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Financial Institutions and Insurance

J-1 Kansas Health Insurance Mandates

Background

Health insurance mandates in Kansas law apply to:

- Individual health insurance policies issued or renewed in Kansas.
- Group health insurance policies issued or renewed in Kansas. (The 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 (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.
- Supplemental benefit policies. Examples include dental care; vision (eye exams and glasses); and hearing aids.

* ERISA = The Employee Retirement Income Security Act of 1974; states' laws that relate to employee benefits are pre-empted under this Act.

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 be paid for certain prescribed types of coverage or benefit (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.

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 - 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
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 provider mandates have been in place, for the most part, longer than the benefit mandates and typically have not been the focus of the 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 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 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 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. On or before March 1, after the 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 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 Review and Legislation

2009 Session

During the 2009 Session, both provider and benefits coverage requirements legislation was introduced. The legislation introduced included: certain

professionals, Behavioral Sciences Regulatory Board (BSRB) (SB 104, HB 2088); assignment of benefits (HB 2128); autism spectrum disorder (SB 12, HB 2367); dietary formulas (HB 2344); colorectal cancer screening (HB 2075/Sub. HB 2075; SB 288); mental health parity-full coverage (SB 181, HB 2231); and orally administered anti-cancer medications (SB 195). Additionally, the Kansas Insurance Department requested language to clarify the state's existing mental health parity requirements to meet compliance requirements of the federal HR 1424. The language of SB 49 was amended during the conference committee process and was incorporated in 2009 HB 2214. Among the modifications and enhancements to the existing mental health parity law, the bill designated the statutes applicable to the small group and large group plans; increased coverage for in-patient coverage of mental illness (small group) from 30 to 45 days and separately specified a limitation of not less than 30 days for in-patient treatment of alcoholism, drug abuse or substance abuse disorders; eliminated first dollar coverage requirements from the statutes now applicable to large and small groups (benefits are subject to same deductibles, copays, coinsurance, treatment limitations and out-of-pocket expenses as apply to other covered services); replaced references to "nervous or mental conditions" with the term "mental illness, alcoholism, drug abuse or substance use" (as defined in the DSM-IV, 1994); and increased the lifetime benefit for costs of out-patient treatment for mental illness, alcoholism, drug abuse and substance use disorders from $7,500 to $15,000, with no annual limit for outpatient treatment.

Legislative Review (pursuant to requirements of KSA 40-2249a). The Senate Financial Institutions and Insurance Committee and the House Insurance Committee also received briefings, during the regular session, from Committee staff on the current and recently considered health insurance mandates. Testimony also was received from interested parties.

2010 Session — An Emerging Trend: the Study Directive

The 2010 Legislature reviewed carryover mandates legislation and also introduced new measures for consideration. A modified version of 2009 SB 195 (oral anticancer medications; parity of pharmacy and medical benefits) was amended into 2010 SB 390, a bill updating requirements on insurers for genetic testing. Ultimately, the oral anticancer medication provisions were enacted in Senate Sub. for HB 2160, a bill that incorporated both oral anticancer medication provisions and an autism benefits study in the State Employee Health Plan. Those provisions, introduced in 2010 SB 554, are discussed below. The Legislature further considered the reimbursement of services provided by certain licensees of the BSRB, as proposed in 2010 HB 2546 (identical to 2009 SB 104 and HB 2088, with technical amendments to update statutory references). This legislation is discussed below under the study directives from the 2009-2010 Legislature. The Legislature again considered a bill that would have required health insurance plans to provide coverage for telemedicine, defined by the bill as using telecommunications services to link health care practitioners and patients in different locations. The bill was jointly referred to two House committees and died in Committee.

The Study Before the Law. Recently, the Legislature's review and response to health insurance mandates has included a new direction: the study before the mandate is considered and enacted by the Legislature. Procedurally (as prescribed by the 1999 statute), a mandate is to be enacted by the Legislature, applied to the State Employee Health Plan for at least one year and then a recommendation is made about continuation in the Plan or statewide (KSA 40-2249a). 2008 HB 2672 directed the KHPA to conduct a study on the impact of extending coverage for bariatric surgery in the State Employee Health Benefit Plan (corresponding mandate legislation in 2008: SB 511; HB 2864). No legislation requiring treatment for morbid obesity (bariatric surgery) was introduced during the 2009-2010 Session. 2009 Sub. for HB 2075 would have directed the KHPA to study the impact of providing coverage for colorectal cancer screening in the State Employee Health Plan, the affordability of the coverage in the small business employer group, and the state high risk pool (corresponding legislation in 2009: SB 288; introduced HB 2075). The study bill was re-referred

