Approved MARCH 29, 1988
Date

MINUTES OF THE HOUSE COMMITTEE ON INSURANCE.

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

3:30 XXm./p.m. on MARCH 28, 19 88n room 531-N of the Capitol.

All members were present except:
Representative Schauf
Representative Sawyer-excused

Committee staff present:
Emaline Correll, Research Department
Chris Courtwright, Research Department
Bill Edds, Revisor of Statutes Office
Nancy Wolff, Secretary

Conferees appearing before the committee:
Dick Brock, Kansas Insurance Department
Dr. John D. Gay, American Cancer Society
Darlene Hall, American Cancer Society
Jack Roberts, Blue Cross-Blue Shield

Representative Littlejohn made a motion that the minutes of the meetings held March 21, 1988, March 22, 1988 and March 23, 1988 be approved as written and Representative Hoy seconded the motion. The motion carried.

Chris Courtwright gave a brief review of Senate Bill 668 which would require health insurance policies and contracts and contracts of health maintenance organizations to provide coverage for mammogram and pap smears.

Dick Brock, Kansas Insurance Department testified with regard to Senate Bill No. 668 and suggested some cleanup amendments for the bill. (Exhibit I)

John Gay, M.D., Director of Breast Imaging Services at Stormont-Vail Regional Medical Center in Topeka, appeared on behalf of the American Cancer Society. He testified in support of S.B. 668 which would require inclusion of coverage for mammography in health insurance policies. (Exhibit II)

Darlene Hall, a registered nurse with Home Healthcare of Stormont-Vail Hospital, and Public Education Chairman for the American Cancer Society, also testified in support of S.B. 668. (Exhibit III)

The American Cancer Society also distributed testimony from Rita Whelan, a victim of breast cancer, who was unable to be in attendance at the meeting. (Exhibit IV)

Jack Roberts, Blue Cross and Blue Shield, testified in opposition to the legislation. He testified that any mandated coverage will always increase the cost of insurance and removes choice on the part of the buyer.

There being no other conferees on SB 668, the hearings were closed.

The committee then turned its attention to SB 539 which was passed out of the committee on 3/24/88 and placed on the consent calendar. Due to an oversight, an amendment requested by the Health Insurance Association of America was not acted on when the bill was passed out of committee. Chris Courtwright, Research Department, reviewed the bill and the amendments requested. Dick Brock, Kansas Insurance Department stated that when his Department reviewed the requested amendments, it was their feeling that the first of the requested amendments was not needed, but the second would technically made the bill better. (Exhibit V)

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON INSURANCE,
room 531-N, Statehouse, at 3:30 XXX a.m./p.m. on MARCH 28, 1988.

Representative Hoy made a motion that the committee rescind their prior action on SB 539 and Representative Gross seconded the motion. The motion carried.

Representative Gross made a motion that SB 539 be amended in line 0057 following the word "employees" by inserting "and individual dependent or family members" and Representative Bryant seconded the motion. The motion carried.

Representative Bryant made a motion that SB 539 be reported favorable for passage as amended and Representative Hoy seconded the motion. The motion passed.

The committee then turned its attention to SCR 1617 which requested a study of the entire issue of Accident and Health Risk Pool Insurance. Dick Brock, Kansas Insurance Department, appeared and stated that the Department feels that such a study is necessary as other states are having some difficulties with Health Risk Pools and the entire matter needs further study. He also stated that the auto plan is working alright and that the costs are better able to be estimated for auto than for health. (Exhibit VI)

The meeting was adjourned at 4:28.

[As Amended by Senate Committee of the Whole]

As Amended by Senate Committee

Session of 1988

SENATE BILL No. 668

By Committee on Federal and State Affairs

2-17

AN ACT relating to insurance; requiring mammogram and pap smear coverage to be offered for inclusion in certain health and accident policies *and contracts*; amending K.S.A. 40-19c09 and repealing the existing section.

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

New Section 1. *Except as otherwise provided,* this act applies to any individual, group or blanket policy of accident and sickness, medical or surgical expense coverage~~,~~ ~~or~~ *and* any provision of a policy, contract, plan or agreement for medical service~~,~~ ~~issued,~~ ~~issued for delivery,~~ ~~continued or renewed,~~ ~~covering~~ ~~Kansas residents~~ *including any contract of a health maintenance organization as defined by K.S.A. 40-3202, and amendments thereto, delivered, renewed or issued for delivery* on or after the effective date of this act *within or outside of this state or used within this state by or for an individual who resides or is employed in this state. The provisions of this act shall not apply to any medicare supplement policy of insurance, as defined by the commissioner of insurance by rule and regulation,* ~~or~~ *any policy of long-term care insurance, as defined by K.S.A. 1987 Supp. 40-2227, and amendments thereto.*

New Sec. 2. Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this act applies, whenever reimbursement or indemnity for ~~*diagnostic,*~~ laboratory, x-ray or ~~both~~ *any of* such services are covered, reimbursement or indemnification shall not be denied for mammograms or pap smears when performed at the direction of a ~~licensed practitioner~~ *person licensed [to practice medicine and surgery] by the*

Delete.

any specified disease or specified accident coverage or any accident only coverage as defined by the commissioner of insurance by rule and regulation whether written on a group, blanket or individual basis,

Delete.

