Approved 2-14-85
Date

MINUTES OF THE House COMMITTEE ON Insurance.

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

3:30 ~~xxx~~/p.m. on ~~Wednesday, February 13~~, 1985 in room ~~521-S~~ of the Capitol.

All members were present except:
Reps. King, Lowther and Littlejohn - All excused

Committee staff present:
Melinda Hanson, Research Dept.
Emalene Correll, Research Dept.
Helen Carlson, Secretary

Conferees appearing before the committee:
Mr. Bob Williams, Kansas Dental Assn.
Mr. Steve Robertson, Health Insurance Assn., Chicago, Ill.
Mr. Walter Whalan, Pyramid Life Ins. Co., Johnson County
Mr. Dave Hansen, Kansas Life Assn.

Mr. Bob Williams appeared before the Committee to request the introduction of two bills. One would prevent overbilling among dentists as some accept a third party payment under a co-payment plan as payment in full without disclosing to the third party payor that the patient's payment portion will not be collected. The American Dental Assn. considers this practice unethical. Mr. Williams second request concerns freedom of choice legislation similar to the HMO law. The Dental Assn. believes if an employer offers his/her employees a health care plan which restricts provider selection, he/she should also offer his/her employees an optional plan which does not restrict provider selection.

It was moved by Rep. DeBaun and seconded by Rep. Blumenthal that the above two proposals be introduced as Committee bills and referred back to the Committee for study. Motion carried.

HB 2167 - Ms. Hanson stated this bill would give the Insurance Commissoner the authority to set up a mechanism to make accident and sickness insurance coverage available to persons unable to obtain such coverage under ordinary market conditions.

Mr. Todd stated there is a bill similar to HB 2167 now in the Senate - (SB 121), He said the mechanism for some to obtain insurance coverage is badly needed and that perhaps it should be handled in same manner as for fire, casualty, property and liability and have enabling insurance. He further stated there were two big problems in health insurance - cost and availability. This bill would affect the availability, but not the cost.

The question was asked why a specific bill was not submitted and Mr. Todd said one reason in obtaining approval is a law of concerns on behalf of the individuals in getting these details worked out.

Mr. Robertson spoke in opposition to HB 2167 saying it is a very short bill for a lot of responsibility for the Insurance Dept. He feels SB 121 is more definitive in its requirements. He further feels this is a social program and the responsibility should not be forced on the Insurance companies. Mr. Robertson made the following recommendations: find out if there is a need for this type of program and consider the funding of it and to include self-insuror.

Mr. Whalan told the Committee that the Insurance Industry is competative and aggressive and provides coverage for the impaired risk, and if a person is uninsurable it is a social problem. He does not feel a need has been demonstrated for this type of insurance.

Mr. Hansen said he supports the previous two speakers and opposes HB 2167.

Sen. Francisco said he was not saying that either of these bills are the answer to this problem, but that he feels it is one that has to be dealt with. He presented a summary of SB 121 for the Committee to review, plus a print-out on Pooled Risk Insurance. (Attachment I).

The minutes of February 12, 1985, were approved.

The Chairman announced we would continue discussion on HB 2167 on Thursday.

Meeting adjourned at 4:30 PM

Rex B Hoy

GUEST LIST

COMMITTEE: House Insurance DATE: 2-13-85

NAME	ADDRESS	COMPANY/ORGANIZATION
Bob Williams	5200 Huntoon	KS Dental Assoc. Topeka,
JACK ROBERTS	TOPEKA	BC-BS
Lee WRIGHT	MISSION	FARMERS
WALT WITHAM	Mission	Sygma Life
DAVE HANSON	Topeka	Ks Life Insur Assoc
Steve ROBERTSON	Chicago Ill	N.I.A.A

Summary of Senate Bill No. 121

Section 1. This section provides definitions for the act. Among the words defined is eligible person, health insurance and insurer.

Section 2. Gives the Commissioner of Insurance authority to adopt rules and regulations establishing a plan of health insurance coverage for eligible persons under the act.

