Approved MARCH 28, 1988
Date

MINUTES OF THE HOUSE COMMITTEE ON INSURANCE.

The meeting was called to order by REPRESENTATIVE DALE SPRAGUE at
Chairperson

3:30 ~~XX~~ a.m./p.m. on MARCH 21, 19 88 in room 531-N of the Capitol.

All members were present except:

Representative Sawyer
Representative Hoy
Representative Turnquist

Committee staff present:

Chris Courtwright, Research Department
Bill Edds, Revisor of Statutes Office
Nancy Wolff, Secretary

Conferees appearing before the committee:

Senator Nancy Parrish
Dick Brock, Kansas Insurance Department
Jerry Slaughter, Kansas Medical Society

The meeting was called to order by the Chairman.

Chris Courtwright, Research Department, reviewed Senate Bill 624, which would amend the Kansas statutes with regard to the liability of the Health Care Stabilization Fund. The bill would provide that the Fund shall not be liable for "tail coverage" for the actions of resident inactive health care providers, or nonresident inactive health care providers, unless the provider has participated in the Fund for ten or more years at the time the providers discontinues rendering professional services in this state.

Senator Nancy Parrish, one of the bill's sponsors, testified in support of the legislation. (Exhibit I)

Dick Brock, Kansas Insurance Department, testified that the Department was neither a proponent or opponent to the legislation, but stated that doctors have no where to go for tail coverage as there is no buy-back and this bill does not create a buy-back.

Jerry Slaughter stated that the Kansas Medical Society is vehemently opposed to Senate Bill 624. He stated that this legislation would really make Kansas an island when it comes to doctors practicing in the state.

There being no further conferees on Senate Bill 624, the hearings were closed.

The committee then turned to Senate Bill 536 which would provide conversion provisions for health maintenance organization contracts for discussion and action.

Representative Harper made a motion that the balloon amendments (Exhibit II) which was in regard to clean-up amendment proposed in committee by Emaline Correll of the Research Department be encorporated into the bill. Representative Neufeld seconded the motion. The motion carried.

Representative Gross made a motion that SB 536 be passed as amended and Representative Cribbs seconded the motion. The motion carried.

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON INSURANCE,

room 531-N, Statehouse, at 3:30 XX a.m./p.m. on MARCH 21, 1998.

The committee then turned their attention to House bill 3056 which relates to the operation and regulation of fraternal benefit societies and would make certain acts unlawful and prescribe penalties therefor.

Representative Schauf made a motion that HB 3056 be amended on line 377 by deleting the word "objection" and replacing it with the word "objective. Representative Brown seconded the motion and the motion carried.

Representative Bryant made a motion that HB 3056 be amended on page 16, line 31 by deleting the period after "situated" and adding ", except that no examination shall be required of a person who is an agent of a society immediately prior to the effective date of this act, but this exception shall apply only for the particular kind of insurance for which such person was acting as agent." Representative Beauchamp seconded the motion and the motion carried.

Representative Cribbs made a motion that House Bill 3056 be passed as amended and Representative Neufeld seconded the motion. The motion carried.

The meeting was adjourned.

VISITORS TO HOUSE INSURANCE COMMITTEE

DATE: March 21, 1988

NAME	REPRESENTING
Ken Bahr	Kaiser Permanente
Nancy Parrish	Senate
Jess Taylor	Ks Fraternal Congress
Richard Mason	KTA
Harold E. Kyeran	KAOM
Tom Bell	KHA
[illegible]	[illegible]
Tom C Simpson, MD	KAFP - Pa for a Day
Dick Brock	Ins. Dept

STATE OF KANSAS

NANCY PARRISH
STATE SENATOR, NINETEENTH DISTRICT
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3632 S. E. TOMAHAWK DR.
TOPEKA, KANSAS 66605
913-379-0702 HOME
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TOPEKA

SENATE CHAMBER

COMMITTEE ASSIGNMENTS
CHAIRMAN: ADVISORY COMMISSION ON JUVENILE OFFENDER PROGRAMS
MEMBER: ASSESSMENT AND TAXATION
JUDICIARY
EDUCATION
JOINT COMMITTEE ON SPECIAL CLAIMS AGAINST THE STATE

TESTIMONY ON S.B. 624

March 21, 1988

S.B. 624 modifies the current statutory policy of providing tail coverage for all health care providers through the Health Care Stabilization Fund. The purpose of S.B. 624 is to reduce the liability of the Fund which would subsequently reduce the surcharges assessed to health care providers.

