Approved March 13, 1984
Date

MINUTES OF THE House COMMITTEE ON Insurance.

The meeting was called to order by Rep. Rex Hoy at
Chairperson

3:30 ~~a.m.~~/p.m. on February 28, 1984 in room 521 S of the Capitol.

All members were present except:
Rep. L. Johnson, Rep. M. J. Johnson, Rep. Long and Rep. Peterson, who were excused.

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

Conferees appearing before the committee:

Rep. Spaniol	Rep. Wagnon	Rep. Luzzati
Marlon Dauner	Alice Reed	Linda Woody
Frank Gentry	Loreen Stein Parnacott	Sylvia Hougland
Jerry Slaughter	Barbara Reinert	

Others present:
See List: (Attachment 1)

HB 3008--No-Fault act, subrogation and attorney fees, was up for final action. Rep. Sprague passed around Attachment 2, an amendment proposed by Rep. Sprague and Rep. Peterson, and explained the proposed amendment. Rep. Littlejohn moved to adopt the proposed amendment. Rep. Cribbs seconded. Rep. Spaniol offered a substitute motion to offer a conceptual motion by adding "by certified mail" to the proposed amendment. Rep. Cribbs seconded. There was discussion and a vote taken. The substitute motion carried. Rep. Littlejohn moved to pass out HB 3008 favorably, as amended. Rep. Fuller seconded. The motion carried.

HB 2251--providing for the regulation of continuing care agreements and registration of providers. Rep. Sprague explained the proposed amendments submitted by the subcommittee (Attachment 3), and the background of the proposed amendments. He said the Insurance Department will administer this bill if it is enacted. Dick Brock, of the Insurance Department, said there would be a minimum fiscal impact as far as the insurance department is concerned, and the registration fees provided in the bill would go into the general fund. Mr. Brock said he thought the bill, as amended, would benefit the consumer. Rep. Webb moved to adopt the subcommittee report and the proposed amendments. Rep. Turnquist seconded. The motion carried. Rep. Webb moved to pass HB 2251 favorably as amended. Rep. Weaver seconded. The motion carried.

HB 2885, by Rep. Spaniol--Reimbursement for services of certain health care providers. Rep. Spaniol passed around his written testimony (Attachment 4) and then passed around Attachment 5, Draft Proposal Substitute for House Bill No. 2885. He explained the differences between the two forms of HB 2885 and asked for introduction and support of the substitute bill. There were questions of Rep. Spaniol. Dick Brock, of the Kansas Insurance Department, said this bill would help with a recurring problem over the years, and the department supports the bill.

Marlon Dauner, Senior Vice President, External Affairs, Blue Cross/Blue Shield, furnished his written testimony (Attachment 6) and stated that this bill would appropriately resolve this problem for Blue Cross and Blue Shield subscribers.

Frank Gentry, representing the Kansas Hospital Association, said his testimony had been prepared in opposition to the original bill, but he was not opposed to the substitute bill, as he read it.

Jerry Slaughter, representing the Kansas Medical Society, said their organization opposed the original bill and he had not studied the substitute bill.

HB 3065, Group Accident and Sickness Insurance, continuation and conversion privileges, and HB 3087, Continuation of coverage of certain persons in group

* * * *

policy of sickness and accident insurance. Rep. Wagnon spoke briefly in support of the bills, but primarily to HB 3065, and said several conferees would be speaking to the committee.

Alice Reed, who is in theDisplaced Homemaker Program of the Topeka YWCA, spoke in support of HB 3065. She said that after her divorce last fall her health insurance coverage, which was under her former husband's policy, was cancelled, but she was not notified. She returned to Topeka and has had two jobs, but neither furnished health insurance, so she has been without any health insurance since December 1st of last year.

Loreen Stein Parnacott, Vocational Counselor for the YWCA Displaced Homemaker Program, passed around her written testimony (Attachment 7). She asked support for HB 3065 and spoke of the need for recently divorced and widowed women, sometimes with children, to have health insurance continued, or have the option to convert. There were questions of Ms. Reed and Ms. Parnacott.

Rep. Luzzati spoke in Support of HB 3065 and HB 3087, and gave several examples of the need for such continuation or conversion due to the death of a husband, leaving an older widow who still needs health insurance.

Barbara Reinert, representing the Kansas Women's Political Caucus, spoke briefly in support of the bills. She said six months would help give the women coverage while they have time to make more permanent arrangements about health insurance.

Linda Woody, with the National Organization for Women, spoke in support of HB 3065 and HB 3087, and also SB 704. She passed out Attachment 8, a letter from Joan K. Upshaw, Director, Social Services, Shawnee Mission Medical Center dated February 27, 1984, and addressed to Neil H. Arasmith, Chairman of the Senate Commercial and Finance Committee; and also Attachment 9, statistics furnished to the Kansas Women's Equity Action League by the ETC Institute of Olathe, KS. Ms. Woody asked for six months extension of coverage to give a woman time to get over the death of her husband or a divorce, and to study whether to convert or buy new insurance.

There was discussion with Dick Brock of the Insurance Department as to current rules for conversion or continuation. Rep. Wagnon said the women need HB 3065 at this time, and then go on to study HB 3087.

Sylvia Hougland, Secretary of Aging for the Kansas Department on Aging, passed out her written testimony (Attachment 10) and she referred to it in her testimony. She asked support of HB 3065 and HB 3087, with six months continuation, at group rates, to convert or obtain new coverage, with the premiums to be paid by the insured.

Chairman Hoy said that Jack Roberts will be given time another day to testify in opposition to the bills, if he so desires.

Also furnished, for information, were Attachment 11, testimony of Alice Kitchen, from the Kansas Women's Equity Action League to the Senate Commercial and Financial Institutions Committee and the House Insurance Committee, supporting SB 704, HB 3065, and HB 3087; and Attachment 12, from Kathleen Sebelius of the Kansas Trial Lawyers Assn., giving statistics on wrongful death laws in other states and urging support of HB 2905 or HB 2932.

The meeting adjourned at 5:00 PM.

GUEST LIST Attachment 1

COMMITTEE: House Insurance DATE: Tues Feb. 28, 1984

NAME	ADDRESS	COMPANY/ORGANIZATION
Frank L. Gentry	Topeka	Ks Hosp. Assoc.
Jack Roberts	"	BC-BS
Marion Degner	"	BC-BS
Wayne Johnston	"	BC-BS
[illegible]	"	BC-BS
Joanne Temple	"	KU Intern -- AG's Office
Steve Hartmann	"	KTLA
Ed Mullins	"	Budget
Bob Williams	"	Ks. Dental Assoc.
[illegible]		55th Dist
Cynthia Rumford	"	KDOA
Alice Reed	"	
H.C. Woody	Cottonwood Falls	Nat'l Organization for Women
Barbara Reinert	Topeka	Ks. Women's Political Caucus
Ruth Luzzati		84th District
Doreen Stein Pomeroy	225 W 12th	YWCA
L. M. Cornish	Topeka	P & C Cos
Dick Brock	"	Ins. Dept

Atch. 1

Attachment 2

pa3308

PROPOSED AMENDMENTS TO H.B. NO. 3008

(e) Pursuant to this section, the attorney for the injured person, such person's dependents or personal representatives shall notify the insurer or self-insurer in writing by mail of such attorney's engagement and the level of compensation agreed for such engagement. The insurer or self-insurer shall pay attorney fees to such attorney upon any recovery by it through its right of subrogation at the same level of compensation as agreed between such attorney and the injured person, such person's dependents or personal representatives unless the insurer shall within thirty days of its recept of notification (a) notify such attorney that it does not desire such attorney's representation of its interests or (b) agree in writing with such attorney to represent its interests at a level of compensation different from that agreed between such attorney and the injured person, such person's dependents or personal representatives.