EXHIBIT I

board of healing arts within the lawful scope of such ~~practitioner's~~ *person's* license. *A policy, provision, contract, plan or agreement may apply to mammograms or pap smears the same deductibles, coinsurance and other limitations as apply to other covered services.*

Sec. 3. 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 ~~K.S.A. 40-2,116 and 40-2,117~~ *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, *40-2,116, 40-2,117*, 40-2a01 to 40-2a19, inclusive, 40-2111 to 40-2116, 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. 4. K.S.A. 40-19c09 is hereby repealed.

Sec. 5. This act shall take effect and be in force from and after its publication in the statute book.

Legislation requiring inclusion of coverage for mammography in health insurance policies is badly needed.

Mammography can find breast cancers in significant numbers that cannot be felt. Most of these will be early stage cancers with no lymph node involvement (B.C.D.D.P; U.S.; 1973-1981; A.C.S. and N.C.I. sponsored). This ability to detect small, early cancers in women of all ages has prompted the American Cancer Society to recommend regular mammography for all women beginning at age 40. Early detection is the only chance for a reduction in the mortality rate from breast csncer. Mammography is the most sensitive method of screening for breast cancer and is the only imaging procedure capable of finding early cancer in women who have no symptoms.

All experts agree that mammography should be performed regularly in women over 50 years of age. Four controlled studies (U.S. 1963; Sweden 1977; Netherlands 1975; Italy 1979) have proven that a decrease in mortality from breast cancer of 30-50% results from routine screening using mammography alone or mammography and physical examination combined.

For women 40-49 years of age, there is continued controversy about the use of mammogrpahy. Nevertheless, the Italian study and the U.S. study (after the 6th year of screening) have shown reduced mortality rates for these younger women. Experts believe that some breast cancers grow more rapidly in younger women and that screening mammography must be performed annually in this age group in order to prevent an excess of larger, more advanced cancers.

There is ample and sufficient medical evidence to support screening mammography for all women, age 40 and over. For economic reasons however, health care planners often claim no benefit from mammography.

The radiation dosages associated with mammography have been reduced dramatically since the 1960's. Current dosages using modern mammographic equipment are extremely small. There is no direct evidence that the low doses of radiation used in diagnostic radiology are dangerous. Estimates of theoretical danger are based upon high dose exposures 100 times or more the doses used in mammography. Little, if any, risk exists for women 40 years of age and older.

The quality of the mammographic exam and the ability of radiologists to diagnose early breast cancer has improved significantly in the last 10-15 years. There are several national seminars held each year to aid radiologists in upgrading their diagnostic skills. Many fellowship programs exist for the same purpose. These are well attended. Recently, an accreditation program sponsored by the American College of Radiology has been developed to asses and insure the quality of mammographic facilities in this country. Accrediation has already been sought and received by some facilities in Kansas.

Cost has been the greatest deterrent to the acceptance of routine mammography. Average costs for mammography in this country have been $100-105 with some as high as $150. Considerable effort is being made by some private radiologists, as well as the American Cancer Society and the American College of Radiology, to make affordable mammography a reality. Excellent quality mammography is now available in Kansas for $50.

John D. Gay, M.D.

Director of Breast Imaging Services
Stormont-Vail Regional Medical Center
Topeka, Kansas

Member, American Cancer Society
Kansas Division Board of Directors
and Breast Cancer Detection Awareness
Committee

I am Darlene Hall, a registered nurse with Home Healthcare of Stormont-Vail Hospital, and Public Education Chairman for the American Cancer Society, Kansas Division, Inc.

The American Cancer Society was founded in 1913 for the express purpose of educating people about cancer. For many years dedicated Kansas Volunteers have taught thousands of Kansans ways to detect cancer early when it is most curable. One of our most notable successes has been in the area of cervical/uterine cancer. Since the introduction of the pap smear as a regular part of womens' health care, the death rate has dropped 70%. The American Cancer Society and the American College of Gynoclogists recommend women over the age of eighteen or who are sexually active have yearly pap smears until they have three consecutive, annual normal examinations. After that they should have examinations every three years or as recommended by their physician.

With regular examination, cervical and uterine changes can actually be detected before they can become cancer. At this point they are entirely curable. However, as many as 125 Kansas women will die this year from uterine or cervical cancer.

In recent years mammography has emerged as the test which can have the same effect on deaths from breast cancer that the pap smear had on cervical and uterine cancer. Mammography is a low-dose

x-ray of the breast which can detect a tumor or mass in a woman's breast when it is so small it could not be detected by any physical examination. At this stage, breast cancer is virtually 100% curable. In 1988, an estimated 125 Kansas wives, mother, sisters and daughters will die of breast cancer, a disease which is almost entirely curable. Why? Why are women dying from diseases we have the medical capability to cure? Many of them are not having the test necessary for early detection. Pap smears and mammograms cost money. The primary reason women give for not having regular exams is the cost. The American Cancer Society feels so strongly in the benefits of these tests that both the National Board of Directors and the Kansas Division Board have called for insurance coverage.

What good does all our knowledge do if it cannot benefit the people who need them? The American Cancer Society, Kansas Division, Inc. urges the members of this committee to support Senate Bill 668 for Insurance coverage of mammography and pap smears.

Thank you.