A brief background is necessary to understand the concept of tail coverage. As I understand, in the mid 70's when the Health Care Stabilization Fund was established, the legislature changed medical malpractice insurance coverage from "Occurrence" policies to "Claims-made" policies. "Occurrence" policies are ones in which the insurance company that carries the insurance at the time a medical malpractice incident occurs is liable for the claim. A "Claims-made" policy is one in which the insurance company that carries the insurance at the time the claim for damages is made, is liable for the claim. There is not a problem with tail coverage if the insurance policy is an Occurrence policy because the insurance carrier who provides the insurance at the time of the incident is still responsible 2 or 3 years later when the claim is filed.

But in the case of a "Claims-made" policy, tail coverage is important. For example, in 1980, Dr. X performs an operation at which time malpractice occurs. Company A is the insurance company for Dr. X in 1980. In 1982 Dr. X leaves the state of Kansas to practice in Arizona at which time he purchases insurance with Company B. In 1983, victim files medical malpractice suit against Dr. X. Neither Company A nor Company B is liable to cover Dr. X's case. Company A isn't liable because Dr. X didn't have coverage with Company A during 1983. Company B isn't liable because Dr. X didn't purchase tail coverage from Company B. Instead, the Health Care Stabilization Fund is liable for the tail coverage for not only active and inactive providers within the State but also non-resident providers.

EXHIBIT I

Kansas is the only state in the U.S. that provides tail coverage. Our total premiums appear high in comparison to some other states, but included in the Kansas premium is tail coverage for the physician. The attached charts that were compiled by the Insurance Commissioner's office show Kansas rates in Comparison to several other states.

There are several problems with providing tail coverage. First of all, by the Fund providing tail coverage, doctors inadvertently are encouraged to leave the state to avail themselves of lower premiums for at least the initial 2 to 3 years. Some of these doctors have lost their licenses in Kansas.

Out-of-state doctors tend to be unavailable to defend cases against themselves when it involves travel back to Kansas. This makes it difficult for the Fund to defend a case on behalf of an out-of-state doctor.

Providing tail coverage is not altogether an undesirable feature. It provides flexibility to doctors who want to change companies. It provides tail coverage for retired doctors no longer in practice.

Realizing the benefits as well as the pitfalls of the Tail Coverage, S.B. 624 provides that tail coverage will continue if the health care provider has participated in the Fund for 10 or more years. Under S.B. 624, the Fund would no longer pick up the tail coverage for a young doctor practicing less than 10 years who decides the grass is greener and the medical malpractice premiums are less in the west. No longer would the Fund pay tail coverage for a doctor who leaves Kansas because he lost his license if that doctor had been practicing less than 10 years. Under S.B. 624 the Fund would pay tail coverage for retired doctors if they had practiced in Kansas 10 years or more.

Senate Committee amendments provide that the bill doesn't apply to doctors currently practicing in Kansas. It only applies to new doctors starting practice as of July 1, 1988. Another committee amendment was to provide an exemption for any doctor who becomes disabled through no fault of his or her own.

COST COMPARISON FOR A FAMILY PRACTICE DOCTOR INSURED BY ST. PAUL

State	Total Coverage Limits	Total Cost	Additional Cost For Tail Coverage
Oklahoma	$1,200,000/$3,600,000	$10,310	$17,529
Nebraska	$1,200,000/$3,600,000	$11,760	$20,869
Indiana	$500,000	$16,578	$26,483
Kansas	$1,200,000/$3,600,000	$18,162	$0
St. Louis, MO	$1,200,000/$3,600,000	$46,267	$81,442
Los Angeles, CA	$1,200,000/$3,600,000	$51,740	$81,797