Att. 2

Session of 1983

HOUSE BILL No. 2251

By Representatives Moore, D. Miller and Weaver

2-8

AN ACT concerning continuing care agreements; providing for the regulation thereof; providing for the registration of providers of continuing care; granting certain powers to and imposing certain duties and functions upon the commissioner of insurance; imposing certain penalties for certain providers not complying with provisions of this act

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

Section 1. As used in this act:

(a) "Continuing care agreement" means an agreement by a provider to furnish to an individual for the payment of an entrance fee or periodic charges, or both, living accommodations or meals and related services, or both, in a home possibly but not necessarily together with nursing care services, medical services or other health-related services, or any combination of such services, which is effective for the life of the individual or for a period in excess of one year.

(b) "Entrance fee" means the sum of money or other property paid or transferred, or promised to be paid or transferred, in consideration for one or more individuals' becoming a resident or residents of a home pursuant to an agreement for the providing of continuing care by the home.

(c) "Application fee" means the fee charged to an individual, apart from the entrance fee, to cover only the provider's costs in processing the individual's application to become a resident regardless of whether the individual becomes a resident.

(d) "Home" means the facility or facilities occupied, or planned to be occupied, by five or more residents where the provider undertakes pursuant to a continuing care agreement to provide continuing care to such residents.

(e) "Living unit" means a room, apartment, cottage or other

DRAFT OF PROPOSED SUBCOMMITTEE AMENDMENTS TO H.B. NO. 2251

Att. 3

area within a home set aside for the use of the residents.

(f) "Provider" means the person, corporation, partnership, association or other legal entity which agrees to provide continuing care to residents in a home and includes a provider establishing a new home even though the provider has previously been registered with respect to other homes.

(g) "Resident" means an individual or individuals who has or have entered into an agreement with a provider for continuing care at a home.

(h) "Manager" means a person, corporation, partnership, association or other legal entity, other than an individual employed by the provider or an affiliated corporation or other legal entity controlled by the provider.

(i) "Solicit" means all actions of a provider in seeking to have individuals residing in this state pay an application fee and enter into a continuing care agreement by any means including, without limitation, personal, telephone or mail communication or any other communication directed to and received by any individual in this state and any advertisements in any media distributed or communicated by any means to individuals residing in this state.

(j) "Omission of a material fact" means the failure to state a material fact required to be stated in any disclosure statement or registration in order to make the statements made therein, in light of the circumstances under which they were made, not misleading.

(k) "Commissioner" means the commissioner of insurance.

Sec. 2. (a) Unless a provider is registered with respect to the home pursuant to the provision of this act, ~~no~~ provider ~~shall~~ enter into a contract to provide continuing care to any person or extend the term of an existing contract to provide continuing care to any resident at any home located in this state nor solicit the execution of any continuing care contract by persons residing within this state. This act shall not apply to any continuing care agreement entered into prior to the effective date of this act.

(b) The application for registration shall be filed with the commissioner by the provider on terms prescribed by the commissioner and shall include:

to

it is unlawful for any

It is unlawful for any provider, in connection with the solicitation of individuals to provide such individuals services pursuant to a continuing care agreement, or in connection with the process of entering into a continuing care agreement with an individual, to:

(1) Employ any device, scheme or artifice to defraud;

(2) make any untrue statement of a material fact or to omit to state a material fact necessary in order to make the statements made, in the light of the circumstances under which they are made, not misleading; or

(3) engage in any act, practice or course of business which operates or would operate a fraud or deceit upon any individuals.

Sec. 3.

(1) All information required by the commissioner pursuant to regulations adopted by it under this act; and

(2) a proposed disclosure statement meeting the requirements of section ~~3~~ 4 of this act.

(c) Upon receipt of the application for registration in proper form, the commissioner shall, within 10 business days, issue a notice of filing to the provider-applicant. Within 60 days of the notice of filing, the commissioner shall enter an order registering the provider or rejecting the registration. If no order of rejection is entered with 60 days from the date of notice of filing, the provider shall be deemed registered unless the provider has consented in writing to an extension of time. If no order of rejection is entered within the time period as extended by consent, the provider shall be deemed registered.

(d) If the commissioner determines that the requirements of sections ~~3~~, 4, 5~~,~~ ~~6~~ and 7 have been met, the commissioner shall enter an order registering the provider. If the commissioner determines that any of the requirements of sections ~~3~~, 4, 5~~,~~ ~~6~~ and 7 have not been met, the commissioner shall notify the applicant that the application for registration must be corrected within 30 days in such particulars as designated by the commissioner. If the requirements are not met within the time allowed, the commissioner may enter an order rejecting the registration which shall include the findings of fact upon which the order is based and which shall not become effective until 20 days after the end of the foregoing thirty-day period. During the twenty-day period, the applicant may petition for reconsideration and shall be entitled to a hearing. Such order of rejection shall not take effect, in any event, until such time as the hearing, once requested, has been given to the applicant.

(e) With respect to continuing care agreements offered by a provider to existing or prospective residents in a home established prior to the effective date of this act, which home has one or more residents living there pursuant to such agreements entered into prior to the effective date of this act, the commissioner may after the filing of an application for registration, issue a temporary order registering the provider which may then enter

into continuing care agreements in compliance with all applicable provisions of this act until the order of permanent registration has been issued pursuant to this subsection (e).

(f) If the provider is granted permanent registration, any resident who entered into an agreement while registration was temporary shall be provided with all amendments to the application for registration and the initial disclosure statement required by subsection (b). If the provider is denied permanent registration, any resident who entered into a continuing care agreement during temporary registration shall be entitled to all the remedies provided by section 9.

Sec. 4. After the entry of an order registering the provider and prior to the provider's acceptance on behalf of the home of part or all of any application fee or the entrance fee or the execution of the continuing care agreement by the resident, whichever occurs first, the provider shall deliver and obtain a receipt for the delivery of an initial disclosure statement to the individual or individuals who are the prospective residents and with whom the continuing care agreement is to be entered into. The initial disclosure statement shall be delivered to prospective residents in accordance with this section until the first annual disclosure statement is filed pursuant to section 5. The text of the initial disclosure statement shall contain the following information:

(a) The name and business address of the provider and a statement of whether the provider is an individual, partnership, corporation or any other legal entity.

(b) The names of the individual or individuals who constitute the provider or, if the provider is a partnership, corporation or other legal entity, whether for profit or not-for-profit, the names of the officers, directors, trustees or managing or general partners of the provider and a description of each such individual's duties on behalf of the provider.

(c) With respect to a provider which is not incorporated or established and operated on a not-for-profit basis, the names and business addresses of any individual having any ownership or any beneficial interest in the provider and description of such

individual's interest in or occupation with the provider.

(d) With respect to any person named in response to subsections (a) to (c), inclusive, and to any proposed manager:

(1) A description of the business experience of such person, if any, in the operation or management of the home or other homes;

(2) the identity of any business or professional service entity in which such person has a 10% or greater ownership or beneficial interest and which the provider will employ to provide goods, services or any other thing of value of a value in excess of $500 within any year and a description of goods, services and other thing of value and the anticipated costs thereof to the provider or a statement that such costs cannot currently be estimated; and

(3) a statement as to whether any such person has been convicted of a crime or been a party to any civil action claiming fraud, embezzlement, fraudulent conversion or misappropriation of property which resulted in a judgment against the person for damages or enjoining any such activity and whether any such person has had any state or federal licenses or permits suspended or revoked in connection with any health care activities or any business activities related thereto.

(e) If the home is or is to be operated by a manager, the following information shall be supplied in the disclosure statement:

(1) The name and business address or addresses of any such manager, the identities of any other homes managed by the individual or entity and a copy of the agreement currently in effect or to be entered into between the provider and the manager for the operation of the home;

(2) if the manager is incorporated or established and operated on a for-profit basis, the identity of all individuals or entities holding any ownership or beneficial interest in the manager and the fees or any other compensation anticipated to be paid by the provider to the manager for the operation of the home; and

(3) the method by which the manager was chosen to manage the home and, if the manager was chosen because of a condition in a mortgage commitment to the provider, the identity of the

mortgagee requiring the condition in the commitment.

(f) A statement of the experience of the provider in establishing and operating homes providing continuing care.

