of some recent policies for small businesses that contained no mandates. The pricing of those policies was only slightly lower than the cost of the same policy with the mandates.

The Chairperson thanked the Committee and conferees, and announced that tomorrow's meeting would convene at 9:00 a.m. The meeting was recessed at 2:30 p.m.

September 19
Morning Session

Senator Teichman called the meeting to order at 9:00 a.m. She indicated that the first topic for hearings was mandated coverage for clinical trials. Karen Carlin, of the Leukemia and Lymphoma Society, introduced Marcus Neubauer, M.D., an oncologist in Overland Park, Kansas, to make a presentation (Attachment 11).

Dr. Neubauer explained the benefits of mandating insurance coverage for the routine costs of clinical trials. He stated that clinical trials expand the treatment options for patients and, thus, create cost savings by establishing superior treatment of disease. He stated that Medicare's position of covering routine costs is very reasonable, explaining that these costs would be incurred with or without the clinical trial and that the unique costs incurred by the

clinical trial, *e.g.*, drugs, are paid by the trial's sponsor. He concluded his testimony by requesting legislation mandating insurance companies to pay for routine costs of a clinical trial.

A member asked how a patient gets into a clinical trial. Dr. Neubauer informed the Committee that physicians are aware of and can offer suggestions and resources regarding trial opportunities. Clinical trials are offered for all stages of cancer, as well as prevention of disease.

It was further asked if insurance companies pay for clinical trials. Dr. Neubauer stated that it varies by policy and is determined through the precertification process. Just the indication that the covered person will participate in a trial may lead to refusal of payment, and that is why he brought this topic to light today. Some incurred treatment and charges that may not be part of the trial, however, are denied by some companies. Established treatment is not written into the budget of a trial.

A question was asked as to what type of prevention is studied in clinical trials and why this is important. In response, Dr. Neubauer offered the example of a current trial regarding prevention of breast cancer for women of high risk. In this trial, two currently approved medications are being tested in a new way to be utilized for prevention purposes.

A member asked for a written example of costs and payments in order to better understand the technicalities. Dr. Neubauer gave a breakdown of a typical office visit for a patient involved in a clinical trial. He said he would provide information as to the costs covered and those not covered under the Medicaid program.

A printed PowerPoint presentation from Margaret Tempero, M.D., President of the American Society of Clinical Oncology, was distributed (Attachment 12).

Next to testify was Brett Wilson, parent of a cancer victim (Attachment 13). He gave the account of his daughter's battle with a cancer called acute lymphocytic leukemia. He briefly discussed the disease process and steps of bone marrow transplant, relapse, and second transplant.

According to Mr. Wilson, insurance claims were rejected for the simple reason that his daughter's treatment results would be published as part of a study. When she received identical treatment that was not part of a research study, the insurance claims were paid. These costs, whether part of a clinical trial or not, would not have resulted in additional costs to the insurer. Mr. Wilson felt that his insurance company was denying claims to see if he would back down and not pursue coverage. He stated that families in such situations should not have to fight the system when they have so many other issues to contend with in caring for their family member.

A member asked Mr. Wilson what expenses he incurred outside of the insurance issues. He stated that they needed an apartment in the city where their daughter was receiving treatment, his wife's income was lost when she took a leave of absence to care for their daughter, and travel expenses were incurred to obtain treatment.

It was asked if costs were increased by going outside of Kansas for the clinical trial. Mr. Wilson explained that it was the complications, such as infection, that were routine costs not covered by insurance until he fought for coverage.

Next introduced was George Dahlman, Vice President of Public Policy of the Leukemia and Lymphoma Society (Attachment 14). Elizabeth Kinch read Mr. Dahlman's testimony in his absence. The testimony discussed the benefits of clinical trials and stated that most patients will not enter into trials if their care will not be covered by insurance. Eighteen other states have passed legislation to provide coverage for routine costs incurred during clinical trials. His testimony concluded by endorsing legislation to cover care during clinical trials, and a model was submitted, along with a packet of information that is available from the Leukemia and Lymphoma Society.

