Approved 2-20-86
Date

MINUTES OF THE House COMMITTEE ON Insurance.

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

3:30 XX a.m./p.m. on February 19, 1986 in room 521-S of the Capitol.

All members were present except:

Rep. King, excused
Rep. Turnquist, excused

Committee staff present:

Emalene Correll, Research Department
Melinda Hanson, Research Department
Gordon Self, Revisor's Office
Deanna Willard, Committee Secretary

Conferees appearing before the committee:

Ms. Dianne Kienlen, Westworld Community Healthplans
Mr. Ken Schafermeyer, Kansas Pharmacists Assoc.
Mr. Dick Brock, Kansas Insurance Department
Mr. Jack Roberts, Blue Cross Blue Shield
Mr. E. W. Rakestraw, Community Mental Health Centers

The meeting was called to order by the Chairman.

Ms. Dianne Kienlen, Westworld Community Healthplans, spoke in opposition to HB 2809 - mandating payment by HMOs for involuntary commitments. She stated that this bill would avert the concept of an HMO - providing quality care economically through oversight and control - and would possibly mandate coverage for custodial purposes, which HMOs are not in the business to provide. (Attachment 1.)

Ms. Kienlen also expressed "partial opposition" to HB 2810 - relating to continuation privileges by HMOs. The bill would mandate continuation coverage when a group member's coverage has been ended for whatever reason. She cited some instances when termination is for "good cause." Included in her handouts was suggested wording for an amendment. (Attachment 2.)

Mr. Ken Schafermeyer, Kansas Pharmacists Association, requested a committee bill to provide for an enabling act to establish a nonprofit pharmacy service corporation; the bill will be drafted with the assistance of the Insurance Department. Rep. Littlejohn made a motion that such a bill be presented; Rep. Blumenthal seconded the motion. The motion carried.

Hearing on: HB 2811 - regulation of trade practices of nonprofit hospital and medical service corporations and HMOs.

Mr. Dick Brock, Kansas Insurance Department, stated that this bill would make the Unfair Trade Practices Act pertain to HMOs. In particular, the Department feels the advertising of some HMOs has been questionable, and this is generally the body of law through which disciplinary actions are handled.

Briefing on: HB 2737 - relating to mental illness coverage mandate.

MINUTES OF THE House COMMITTEE ON Insurance,

room 521-S, Statehouse, at 3:30 ~~a.m.~~/p.m. on February 19, 1986.

Mr. E. W. Rakestraw, Community Mental Health Centers, stated that there were fears there would be inappropriate utilization of mental health coverage. The DSM-III, the mental health diagnostic manual, includes classifications of 13 "V codes," problems for which treatment is sought which are not due to a mental disorder. He discussed each of these items and fielded questions as to the universality of the DSM-III, length of time needed to diagnose a "V code," and whether quality service is available statewide. (Attachment 3.)

There were requests for committee bills: 1) A bill that would make mutual life insurance companies that offer group health insurance subject to regulation and rate review by the Insurance Commissioner, and 2) A bill that would make all insurance companies that offer group health insurance subject to the Insurance Commissioner and rate review. Rep. Blumenthal moved that the bills be presented; Rep. Graeber seconded the motion. The motion carried.

The meeting was adjourned at 4:40 p.m. by the Chairman.

GUEST LIST

COMMITTEE: Insurance DATE: 2-19-86

NAME	ADDRESS	COMPANY/ORGANIZATION
Tom Palace	Topeka	Savings League Service
DAN MORGAN	Topeka	AGC of KS
DIANNE KENTEN	Custer So. Dakota	WESTWORLD COMMUNITY HEALTHPLANS
Dwight Young	Great Bend	Assn. Com. Mental Health Centers
Paul M. Klotz	Topeka	Assc. of CMHC of Ks.
Dub Rakestraw	"	"
Bill Pitsenberger	Topeka	Blue Cross
JACK ROBERTS	TOPEKA	"
Richard Harmon	Topeka	KS Life Assn.
Dick Brock	"	Ins Dept

TESTIMONY OF: WESTWORLD COMMUNITY HEALTHPLANS, INC.

RE: HB 2809

DATE: 02-18-86

We are opposed to HB 2809. Under this bill, the legislature substantially limits the burden of the traditional parens patriae role of the state. While shifting the cost, the state would maintain the right to decide which persons needed commitment, under what circumstances, the type of care to be provided and its duration.