(g) A statement as to whether or not the provider is, or is affiliated with, a religious, charitable or other nonprofit organization and the extent of the affiliation, if any, and the extent to which any affiliate organization will be responsible for the financial and contractual obligations of the provider and the provision of the United States internal revenue code, if any, under which the provider or any of the provider's affiliates is or are exempt from the payment of federal income taxes and a statement of whether the home is exempt from local property taxation.

(h) The location and description of the properties of the provider, both existing and proposed, and to the extent proposed, the estimated completion date or dates, a statement as to whether or not construction has begun and any contingencies subject to which construction may be deferred.

(i) A description of all services provided or proposed to be furnished by the provider under its continuing care agreements with residents including, without limitation, the extent to which medical care is furnished, the present or proposed cost of all such services and a description of any services made available by the home at an extra charge and above the entrance fee and periodic charges provided for in the continuing care agreement.

(j) A description of all fees required of residents, including the entrance fee and any periodic charges. The description shall include:

(1) The circumstances under which the resident will be permitted to remain in the home in the event the resident is unable to pay periodic or other charges;

(2) the terms and conditions under which the continuing care agreement may be cancelled by the provider and by the resident and the conditions, if any, under which any or all of the entrance fees will be refunded in the event of cancellation by either the provider or the resident or in the event of the death of the resident prior to or following occupancy of the living unit;

(3) the conditions under which a living unit occupied by a resident may be made available by the provider to another resident other than on the death of the resident executing the continuing care agreement;

(4) the manner by which the provider may adjust periodic charges or other recurring fees. If the home is already in operation or if the provider or manager operates one or more similar homes within this state, the statement shall include tables showing the frequency and average dollar amount of each increase in periodic rates at each such home for the previous five years or for such shorter period if the home has been operated for less than five years; and

(5) a statement of any fee charged if the resident remarries while at the home.

(k) A description of the health and financial conditions required for an individual to be accepted as a resident and to continue as a resident once accepted, including the effect of any change in the health or financial condition of a person between the date the individual executes the continuing care agreement and the date of initial occupancy of a living unit.

(l) Certified financial statements of the provider including a balance sheet as of the end of the provider's most recent fiscal year and income statements for the three most recent fiscal years of the provider or such shorter period of time as the provider shall have been in existence. If the provider's fiscal year ended more than 90 days prior to the date and the application is filed, interim uncertified financial statements shall be included as of a date not more than 90 days prior to the filing.

(m) If the operation of the home has not begun, a statement of the anticipated source and application of funds used or to be used in the purchase or construction of the home including:

(1) An estimate of the cost of purchasing or constructing and equipping the home, including related costs such as financing expenses, legal expenses, land costs, occupancy development costs and all other similar costs which the provider expects to incur or become obligated for prior to the commencement of the operation of the home;

(2) a description of any mortgage loan or other long-term financing intended to be used for the financing of the home, including the terms and conditions and costs of such financing;

(3) an estimate of the total entrance fees to be received from the residents at or prior to the commencement of operation of the home; and

(4) an estimate of the funds, if any, which are anticipated to be necessary to pay for start-up losses.

(n) A pro forma income statement for the home for the next fiscal year, which may be either on an accrual or a cash basis but shall employ the same accounting system used for the certified financial statement, including:

(1) A beginning cash balance and, if the operation of the home has not commenced, the beginning cash balance shall be consistent with the statement of anticipated source and application of funds required by subsection (m);

(2) anticipated earnings on cash reserves, if any;

(3) estimates of net receipts from entrance fees, other than entrance fees included in the statement of source and application of funds required by subsection (m), less estimated entrance fee refunds, if any, and a description of the actuarial basis and method of calculation for the projection of entrance fee receipts;

(4) an estimate of gifts or bequests if any are to be relied upon to meet capital or operating expenses;

(5) a projection of estimated income from fees and charges other than entrance fees, showing individual rates presently anticipated to be charged and including a description of the assumptions used for calculating the estimated occupancy rate of the home and the effect on the income of the home of third-party payments for health care services, if any, to be provided pursuant to continuing care agreements;

(6) a projection of estimated operating expenses of the home including a description of the assumptions used in calculating the expenses and separate allowances, if any, for the replacement of equipment and furnishings and anticipated major structural repairs or additions;

(7) an estimate of annual payments of principal and interest

required by any mortgage loan or other long-term financing;

(8) an estimate of annual payments of local property taxes, if any, and of any other taxes imposed; and

(9) if the income statements are on an accrual basis, a separate cash flow statement shall also be provided.

(o) Such other material information concerning the home as the provider wishes to include.

(p) The cover page of the disclosure statement shall state, in a prominent location and type face, the date of the disclosure statement and that registration of the home does not constitute approval, recommendation or endorsement of the home by the commissioner nor does such registration evidence the accuracy or completeness of the information set forth in the disclosure statement.

(q) A copy of the form or forms of agreement for continuing care used or to be used by the provider for the home shall be attached as an exhibit to the disclosure statement.

Sec. 15. (a) The provider shall file with the commissioner annually within four months following the end of the provider's fiscal year, unless such time shall be extended by the written consent of the commissioner, an annual disclosure statement which shall contain a statement setting forth, as of the end of such fiscal year, any material changes in the information required by section 3 of this act for the initial disclosure statement. The annual disclosure statement shall also be accompanied by a narrative describing any material differences between (1) the pro forma income statements filed pursuant to paragraph (n) of section 3 either as part of the application for registration or as part of the most recent annual disclosure statement; and (2) the actual results of operations during the fiscal year. The annual disclosure statement shall also contain the revised pro forma income statement for the next fiscal year filed as part of the current annual disclosure statement.

(b) From the date an annual disclosure statement is filed until the date the next succeeding annual disclosure statement is filed with the commissioner and prior to the provider's acceptance on behalf of the home of part or all of any application fee or

part of the entrance fee or the execution of the continuing care agreement by the resident, whichever first occurs, the provider shall deliver and obtain a receipt for the delivery of the then current annual disclosure statement to the individual or individuals who are the prospective residents and with whom the continuing care agreement is to be entered into and to the individual or individuals who are residents.

(c) In addition to filing the annual disclosure statement, the provider may amend its currently filed disclosure statement at any other time if, in the opinion of the provider, an amendment is necessary to prevent the disclosure statement and annual disclosure statement from containing any material misstatement of fact or omission to state a material fact required to be stated therein. Any such amendment or amended disclosure statement must be filed with the commissioner before it is delivered to any resident or prospective resident and is subject to all the requirements of this act.

Sec. 7. A purchaser of a continuing care agreement which is subject to registration under this act shall have the right to rescind the purchase of the continuing care agreement within seven days, without penalty, after making an initial deposit and executing the agreement, and after receipt of a copy of the disclosure statement. During the seven-day period a purchaser's funds shall be retained in a separate escrow account under terms approved by the commissioner. A person shall not be required to move into the facility before the expiration of the seven-day period.

Sec. 6. The commissioner shall require, as a condition of registration, that the provider establish an interest-bearing escrow account with a bank, trust company or other escrow agent approved by the commissioner and that any entrance fees received by the provider prior to the date the resident is permitted to occupy the living unit in the home be placed in the escrow account subject to release as follows:

(a) If the entrance fee gives the resident the right to occupy a living unit which has been previously occupied, the entrance fee and any income earned thereon shall be released to the provider

Sec. 6. It shall be unlawful for any provider to make or cause to be made, in any document filed with the commissioner or in any proceeding under this act, any statement which is, at the time and in light of the circumstances under which it is made, false or misleading in any material respect.

at such time as the living unit becomes available for occupancy by the new resident;

(b) if the entrance fee applies to a living unit which has not been previously occupied by any resident, the entrance fee shall be released to the provider at such time as the commissioner is satisfied that:

(1) Aggregate entrance fees received or receivable by the provider pursuant to executed continuing care agreements plus anticipated proceeds of any first mortgage loan or other long-term financing commitment plus funds from other sources in the actual possession of the provider are equal to not less than 50% of the aggregate cost of constructing or purchasing, equipping and furnishing the home plus not less than 50% of the funds estimated in the statement of anticipated source and application of funds submitted by the provider as part of its application to be necessary to fund start-up losses of the home; and

(2) a commitment has been received by the provider for any permanent mortgage loan or other long-term financing described in the statement of anticipated source and application of funds submitted as part of the application for registration and any conditions of the commitment prior to disbursement of funds thereunder, other than completion of the construction or closing of the purchase of the home, have been substantially satisfied.

