Approved Feb. 15, 1983
Date

MINUTES OF THE HOUSE COMMITTEE ON INSURANCE.

The meeting was called to order by Chairman Rex Hoy at
Chairperson

3:30 ~~a.m.~~/p.m. on February 8, 1983 in room 521-S of the Capitol.

All members were present except:

Committee staff present:
Wayne Morris, Legislative Research
Gordon Self, Revisor's Office
Mary Sorensen, Committee Secretary

Conferees appearing before the committee:
Dick Brock, Kansas Insurance Department
Wayne Johnston, President, Blue Cross/Blue Shield of Kansas

Others Present:
See List (Attachment 1)

Wayne Morris, Legislative Research, presented a brief summary of Proposal No. 2 requested by the Kansas Insurance Department, which was introduced as HB 2246 (Attachment 2). This bill relates to health insurance cost containment and Blue Cross/Blue Shield. Mr. Morris then summarized HB 2247 (Attachment 3), which is Proposal No. 3 presented by the Insurance Department. This is an act relating to health maintenance organizations; protection against insolvency.

Dick Brock, of the Kansas Insurance Department, then spoke on HB 2246. He said this is the Department's latest attempt to have some influence on the escalating cost of health care, and past efforts were not overly successful. He said the Department had, in the past, heard comments about the voluntary cost containment efforts of provider groups, but this is the first time the department has attempted to suggest that one way to influence health care costs is to reduce the amount of money that is available to providers. HB 2246 would do this by placing a limitation on the amount of increase that Blue Cross and Blue Shield can pay their participating providers from one year to the next. That increase would be geared to the consumer price index for all items. Medical care items would be included in the consumer price index, not excluded as they have been in the past. Mr. Brock passed out Attachment 4, showing figures concerning the consumer price index for the years from 1972 to 1982, and comparing changes in various items. Mr. Brock then discussed the second part of Proposal 2 (HB 2246), which he said was really a first step toward the preferred provider concept, which means that Blue Cross/Blue Shield would only contract with those institutions in the community that offered their services at a lesser rate. In that event, people would need to know who those providers are, because if they go to someone else they would be charged the difference between what Blue Cross/Blue Shield will pay and what the charge is. Mr. Brock said that, even without the preferred provider provision, we now have participating and non-participating providers and there may be an additional charge to a subscriber if a non-participating provider charges more than Blue Cross/Blue Shield will pay for a particular service. Discussion followed, concerning the relation of the consumer price index to the rate of increase in HB 2246, and the figures on Attachment 4.

Wayne Johnston, President of Blue Cross and Blue Shield, then spoke on HB 2246. He said they were very much aware of the cost of health care, that they received many letters each week on the subject. Mr. Johnston said that the entire private health care industry in this country was having serious problems, and if the problems are not satisfactorily resolved he does not know what it will lead to, as they were pricing themselves right out of the market. He passed out "Some Factors Affecting Costs" (Attachment 5), and then gave a brief explanation of each page.

MINUTES OF THE House COMMITTEE ON Insurance,

room 521 S, Statehouse, at 3:30 ~~a.m.~~/p.m. on February 8, 1983

Mr. Johnston said he felt that Kansans used services covered by Blue Cross/ Blue Shield much more frequently than the national average which, of course, would contribute to the high cost of health insurance. Other factors contributing are set out on the first page of Attachment 5, and were briefly explained by Mr. Johnston. He said they had, in the last few years, introduced their OPT program, out-patient treatment, where it could be utilized, and reducing the number of hospital admissions and days of hospital care; and he thought this program was bringing Kansas closer to the national average in this area. Mr. Johnston said that, after much study of the problem of high cost of health care, Blue Cross and Blue Shield had come to the conclusion that there was only one way to deal with it, so they were proceeding with the development of what is known as the Preferred Provider Concept. He said their Board of Directors had studied the situation and they would arrive at what they thought the increased cost should be, he was not sure it should be mandated by legislation. He said that he was certainly not in opposition to the bill because it is supportive of what Blue Cross/Blue Shield plans to do whether the bill passes or not, he just does not believe it should mandate the cost. There was discussion on the information contained in Attachment 5 and the Preferred Provider Concept.

Chairman Hoy announced that the balance of the agenda would be taken up at Thursday's meeting, and the meeting adjourned at 4:40 PM.

Attachment 1.