It was asked if the states listed as covering routine costs of clinical trials include Phase I. Conferees said this varies by state, but the request in Kansas was for legislation that includes all phases of testing.

A member inquired if the patient's physician knows when the patient is involved in a clinical trial. The answer is yes, that the patient must return to the physician for follow-up evaluation.

The question was raised as to the percentage difference in the rate of participation and success for children versus adults in clinical trials. The reply indicated that many adults back away from clinical trials due to cost; however, a parent will go to any expense to save a child's life.

A member wanted to know if there are clinical trials for other diseases, or just for cancer. Diseases such as Parkinson's and diabetes also are involved in clinical trials.

Clarification of the model legislation was requested by a member, *i.e.*, costs and coverage associated with clinical trials. Representatives from the Leukemia and Lymphoma Society offered to send additional information, if so desired.

The Chairperson then recognized Gwendolyn Cargnel, of the American Cancer Society (Attachment 15). Ms. Cargnel reiterated the importance of clinical trials to the patient and that routine costs are indeed routine, not placing additional burden on the insurers. She then introduced Joe Giere, a volunteer with the American Cancer Society, and a cancer patient (Attachment 16).

Mr. Giere related his experience to the Committee, discussing decisions that must be made once a patient is diagnosed with cancer. He explained the process of participating in a clinical trial, and that his treatment costs were paid by the trial sponsor.

There being no further conferees or questions on the topic of clinical trials, the Chairperson asked the members to turn their attention to the topic of mandated insurance coverage for contraceptives.

Carolyn Middendorf, of the Kansas State Nurses Association, began the discussion (Attachment 17). She stated the Association's support of legislation requiring that insurers provide coverage for prescription contraceptives. She related to the Committee that these are the one high-volume type of medication not requiring insurers to provide coverage.

A member asked how many insurance companies do not provide coverage for oral contraceptives. It was stated that very few do not provide this coverage. Additional information was requested as to which companies do not already cover contraceptives. Further, a member wondered if any other drug in Kansas is mandated for coverage. A discussion ensued regarding the fairness of insurers not paying for oral contraceptives, but covering Viagra. The member wondered if both should be mandated.

Sally Finney, Executive Director of the Kansas Public Health Association, was introduced (Attachment 18). She discussed the positive impact of contraceptives on women's, as well as men's, health. She stated her Association's support of insurance coverage for all contraceptives. The Center for Disease Control reported 4,200 pregnancy-related deaths in 1990; however, they believe this number is under reported. In addition, 11.8 deaths per 100,000 live births were pregnancy-related.

A member asked if contraceptives are available through public health clinics. Ms. Finney stated that they are available to people of lower income through these clinics.

The Chairperson introduced Janis McMillen, President of The League of Women Voters (Attachment 19). She stated support for insurance coverage of contraceptives to prevent unwanted pregnancies. Ms. McMillen stated that in 2000, the Washington Business Group on Health reported that an unintended pregnancy may cost an employer 15-17 percent more than providing coverage for contraceptives. She stated that women of reproductive age pay 68 percent more out-of-pocket costs than their male counterparts.

Ruth Williams, President of the Kansas Foundation of Business and Professional Women, was next to speak (Attachment 20). She cited that only a 1 percent increase in cost of health insurance to employers would be incurred as a result of adding contraceptive coverage. Ms. Williams stated that contraceptive coverage would be another step toward equitable medical coverage for women. Insurers pay for medicines to treat sexual dysfunction, such as Viagra, but they do not cover contraceptives, causing inequity in health care for women.

Additional written testimony was submitted from Travis Stembridge, M.D., Chairman of the Kansas Section of the American College of Obstetricians and Gynecologists (Attachment 21).