(c) If the funds in an escrow account to which subsections (a) and (b) apply and any interest earned thereon are not released within such time as provided by the rules and regulations adopted by the commissioner, then such funds shall be returned by the escrow agent to the persons who made the payment to the provider.

(d) Nothing in this section shall require the escrow of any nonrefundable application fee charged to prospective residents.

(e) In lieu of any escrow which may be required by the commissioner under this section, a provider shall be entitled to post a letter of credit from a financial institution, negotiable securities or a bond by a surety authorized to do business in this state and approved by the commissioner as to form and in an amount not to exceed the amount required by paragraph (b)(1).

The bond, letter of credit or negotiable securities shall be executed in favor of the commissioner on behalf of individuals who may be found entitled to a refund of entrance fees from the provider.

(f) An entrance fee held in escrow may be returned by the escrow agent at any time to the person or persons who paid the fee to the provider upon receipt by the escrow agent of notice from the provider that such person is entitled to a refund of the entrance fee.

Sec. 7. The commissioner shall require, as a condition of the registration pursuant to section 3, that the provider establish at the time the facility is first occupied by any resident and maintain on a current basis, in escrow with a bank, trust company or other escrow agent approved by the commissioner, an amount which equals the aggregate principal and interest payments due during the next 12 months on account of any first mortgage or other long-term financing of the facility. The principal of the escrow account may be invested with the earnings thereon payable to the provider, and up to 1/12 of the total principal shall be released to the provider upon written notice to the division. A release of funds shall not be made more than once during any calendar month, and then only after the escrow agent has given written notice to the division at least 10 days prior to the release. This section shall not apply to any facility occupied by any resident prior to the effective date of this act.

Sec. 8. (a) The registration of a provider shall remain in effect until revoked, after notice and hearing, upon written findings of fact by the commissioner that the provider has:

(1) Willfully violated any provision of this act or of any rule, regulation or order adopted hereunder;

(2) failed to file an annual disclosure statement required by section 4;

(3) failed to deliver to prospective residents the disclosure statements required by sections 4 and 5;

(4) delivered to prospective residents a disclosure statement which makes an untrue statement of material fact or omits a material fact and the provider, at the time of the delivery of the

disclosure statement, had actual knowledge of the misstatement or omission; or

(5) failed to comply with the terms of a cease and desist order.

(b) Findings of fact in support of revocation, if set forth in statutory language, shall be accompanied by a concise and explicit statement of the underlying facts supporting the findings.

(c) If the commissioner finds, after notice and hearing, that the provider has been guilty of a violation for which revocation could be ordered, it may first issue a cease and desist order. If the cease and desist order is or cannot be effective in remedying the violation, the commissioner may order after notice and hearing, that the registration be revoked.

Sec. 9. (a) If a provider enters into a continuing care agreement (1) in violation of section ~~3~~ 4, or (2) without having first delivered to the prospective resident the disclosure statement required by section ~~3 or~~ 4 or 5, or (3) delivers to the prospective resident a disclosure statement which makes an untrue or misleading statement of material fact or omits a material fact; or (4) in any other way violates the provisions of this act, the provider shall be liable to the individual or individuals who entered into the continuing care agreement under such circumstances for the repayment of all entrance, application, periodic charges or other fees paid by such person to the provider, less the reasonable value of care and lodging provided to the resident up to the time when the untrue statement, misstatement or omission was actually or should reasonably have been discovered by the resident, together with interest thereon at the legal rate for judgments, costs and reasonable attorney's fees.

(b) Liability of the provider under this section for any untrue statement, misstatement or omission in the disclosure statement shall exist only if the provider had actual knowledge or, in the exercise of reasonable care should have known, of the untrue statement, misstatement or omission.

(c) An action shall be maintained by any individual to enforce liability under section 8 unless commenced before the expiration of ~~two~~ three years after the execution by the parties of the

continuing care agreement which gave rise to the violation or ~~two~~ three years after the failure to deliver the disclosure statement or ~~two~~ years after the delivery of the disclosure statement with the untrue statement, misstatement or omission contained therein, whichever shall occur later.

Sec. 10. The commissioner may:

(a) Accept, in lieu of the registration required by section ~~2~~ 3, the initial disclosure statement required by section ~~3~~ 4 and the annual disclosure statement required by section ~~4~~ 5, other registrations or disclosure statements or other documents filed by the provider in this state, in any other state or with the federal government if the commissioner determines that such other registrations or disclosure statements or other documents substantially comply with the applicable requirements of this act;

(b) grant exemptions from any provision of this act pursuant to the commissioner's rules and regulations;

(c) make necessary public or private investigations within or outside of this state, or determine whether any person has violated or is about to violate this act or any rule or order hereunder or to aid in the enforcement of this act or in the prescribing of rules and forms hereunder;

(d) require or permit any person to file a statement in writing, under oath or otherwise as the commissioner determines, as to all the facts and circumstances concerning any matter to be investigated;

(e) for the purposes of any investigation or proceeding under this act, administer oaths or affirmations and, upon the commissioner's own motion or upon request of any party, may subpoena witnesses and compel their attendance, take evidence and require the production of any matter which is relevant to the investigation, including the existence, the description, nature, custody, condition and location of any books, documents or other tangible things and the identity and location of persons having knowledge of relevant facts or any other matter reasonable calculated to lead to the discovery of material evidence;

(f) upon failure to obey a subpoena or to answer questions propounded by the investigating officer and upon reasonable

notice to all persons affected thereby, apply to a court for an order compelling compliance.

Sec. 11. (a) If the commissioner determines, after notice and hearing, that any person has violated or is about to violate any provision of this act or of any rule and regulation or order issued hereunder, the commissioner may issue an order requiring the person to cease and desist from the unlawful practice or to take such affirmative action as in the judgment of the commissioner will carry out the purposes of this act.

(b) If the commissioner makes a finding of fact in writing that the public interest will be irreparably harmed by delay in issuing a cease and desist order, the commissioner may issue a temporary cease and desist order which shall include in its term a provision that, upon request, a hearing shall be held within 10 days of such request to determine whether or not the order becomes permanent. Any such temporary cease and desist order shall be served on the person subject to it by certified mail, return receipt requested.

(c) If it appears that a person has engaged, or is about to engage, in an act or practice constituting a violation of any provision of this act or of a rule and regulation or order adopted pursuant to the provisions of this act, the commissioner with or without prior administrative proceedings, may bring an action in the district court to enjoin the acts or practices or to enforce compliance with this act or any rule and regulation or order adopted pursuant to the provisions of this act. Upon proper showing, injunctive relief or temporary restraining orders shall be granted. The commissioner shall not be required to post a bond in any court proceeding.

Sec. 12. The commissioner shall adopt rules and regulations necessary for the enforcement of the provisions of this act.

Sec. 13. (a) The commissioner shall charge and collect the fees fixed by this section. The fee for filing an application for registration of the offer or sale of life interests and long-term leases shall be $250. When an application for registration is withdrawn before the effective date or a stop order is issued before the effective date of a registration, the commissioner shall

, restitution, writ of mandamus or other equitable relief

and a receiver or conservator may be appointed for the defendant or the defendant's assets

(a) Any provider who willfully violates any provision of this act except section 7 or who willfully violates any rule or regulation adopted or order issued under this act, or who willfully violates section 7 knowing the statement made to be false or misleading in any material respect, shall upon conviction be fined not more than $5,000.

No prosecution for any crime under this act may be commenced more than five years after the alleged violation. A prosecution is commenced when a complaint or information is filed, or an indictment returned, and a warrant is delivered to the sheriff or other officer for execution, except that no prosecution shall be deemed to have been commenced if the warrant so issued is not executed without unreasonable delay.