I AM RITA WHELAN AND I HAVE HAD BREAST CANCER. I WOULD LIKE TO SHARE MY STORY WITH YOU.

I WENT TO MY GYNECOLOGIST FOR A REGULAR CHECK UP AND TO SEE IF I WAS A CANDIDATE FOR ESTROGEN REPLACEMENT THERAPY. THIS WAS IN OCTOBER OF 1985. MY DOCTOR REQUIRED TWO TESTS BEFORE HE WOULD PRESCRIBE THE ESTROGEN. THE FIRST TEST CAME BACK NEGATIVE AND THEN I WENT FOR THE SECOND TEST, A MAMMOGRAM. THIS WAS MY FIRST MAMMOGRAM. I SHOULD HAVE HAD SEVERAL MAMMOGRAMS PRIOR TO THIS ACCORDING TO THE AMERICAN CANCER SOCIETY GUIDELINES, BUT I REALLY WASN'T EDUCATED TO KNOW THAT THIS TEST SHOULD BE DONE ON A REGULAR BASIS AT MY AGE. THIS MAMMOGRAM WAS TOTALLY AN ASYMPTOMATIC TEST "JUST ROUTINE" I WAS TOLD. THE X-RAYS WERE TAKEN AND A RADIOLOGIST READ THEM IMMEDIATELY. THE FIRST WORDS I HEARD FROM THE RADIOLOGIST WERE, "I RECOMMEND SURGERY." IF ANY OTHER WORDS WERE SAID, I DON'T REMEMBER. I FOCUSED ON THOSE THREE WORDS. HOW THEY STOOD OUT!!

THE DOCTOR WENT ON TO SAY THAT I HAD A MASS THAT COULD NOT HAVE BEEN DETECTED ANY OTHER WAY THAN BY MAMMOGRAM AND IT HAD BEEN THERE FOR A TIME. HE EXPLAINED THAT A BIOPSY WOULD BE NECESSARY. I REALIZED I HAD A PROBLEM AND THOUGHT, "I MUST GET RID OF IT." THE BIOPSY WAS PERFORMED WITHIN THE WEEK. IT WAS POSITIVE. I DID HAVE CANCER. WITHIN TWO WEEKS I WAS SCHEDULED FOR SURGERY AND HAD A MASTECTOMY. I WAS SURPRISED RECENTLY WHEN I HEARD NANCY REAGAN'S CANCER DESCRIBED IN EXACTLY THE SAME MANNER AS MY BREAST CANCER. IN ALL MY VISITS WITH OTHER WOMEN, I HADN'T HEARD ANYONE USE THE EXACT TERMINOLOGY.

TODAY, I GO TO MY DOCTOR FOR REGULAR CHECK UPS. I AM VERY HEALTHY BECAUSE I CAUGHT MY CANCER EARLY. THAT WAS ENTIRELY DUE TO MAMMOGRAPHY. EARLY DETECTION WAS THE KEY! I FEEL THE MAMMOGRAM SAVED MY LIFE AND I WOULD HATE TO THINK THAT ANY WOMAN WOULD BE UNABLE TO GET A MAMMOGRAM BECAUSE SHE COULD NOT AFFORD IT OR HER INSURANCE WOULD NOT COVER THE TEST.

IF THIS WAS YOUR WIFE, OR MOTHER, OR DAUGHTER, WOULDN'T YOU WANT THIS TEST AVAILABLE FOR THEM?

STATEMENT TO THE HOUSE INSURANCE COMMITTEE

OF THE KANSAS LEGISLATURE

ON BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA

CONCERNING SENATE BILL 539

The Health Insurance Association of America (HIAA) represents approximately 360 insurance companies responsible for over 85% of the health insurance written by health insurance companies in the United States today. The HIAA opposes the proposed language in Senate Bill 539 unless there are additional amendments to clarify the language that has been proposed.

First, on page 2, line 51 through 56, provides for a continuation of coverage in situations involving the replacement of one policy by another policy. While the HIAA has long supported the National Association of Insurance Commissioners "Group Coverage Discontinuance and Replacement Model Regulation", there is a need for additional language which makes it clear that the insured under the replaced policy is subject to preexisting condition limitations, deductibles and waiting periods of a replacing policy. As a result, the HIAA would suggest the following underlined language be added in page 2 on line 56 after the word "policy".

A replacing policy may subject an insured to any preexisting condition waiting periods, deductibles and other such limitations only to the extent to which similar limitations remain unexpired under the policy being replaced.

EXHIBIT V

Second, the proposed amendatory language from line 56 through 69 appears to apply to "new issue" policies. Most situations involving a change in health care plans are the result of the replacement of one insurance policy with another policy. However, there are "new issue" situations in which a company decides for the first time to offer health care benefits to its employees or a self-insured makes a determination to obtain health care benefits for its employees under a health insurance contract. The HIAA requests a second amendment which is technical in nature and would be inserted in line 0057 as follows:

> Except employees and individual dependent or family members enrolling in a group policy . . . This amendment clarifies the status of dependents and family members as being eligible as "late entrants". "Late entrants" are persons attempting to enroll in the group policy after the open enrollment period.

