Approved February 27, 1985
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by Neil H. Arasmith at
Chairperson

9:00 a.m./~~p.m.~~ on February 26, 1985 in room 529-S of the Capitol.

All members were present except:

Senators Warren and Gannon - Excused

Committee staff present:

Bill Wolff, Legislative Research
Myrta Anderson, Legislative Research
Bruce Kinzie, Revisor of Statutes

Conferees appearing before the committee:

Ron Todd, Kansas Insurance Department
Dean Parker, Administrator, Kansas Building Trades Health Insurance
Missouri-Kansas Health Care Cost Containment
Werner Gliebe, Kansas Employer Coalition on Health
Bob West, National Electrical Contractors Association
Bill Gloy, HMO Kansas, Inc.
Jack Roberts, Blue Cross/Blue Shield
Bud Cornish, Humana, Inc.
Jerry Slaughter, Kansas Medical Society
Peter Rinn, Department of Social and Rehabilitation Services

The minutes of February 21 were approved.

The hearing began on SB 285 concerning unauthorized insurers with the testimony of Ron Todd of the Kansas Insurance Department. Mr. Todd explained that the bill amends K.S.A. Chapter 40, Article 27 which has been on the books several years to make it clear that nonprofit dental, nonprofit optometric, nonprofit hospital and medical service corporations, health maintenance organizations and third party administrators are subject to the unauthorized insurers statute, commonly called the "mail-order statute". The bill would insure that organizations of this kind domiciled outside of Kansas but doing business in Kansas through the mail would be subject to these Kansas laws.

Dean Parker, representing several health care plans, appeared to express his concern about portions of the bill. His main concern is with subsection 7 which he would like to amend to allow for the exemption of those organizations falling under 501C9 of the Internal Revenue Service regulations, those organizations being any ones which qualify under Internal Revenue regulations as an ERISA plan.

Sen. Werts asked for some examples of organizations falling under 501C9, and Mr. Parker said included are such organizations as Goodyear health plan.

The chairman asked Mr. Parker why this concern is being expressed at this particular time since this statute has been on the books for several years. Mr. Parker answered that it was felt that he might as well bring this to the committee's attention since the bill was being considered at this time.

The hearing was concluded on SB 285.

The hearing began on SB 283 dealing with preferred provider agreements with the testimony of Ron Todd of the Kansas Insurance Department. Mr. Todd said that in recent years there has been a lot of activity in groups to provide health care insurance at lower costs, and one method devised is the preferred provider organization (PPO). He explained that, basically, this occurs when an employer makes a contract with a provider to provide insurance for certain health care through a third party, the PPO. The bill clarifies the statutes so that the third party organization does not become an unlicensed insurer because of not following the statutory guidelines governing prepaid service organizations. Mr. Todd informed the committee that Section 8 and all that follows is patterned from third party administrator statutes. He added, these organizations have to keep records, keep monies in trust, and the Commissioner has to inspect to determine if the organization is complying with the rules. He noted that SB 19 which the committee had passed

earlier in the session is a companion bill to SB 283 in that it allows insurance companies to contract with PPOs. He concluded that these bills allow more flexibility to accomodate these alternative methods of providing health care at lower costs.

The chairman questioned Mr. Todd as to Section 1, subparagraph (d). Mr. Todd clarified that the section is referring to someone who is administrating the service, a "go between". Mr. Todd said the "go between" provision would apply to the PPOs as it does to insurance companies or HMOs.

The Chairman inquired further as to how the profit is collected by the third party. Mr. Todd said it comes from administrative charges. The chairman quoted Section 9 of the bill, asking Mr. Todd how the profit could be collected under this provision. Mr. Todd pointed out that the bill also provides for an administrator's contract on lines 149 and 150.

Sen. Karr asked how the Insurance Department gets involved if the group does not comply to the regulations in the bill. Mr. Todd answered that the Department could be involved to a limited extent. They could look at records and suspend certification for not holding the money properly. The chairman added that the Department gets involved on a complaint basis.

Staff explained that Seciton 12 of the bill makes clear the other penalties and statutes that might apply.

Werner Gliebe, Kansas Employer Coalition on Health, followed with testimony in support of SB 283. He briefly explained the background of the construction of the bill which involved the largest groups in the state addressing the contents of the bill. He said that the bill is another competitive device for employers to use in containing health care costs.

Bob West, National Electrical Contractors Association, briefly testified next on the bill explaining that Mr. Parker would speak for his interests also. He noted that PPO agreements have been responsible for holding costs of health care down for a large number of electricians.