(b) The commissioner may refer such evidence as may be available concerning violations of this act or of any rule and regulation or order to the attorney general or the proper county or district attorney, who may in the prosecutor's discretion, with or without such a reference, institute the appropriate criminal proceedings under this act. Upon receipt of such reference, the attorney general or the county attorney or district attorney may request that a duly employed attorney of the commissioner prosecute or assist in the prosecution of such violation or violations on behalf of the state. Upon approval of the commissioner, such employee shall be appointed a special prosecutor for the attorney general or the county attorney or district attorney to serve without compensation from the attorney general or the county attorney or district attorney. Such special prosecutor shall have all the powers and duties prescribed by law for assistant attorneys general or assistant county or district attorneys and such other powers and duties as are lawfully delegated to such special prosecutor by the attorney general or the county attorney or district attorney.

Sec. 14.

retain a fee of $25 if the initial review has not been commenced and the full filing fee after review has commenced. The renewal registration fee shall be $100.

(b) The commissioner shall remit all moneys received by the commissioner under this act to the state treasurer at least monthly. Upon receipt of any such remittance the state treasurer shall deposit the entire amount thereof in the state treasury and the same shall be credited to the state general fund.

Sec. ~~14.~~ 15. This act shall take effect and be in force from and after its publication in the statute book.

DENNIS SPANIOL
REPRESENTATIVE, NINETY-FOURTH DISTRICT
SEDGWICK COUNTY
436 S SOCORA
WICHITA, KANSAS 67209
(316) 722-2044
ROOM 280-W, CAPITOL BLDG
TOPEKA, KANSAS 66612
(913) 296-2734

STATE OF KANSAS

TOPEKA

HOUSE OF
REPRESENTATIVES

Attachment 4

COMMITTEE ASSIGNMENTS
VICE-CHAIRMAN: INSURANCE
MEMBER ASSESSMENT AND TAXATION
JOINT COMMITTEE ON ADMINISTRATIVE
RULES AND REGULATIONS
PUBLIC HEALTH AND WELFARE

H.B. 2885 APPLIES TO THE CONTRACT BETWEEN A HOSPITAL AND ANY THIRD PARTY PROVIDER THAT THE HOSPITAL MIGHT USE. MOST HOSPITALS DO NOT DIRECTLY PROVIDE ALL OF THE SERVICES WITHIN THEIR WALLS. IT IS COMMON FOR RADIOLOGISTS, PATHOLOGISTS, AND ANAESTHESIOLOGISTS TO BE THIRD PARTY CONTRACTORS AND NOT SUBJECT TO THE BLUE CROSS PARTICIPATING AGREEMENT THAT THE HOSPITAL SIGNED.

IF YOU WILL REFER TO THE LETTER ATTACHED, PLEASE NOTE PARAGRAPHS SIX AND SEVEN WHERE THE GENTLEMAN COMPLAINS ABOUT NOT HAVING ANY CHOICE IN THE SELECTION OF THE RADIOLOGIST USED. IT WAS NEVER EXPLAINED TO HIM THAT THE THIRD PARTY PROVIDER WOULD NOT ACCEPT THE PAYMENT PROVIDED IN THE BLUE CROSS AGREEMENT THE HOSPITAL HAD SIGNED. YET THIS GENTLEMAN WAS STILL OBLIGATED TO PAY THE EXCESS CHARGES ON THE RADIOLOGY BILL.

IN CHECKING WITH BLUE CROSS, I HAVE BEEN ADVISED THAT THIS BILL WOULD APPLY ONLY TO 6 TO 8 PERCENT OF THE PHYSICIANS IN KANSAS. ALTHOUGH IT AFFECTS ONLY A RELATIVELY SMALL NUMBER OF PHYSICIANS, THE KANSAS INSURANCE DEPARTMENT HAS RECEIVED NUMEROUS COMPLAINTS REGARDING THE SITUATION.

I ASK FOR YOUR FAVORABLE SUPPORT OF H.B. 2885.

Att. 4

Bill Campbell
9117 Westport
Wichita, KS 67212

Nov. 9, 1983

Fletcher Bell
Commissioner of Insurance
420 SW Ninth
Topeka, KS 66612

Dear Commissioner Bell:

I am writing to complain about a circumstance that, while I imagine it is legal under Kansas insurance regulations, I think is unfair to consumers.

About a year ago my son broke his arm in an accident. We took him to the emergency room at Wesley Medical Center in Wichita to have it set. During the course of his treatment at Wesley, four X-rays of his arm were taken.

A few weeks later we received a bill from Wichita Radiology Group for the services of a radiologist to read each of the X-rays--a procedure which I understand is mandated by Kansas' hospital licensing regulations.

At the time we had medical insurance through Kansas Blue Cross/Blue Shield which provided 100 percent coverage for an accident, so we filed the bill from Wichita Radiology Group with Blue Cross. As you are undoubtedly aware, Blue Cross/Blue Shield allows a maximum benefit for any service provided, which member medical providers have agreed to accept.

Wesley is a Blue Cross member provider. Wichita Radiology Group is not. Consequently, when Blue Cross paid its maximum allowed charge for the radiologist's services, Wichita Radiology Group refused to drop the remainder and continued to bill me for the balance.

My beef is this: As a Blue Cross/Blue Shield insured, I am aware of the limits of my coverage and have the option of selecting a member provider in order to obtain the maximum coverage under my policy. I did this when I took my son to Wesley. But I had no choice in the selection of the radiologist--I didn't even know such a service was going to be performed; another bone of contention but one not under your purview.

I feel I was unfairly obligated to a debt to Wichita Radiology Group. If a member provider contracts outside for a service, either that provider ought to be bound by the same financial limitations as a member provider, or the patient ought to have an option in the selection of the outside contractor.

I have no doubt that the actions of both Wesley Hospital and Wichita Radiology Group are perfectly legal, but I am adamant that they were not morally proper.

I have refused to pay the difference to Wichita Radiology Group, and my account has been turned over the credit bureau, presumably to come back and haunt me the next time I go to visit my friendly banker. The amount in question is less than $20, so it's not a financial question; it's a matter of principal.

I do not know whether the Department of Insurance can, or is interested, in investigating this matter. But I do believe I, and undboubtedly thousands of others like me, have been robbed--legally!

I would be interested in hearing your comments on this.

Sincerely,

William C. Campbell

Bill Campbell

Attachment 5

pa2885

DRAFT PROPOSAL
Substitute for HOUSE BILL NO. 2885

AN ACT concerning providers of professional and hospital services which contract with mutual nonprofit hospital service corporations, nonprofit medical service corporations or nonprofit medical and hospital service corporations; relating to the provision of services by professional providers; amending K.S.A. 40-1809 and 40-19c09 and K.S.A. 1983 Supp. 40-1909 and repealing the existing sections.

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

New Section 1. As used in this act:

(a) "Contracting facility" means a health facility as defined in K.S.A. 65-4801 and amendments thereto which has entered into a contract with a service corporation to provide services to subscribers of the service corporation.

(b) "Contracting professional provider" means a professional provider who has entered into a contract with a service corporation to provide services to subscribers of the service corporation.

(c) "Professional provider" means a provider, other than a contracting facility, of services for which benefits are provided under contracts issued by a service corporation.

(d) "Service corporation" means a mutual nonprofit hospital service corporation organized under the provisions of K.S.A. 40-1801 et seq., and amendments thereto, a nonprofit medical service corporation organized under the provisions of K.S.A. 40-1901 et seq., and amendments thereto or a nonprofit medical and hospital service corporation organized under the provisions of K.S.A. 40-19c01 et seq., and amendments thereto.

New Sec. 2. Whenever a professional provider provides services or otherwise renders care to a subscriber of a service corporation under arrangements which such professional provider

Atch. 5

has established with a contracting facility, and the subscriber does not have a choice of obtaining those services from a contracting professional provider, the professional provider rendering those services shall accept the service corporation's allowable charge level as full payment and may bill the subscriber only for deductibles, coinsurance, shared payments and noncovered services as stipulated in the contract between the subscriber and the service corporation.