to House Insurance and no action was taken by the 2010 Legislature. During the 2010 Session, the House Insurance Committee again considered the reimbursement of services provided by certain BSRB licensees (SB 104; HBs 2088, 2546). The House Insurance Committee recommended a study, amended into SB 388, by the KHPA on the topic of requiring this reimbursement. The study design would have included determining the impact that coverage has had on the State Employee Health Plan, providing data on utilization of such professionals for direct reimbursement for services provided, and comparing the amount of premiums charged by insurance companies which provide reimbursement for these provider services to the amounts of premiums charged by insurers who do not provide direct reimbursement. Under the bill, the KHPA also would 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 also was included as a proviso to the Omnibus appropriations bill (SB 572, section 76). The provision was vetoed by the Governor; the veto was sustained.

Finally, the 2010 Legislature again considered mandating coverage for certain services associated with the treatment of Autism Spectrum Disorders (ASD). The 2010 Legislature in Senate Sub. for HB 2160 requires the Health Care Commission, which administers the State Employee Health Plan, to provide for the coverage of services for the diagnosis and treatment of ASD in any covered individual whose age is less than 19 years during the 2011 Plan Year. Services provided by the autism services provider must include applied behavioral analysis when required by a licensed physician, licensed psychologist, or licensed specialist clinical social worker. Benefits limitations are applied for two tiers of coverage: a covered person whose age is between birth and age seven, cannot exceed $36,000 per year; and a covered person whose age is at least seven and less than nineteen, cannot exceed $27,000 per year. The Health Care Commission was required to submit on or before March 1, 2012, a report to the Senate President and the Speaker. The report was to include information pertaining to the mandated ASD benefit coverage provided during the 2011 Plan Year, including information on cost impact and utilization. The Legislature was permitted to consider in the next session following the receipt of the report whether to require the coverage for autism spectrum disorder to be included in any individual or group health insurance policy, medical service plan, HMO, or other contract which provides for accident and health services and which is 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 State Employee Health Plan) 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 indicates the impact the provisions for orally administered anticancer medications have had on the State Health Care Benefits Program, including data on the utilization and costs of such coverage. The report also was required to include a recommendation on whether such coverage should continue for the State Health Care Benefits Program or whether additional utilization and cost data is required. The report was required to be provided to the legislative representatives on or before March 1, 2011.

The 2012 Legislature considered legislation (HB 2764 and SB 226) to enact ASD coverage requirements for covered individuals under the age of 19, similar to those requirements specified in 2010 Senate Sub. for HB 2160; the proposed requirements, however, would have applied to all individual and group health insurance policies, plans, and contracts subject to state law. The 2012 bills exempted the proposed ASD coverage from the test track requirements specified in KSA 40-2249a. HB 2764, as amended by the House Committee of the Whole, also would have required coverage in the State's Medicaid Autism Waiver, Children's Health Insurance Program (CHIP), and

other Medicaid programs covering children. The bill, among other things, also would have required a study to determine the actual cost of providing coverage for the treatment and diagnosis of ASD in any individual living in Kansas who is under the age of 19. HB 2764, as amended, passed the House and was referred to a Senate Committee. Attempts to advance the bill to Senate General Orders failed and the bill died in Committee. ASD legislation has been introduced during the 2013 Session (SB 175; HB 2317; HB 2395.)

The Health Care Commission has opted to continue ASD coverage in the State Employee Health Plan, 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.

Affordable Care Act Requirements — Essential Benefits

The Affordable Care Act (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), directs the Secretary of HHS to determine the "essential health benefits" to be include in the "essential health benefits" package that Qualified Health Plans (QHPs) in the ACA Exchange marketplaces will be required to cover (coverage effective beginning in 2014). "Essential health benefits", as defined in Section 1302(b), include at least the following 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; additionally, all Medicaid State plans must cover these services by 2014. 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 health plan or health insurance issuer must cover certain items and services, without cost-sharing." 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 will pay 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" which would allow 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.

If the State of Kansas chooses not to select a benchmark, the default option would become the small group plan with the largest enrollment in Kansas. In 2010, the 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 Insurance Commissioner submitted the following recommendations and conclusions to the Governor for consideration of a state Essential Health Benefit benchmark:

- Recommend: Selection of the largest small group plan, by enrollment; the Blue Cross Blue Shield of Kansas Comprehensive Plan.
- Recommend: Supplementing the recommended benchmark plan with the required pediatric oral and vision benefits available in the Kansas CHIP.
- Conclusion: Anticipate further guidance from HHS on the definition of "habilitative services" later in the fall of 2012. No specific recommendation was made by the Commissioner.

A benchmark preference was not provided to the HHS by September 30, 2012 deadline.

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