Mr. Parker continued by telling the committee that over 90,000 families covered by the Taft-Hartly trust fund plan were not represented when the language of this bill was decided, but he is representing several organizations regarding the PPOs. Mr. Parker said he agrees with what the Insurance Department is trying to do in the bill, but he is concerned with this legislation because it is contradictory to numerous federal statutes. There are 6000 pages of federal statutes pertaining to these plans. For an example, the bill uses "plan beneficiary" whereas the federal language reads "plan participant". Also, on line 81 "subscriber" is used which is a Blue Cross/ Blue Shield term and is not used in federal language. Mr. Parker is also concerned that people will confuse provider and preferred provider organization. He feels that much confusion could result as a result of this legislation. He explained that all of the plans he deals with use precise wording, but this is not true of this bill. Furthermore, he feels the bill should be longer to be done correctly.

Mr. Parker continued expressing more concerns he has about the bill. He related information to the committee about a small group of militant attorneys called the National Association of Health Organizations who have filed malpractice suits against doctors who have entered into a contract because of PPO agreements which led to a particular doctor. He is concerned if an individual doctor could be considered a PPO under this bill which would create an additional burden for the doctors. He stated that the bill also needs corrections and the preemption problem needs to be solved before he could support the bill. Labels which have been in place for many years are not in the bill as they should be.

Bill Gloy, HMO Kansas, Inc., gave testimony in general support of the bill. However, he requested that Section 3(a) be clarified on lines 74-76. He is concerned that under this regulation someone might interpret that he could see any doctor he wants instead of the doctor which he had selected as his personal health care physician with his HMO agreement. His suggested amendment would read "except in HMOs organized under Article 32, Chapter 40 of the statute".

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE,

room 529-S, Statehouse, at 9:00 a.m./~~p.m.~~ on February 26, 1985.

Jack Roberts, Blue Cross/Blue Shield, testified in support of the bill saying that it is an effort by the Insurance Department to remove an impediment for other companies entering into PPO contracts. He suggested that an amendment to the bill be made which allows for more accountability by a prior approval provision. (See Attachment I.)

Bud Cornish representing Humana, Inc., appeared in support of the bill with one clarification amendment to offer on line 76. (See Attachment II.)

Jerry Slaughter, Kansas Medical Society, testified in support of the concept of the bill although he noted that his organization was not consulted in preparation of the bill. He agreed with many of the concerns expressed by Mr. Parker. He expressed particular concern about Section 3, subsection (c), lines 82-85 with regard to how this may jeopardize an individual provider insofar as liability. He feels a law should be well thought out and, therefore, there should be more study done on this bill.

The hearing on SB 283 concluded with the testimony of Peter Rinn of the Department of Social and Rehabilitation Services who said he likes the idea of the bill but wants SRS to be exempted from the provisions of the bill. He passed out a balloon of the bill showing the proposed amendment. (See Attachment III.)

There being no further time, the meeting was adjourned.

SENATE COMMITTEE

ON

FINANCIAL INSTITUTIONS AND INSURANCE

OBSERVERS
(Please print)

DATE	NAME	ADDRESS	REPRESENTING
2/26	Robert Corn	9760 Metcalf OP KS.	Savers Life
"	DENNIS DEHN	TOPEKA	SEN. WERTS' INTERN
2/24	HAROLD E. RIEHM	"	KS ASSN OSTEOPATHIC MED
2-26	Peter Rinn	Topeka	SRS
2-26	Ron Moore	Kansas City	Admar Corp
	Werner Gliebe	Top	KS Employer Coalition on Health
2-26	Gary Robbins	Topeka	KS Optometric Assn
	Robert West	Topeka	Nat'l Electrical Contractors Assn
	Ralph Mecum	TOPEKA	KS. AFL-CIO
	[illegible]	"	atty
	Tom Slattery	Top	AGC of Ks.
	JERRY SLAUGHTER	TOPEKA	KS. MEDICAL SOCIETY
	L M CORNISH	"	Humana, Inc.
	JACK ROBERTS	"	BC-BS
	Bill Pitsenberger	"	Blue Cross-Blue Shield
	BILL GLAY	"	HMO Kansas Inc
	ED ROWING	Wichita	DELTA DENTAL PLAN of KANSAS