Finally, while these two proposals urged by the HIAA as clarifications would be helpful in understanding and implementing Senate Bill 539, they do not remove the HIAA's basic objection to legislation that may force employers into the self-funded market. There are valid reasons why a newly issued group policy may exclude an employee or an employee's family member. Some employers may decide not to provide dependent coverage. When an employer becomes self-insured, the Life and Health Guaranty Fund, Unfair Claims Settlement Practices Act, mandated benefit laws, continuation and conversion requirements, etc. do not apply as well as a loss of premium tax revenue to the state. Therefore, the HIAA maintains that this law should not be place on

insurance carriers but if the legislature believes that every working individual should have health insurance coverage, then they should require employers, not insurance companies, to obtain health care coverage for their employees. Thus, all employees would be covered in the state, not just the approximately 50% that have health care benefits provided under insurance contracts.

Thank you for the opportunity to express the position of the HIAA on Senate Bill 539.

Respectfully submitted,

Stephen W. Robertson

Senior Counsel
312-297-1490

FLETCHER BELL

COMMISSIONER OF INSURANCE

January 8, 1988

The Honorable Mike Hayden
Governor of Kansas
2nd Floor, State Capitol Bldg.
Topeka, KS 66612

The Honorable Robert V. Talkington
President of the Senate
State Capitol Bldg., Rm 359 East
Topeka, KS 66612

The Honorable James D. Braden
Speaker of the House
State Capitol Bldg., Rm 380 West
Topeka, KS 66612

The Honorable Michael L. Johnston
Minority Leader of the Senate
State Capitol Bldg., Rm 347-N
Topeka, KS 66612

The Honorable Marvin Wm. Barkis
Minority Leader of the House of Representatives
State Capitol Bldg., Rm 327 South
Topeka, KS 66612

Gentlemen:

The 1986 Kansas Legislature enacted Substitute for Senate Bill No. 121. This bill charged me with the responsibility of collecting data from accident and health insurers regarding the number of risks declined or coverage limitations imposed including the incidents of higher than standard rates being charged. The bill required the Insurance Department to report our findings to you and the legislature no later than the commencement of the 1988 regular session of the Kansas Legislature. Please find attached a copy of the formal "Accident and Health Risk Pool Report".

To meet the statutory directives of Substitute for Senate Bill No. 121, I issued Bulletin 1986-22 to all insurance companies authorized to transact accident and health insurance business in Kansas. This bulletin requested the companies' participation in reporting any adverse underwriting decisions made by the companies. The data has been compiled and incorporated into the attached report.

It should be noted that specific cost data is impossible to project for such a program inasmuch as accurate data is only obtainable after-the-fact. Not only is a pool mechanism for persons unable to obtain necessary coverage in the normal market

EXHIBIT VI

a new idea for the state of Kansas, but it is also a relatively new idea for any state. Even among the few states which have had a "risk pool" in effect long enough to develop credible data, substantial differences exist within the programs that prevent a meaningful cost comparison. In spite of the above, we have been provided with some cost information by the Health Insurance Association of America. Although this information was received after the formal report had already gone to the printer, it provides some data which may be helpful to you.

In summary, I believe the report provides meaningful information and recommendations regarding the uninsurable population in Kansas. I support its recommendations and I am confident the report will be an important aid to you and the Kansas Legislature.

I do want to specifically note, however, that Substitute for Senate Bill No. 121 (1986) requires legislative approval before a plan can be implemented. In addition, implementation of the plan I have suggested would require some additional statutory provisions. Therefore, I hope the attached report and recommendations will be referred to an appropriate legislative body for consideration and possible action.

Very truly yours,

Fletcher Bell
Commissioner of Insurance

FB:lbah
5861fdp
Enclosures

HIAA

Health Insurance Association of America

December 30, 1987

Mr. Richard G. Hunker
Accident and Health Supervisor
Kansas Department of Insurance
420 S.W. 9th Street
Topeka, Kansas 66612

Dear Dick:

This is in response to your inquiry as to whether HIAA has any data that would be useful in projecting an estimate of the costs to the State of Kansas involved with the enactment of an uninsurable pooling program.

There are 15 state "pools" at the present time, but only a smaller number have been operating for a period of time sufficient to develop any meaningful cost information. All of these pools, while based on rather common principles, are somewhat different in terms of premium limitations, scope of coverage, eligibility and the like. For these and other reasons, the actual cost of each pool is substantially different. Unfortunately, a comparative actuarial study has not been done to really identify and evaluate the factors among these pools to determine what might be causing the differences in cost. In the absence of such a study, we can only make rough assumptions about costs for other states in adopting pooling legislation.

The attached material consists of; 1) a list of 11 of the pools having been in existence for the longer time indicating such factors as deductibles, copayment limitations, maximum benefits and pre-existing periods; and 2) the operating cost data for 5 pools having been operational for some time (Florida is missing data since it is just becoming operational). The operational cost data include losses, assessments and several ratios indicating pool costs as per state population and to the insured segment of the population.

Some general observations might be appropriate. First, experience tends to indicate that pool premium rates are generally set too low. In most states, the pool premium is lower than premium rates applicable to conversion policies -- a result that is counter to the purpose of the pool. Also, where pool rates are too low, the assessments must be higher resulting in a higher impact on general revenue through premium tax offsets. Premium tax offsets are essential, however, to spread the cost of such social medical-economic

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programs throughout the population instead of merely through the insurance buying public. It is obvious that, in states where the impact on general revenue is considered too high, the pool rates need to be increased and eligibility tightened. There is growing thought also that pools should be required to administer cost containment programs and perhaps even managed care in order to curtail the inflationary spiral of health care costs themselves.