GUEST LIST

COMMITTEE: House Insurance DATE: 2-8-83

NAME	ADDRESS	COMPANY/ORGANIZATION
David Ross	Mission, Ks.	FIG
Michael FRANCIS	Topeka	AIA
REBECCA KUPPER	TOPEKA	KHA
Bob Williams	Topeka	Ks Dental Assoc
Linnie Norsworthy	Topeka	BCBS
Thomas Miller	Topeka	BCBS
Marlen Dawn	Topeka	BCBS
Steve Carter	Topeka	KS Med Soc.
[illegible] Cundy	Overland Park	Med Fra Co
[illegible]	TOPEKA	KS MED. SOCIETY
[illegible]	Merriam KS	Ks Ind Society
Jeanelle Knight	Topeka	Governor's Office
Wayne Johnston	Topeka	BC-BS
Dick Block	"	Ins Dept
Ron Todd	"	" "
Jack Roberts	"	BC-BS
[signature]	"	Kans Assoc of Ins Ag.

Atch. 1

Attachment 2

MEMBERS COPY

3 RS 0757

Oct. 1931
3405 W 71st

2345000
2329200
782 8100
5241407

HOUSE BILL NO. 2246

By Committee on Insurance

(By Request)

AN ACT relating to nonprofit medical and hospital service corporations; limiting payment to participating members; amending K.S.A. 40-19c10 and repealing the existing section.

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

Section 1. K.S.A. 40-19c10 is hereby amended to read as follows: 40-19c10. (a) No corporation subject to the provisions of the nonprofit medical and hospital service corporation act shall during any one year disburse more than ~~five percent (5%)~~ 5% of the aggregate amount of the payments received from subscribers during that year as expenditures for the soliciting of subscribers, except that during the first year after the issuance of a permit, such corporation may so disburse not more than ~~twenty percentum (20%)~~ 20% of such amount, during the second year not more than ~~fifteen percentum (15%)~~ 15% and during the third year not more than ~~ten percentum (10%)~~ 10%.

(b) No such corporation shall, during any one year, disburse a sum greater than ~~ten percentum (10%)~~ 10% of the payments received from subscribers during that year as administrative expenses. As used in this section the term "administrative expenses" shall include all expenditures for nonprofessional services including all activities, contractual arrangements and projects authorized by K.S.A. 40-19c04 and amendments thereto, and in general, all expenses not directly connected with the furnishing of the benefits specified in this act, but not including expenses referred to in subsection (a) hereof.

(c) Each corporation organized under the nonprofit medical

Atch. 2

and hospital service corporation act shall devote a reasonable effort to control costs, including both its administrative costs and cost charged to it by participating hospitals and physicians. Such effort shall include, but not be limited to, a continuing attempt by such corporation through a combination of education, persuasion and financial incentives and disincentives to control cost and to encourage participating physicians and hospitals to control cost by: (1) Elimination of duplicative or unnecessary services, facilities, and equipment; (2) nonprovider participation in the affairs of the corporation; (3) subscriber support of cost containment activities; (4) promotion of sound management practices in participating hospitals; (5) promotion of efficient delivery of health care services by participating physicians; (6) implementation of sound management practices within the nonprofit medical and hospital service corporation; (7) promotion of alternative forms of health care; and (8) engagement in, and evaluation of, cost control experiments, including incentive reimbursement and utilization and peer review programs.

(d) Notwithstanding such corporation's compliance, or extent of compliance, with this section, no nonprofit medical and hospital service corporation doing business in this state shall enter into any contract or agreement with any hospital, physician or other provider of health care service pursuant to K.S.A. 40-19c04 and amendments thereto, which will permit or require payment of any maximum amount in excess of that paid the previous calendar year for each professional and hospital service provided to subscribers except to the extent any such increase in payments does not exceed the percentage increase in the consumer price index for all urban consumers compiled by the United States department of labor for the immediately preceding calendar year by more than four percentage points. In the event such index ceases to be maintained, the commissioner shall adopt a regulation establishing an appropriate alternate index.

(e) Every corporation subject to the provisions of this act

shall provide annually to each subscriber a list of the names and addresses of the physicians, hospitals and other providers of health care services who have entered into agreements or contracts with such corporation.

Sec. 2. K.S.A. 40-19c10 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after January 1, 1984, and its publication in the statute book.

HOUSE BILL NO. 2247

By Committee on Insurance

(By Request)

AN ACT relating to health maintenance organizations; protection against insolvency; requirements.