Inherent in the concept of an HMO and key to its viability is its assumption of responsibility for coordination and provision of virtually all health care service to its members. An HMO ensures that necessary services are provided in the most efficient and economical way, primarily through contracted with or directly employed providers who agree to work on a capitated or reduced fee-for-service basis. In an HMO, the cost to the member is lower without lessening the quality of care because of this oversight and control. The concept is thus radically different from that of indemnity insurance as are the application of funds and the placement of risk. We are generally not in favor of additional non-bargained for benefits, but particularly hazardous to the healthy functioning of an HMO, and, indeed, contrary to its basic operational concept, are legislatively mandated benefits which take any semblance of control from the HMO. If the HMO cannot control the provision of services, it is no longer operating as an HMO and the benefits of that structure will be lost. If we cannot oversee services, we cannot control costs. Under this bill such oversight is not feasible.

The care mandated by this bill would not necessarily be initiated by medical concerns. An involuntary commitment may be needed to protect the community from the individual committed or to restrain the person from harming or significantly neglecting himself. While HMOs normally do not provide long-term custodial care, the scope of "if otherwise available" is unclear. While this bill is objectionable in its entirety for the reasons stated above, it is also so vague as to possibly require an HMO to pay for care largely divorced from or independent of health care.

Mandating coverage for custodial or protective purposes redefines not only the way in which HMOs provide service but may also impact the basic type of service HMOs provide. We believe that the long-term impact of this bill on an industry which is striving to control costs while providing a quality service to the people of Kansas will be antithetical, not only to the interests of HMOs but to the people they service.

Attachment 1
House Insurance 2/19/86

TESTIMONY OF: WESTWORLD COMMUNITY HEALTHPLANS, INC.

RE: HB 2810

DATE: 02-18-86

We have expressed our partial opposition to HB 2810 in a letter to Mr. Richard Huncker. I have attached that correspondence to this testimony but I would like briefly to summarize the main points.

We do not feel that mandating continuation coverage when a group member's coverage has been ended for whatever reason is appropriate. Certain coverage termination is for good cause. An occasional member may be assaultive or abusive to providers or staff. We cannot adequately serve him whether he is a group member or a member by virtue of a continuation policy. A member may be terminated for repeated refusal to make co-payments; this behavior will not be altered by serving him under a continuation policy. The member may have engaged in fraud; no provider should be required to maintain that relationship under such a circumstance.

Another consideration addressed by counsel is the issue of replacement coverage gamesmanship. Under this bill, an HMO or insurer could be left with high risk employees at a normal risk rate while the other former group members were covered under the replacement policy.

As noted in the attached memo, we believe specification of circumstances, such as divorce or job loss, which give rise to the right of continuation would provide a clear and equitable basis for such coverage which this bill does not. Our suggested revisions are set out in Attachment A.

Attachment 2
House Insurance 2/19/86

COMMENT ON PROPOSED KSA40-3209 AMENDMENT

TO: Richard G. Huncker,
Accident and Health Supervisor,
Kansas Department of Insurance

FROM: Westworld Community Healthplans, Inc.

SUBJ: Proposed K.S.A.40-3209(a)(7)

Westworld Community Healthplans, Inc. ("Westcare") would agree that a health maintenance organization's group contracts should be required to offer continuation coverage if the group policies of health insurers are so required. It does, however, object to the proposed draft of K.S.A.40-3209(a)(7) attached to your January 10, 1986 memorandum. First, and primarily, it objects to the requirement of offering continuation coverage when an enrollee or a covered dependent has been terminated "for any reason." There are several grounds for this objection:

(1) Neither an HMO nor an insurer should have to offer continuation coverage when the group service agreement or policy terminated and was replaced by another group policy or service agreement. Otherwise, an employer or other group could agree with the replacement carrier that its high risk employees' and independents will not be covered by the replacement carrier, but it will instead be covered, at the group rate, by the prior HMO or insurer. The continuation coverage law should not sanction such gamesmanship. The replacement carrier should pick up the employees or group members and their dependents on a "no loss - no gain" basis.

(2) An HMO should not be required to continue coverage for an enrollee or covered dependent who has been terminated for good cause, such as failure to pay copayments, assault or grossly abusive behavior toward HMO plan providers, or fraud.