BC/BS

New Section _____. Every insurance company and preferred provider organization shall file with the commissioner of insurance a copy of all preferred provider agreements that it proposes to use. Every such filing shall indicate the plan of operation contemplated. Any filing made pursuant to this section shall be approved by the commissioner unless the commissioner finds that such filing does not meet the requirements of this act. As soon as reasonably possible after the filing has been made the commissioner shall in writing approve or disapprove the same. Any such filing shall be deemed approved unless disapproved within thirty (30) days after receipt of such filing or supporting information connected therewith. In the event the commissioner disapproves a filing, the commissioner shall specify in what respect such filing does not meet the requirements of this section and shall state that a hearing will be granted within twenty (20) days after receipt of such request in writing by such corporation. The commissioner may at any time after a hearing, of which not less than twenty (20) days' written notice shall have been given, withdraw approval of any such agreement in the event the commissioner finds such filing no longer meets the requirements of the act. The commissioner is hereby authorized to issue such rules and regulations as are necessary and not inconsistent with this act. Any party adversely affected by the order or action of the commissioner of insurance may, within sixty (60) days from the date of such order or action, commence an action in a court of competent jurisdiction against the commissioner of insurance in the commissioner's representative capacity to vacate or set aside said order or action in whole or in part on the ground that said order or action is unlawful.

2/26/85
Attachment I

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RALPH F. GLENN
OF COUNSEL

February 25, 1985

Senator Neil Arasmith
Chairman
Senate Financial Institutions and
Insurance Committee
Statehouse
Topeka, Kansas 66612

RE: S 283

Dear Senator Arasmith:

Our client, Humana, Inc., requests the following amendment to S 283 at Line 0076 following the word "provider":

"; but the agreement may provide economic incentives to use the services of the preferred providers."

Humana, Inc. supports S 283 and believes the amendment will clarify Sec. 3(a) of the bill by setting forth that the agreement may include specific economic incentives to encourage the usage of preferred providers and thereby reduce total cost.

We are advised that the sponsors of this bill have no objection to the above amendment.

Cordially yours,

L. M. CORNISH

LMC:sh

2/26/85
Attachment II

Session of 1985

SENATE BILL No. 283

By Committee on Financial Institutions and Insurance

2-19

AN ACT relating to insurance; concerning preferred provider agreements; relating to preferred provider organizations.

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

Section 1. As used in this act:

(a) "Alternative rates of payment" means the rate at which or sum for which the provider agrees to perform specified services;

(b) "insurance company" shall include those entities authorized to conduct business in Kansas under articles 11, 18, 19, 19a, 19b, 19c and 32 of chapter 40 of the Kansas Statutes Annotated;

(c) "plan beneficiary" means any person eligible to receive provider services under a plan entered into by a purchaser;

(d) "preferred provider agreement" means a contractual agreement to provide for alternative rates of payment in which the provider agrees to accept these alternative rates of payment and accept reasonable quality, professional and efficiency standards in return for tangible benefits to the provider;

(e) "preferred provider organization" means a separate entity established for the purpose of marketing and administering a preferred provider agreement;

(f) "provider" means one or more entities which offer health care services;

(g) "purchaser" means one or more persons, organizations or entities which contract with providers for the purpose of entering into a preferred provider agreement;

(h) "tangible benefits" means any reasonable expectation of monetary or administrative advantage including, but not limited to, an increase in the number of patients, prompt payment for services or assistance in resource monitoring procedures.

Sec. 2. No provider shall act as a preferred provider without

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Attachment III

a written preferred provider agreement between the provider and the purchaser and when applicable between the provider, purchaser and the preferred provider organization, or other entity authorized to conduct business under chapter 40 of the Kansas Statutes Annotated. A direct agreement between a provider and a purchaser will not be required when:

(a) An insurance company authorized to conduct accident and health insurance business in Kansas has obtained a preferred provider agreement with providers and permits their accident and health insurance customers to use such services;

(b) a preferred provider organization has entered into a preferred provider agreement with providers and offers or permits an insurance company authorized to conduct accident and health insurance business in Kansas, to offer these preferred provider services to purchasers covered, or to be covered, by an insurance policy issued by such insurance company and pursuant to a written contract between the preferred provider organization and the insurance company. All written agreements shall be retained as part of the official records of the provider, the purchaser and when applicable, the preferred provider organization or other entity authorized to conduct business under chapter 40 of the Kansas Statutes Annotated for the duration of the agreement and five years thereafter. Such written agreements shall contain provisions which include the requirements of this act insofar as applicable.

Sec. 3. Preferred provider agreements may be entered into for the purpose of reducing health care costs and improving provider efficiency, subject to the following limitations:

(a) No preferred provider agreement shall deny reimbursement to a plan beneficiary because the plan beneficiary elects to use such beneficiary's own health care provider;

(b) no preferred provider agreement shall preclude any party from entering into other preferred provider agreements;

(c) no preferred provider agreement shall permit the plan beneficiary to be billed for covered health care costs except amounts for which the subscriber is contractually responsible. Providers shall hold purchasers harmless for costs, expenses and

liability arising by reason of a preferred provider organization's unlawful or negligent failure to pay provider costs on behalf of purchasers when due and payable.