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

Section 1. (a) Unless otherwise provided below, each health maintenance organization doing business in this state shall deposit with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities or any combination of these or other measures that are acceptable in the amount set forth in this section.

(b) The amount for an organization that is beginning operation shall be the greater of: (1) Five percent of its estimated expenditures for health care services for its first year of operation; or

(2) twice its estimated average monthly uncovered expenditures for its first year of operation; or

(3) $100,000.

At the beginning of each succeeding year, unless not applicable, the organization shall deposit with the organization or trustee, cash, securities or any combination of these or other measures acceptable to the commissioner, in an amount equal to 4% of its estimated annual uncovered expenditures for that year.

(c) Unless not applicable, an organization that is in operation on the effective date of this act shall make a deposit equal to the larger of: (1) One percent of the preceding 12 months' uncovered expenditures; or

(2) $100,000 on the first day of the first fiscal year beginning six months or more after the effective date of this act.

In the second fiscal year, if applicable, the amount of the additional deposit shall be equal to 2% of its estimated annual

uncovered expenditures. In the third fiscal year, if applicable, the additional deposit shall be equal to 3% of its estimated annual uncovered expenditures for that year. In the fourth fiscal year and subsequent years, if applicable, the additional deposit shall be equal to 4% of its estimated annual uncovered expenditures for each year. Each year's estimate, after the first year of operation, shall reasonably reflect the prior year's operating experience and delivery arrangements.

(d) The commissioner may waive any of the deposit requirements set forth in subsections (b) and (c) whenever satisfied that: (1) The organization has sufficient net worth and an adequate history of generating net income to assure its financial viability for the next year; or (2) the organization's performance and obligations are guaranteed by an organization with sufficient net worth and an adequate history of generating net income; or (3) the assets of the organization or its contracts with insurers, hospital or medical service corporations, governments or other organizations are reasonably sufficient to assure the performance of its obligations.

(e) When an organization has achieved a net worth not including land, buildings and equipment of at least $1,000,000 or has achieved a net worth including organization-related land, buildings and equipment of at least $5,000,000, the annual deposit requirement shall not apply.

The annual deposit requirement shall not apply to an organization if the total amount of the accumulated deposit is equal to 25% of its estimated annual uncovered expenditures for the next calendar year, or the capital and surplus requirements for the formation for admittance of an accident and health insurer in this state, whichever is less.

If the organization has a guaranteeing organization which has been in operation for at least five years and has a net worth not including land, buildings and equipment of at least $1,000,000 or which has been in operation for at least 10 years and has a net worth including organization-related land, buildings and equipment of at least $5,000,000, the annual deposit requirement shall not apply. If the guaranteeing

organization is sponsoring more than one organization, the net worth requirement shall be increased by a multiple equal to the number of such organizations. This requirement to maintain a deposit in excess of the deposit required of an accident and health insurer shall not apply during any time that the guaranteeing organization maintains for each organization it sponsors a net worth at least equal to the capital and surplus requirements for an accident and health insurer.

(f) All income from deposits shall belong to the depositing organization and shall be paid to it as it becomes available. A health maintenance organization that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities or any combination of these or other measures of equal amount and value. Any securities shall be approved by the commissioner before being substituted.

(g) In any year in which an annual deposit is not required of an organization, at the organization's request the commissioner shall reduce the required, previously accumulated deposit by $100,000 for each $250,000 of net worth in excess of the amount that allows the organization not to make the annual deposit. If the amount of net worth no longer supports a reduction of its required deposit, the organization shall immediately redeposit $100,000 for each $250,000 of reduction in net worth, provided that its total deposit shall not exceed the maximum required under this section.

(h) Each health maintenance organization that obtains a certificate of authority after the effective date of this act shall have and maintain a capital account of at least $100,000 in addition to any deposit requirements under this section. The capital account shall be net of any accrued liabilities and be in the form of cash, securities or any combination of these or other measures acceptable to the commissioner.

Sec. 2. This act shall take effect and be in force from and after January 1, 1984, and its publication in the statute book.