Section 3. This section essentially defines who an eligible person is for purposes of the plan. Essentially, this person would be one who within six months prior to making application for coverage by the plan has received a notice of rejection or cancellation of coverage from two or more insurers, a notice of reduction or limitation of coverage, a notice of increase in premium exceeding the premium then in effect for the insured person by 50% or more or a notice of premium for a policy not yet in effect from two or more insurers exceeds the premium applicable to a person considered a standard risk by 50% or more.

Section 4. This section establishes the health insurance risk-sharing fund which is created for the purpose of the payment of administrative expenses under the act.

Section 5. This section requires every inurer to participate in the cost of administering the plan except those insurers whose share would be so minimual as to not to exceed the estimated cost of levying the assessment. This section also specifies the manner in which an insurer is assessed. If assessments exceed losses then the excess is to be used to offset future losses or to reduce premiums. Any deficit incurred under the plan may be recouped by assessments from among the participating insurers who may recover these amounts in the normal course of their respective businesses without time limitation.

Section 6. Coverages which must be offered are established by this section. Major medical expense coverage and covered expenses is mentioned under the provision of this section. Exclusions from covered expenses are also enumerated in this section. The plan is to offer a $1,000 deductible in combination with appropriate premiums determined under the act for major medical expense coverage. The rating plan is not to provide for rates greater than 150% of the rate which a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as provided under this section. Pre-existing conditions are excluded from the plan for a period of six months.

Section 7. This section establishes a board of governors to oversee the operation of the plan, provides for their appointment and for their duties.

Section 8. Section 8 requires that the board select an insurer through a competitive bidding process to administer the plan. It

provides for the duties of the insurer so selected in administering the plan.

Section 9. This section specifies what the plan must include and provides that the rate of charge may not be greater than 150% of the standard risk rate.

Section 10. This section provides that the act would take effect upon publication in the statute book which would be July 1, 1985.

50 copies

Sat. Feb 9

POOLED RISK INSURANCE

Some Questions and Answers

Q: What are "pooled or shared risk" insurance plans?
A: Organizations that provide health benefits coverage for a State's residents form a pool or association to share the risks involved in providing coverage for otherwise uninsurable individuals. The plans are intended for persons who are not eligible for group health insurance, Medicare or Medicaid, and who cannot obtain adequate health insurance in the private marketplace.

Q: Do all States have pooled risk insurance?
A: No, there are seven States currently offering some form of shared risk insurance, including two DCP States— Rhode Island, and Minnesota. The remaining States are Connecticut, Florida, Indiana, North Dakota, and Wisconsin. Other States considering pooled risk insurance are California, Mississippi, Missouri, Nebraska, and Ohio.

Q: What are the eligibility requirements for membership in the plan?
A: All plans require that applicants be State residents. Every State except Rhode Island and Connecticut stipulate that individuals receive a rejection or cancellation from two or more health insurers or have riders attached to their policies that limit coverage.

Q: Once an applicant is enrolled in a pooled risk plan, does he/she receive free health insurance coverage?
A: Every State plan, except Rhode Island, requires payment of a health insurance premium with the rate ranging from 125 to 200% of the standard individual premium rate. In addition, participants are responsible for deductibles and co-payments. In Rhode Island, however, recipients are required to make a personal resource payment based on the extent of health benefits coverage the individual already has, if any.

Q: Do plans have clauses for pre-existing conditions in which benefits are not provided, such as a waiting period for any medical conditions diagnosed or treated prior to coverage?
A: All States, with the exception of Rhode Island, have clauses for pre-existing conditions ranging from three to six months, with coverage excluded from 30 days to 12 months.

Q: How can additional information on pooled risk insurance be obtained?
A: Individuals interested in learning more about shared risk plans should contact the State Departments of Insurance in the States that currently have plans. A copy of a model bill for pooled risk legislation can be obtained by writing the National Association of Insurance Commissioners, 1125 Grande Street, Kansas City, Missouri 64106.