Sec. 4. Subject to the provisions of this act, insurance companies and other entities authorized to conduct accident and health insurance business in Kansas under chapter 40 of the Kansas Statutes Annotated may negotiate and enter into preferred provider agreements with providers or preferred provider organizations on behalf of a purchaser insured or to be insured by such insurance company.

Sec. 5. Preferred provider agreements may provide for:

(a) Alternative rates of payments for providers;

(b) resource monitoring to assure quality control for both patient care and cost effectiveness;

(c) administrative procedures for submitting claims and paying benefits;

(d) accelerated payment of medical charges;

(e) utilization review procedures; or

(f) other provisions that reduce health care costs or increase medical efficiency for Kansas consumers.

Sec. 6. Preferred provider organizations may be established by providers, purchasers, independent persons or entities or organizations operating under the insurance laws provided under chapter 40 of the Kansas Statutes Annotated. Preferred provider organizations shall not assume the risk for indemnifying purchasers or employees of purchasers for covered health care services or of contracting to provide such services.

Sec. 7. A preferred provider agreement shall provide for written notice to the purchaser upon the addition or deletion of providers to the agreement.

Sec. 8. Every preferred provider organization shall maintain at its principle administrative office for the duration of the written agreement referred to in section 2 and five years thereafter, adequate books and records of all transactions between it, providers and purchasers. Such books and records shall be maintained in accordance with prudent standards of insurance record keeping. The commissioner of insurance shall have ac-

cess to such books and records for the purpose of examination, audit and inspection. Any trade secrets contained therein shall be confidential, except the commissioner may use such information for proceedings instituted against the preferred provider organization.

Sec. 9. All moneys collected by a preferred provider organization shall be held by the preferred provider organization in a fiduciary capacity. Such funds shall be immediately remitted to the person or persons entitled thereto or shall be deposited promptly in a bank account established and maintained by the preferred provider organization. If moneys so deposited have been collected on behalf of or for more than one purchaser, the preferred provider organization shall maintain records clearly recording the deposits in and withdrawals from such account on behalf of or for each purchaser. The preferred provider organization shall keep copies of all such records and upon request of a purchaser shall furnish the purchaser with copies of such records pertaining to deposits and withdrawals on behalf of the purchaser. The preferred provider organization shall not pay any claim by withdrawal from such account. Withdrawals from the funds deposited in such account shall be made, as provided in the written agreement between the preferred provider organization and the purchaser, for:

(a) Remittance to the provider entitled thereto;

(b) deposit in an account maintained in the name of such purchaser;

(c) transfer to and deposit in a claims paying account, with claims to be paid as provided in the preferred provider agreement or remittance to the provider entitled thereto;

(d) payment to the preferred provider organization of its commission, fees or charges; or

(e) remittance of returned premiums to the person or persons entitled thereto.

Sec. 10. No person shall act as or hold themselves out to be a preferred provider organization in this state, unless such person holds a certificate of registration as a preferred provider organization issued by the commissioner of insurance. Application for

such certificate shall be made to the commissioner on a form prescribed by the commissioner and shall be accompanied by a filing fee of $100. The certificate may be continued for successive annual periods by notifying the commissioner of such intent and payment of a $50 continuation fee. The certificate shall be issued or continued by the commissioner to a preferred provider organization unless the commissioner after due notice and hearing shall have determined that the preferred provider organization is not competent, trustworthy, financially responsible or of good personal and business reputation.

Sec. 11. (a) Failure to hold the certificate required by section 10 or to comply with any other provision of this act, shall subject the preferred provider organization to a fine of not more than $500 unless such preferred provider knew or reasonably should have known that such failure was a violation of this act in which case the penalty shall be not more than $5,000.

(b) After reasonable notice and hearing, the commissioner may impose a penalty as provided in subsection (a) or revoke or suspend such certificate, upon finding that either the preferred provider organization violated any of the requirements of this act or the preferred provider organization is not competent, trustworthy, financially responsible or of good personal and business reputation.

Sec. 12. Nothing in this act shall relieve any person, organization or insurance company of regulation under any other insurance law.

Sec. 13. This act shall not apply to organizations exempt under K.S.A. 40-202, and amendments thereto.

Sec. ~~14.~~ This act shall take effect and be in force from and after its publication in the Kansas register.

Sec. 14. This act shall not apply to the provision of services under a plan developed by the secretary of social and rehabilitation services pursuant to subsection (s) of K.S.A. 39-708c and amendments thereto. Nothing in this act shall be construed to prohibit the secretary of social and rehabilitation services from contracting with a preferred provider organization holding a certificate of registration to provide services under such a plan.

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