Attachment 4

BLUE CROSS TRENDS

YEAR	CHARGES *	USE**
1972	11.2%	-0.6%
1973	9.5%	-2.0%
1974	16.6%	-2.2%
1975	20.3%	-3.0%
1976	17.5%	-2.9%
1977	17.7%	-4.6%
1978	15.4%	-1.3%
1979	14.8%	-1.8%
1980	15.4%	-1.3%
1981	18.5%	-.7%

BLUE SHIELD TRENDS

YEAR	CHARGES	USE
1972	1.7%	5.9%
1973	5.1%	2.1%
1974	10%	3.7%
1975	11.8%	3.1%
1976	10.8%	2.6%
1977	8.7%	4.0%
1978	6.9%	3.4%
1979	8.0%	4.4%
1980	12.4%	7.3%
1981	12.0%	5.9%

PROJECTIONS

YEAR	CHARGES	USE
1982	20.5%	-1.0%
1983	19.5%	-1.5%

YEAR	CHARGES	USE
1982	12.0%	6.0%
1983	11.0%	6.0%

* Based on Inpatient Charges

** Based on Inpatient Days

ALL URBAN CONSUMERS (CPI-U) Index 1967=100

	All Items	% Change 1 Year Ago		Medical Care	% Change 1 Year Ago
Nov. 1982	293.6	4.6	Nov. 1982	342.2	11.0
" 1981	280.7	9.6	" 1981	308.2	12.3
" 1980	256.2	12.6	" 1980	274.5	10.7
" 1979	227.5	12.6	" 1979	248.0	9.3
" 1978	202.0	9.0	" 1978	227.0	9.1
" 1977	185.4	6.7	" 1977	208.1	8.8
" 1976	173.8	5.0	" 1976	191.3	10.4
" 1975	165.6	7.3	" 1975	173.3	10.3
" 1974	154.3	12.1	" 1974	157.5	11.8
" 1973	137.6	8.4	" 1973	140.9	5.1
" 1972	126.9	3.5	" 1972	134.1	3.4

Medical Care is made up of Medical Care Commodities (doctors fees, hospital services, etc.) plus Medical Care Services (fees for drugs, supplies, etc.)

The CPI for All Urban Consumers covers about 80 percent of the total noninstitutional population. It includes, in addition to wage earners and clerical workers, groups which historically have been excluded from CPI coverage - salaried workers, the self-employed, retirees, and the unemployed.

Atch. 4

Johnston
Attachment 5

SOME FACTORS AFFECTING COSTS

- INFLATION
- ADVANCES IN MEDICAL TECHNOLOGY
- COMPOSITION OF POPULATION
- NUMBER OF HOSPITAL BEDS
- DEFENSIVE MEDICINE (MEDICAL MALPRACTICE)
- LIFE STYLES
- MANDATED BENEFITS
- THIRD PARTY PAYORS
- DEMAND

- HIGH HOSPITAL UTILIZATION
- INCREASE IN PROVIDERS
- NURSE SHORTAGE
- COST TRANSFERENCE

Atch. 5

DEMOGRAPHIC REVOLUTION

AMERICANS NOW OVER 65	BY 2035
25,000,000	55,000,000
11% OF POPULATION	20% OF POPULATION

BY 2040 -- THE 75+ WILL BE IN THE MAJORITY --
MORE OF THEM THAN THERE ARE 65+ TODAY

1981 ACTUAL

	DAYS	ADM	LOS	OUT-P.
KANSAS —	986	171	5.76	426
NATIONAL AVERAGE —	717	113	6.33	380

1982 3RD QUARTER

KANSAS —	874	153	5.72	412
NATIONAL AVERAGE —	687	111	6.18	389

COST TRANSFER

DEDUCTIBLES AND CO-INSURANCE

DENIAL OF CLAIMS

CUTTING OF PAYMENTS TO PROVIDERS

COST AVOIDANCE

NOT GOING TO HOSPITAL

NOT GOING TO DOCTOR

NOT BUILDING A FACILITY

NOT TAKING QUESTIONABLE TESTS

CHANGING LIFE STYLES

LEAVING HOSPITAL A DAY EARLY

USING OUT-PATIENT SERVICES

Cost Containment

- Prospective Rate Review
- OPT
- Range Maximum — 8.9%
- Utilization Review
- Benefit Changes — Home Health — Hospice
- New Benefit Packages
- Financial Incentives
- Better Health Promotion
- COB — No Fault — Workers Compensation
- PAT

Bottom Line

- We Can't Ration Health Care
- Providers Won't Slow Down
- BC-BS Costs Too High
- Public Has Insatiable Appetite

Solution

- Reduce $'s Going To Health

Strategy

- Preferred Provider Concept