After you have had an opportunity to look over the attachments, you might want to call Peter Thexton in our Washington office for further information or explanation of the data. Perhaps an actuary might be able to draw some meaningful inferences as to projected costs better than we attorneys.

I hope this will be of assistance. Please let us know if we can provide anything further.

Yours truly,

Carroll Callaway
Senior Associate General Counsel

CC/dvp
Attachment

STATE HIGH RISK POOLS
BENEFIT PLANS

Premium Cap. State	Deductibles	Stop Loss Indiv.	Stop Loss Fam.	Maximum	Pre-existing Define	Pre-existing Wait	Pre-existing Wvr?	Med. Supp.
150% Conn.	400;1,000;1,500	2,000	4,000	$1 Mill.	6 mo.	12 mo.	No	No
200% Fla.	1,000 1,500 2,000	2,500(1) 3,000(1) 3,500(1)	4,000 4,500 5,000	500,000	6 mo.	6 mo.	No	Yes
135% Ill.	250;500;1,000	1,500(2)	3,000	500,000	6 mo.	6 mo.	10%(3) Conv.*	Yes
150% Ind.	200 500 1,000	1,000 1,500 2,000	2,000 3,000 4,000	Unlim.	6 mo.	6 mo.	25%	No
150% Iowa	500 1,000	1,500 2,000	3,000 4,000	250,000	6 mo.	6 mo.	Conv.*	Yes
125% Minn.	500;1,000	3,000	-	250,000	90 d.	6 mo.	Conv.*	Yes
400% Mont.	1,000	5,000	-	100,000	5 yrs.	12 mo.	Conv.*	Yes
165% Neb.	250 500 1,000	5,250 5,500 6,000	- - -	500,000	6 mo.	6 mo.		
135% N. Dak.	150;500;1,000	3,000	-	250,000	90 d.	180 d.	Conv.*	Yes
150% Tenn.	500 2,000	1,500 2,500	2,500 3,500	500,000	6 mo.	6 mo.		Yes
150% Wisc.	1,000	2,000	4,000	250,000	6 mo.	6 mo.	No	No

(1) Individual stop loss for medicare supplement plans is $1,500, $2,000, $2,500.
(2) $500 for medicare supplement.
(3) Change from 6 mo./6 mo. to 2 mo./2 mo. for 10% extra premium.
* Waiting period can be waived if previously covered and other defined requirements.

STATE HIGH RISK POOLS
ACCRUED EXPERIENCE DATA ($1,000's) FOR CALENDAR YEAR 1986

State	Premium	Benefit	Bene. Ratio	Expense	Inv. Inco.	Expense-Inv. Inco. /Enr.	%Prem	% Bene
Conn.	$3,533	$ 4,228	120%	$ 222	$ 32	$ 60.00	5.4%	4.5%
Fla.								
Ind.	6,869	11,648	~~108~~ 170	436	55	127	5.5	3.3
Minn.	10,772	18,914	176	989	106	74	8.2	4.7
N. Dak.	1,322	2,864	217	109	17	72	7.0	3.2
Wisc.*	2,617	3,106	119	282	91	91	7.3	6.1

* Fiscal year ending June 30.

FINANCIAL DATA ($1,000's) FOR YEAR 1986

State	Loss(1)	Loss/Popul Total	Loss/Popul Insd.*	Loss/ Enrol	Assess Base Type	Assess Base Amt(Mil)	Assess Amount(1)	Assess Ratio
Conn.	$ 885	$ .28	$ .34	$ 385			1,490	
Fla.								
Ind.	5,161	.94	1.14	1,720			4,684	
Minn.	9,024	2.15	2.63	755	A&H Prem		9,024	
N. Dak.	1,633	2.38	2.91	1,276			1,510	
Wisc.	679	.14	.17	323			770	

(1) Losses are based on accrual amounts. Assessments are generally based on cash amounts.

ACCIDENT AND HEALTH

RISK POOL REPORT

1986 SUBSTITUTE FOR SENATE BILL NO. 121

A REPORT FROM THE KANSAS INSURANCE DEPARTMENT ON THE FEASIBILITY OF IMPLEMENTING A HEALTH INSURANCE HIGH RISK POOL TO: MIKE HAYDEN, GOVERNOR, ROBERT V. TALKINGTON, PRESIDENT OF THE SENATE, MICHAEL L. JOHNSTON, MINORITY LEADER OF THE SENATE, JAMES D. BRADEN, SPEAKER OF THE HOUSE OF REPRESENTATIVES, AND MARVIN WM. BARKIS, MINORITY LEADER OF THE HOUSE OF REPRESENTATIVES.

JANUARY, 1988

Preamble

K.S.A. 40-2111 as amended by L. 1986, Chapter 178 requires the Commissioner of Insurance to accumulate data concerning declinations, terminations and offers to provide accident and sickness insurance at higher than standard rates and report such information to the governor and the legislature no later than commencement of the 1988 legislature.

This report is submitted in compliance with this statutory directive and is designed to address the issue identified in Section I.