(3) It would be even better, as many states do, to specify the terminations which give rise to the right of continuation: loss of employment in the case of the enrollee, the death or divorce of the enrollee in the case of the covered spouse and children, and age limits in the case of children. There are other technical revisions we recommend. The revisions we suggest are set forth in Attachment "A".

ATTACHMENT "A"

Westcare proposes the following:

"K.S.A.40-3209 is hereby amended to read as follows: ...; and

(7) A provision that an enrollee or a covered dependent of an enrollee whose coverage under a group health maintenance organization contract has been terminated and who has been continuously covered by that health maintenance organization for at least three (3) months, shall be entitled to have such coverage continued for six (6) months, if that enrollee or covered dependent's coverage under that contract has been terminated for any reason other than nonpayment of premiums or copayments, abusive behavior, or other good cause as permitted by the Commissioner, and except if the group contract is terminated or is replaced by other health maintenance organization or health insurer coverage for which the enrollee would be eligible but for underwriting restrictions of the replacement carrier, and further provided that the enrollee or covered dependent complies with the following requirements. The terminated enrollee or dependent shall pay the premium for the six (6) month continuation of coverage and such premium shall be the same as that applicable to enrollees remaining in the group. Failure to pay such premium after receiving reasonable notice of the amount and due date of the required payment shall terminate coverage under the health maintenance organization contract at the end of the period for which the premium was paid. The frequency of premium payment shall not be less than quarterly."

C:/DW3/MCTBL3/O.9

V Codes For Conditions Not Attributable To a Mental Disorder That Are A Focus of Attention Or Treatment

The ICD-9-CM includes V Codes for a "Supplementary Classification of Factors Influencing Health Status and Contact with Health Services." A brief list of V Codes adapted from ICD-9-CM is provided here for conditions that are a focus of attention or treatment but are not attributable to any of the mental disorders noted previously. In some instances one of these conditions will be noted because, after a thorough evaluation, no mental disorder is found. In other instances the scope of the diagnostic evaluation has not been adequate to determine the presence or absence of a mental disorder but there is a need to note the reason for contact with the mental health care system. (With further information, the presence of a mental disorder may become apparent.) Finally, an individual may have a mental disorder, but the focus of attention or treatment is on a condition that is not due to the mental disorder. For example, an individual with Bipolar Disorder may have marital problems that are not directly related to manifestations of the Affective Disorder but are the principal focus of treatment.

V65.20 Malingering

The essential feature is the voluntary production and presentation of false or grossly exaggerated physical or psychological symptoms. The symptoms are produced in pursuit of a goal that is obviously recognizable with an understanding of the individual's circumstances rather than of his or her individual psychology. Examples of such obviously understandable goals include: to avoid military conscription or duty, to avoid work, to obtain financial compensation, to evade criminal prosecution, or to obtain drugs.

Under some circumstances Malingering may represent adaptive behavior, for example, feigning illness while a captive of the enemy during wartime.

A high index of suspicion of Malingering should be aroused if any combination of the following is noted:

(1) medicolegal context of presentation, e.g., the person's being referred by his attorney to the physician for examination;
(2) marked discrepancy between the person's claimed distress or disability and the objective findings;
(3) lack of cooperation with the diagnostic evaluation and prescribed treatment regimen;
(4) the presence of Antisocial Personality Disorder.

The differentiation of Malingering from Factitious Disorder depends on the clinician's judgment as to whether the symptom production is in pursuit of a goal that is obviously recognizable and understandable in the circumstances. Individuals with Factitious Disorders have goals that are not recognizable in

light of their specific circumstances but are understandable only in light of their psychology as determined by careful examination. Evidence of an intrapsychic need to maintain the sick role suggests Factitious Disorder. Thus, the diagnosis of Factitious Disorder excludes the diagnosis of the act of Malingering.

Malingering is differentiated from Conversion and the other Somatoform Disorders by the voluntary production of symptoms and by the obvious, recognizable goal. The malingering individual is much less likely to present his or her symptoms in the context of emotional conflict, and the symptoms presented are less likely to be "symbolic" of an underlying emotional conflict. Symptom relief in Malingering is not often obtained by suggestion, hypnosis, or intravenous barbiturates, as it frequently is in Conversion Disorder.