Sec. 3. K.S.A. 40-1809 is hereby amended to read as follows: 40-1809. Such corporations shall be subject to the provisions of the Kansas general corporation code, articles 60 to 74, inclusive, of chapter 17 of the Kansas Statutes Annotated, applicable to nonprofit corporations, to the provisions of sections 1 and 2 of this act and to the provisions of K.S.A. 40-214, 40-215, 40-216, 40-218, 40-219, 40-222, 40-223, 40-224, 40-225, 40-226, 40-229, 40-230, 40-231, 40-235, 40-236, 40-237, 40-247, 40-248, 40-249, 40-250, 40-251, 40-252, 40-254, 40-2,102, 40-2,105, 40-2a01 to 40-2a19, inclusive, 40-2216 to 40-2221, inclusive, 40-2401 to 40-2421, inclusive, 40-3301 to 40-3313, inclusive, and amendments thereto, except as the context otherwise requires, and shall not be subject to any other provisions of the insurance code except as expressly provided in this act.

Sec. 4. K.S.A. 1983 Supp. 40-1909 is hereby amended to read as follows: 40-1909. Such corporations shall be subject to the provisions of the Kansas general ~~corporations~~ corporation code, articles 60 to 74, inclusive, of chapter 17 of the Kansas Statutes Annotated, applicable to nonprofit corporations, to the provisions of sections 1 and 2 of this act and to the provisions of K.S.A. 40-214, 40-215, 40-216, 40-218, 40-219, 40-222, 40-223, 40-224, 40-225, 40-226, 40-229, 40-230, 40-231, 40-235, 40-236, 40-237, 40-247, 40-248, 40-249, 40-250, 40-251, 40-252, 40-254, 40-2,100, 40-2,101, 40-2,102, 40-2,103, 40-2,104, 40-2,105, 40-2,114, 40-2a01 to 40-2a19, inclusive, 40-2216 to 40-2221, inclusive, 40-2401 to 40-2421, inclusive, 40-3301 to 40-3313,

inclusive, and amendments thereto, except as the context otherwise requires, and shall not be subject to any other provisions of the insurance code except as expressly provided in this act.

Sec. 5. K.S.A. 40-19c09 is hereby amended to read as follows: 40-19c09. Corporations organized under the nonprofit medical and hospital service corporation act shall be subject to the provisions of the Kansas general corporation code, articles 60 to 74, inclusive, of chapter 17 of the Kansas Statutes Annotated, applicable to nonprofit corporations, to the provisions of sections 1 and 2 of this act and to the provisions of K.S.A. 40-214, 40-215, 40-216, 40-218, 40-219, 40-222, 40-223, 40-224, 40-225, 40-226, 40-229, 40-230, 40-231, 40-235, 40-236, 40-237, 40-247, 40-248, 40-249, 40-250, 40-251, 40-252, 40-254, 40-2,100, 40-2,101, 40-2,102, 40-2,103, 40-2,104, 40-2,105, 40-2a01 to 40-2a19, inclusive, 40-2216 to 40-2220, inclusive, 40-2401 to 40-2421, inclusive, and 40-3301 to 40-3313, inclusive, and amendments thereto, except as the context otherwise requires, and shall not be subject to any other provisions of the insurance code except as expressly provided in this act.

Sec. 6. K.S.A. 40-1809 and 40-19c09 and K.S.A. 1983 Supp. 40-1909 are hereby repealed.

Sec. 7. This act shall take effect and be in force from and after its publication in the statute book.

Attachment 6

TESTIMONY ON HOUSE BILL ~~2285~~ 2885

By Marlon R. Dauner

Senior Vice President

External Affairs

Blue Cross and Blue Shield of Kansas

Blue Cross and Blue Shield of Kansas provides health care coverage for approximately 35% of eligible Kansans. Blue Cross provides coverage for institutional (or hospital) services. Blue Shield provides coverage for professional (or physician) services.

Kansas statutes, commonly referred to as the Blue Cross and Blue Shield Enabling Acts, authorize Blue Cross and Blue Shield to enter into contracts with providers of care on behalf of subscribers to facilitate the financing and delivery of health care services in a cost effective manner. At this time, Blue Cross has contracts with 100% of the hospitals in the Kansas Plan area and Blue Shield has contracts with 87.5% of the physicians. The providers who have signed contracts have agreed to accept the Blue Cross and Blue Shield allowances for services as payment in full for services rendered to subscribers. These providers may bill subscribers for deductibles, coinsurance, and noncovered services.

Testimony on House Bill ~~2285~~ 2585
Marlon R. Dauner

There exists in the delivery of medical care some services that are arranged for and provided by hospitals although they also involve the physician. Most commonly, the services involved are radiology, anesthesiology, and pathology services. It is not unusual for hospitals to enter into arrangements with professional providers of these specialties to render the professional portion of these services to hospital patients. Often, these arrangements are exclusive to a limited number of professional providers.

These arrangements result in a problem for Blue Cross and Blue Shield subscribers when they seek services from a contracting hospital expecting to have full coverage for services rendered and then receive a bill from a non-contracting professional provider for balances above the Blue Shield allowances. The patient may not have even seen the professional provider and, in most cases, has had no choice of provider rendering those services. In essence, the patient expected the contracting hospital to provide services in accordance with the contract with Blue Cross and Blue Shield and without choice or notification received services and a billing from a non-contracting professional provider. Blue Cross and Blue Shield receives numerous complaints each year over this issue. Most of these complaints involve Wichita providers.

House Bill ~~2285~~ 2585 resolves this problem by requiring a non-contracting professional provider rendering services under arrangement with a contracting hospital to accept the Blue Shield allowance as payment in full, except for copayments, if the subscriber was not given the option of receiving services from a contracting professional provider. If the subscriber has a choice of receiving care from a contracting professional provider, such as a contracting radiologist, or in the case of the independent physician (general practitioner), the provisions of this bill are not applicable.

There are only 12.5% of the physicians in Kansas who have elected not to contract with Blue Cross and Blue Shield. Of these physicians, between 6% and 8% represent those physicians that might be affected by the legislation. Although few professional providers will be affected, the benefit and predictability of costs for subscribers is much improved. Several non-contracting specialty groups in Wichita provide many services under arrangements with hospitals in the Wichita area. Virtually every subscriber in Wichita may currently be subjected to a "no choice" balance billing from a non-contracting professional provider although the primary provider, the hospital, from which they sought service is contracting. This bill would appropriately resolve this problem for Blue Cross and Blue Shield subscribers.

2/28/84

Attachment 7

TOPEKA YWCA

Young Women's Christian Association

225 W. 12th St., Topeka, Kansas 66612
913-233-1750

TO: House Committee on Insurance

FROM: Loreen Stein Parnacott

DATE: February 28, 1984

REF: House Bill 3065

I am employed as Vocational Counselor for the YWCA Displaced Homemaker Program, a service designed to assist newly single women to economic independence through employment assistance. This program has been in operation for 4 years, and serves a yearly minimum of 150 persons. The typical client entering our program is 40 years of age or older, has dependent children in her care, is unemployed, and newly divorced. A significant number of our clients are also separated and in the process of divorce, or recently widowed. During 1978, the YWCA conducted a formal needs assessmentof the Topeka Metropolitan Area to determine the numbers of potential clients, their financial characteristics, and the types of services which would have the greatest positive impact upon their situation. The YWCA projected a continuing population of 3,000 women and the Displaced Homemakers Program presently defines the services indicated by that survey.

My major counseling function in working with this group is to assist the individual client in assessing a realistic picture of her present circumstances including finances, personal needs and employment options. I also work with each client in setting and achieving educational and employment goals which will bring her some degree of financial independence from both public assistance and the ex-spouse.

My comments arise out of my professional expertise having gained intimate knowledge of the typical financial needs of recently divorced and widowed women. I believe an extended time option in continuation or conversion of insurance coverage would be most helpful to these women.