STATE LEGISLATIVE NEWS

- **California Senate Bill No. 1187,*** which establishes group insurance for outpatient diabetes education, became law in the State of California, January 1982. SB No. 1187, introduced by Senator Alan Sieroty, was amended in both the Senate and Assembly to restrict coverage in several ways. In its final version, SB No. 1187 does not include individual policies, nor does it include Medi-Cal (Medicaid) or Medicare, both Federally-sponsored programs. Although there are no stated limits to the number of persons with diabetes who may enroll in an outpatient education program, family members are not covered. Each course must be supervised by a physician who is board-certified in internal medicine or pediatrics. In addition, employees are covered only if diabetes education has been chosen as an included benefit by the buying contractor. Since most group coverage is negotiated through collective bargaining, employee representatives must urge for coverage of diabetes education in order for individuals to receive this benefit. Because this legislation is so recent, its impact throughout California cannot yet be assessed. However, an informal telephone survey revealed that most insurance companies were not aware of SB No. 1187 or the potential cost benefits that diabetes education could have in reducing hospitalizations and other complications. A series of public hearings regarding diabetes was held in California during April and May 1983. Although the hearings addressed many issues, insurance coverage and third party reimbursement for outpatient education were major subject areas. A summary of the hearings, which include recommendations on financing issues, will be available this year.
- **California Assembly Bill No. 681**, sponsored by Assemblywoman Jean Moorhead, removed the sales tax on insulin syringes. The bill was signed by Governor Brown in September 1982 and went into effect immediately.
- **Colorado**. A task force of voluntary health agencies is working together to introduce the health insurance bill which would create a "pooled risk" programs for persons with chronic illnesses. A volunteer from the Colorado Affiliate of the ADA is chairing the task force. Subgroups on legislative drafting, defining the need, and publicity have been formed.
- **Iowa Senate File No. 2262**, a law that provides for payment of diabetic outpatient self-management education was made available to policy holders covered by group health insurance, became effective July 1, 1984.

*California SB#1187 is an update of the bill briefly described in the September 1981 issue of the DCP UPDATE.

Coverage applies only to educational programs directed and supervised by a licensed physician, taught by health care professionals knowledgeable about diabetes and its treatment, and meet the standards of the State Department of Health.

- **Wisconsin Act No. 429** that mandates State insurance company coverage of pumps and other diabetic equipment and supplies, was amended by the 1984 State Legislature to include coverage for diabetes education. The level of reimbursement for education, equipment, and supplies depends upon the type of insurance an individual has. There are two exemptions to the law: self-insured companies and companies in which the master plan of insurance is written in another State.
- Pooled risk health insurance legislation has been introduced in: Arizona, California, Iowa, Mississippi, Missouri, Nebraska, and Ohio

NATIONAL DIABETES MONTH

In a joint resolution, Congress has designated November 1984 as "National Diabetes Month." The text of S.J. Res. 299 is as follows:

Whereas diabetes kills more than all other diseases except cancer and cardiovascular diseases;

Whereas eleven million Americans suffer from diabetes and five million seven hundred thousand of such Americans are not aware of their illness;

Whereas $10,100,000,000 annually are used for health care costs, disability payments, and premature mortality costs due to diabetes;

Whereas up to 85 per centum of all cases of noninsulin-dependent diabetes may be controllable through greater public understanding, awareness, and education; and

Whereas diabetes is a leading cause of blindness, kidney disease, heart disease, stroke, birth defects, and lower life expectancy, which complications may be reduced through greater patient and public understanding, and education:

Now, therefore, be it resolved, That the month of November 1984 is designated as "National Diabetes Month," and the President is authorized and requested to issue a proclamation calling upon the people of the United States to observe that month with appropriate programs, ceremonies, and activities.

STATE FUNDING FOR NEW YORK

In April 1984, the New York Legislature appropriated $250,000 to the Health Research Council for Diabetes Research and $150,000 to the New York DCP for prevention and intervention programs. This amount will be allocated for the development of diabetes outpatient programs. The purpose is to improve significantly the level in the quality of currently existing outpatient diabetes education programs throughout the State. Emphasis will be placed on increasing the number of programs which meet the NDAB *National Standards for Diabetes Education Programs.*

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