V62.89 Borderline Intellectual Functioning

This category can be used when a focus of attention or treatment is associated with Borderline Intellectual Functioning, i.e., an IQ in the 71-84 range. The differential diagnosis between Borderline Intellectual Functioning and Mental Retardation (an IQ of 70 or below) is especially difficult and important when certain mental disorders coexist. For example, when the diagnosis is of Schizophrenic Disorder, Undifferentiated or Residual Type, and impairment in adaptive functioning is prominent, the existence of Borderline Intellectual Functioning is easily overlooked, and hence the level and quality of potential adaptive functioning may be incorrectly assessed.

V71.01 Adult Antisocial Behavior

This category can be used when a focus of attention or treatment is adult antisocial behavior that is apparently not due to a mental disorder, such as a Conduct Disorder, Antisocial Personality Disorder, or a Disorder of Impulse Control. Examples include the behavior of some professional thieves, racketeers, or dealers in illegal substances.

V71.02 Childhood or Adolescent Antisocial Behavior

Same as above. Examples include isolated antisocial acts of children or adolescents (not a pattern of antisocial behavior).

V62.30 Academic Problem

This category can be used when a focus of attention or treatment is an academic problem that is apparently not due to a mental disorder. An example is a pattern of failing grades or of significant underachievement in an individual with adequate intellectual capacity, in the absence of a Specific Developmental Disorder or any other mental disorder to account for the problem.

V62.20 Occupational Problem

This category can be used when a focus of attention or treatment is an occupational problem that is apparently not due to a mental disorder. Examples include job dissatisfaction and uncertainty about career choices.

V62.82 Uncomplicated Bereavement

This category can be used when a focus of attention or treatment is a normal reaction to the death of a loved one (bereavement).

A full depressive syndrome frequently is a normal reaction to such a loss, with feelings of depression and such associated symptoms as poor appetite, weight loss, and insomnia. However, morbid preoccupation with worthlessness, prolonged and marked functional impairment, and marked psychomotor retardation are uncommon and suggest that the bereavement is complicated by the development of a Major Depression.

In Uncomplicated Bereavement, guilt, if present, is chiefly about things done or not done at the time of the death by the survivor; thoughts of death are usually limited to the individual's thinking that he or she would be better off dead or that he or she should have died with the person who died. The individual with Uncomplicated Bereavement generally regards the feeling of depressed mood as "normal," although he or she may seek professional help for relief of such associated symptoms as insomnia and anorexia.

The reaction to the loss may not be immediate, but rarely occurs after the first two or three months. The duration of "normal" bereavement varies considerably among different subcultural groups.

V15.81 Noncompliance with Medical Treatment

This category can be used when a focus of attention or treatment is noncompliance with medical treatment that is apparently not due to a mental disorder. Examples include failure to follow a prescribed diet because of religious beliefs or to take required medication because of a considered decision that the treatment is worse than the illness. The major differential is with Personality Disorders with prominent paranoid, passive-aggressive, or masochistic features.

V62.89 Phase of Life Problem or Other Life Circumstance Problem

This category can be used when a focus of attention or treatment is a problem associated with a particular developmental phase or some other life circumstance that is apparently not due to a mental disorder. Examples include problems associated with going to school, separating from parental control, starting a new career, marriage, divorce, and retirement.

V61.10 Marital Problem

This category can be used when a focus of attention or treatment is a marital problem that is apparently not due to a mental disorder. An example is marital conflict related to estrangement or divorce.

V61.20 Parent-Child Problem

This category can be used when a focus of attention or treatment is a parent-child problem that is apparently not due to a mental disorder of the individual (parent or child) who is being evaluated. An example is child abuse not attributable to a mental disorder of the parent.

V61.80 Other Specified Family Circumstances

This category can be used when a focus of attention or treatment is a family

circumstance that is apparently not due to a mental disorder and is not a Parent-Child or a Marital Problem. Examples are interpersonal difficulties with an aged in-law, or sibling rivalry.

V62.81 Other Interpersonal Problem

This category can be used when a focus of attention or treatment is an interpersonal problem (other than marital or parent-child) that is apparently not due to a mental disorder of the individual who is being evaluated. Examples are difficulties with co-workers, or with romantic partners.