Ninety-five percent of the women I have served find their health insurance coverage and often times that of their children ceases at the time of divorce. They are being severed from their spouse's policies without any advance notice, consideration, extension, or option for conversion. They are simply being cut off. In the first 6 months following the loss of a spouse through death or divorce, women are encountering attorney fees, moving costs, tuition, childcare, and transportation expenses, as well as trying to establish themselves in an increasingly competitive job market. These women encounter a drastic loss of income at the time of divorce and can seldom afford the cost of new insurance. Even when they can afford to purchase health insurance, they are not eligible for coverage pre-existing conditions such as pregnance or

extended illnesses. I believe a 6 month continuation or conversion of insurance coverage option is necessary in an effort to assist these women in establishing economic independence. I believe House Bill 3065 would serve to fill a gap in the economic picture confronting these women.

Loreen Stein Parnacott
DISPLACED HOMEMAKER PROGRAM
YWCA
(913) 232-8265

Attachment 8

SHAWNEE MISSION MEDICAL CENTER

February 27, 1984

Neil H. Arasmith, Chairman
Commercial and Finance Committee
Kansas State Legislature
Topeka, Kansas

Dear Chairman Arasmith,

As a Social Work Department director and a direct service provider, I would like to take this opportunity to support Senate Bill 704 which addresses the problem of persons who, through death, divorce and retirement lose their access to health care coverage.

I briefly wish to cite two situations that typify many others that come to my attention annually.

A couple, composed of a sixty-two year old husband and a fifty-eight year old wife, were referred to me while the wife was hospitalized. The initial purpose was to help the couple with decisions around going home. The paramount concern that emerged, however, was the husband and wife's fear of not having enough money to pay for her doctor's bills and for the medications the physicians prescribed to treat her chronic illness around heart and respiratory problems. The husband had been terminated from his life long employment due to his disabilities to perform the needed work. He was now under Medicare disability coverage for himself. His wife, however, was not covered under that entitlement, nor was covered under her own account because of her age and the fact she had never worked to have insurance coverage of her own.

At this point, the couple was overwhelmed with the multiple bills from many specialists and services validly treating her. She owed each sizable sums of money. Her immediate fear was their stopping treatment until she could pay on those bills. Additionally, her medicine prescriptions were multiple and costly, increasingly stretching the couple's ability to cover them with their very meager income.

Another situation that serves to typify a class of situations is a young twenty-eight year old mother with an eight year old child. She lost her and the child's access to health insurance due to a divorce. She was not covered or continued on her former spouses

plan. She was not notified by either employer or spouse that this was an option. Later the husband lost that job and has not been under covered employment since, leaving their child also uncovered for medical needs.

Presently, this mother is working two jobs, one full time in a filling station where there are no insurance benefits; one part time as a waitress where similarly there are not benefits. She accumulates about seven to eight hundred dollars per month to meet all the needs of rent, utilities, food, clothing, child care and transportation. This leaves nothing for the $150.00 to $200.00 private health insurance premium per month that would be necessary to help assure access to health care services.

Thank you for you and your committee members consideration of these practice experience situations. We hope they help with your understanding of what we consider a prevalent problem with a group of Kansas citizens.

Sincerely,

Joan K. Upshaw

Joan K. Upshaw
Director, Social Services

JKU/jh

Attachment

ETC INSTITUTE
MARKETING RESEARCH. DEMOGRAPHY. INFORMATION MANAGEMENT

1501 E. PARK. OLATHE. KANSAS 66061
(913) 829-1215

February 27, 1984

TO: Kansas Women's Equity Action League

The following is a summary of the information that I was able to secure for the Kansas Women's Equity Action League Project. Since you had some more specific information about California, I secured some information about both California and Kansas so that that the information for California might be used to gain estimates for Kansas.

1980 Population

California	23,668,000	(to nearest thousand)
Kansas	2,364,000	

Source: 1982 State and Metropolitan Area Data Book, U.S. Department of Commerce

Men and Women, Ages 45-64, Year 1980

California	19.2% of population
Kansas	19.4%

Source: 1982 State and Metropolitan Area Data Book, U.S. Department of Commerce

Persons Insured with company policy (excludes companies with self-insurance)

	Number	Percent of Population
California	17,878,000	75.5%
Kansas	1,507,000	63.7%

Source: Obtained by telephone February 23, 1984, from Health Insurance Association of America (202) 862-4124 (This was their "statistics" office; their main number is (202) 331-1336)

Fletcher Bell's Office 296-3071 did not have any information, as of February 23, 1984.

Women, ages 45-64, without insurance

The California data showed there were one-half million women; using the California percentage for Kansas would yield an estimate of 50,000. In view of the lower percentage insured, the number for Kansas might be higher.

Att. 9

Medicare hospital insurance enrollment-1979

	Number	Percentage of Population
California	2,519,000	10.6%
Kansas	319,000	13.5%

Source: 1982 State and Metropolitan Area Data Book, U.S. Department of Commerce

Comment: The difference in percentage of persons with medicare insurance is probably a function of the age distribution; the percentage of persons in California, ages 65 and over, is 10.2%, while the percentage of persons, ages 65 and over, in Kansas is 13.0%.

Kansas has one of the higher percentages of persons, ages 65 and over; the states with a higher percentage are: Rhode Island (13.4%), Iowa (13.3%), Missouri (13.2%), South Dakota (13.2%), Nebraska (13.1%), Florida (17.3%), and Arkansas (13.7%).

Source: 1982 State and Metropolitan Area Data Book, U.S. Department of Commerce

Percentage of Population with medicare or hospital insurance

California	86%
Kansas	77%

Marital Status, 1980 (persons ages 15 and over)

	Males		Females	
	Number	%	Number	%
Single	241,362	27.2%	186,113	19.6%
Married	569,429	64.2	565,595	59.5
Separated	8,260	0.9	10,685	1.1
Widowed	21,294	2.4	121,686	12.8
Divorced	47,119	5.3	66,881	7.0
Total	887,464		950,960	

Married refers to persons currently married, whether married only once or whether they have been widowed or divorced and remarried. Persons classified as single have never been married or whose marriage was annulled.

Using your data for 1983 about deaths, you could say "During 1983 in Kansas,

286 males between the ages of 35-44 died, 740 males who were between 45-54 died, and 1,641 males between the ages of 55-64 died. Using the estimate of 64% of the male population as married, we could project that we are talking about 1,707 women who were spouses."

National marital status, ages 65 and over

	Men	Women
Married		
Spouse present	75.5%	38.0%
Spouse absent	2.0	1.7
Widowed	13.6	51.0
Divorced	3.7	3.4

14.7% of the men and 40.9% of the women live alone.

Average lifetime for people in Kansas (1969-1971)

Males	68.83 years
Females	76.54

Source: 1982 State and Metropolitan Area Data Book, U.S. Department of Commerce

Average Age at Death, Kansas 1981 (this includes all deaths)

Males	67.2 years
Females	74.3

Source: 1981 Kansas Department of Health and Environment Annual Summary of Vital Statistics

Marriages ending in Divorce during 1981 (Kansas)

Duration of Marriage	Number of Divorces
20-24 years	548
25-29	315
30-34	175
35-39	64
40+	36
Total 25 +	1138

Some of these women probably are those who end up without insurance.

Hope this helps! Give me a call if you have questions.

Sincerely yours,

Elaine L. Tatham

Attachment 1

CONTINUATION AND CONVERSION OF GROUP HEALTH INSURANCE POLICIES

Kansas Department on Aging
February 28, 1984

Bill Summary:

Provides continuation benefits to employees and covered dependents for six months with the right to convert.

Bill Provisions:

1. Requires that continuation of group benefits be provided for six months to members and covered dependents.

   a. For commercial insurerers, requires that covered dependents as well as the group member who lose group status, be given continuation and conversion privileges.

   b. For Blue Cross/Blue Shield, requires that members and covered dependents who lose group status be given continuation and conversion privileges.

2. Provides for conversion within 31 days after continuation.

3. Does not apply if termination from the group was because of failure to pay after receiving notice, or if the group coverage was replaced within 31 days.

4. Conversion notice must be given by the insurer on the right to convert at least once during the six months continuation period.