TABLE OF CONTENTS

I. ISSUE

Is it necessary for the state of Kansas to implement a Pooled Risk Program for those who cannot obtain reasonably adequate accident and health insurance in the voluntary market?

II. BACKGROUND

Several times in recent years legislation has been considered or proposed which would address the concerns of uninsured Kansans. In 1976 a legislative recommendation was developed by the Insurance Department which would have established a comprehensive health insurance and health care cost containment mechanism. This recommendation was presented to interested state agencies, health care providers and others, but was subjected to considerable criticism and no support developed.

In 1977, the Insurance Department's Catastrophic Health Insurance and Health Care Cost Containment proposal was presented to the House Committee on Insurance -- the committee ultimately introduced the catastrophic health insurance portion of the proposal. Subsequently, the health care cost containment provisions of the proposal were introduced as an individual bill (House Bill No. 2453) but it was not enacted.

In 1978 a proposal to establish a residual market mechanism for catastrophic health insurance was recommended by the Insurance Department. The recommendation was introduced as House Bill No. 2270 but it was not enacted.

In 1986 House Bill No. 2167 was recommended by the Insurance Department and Senate Bill No. 121 was sponsored by Senator Francisco (D - Mulvane), each of which would have established a Pooled Risk program in the state of Kansas. A combination of these bills was enacted as Substitute for Senate Bill No. 121, which as noted in the Preamble to this report, charged the Insurance Commissioner with the responsibility of collecting data from accident and health insurers regarding the number of risks declined or coverage limitations imposed and reporting to the governor and legislature, no later than the commencement of the 1988 regular session of the Kansas legislature. Such report consists of data obtained from insurance companies along with a proposed plan including an analysis of the cost impact thereof. The Governor and the legislature will therefore have an opportunity to review the data and recommendations contained herein and comment on whether there is a need for implementation of the proposed plan and, if so, consider whether or not the proposed plan should be approved.

III. DATA

On June 27, 1986, the Insurance Department sent Bulletin 1986-22 to authorized Accident and Health companies requesting their participation in the reporting requirements of Substitute for Senate Bill No. 121. (Appendix A contains a copy of Bulletin 1986-22 and a copy of Substitute for Senate Bill No. 121) The prescribed reporting period was July 1, 1986 to June 30, 1987. The results of this survey have been tabulated and companies have reported processing 79,230 applications, of which 5.14% were declined. Of those not declined, 16.74% were issued with health restrictions (riders) and/or substandard rates. In addition, Blue Cross and Blue Shield of Kansas, Inc., the company which reported the largest number of applications, has reported that, during the reporting period, 1,635 or 43.16% of the applicants who were accepted with health restrictions terminated their policies within 60 days of issue. (See Appendices B and C)

The above statistics along with the grim predictions of the escalating AIDS crisis suggest that a new crop of uninsurable Kansans may be emerging over the next decade -- certainly a factor to be considered.

The data collected from companies is not without its weaknesses. We know how many applications were denied during the time period of the study, but that figure may be misleading in that many of those applicants rejected by one company may have been accepted by another, or may have later secured group coverage. Of those rejected, we will not know how many could afford to participate in a risk pool. On the other hand, we will not know how many of the uninsured were not counted in the study, such as those whose applications were never processed because the agent in the field informed the applicant that he/she was uninsurable, those whose applications were processed before or after the reporting period, or those who did not apply because they already knew they were not an insurable risk. In other words, the data which we have compiled only tells us the frequency of adverse underwriting. An approximate number of uninsureds or uninsurables is not something which can be concluded from our study, and even if it could, we would not know how many of those could afford to be candidates for the risk pool. We simply do not know how many Kansans will benefit from such a program but, we do know with absolute certainty that a number of Kansans cannot obtain adequate health insurance and we also know it does not require huge numbers to determine that a significant public policy consideration exists.

IV. OPTIONS

Alternative I. Establish a pooled risk program to be administered either through a risk assignment mechanism or through a single plan administered by a selected insurer or administrator. Similar plans in other states typically include a minimum level of benefits and premium rates which are capped at a level ranging from 125 to 400 percent of the average charged for an individual policy. Despite the substandard rates, plans in other states tend to operate at a loss, which is typically assessed to insurers, distributed in proportion to the insurer's share of the state's total premium income. In some states, these costs are then transferred to the state by permitting insurers to deduct the amount they are assessed from the premium taxes otherwise payable in subsequent years.

Alternative II. Under this alternative, catastrophic medical expenses are financed directly by state appropriations and administered by a state agency. Basically, under this type of program, residents become eligible for assistance if their medical bills exceed a certain portion of their income. This program is intended to be the "payer of last resort" -- that is, state financial support begins only after all other forms of private insurance have been exhausted. This arrangement is designed, as is Alternative I, to protect people who are in poor health and who need insurance protection. Generally, in the states that administer their own risk pools, participants do not include those eligible for Medicaid assistance.

Over the years, practically all of the programs of this nature that states have adopted have experienced excessively high costs and utilization. As a result, some states have tightened their eligibility requirements whereas other states have curtailed funding altogether. This alternative is administratively feasible but is impractical without adequate state funding to provide the needed protection for those desiring coverage.