Representative Paul Davis was introduced by the Chairperson (Attachment 22). He discussed the increased need for contraceptive parity, relating his experience with the Kansas Insurance Department and his findings on costs. Representative Davis stated that contraception is more than the prevention of pregnancy; it is a choice. The net benefit will result in lower premiums. Representative Davis also presented the Committee with a packet of additional materials.

A member asked about the number of insurance companies that cover Viagra but not contraceptives. Representative Davis referred to information contained in the packet, stating that this data may be national statistics and not necessarily reflect that of Kansas.

Staff called attention to material in the folder regarding several court cases, each invoking the Pregnancy Discrimination Act. He asked if that act would be pre-emptive of state law, since these decisions are applied only in the employment context, and not as insurance mandates. Representative Davis thought that these were in an employment context and stated he included that information to demonstrate what is happening in the private sector.

The Chairperson entertained additional questions and comments. Seeing none, the Committee recessed until 1:30 p.m.

Afternoon Session

The Committee was called to order by the Chairperson at 1:30 p.m.

Lou Saadi, PhD, Center for Health and Environmental Statistics of the Kansas Department of Health and Environment, was introduced (Attachment 23). Ms. Saadi gave an overview of the Kansas Health Insurance Information System (KHIIS) database. This database contains Kansas-specific data regarding health insurance claims. Since its inception, KHIIS has been used to develop estimates of costs for implementing several mandates considered by the Legislature, including mental health parity, durable medical equipment, and contraceptive coverage.

In response to a question regarding the number of persons affected by the mandate for payment of birth mother expenses in an adoption situation, Dr. Wolff noted that the mandate to pay the expenses of the birth mothers is a mandate which only requires that companies offer such coverage, not that they pay such expenses.

Information regarding KHIIS was requested, particularly as to who is in charge and how to obtain information. Ms. Saadi stated that the Insurance Commissioner has authority over KHIIS, and that the Commissioner's office can provide information from the database.

Ms. Saadi then introduced Gene Blobaum, an actuary with Miller & Newberg, Inc., the contracting actuary for KHIIS, who would present the cost data associated with mandating coverage for contraceptives (Attachment 23, page 2). Mr. Blobaum informed the Committee on available data and said that the data is specific to Kansas. He gave statistics on claims, payments, and premium increases regarding coverage of contraceptives. The analysis was performed on 2001 Kansas data, as data for 2002 are not yet published.

Mike Farmer, Executive Director of the Kansas Catholic Conference, was recognized (Attachment 24). He stated that the Legislature should not mandate coverage of

contraceptives and elective devices when many Kansans do not have basic health care coverage. He referred to the fact sheet attached to his testimony to illustrate further points, some of which relate to the position of the church on the issue of contraceptives, and the difficult position church employers would be in if the health benefits they provided to employees required coverage for contraceptives.

A member asked about prescription coverage. Mr. Farmer stated that coverage varies by policy. He explained the criterium in 2003 HB 2185.

Larrie Ann Lower, Executive Director of the Kansas Association of Health Plans presented testimony (Attachment 25). She informed the Committee that a 1 percent increase in premiums equals $22 million. She further stated that insurance mandates affect only 33 percent of the population of Kansas. Self-insured plans are exempt and will continue to choose benefits for their specific groups. Medicaid, Medicare, and Healthwave are also not affected.

Ms. Lower addressed questions posed by the Committee over the course of the two-day meeting. She stated that no one has shown a Kansas-specific problem for the coverages the various conferees requested to be mandated.

Written testimony from Bill Sneed, Legislative Counsel for Health Insurance Association of America, was distributed to the Committee (Attachment 26).

Senator Teichman asked that the Committee review material obtained and be prepared for discussion at the next meeting, October 20, 2003.

The meeting was adjourned at 2:30 p.m.

Prepared by Gina Poertner and Bill Wolff

Approved by Committee on:

December 8, 2004
(date)