COST COMPARISON FOR A OB / GYN SPECIALIST INSURED BY ST. PAUL

State	Total Coverage Limits	Total Costs	Additional Cost For Tail Coverage
Oklahoma	$1,200,000 / $3,600,000	$32,232	$55,060
Nebraska	$1,200,000 / $3,600,000	$36,681	$65,483
Indiana	$500,000	$45,578	$37,515
Kansas	$1,200,000 / $3,600,000	$51,815	– 0 –
Colorado	$1,200,000 / $3,600,000	$66,818	$105,703
St. Louis, MO	$1,200,000 / $3,600,000	$143,092	$252,432
Los Angeles, CA	$1,200,000 / $3,600,000	$169,060	$267,719

As Amended by Senate Committee

Session of 1988

SENATE BILL No. 536

By Committee on Financial Institutions and Insurance

1-28

AN ACT relating to insurance; requiring that health maintenance organization contracts provide certain conversion of coverage provisions; amending K.S.A. 40-3209 and repealing the existing section.

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

Section 1. K.S.A. 40-3209 is hereby amended to read as follows: 40-3209. (a) All forms of contracts issued by the organization to enrollees or other marketing documents purporting to describe the organization's health care services shall contain as a minimum:

(1) A complete description of the health care services and other benefits to which the enrollee is entitled;

(2) the locations of all facilities, the hours of operation and the services which are provided in each facility;

(3) the predetermined periodic rate of payment which the enrollee is obliged to pay;

(4) all exclusions and limitations on services or any other benefits to be provided including any deductible or copayment feature and all restrictions relating to pre-existing conditions;

(5) all criteria by which an enrollee may be disenrolled or denied re-enrollment; ~~and~~

(6) service priorities in case of epidemic, or other emergency conditions affecting demand for medical services~~.~~*; and*

(7) a provision that an enrollee or a covered dependent of an enrollee whose coverage under a health maintenance organization [group] *contract has been terminated for any reason but who remains in the service area and who has been continuously covered by the health maintenance organization for at least three months shall be entitled to obtain a converted contract*

EXHIBIT II

The converted contract shall provide coverage at least equal to the conversion coverage options generally available from insurers or mutual nonprofit hospital and medical service corporations in the service area at the applicable premium cost. The group or group members shall be solely responsible for paying the premiums for the alternative coverage. The frequency of premium payment shall be the frequency customarily required by the health maintenance organization or insurer for the policy form and plan selected, except that the insurer or health maintenance organization shall not require premium payments less frequently than quarterly. The coverage shall be available to all members of the group without medical underwriting. The requirement imposed by this subsection shall not apply to a contract which provides benefits for specific diseases or for accidental injuries only, nor shall it apply to any employee or member or such employee's or member's covered dependents ~~whose termination of benefits under the contract occurred because~~ when:

(A) Such person was terminated for cause as permitted by the group contract approved by the commissioner;

(B) any discontinued group coverage was replaced by similar group coverage within 31 days; or

(C) the employee or member is or could be covered by any other insured or noninsured arrangement which provides expense incurred hospital, surgical or medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination. Written application for the converted contract shall be made and the first premium paid not later than 31 days after termination of the group coverage and shall become effective the day following the termination of coverage under the group contract. In addition, the converted contract shall be subject to the provisions contained in paragraphs (2), (4), (5), (6), (7), (8), (9), (13), (14), (15), (16), (18), (19), (20) and (21) of subsection (D) of K.S.A. 40-2209, and amendments thereto.

(b) No health maintenance organization authorized under this act shall contract with any provider under provisions which

enrollee or enrollees

, mutual nonprofit hospital and medical service corporation

at least

enrollees of any

require enrollees to guarantee payment, other than copayments and deductibles, to such provider in the event of nonpayment by the health maintenance organization for any services which have been performed under contracts between such enrollees and the health maintenance organization.

(c) No contract form or amendment to an approved contract form shall be issued unless it is filed with the commissioner. Such contract form or amendment shall become effective within ~~thirty (30)~~ *30* days of such filing unless the commissioner finds that such contract form or amendment does not comply with the requirements of this section.

(d) Every contract shall include a clear and understandable description of the health maintenance organization's method for resolving enrollee grievances.

(e) The rate of payment for a health maintenance contract shall be a part of the contract and shall be stated in individual contracts by endorsement or certificate of coverage issued to enrollees.

Sec. 2. K.S.A. 40-3209 is hereby repealed.

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