V. RECOMMENDATION

The Insurance Department recommends proceeding with Alternative I. In addition to those health insurance applications which are declined, there are a number of situations where policies are issued with broad health restrictions which render the insured effectively uninsured due to chronic health problems which are not covered by the policy. Further, as the AIDS epidemic worsens in Kansas, private insurance will become harder to obtain, more and more victims will be financially dependent on the state unless the medical costs of this disease can be alleviated by catastrophic health insurance coverage.

Although a pooled risk program of this nature would provide availability of coverage, it is important to recognize that affordability would not be assured. Obviously, the uninsured are generally not entitled to group coverage through their place of employment. Many are unemployed, self-employed, farmers, part-time or temporary workers, those employed by firms which do not provide health insurance to workers, or those who cannot afford the employee health plan despite employer contribution. Coverage under the risk pool will no doubt be expensive, and will be out-of-reach to many uninsured Kansans even though limitations on the maximum extent premiums can exceed those charged in the standard market will result in some subsidization. Consequently, this plan should not be viewed as a panacea -- it would not insure all of the uninsured, it would not compensate for all uncompensated care, and it probably would not significantly impact a savings on Medicaid reimbursements. Nevertheless, the plan can be very effective in providing insurance to a subset of the Kansas population - people in poor health who are able to afford the cost of the premiums. Even a catastrophic health insurance plan with high deductibles and co-payments places an upper limit on an individual's or family's health care expenditures. This gives them a target to budget for whereas now they are faced with the possibility of a limitless drain on their resources and ultimately dependency on public programs.

The establishment of a plan of this nature will also permit the acquisition of better data through which to measure more precisely the cost of such a program. From such data it is possible that at some point in the future, public funding might be effectively used to subsidize the premium for the medically indigent at a lower cost than would be the case if the Medicaid program or other public assistance alternatives are required to absorb the entire burden.

Although Alternative I will have some degree of fiscal and administrative effect upon the operations of the Kansas Insurance Department, we believe our current staff can handle such tasks.

VI. PROPOSED PLAN

Pursuant to Substitute for Senate Bill No. 121, the Kansas Insurance Department has prepared a proposed plan. (See Appendix D). This health insurance pooling mechanism is patterned after the National Association of Insurance Commissioners model law and includes, in part, provisions relating to operation of the pool, eligibility, assessments, minimum benefits and complaint and grievance procedures.

VII. LEGISLATIVE CONSIDERATIONS

The following subsections of this Section VII, are topics relating to the risk pool mechanism which may require additional

legislative resolutions for effective implementation of the pool mechanism.

A. Subsidizing Pool Losses:

According to the September 1987, second edition of a report entitled, Comprehensive Health Insurance for High Risk Individuals, which was developed by Aaron K. Trippler of Communicating for Agriculture, Inc., fifteen states have enacted legislation creating risk pools of which nine are currently active. The other six are expected to begin enrolling people and become operational sometime during 1988. Approximately 67% of these states share or offset the losses assessed against the pool participants. Generally the states have chosen to subsidize pool losses through some form of tax credit. Twenty (20) percent of the states require the pool participants to bear the entire burden of pool losses, while one state or approximately 6.5% will recoup any losses through appropriations made by the General Assembly. The remaining state has a unique manner to offset the losses in that an assessment on hospital revenues will be used to pay for losses sustained by the pool.

In light of the above statistics it appears that some form of premium tax offset for adverse loss experience would make the pooling mechanism an equitable and viable program in the state of Kansas. Enabling legislation will be necessary if the legislature chooses to allow for state subsidies in conjunction with the Kansas Health Insurance Risk Pool.

Under a premium tax offset approach, the pooled risk mechanism would be implemented by the member insurers with start-up and administrative costs born by said members. Annually, or at such other times as the legislature may direct, the premium revenue and investment income thereon would be compared to the losses incurred during the same period of time. Member insurers would then be assessed for the amount the losses exceeded revenues. Each member insurer would then be permitted to deduct the amount of such assessment from premium taxes due the state of Kansas under such formula as the legislature may direct.

B. Collective Action

In order to protect the participants of the pool from legal action as a result of actions required by the pool, it would also appear necessary to provide for such protection via a separate law which may read as follows:

> "Neither the participation in the pool as members, the establishment of rates, forms or procedures nor any other joint or collective action required by the pool mechanism

shall be the basis of any legal action, criminal or civil liability or penalty against the pool or any of its members."

C. Effective Date

We suggest that the provisions of the pooling mechanism contained in Appendix D become effective January 1, 1989.

VIII. CONCLUSION

From the information presented above, we believe it is apparent that a need for a risk pool arrangement, however small it may be, has been identified. It is always important to remember the original purpose of a high risk pool. That is, to develop a mechanism which provides a comprehensive health insurance product for individuals who are high risks even though it does not address the major issue of affordability.

Naturally, these types of programs are expensive and decisions must be made regarding the entities which will pick up the costs. A major problem to be addressed at the federal level is the effect of ERISA in precluding states from developing a broad base for subsidization. Specifically, federal law now prevents states from including self-insurers as members of any risk pool which, in turn, permits self-insurers to avoid participation.