Testimony:

The purpose of this bill is to provide a transition period of affordable health care insurance, to dependents or members who lose their group health insurance benefits. The bill is especially aimed at dependents, who through widowhood or change in status, are no longer covered by a group plan.

To be without health insurance can mean having no medical care at all. Often these people are those who are no longer eligible for group insurance, especially older women through widowhood or divorce. This bill provides a six-month period, where the member or member's covered dependent, and we hope this language in the bill applies to widows(ers) and ex-spouses or former covered members, can continue with the group benefits at group rates while they seek other affordable insurance. The premium is not paid by the company, but by the individual themselves. The time period is limited to six months, thereby not appreciably changing the group's experience. Conversion is extended after the continuation period after notification by the insurer.

Att. 10

The problem was brought to the attention of the State Advisory Council this summer when the Blues, for the first time, age rated small group policies, conversion policies, and individual policies providing dramatic increases in premiums for older persons. Rates went up between 25-45% for those 60-64, between $224 and $448 per month. The State Advisory Council directed KDOA to investigate the issues of inadequate or unaffordable health insurance.

What we discovered was that there was a certain group of people who, when cut off from the income-earning member of their family, were often unable to secure adequate health insurance at an affordable price. When no longer covered by a spouse's employment-related health insurance, because of death or retirement of the spouse, or change in marital status, many older people under Medicare age, especially older women, are without access to any affordable health insurance at a time when they need it most.

Approximately 11% of all Older Kansans 60-64 have no health insurance. Under Kansas statute some conversion options exist. However, conversion policies are the most expensive for most people. Even the exercising of conversion options may be missed because of the narrow gap in time (31 days) in which they are entitled to exercise this privilege.

This bill, therefore, is an attempt to provide group benefits at group rates for a period of time to allow that person to seek affordable health insurance. It also provides notice of the right to convert within the continuation period so that the right can legitimately be exercised.

KDOA strongly supports the bill, but we have two concerns:

1. That the language truly covers dependents such as widows.

2. That the continuation rate be at the same rate as the covered policy.

Attachment 11

WEAL
Women's Equity Action League

Specialists in Women's Economic Issues

KANSAS W.E.A.L.
4718 W. 66th St.
Prairie Village, KS 66208
(913) 362-8503

To: Senate Commercial and Financial Institutions Committee
House Insurance Committee

From: Alice Kitchen, Kansas Women's Equity Action League

Re: Hearings on S. 704, HB 3065 and HB 3087

ACCESS TO AFFORDABLE MEDICAL COVERAGE

1. What is needed is the current legislation?
Access to affordable medical coverage is a privilege most people enjoy. However, there is a small but significant group of people who have lost medical coverage due to death, divorce, or retirement of a spouse.

2. Who are these people?
Usually mid-life women between 45-65. Based on the number of males who died in 1983 and a 64% formula for number of males married, we estimate that we are talking about 1,707 women who were left alone due to death. We also would predict that a large portion of these males were employed and covered under a group plan.
Those dependents left without insurance due to divorce number 1,138 (81) and again a large portion of those people had access to medical insurance through the worker in the household. These people were figured into the group rate prior to the change in status. These dependents are actuarily the same people they were before change in status.

3. What is absent is the current law?
Continuation in the group plan at the group rate. This feature would eliminate the "adverse selection" experience commented on by some insurers.
Requirement that coverage be identical in scope to previous plan with no new waiting period.
Notification by insurer/employer to affected spouse.
Inclusion of those left without coverage due to the retirement of a spouse who is now covered under Medicare.
Inclusion of dependents in these remedies.

4. What are the consequences of not having medical coverage?
To be without medical coverage in our society is to be without a basic necessity. It is hard to imagine anyone feeling secure without a medical plan, much less having dependents whose medical bills could be significant. Visits to doctors offices are usually over $20 and a hospital bed begins at $200 for a semi private room in many hospitals. Group coverage for this group is the most desirable and the conversion rate is second best. Individual plans a usually prohibitive in cost and fraught with riders.

5. What have other states done in this regard?
Presently 25 states have conversion privileges for divorced spouses, this includes Kansas. 24 states have conversion/continuation in case of death. 18 have mandated continuation of one kind or another.

Atch. 11

Attachment 12

ktla

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(913) 232-7756

February 24, 1984

TO: The Chairman and Members of the House Insurance Committee.
FROM: Kathleen Sebelius.
RE: Wrongful Death Legislation.

Attached is a summary of the wrongful death laws in other states. As you can see, 44 states have no lid at all on any wrongful death cases and 22 of those states allow juries to award punitive damages in addition to pecuniary and non-pecuniary loss. Kansas currently has a $25,000 lid on non-pecuniary loss and does not allow the award of punitive damages.

The cases which are particularly affected by this outmoded and discriminatory law are cases involving non-wage earners: children, spouses not employed outside the home and retired persons. Regardless of the shocking nature of their deaths, or the negligence of the wrongdoer, we have decided in Kansas that those lives are worth only $25,000.

The Kansas Trial Lawyers Association supports H.B. 2905 which repeals the lid on wrongful death awards. Passage of this bill would bring Kansas law into line with other states. Since the overwhelming number of states have no limit on wrongful death awards, it seems likely that the insurance experience is readily available and does not cause severe problems for anyone.

If the Committee feels that H.B. 2905 will not pass the Legislature this year, we urge you to favorably recommend H.B. 2932, with amendments, for passage.

While the recommended $100,000 is far more equitable than the current law, we feel that the evidence of remarriage, on lines 55-56, page 2, would create another inequity. The situations in which this evidence would be particularly significant are death cases where the wage earner, often the father, is killed, leaving a widow and several children.

Currently, the jury would determine the loss to that family based only on the circumstances of the death, the estimated life expectancy of the father and his wage-earning capacity. What insurance companies would argue, if evidence of remarriage is admitted, is that the loss really wasn't as significant because the widow had married again.

We feel that remarriage has nothing to do with the death of a former spouse and that it is particularly precarious to assume that a new step-parent will provide adequately for the children of a first marriage. They are likely to suffer from a reduced award.

We urge the Committee to take action to correct the injustice in the Kansas law. Please consider favorably H.B. 2905 or as an alternative H.B. 2932, removing lines 55-56.

KGS:jlc
Enclosure.

Atch. 12

H.B. 2061 - Raises lid on non-pecuniary loss to $100,000.
Current Status - Recommended favorable for passage in 1982, Re-referred to House Insurance Committee.

H.B. 2905 - Abolishes lid on non-pecuniary loss for wrongful death.
Current Status - Assigned to House Insurance Committee.

H.B. 2932 - Raises lid on non-pecuniary loss to $100,000; allows evidence of remarriage.
Current Status - Referred to House Insurance Committee.

Kansas law was last changed in 1975. Total lid of $50,000 on awards was lifted and compromise reached. Pecuniary losses (including tangible economic damages) have no limitations. Non-pecuniary damages (pain and suffering, loss of services) have a $25,000 limitation.

DEFENSE RESEARCH INSTITUTE: 1980

Study on Wrongful Death Laws

"Compensatory" covers pecuniary and non-pecuniary damages.

44 States: No Ceiling on Compensatory Damages -- those with * allow Punitive Damages.

Arizona*, Arkansas*, California, Connecticut, Delaware, District of Columbia*, Florida*, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky*, Louisiana, Maryland, Massachusetts*, Michigan, Minnesota, Mississippi*, Missouri*, Montana*, Nebraska, Nevada*, New Hampshire, New Jersey, New Mexico*, New York, North Dakota, Ohio, Oklahoma*, Oregon*, Pennsylvania*, Rhode Island*, South Carolina*, South Dakota, Tennessee*, Texas*, Utah, Vermont*, Virginia, Washington, West Virginia*, Wyoming*.

Other:

Kansas: $25,000 non-pecuniary lid - no punitive.
Maine: $10,000 non-pecuniary lid - no punitive.
Colorado: $45,000 total lid - no punitive.
Wisconsin: $10,000 non-pecuniary lid - no punitive.
Alaska: Only allows punitive damages.
North Carolina: Lid of $500.

Cases particularly affected include retired persons, children, non wage-earning spouses.