In this regard, recent federal legislation, which would assist in this area, has been introduced by Representative Kennelly and Senator Heinz (HR 1770 and S1372) and by Representative Stark and Senator Kennedy (HR 3210 and S1346). The enforcement mechanism proposed in these bills is a tax on employers, whether insured or self-funded, whose employee's health benefits plan do not participate. The federal tax mechanism is obviously a way of circumventing ERISA's prohibition against states requiring self-funded employee benefit plans to participate in pools.

Legislative attention should also be drawn to another Federal proposal known as the Access to Health Care Act of 1986 which was introduced in congress by Senators Edward Kennedy, John Heinz, Donald W. Riegle and David F. Dureuberger. This Senate Bill, would, in part, require states to set up insurance pools for people not insured through their jobs, regardless of health history, with premiums no more than 50% higher than the prevailing rate for individual health policies. If the premium is more than 50% higher, employers and insurers would have to subsidize the difference.

On July 1, 1987, the House Ways and Means Health Subcommittee of Congress voted to include a voluntary risk pool provision as part of its reconciliation package. The provision essentially requires all employers with 20 or more employees, whether they provide

insurance or not or whether they are self-funded, to participate in the pool. Qualified employers who do not participate are subject to a tax penalty equal to 5% of gross wages.

Appendix A - Kansas Insurance Department Bulletin 1986-22 - Including a copy of Substitute for Senate Bill No. 121 and a copy of reporting form for adverse underwriting decisions.

Appendix B - Kansas Insurance Department Adverse Underwriting Report

Appendix C - Letter dated October 14, 1987 from Blue Cross and Blue Shield of Kansas regarding the company's adverse underwriting data.

Appendix D - Kansas Health Insurance Pooling Mechanism.

APPENDIX A

STATE OF KANSAS

KANSAS
INSURANCE DEPARTMENT

420 S.W. 9th
Topeka 66612-1678 913-296-3071

1-800-432-2484
Consumer Assistance
Division calls only

FLETCHER BELL
Commissioner

BULLETIN 1986-22

TO: All Companies Authorized to Transact Accident & Health Business in the State of Kansas

FROM: Fletcher Bell, Commissioner of Insurance
Kansas Insurance Department

SUBJECT: Substitute for Senate Bill No. 121

DATE: June 27, 1986

Enclosed for your reference is a copy of Substitute for Senate Bill No. 121 which was enacted by the 1986 session of the Kansas Legislature and becomes effective July 1, 1986.

Substitute for Senate Bill No. 121 charges the Kansas Insurance Department with gathering data from Accident & Health insurers regarding those Kansas residents receiving declinations of coverage, termination of coverage or offers to insure at higher than standard rates. The information is being gathered as part of a study to determine the feasibility and impact of a residual market mechanism for health insurance.

The type of coverage which is involved is hospital, medical and surgical expense coverage. We do not wish, at this time, to gather data on underwriting review of disability income, overhead expense, other income replacement contracts, specified disease, accident only or Medicare Supplement contracts. We do however, need data reported on both individual and group medical contracts which receive underwriting review of the applicant's or insured person's insurability. Please report only on Kansas residents.

K.S.A. 40-2,112, which has been in effect since July 1, 1981, requires that data concerning adverse underwriting decisions be maintained for at least 60 days following notification to the applicant or insured. This includes all underwriting decisions which have the potential of declination, termination or increasing rates above standard. Therefore, we must assume you are already recording the necessary information.

Enclosed is a copy of the form developed for reporting the various kinds of adverse underwriting decisions specified. The report must be filed with this department, at least monthly, no later than the 15th of the month following the reported month. The period on which the data is to be reported begins July 1, 1986 and ends June 30, 1987. The first report is due August 15, 1986 and the last report is due July 15, 1987.

Instructions for completing the form are numbered to correspond with the line numbers on the form.

1. Company name and address.

2. Date report compiled.

3. Indicate the total number of applicants for medical coverage on which underwriting review was completed. This number should include the person applying, the spouse and any children as long as each person was reviewed for insurability prior to contract issuance. Please do not report applicants on which underwriting review is pending or not yet finalized.

4. Indicate the total number of applicants (See 3 above) who are declined medical coverage as uninsurable.

5. Indicate the total number of applicants who have specific conditions excluded from coverage, as a requirement of contract issuance.

6. Indicate the number of applicants requiring rates higher than standard in order to obtain the medical coverage involved. This total should reflect the number of people rated up, not the number of applications.

7. Indicate the number of applicants requiring exclusion of specific health conditions combined with rates higher than standard as a condition for policy issuance.

8. Indicate the number of existing insureds whose coverage is terminated in the month reported because of benefit utilization reflected by claims experience. This total should reflect the number of people terminated, not the number of contracts.

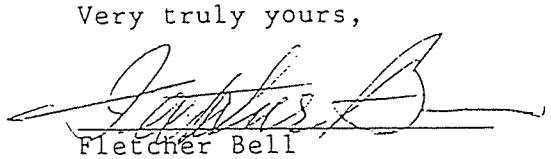
9. Indicate the number of existing insureds whose rates are increased above standard because of benefit utilization reflected by claims experience, as a condition of continued coverage.

If, after reviewing the form and these instructions you have questions, please let us know.

If your company currently does not perform underwriting review on medical, hospital and surgical contracts, or if you do not currently have these kinds of contracts issued in Kansas, please provide written verification to us immediately. In these instances you are not required

to report on a monthly basis. If, in the future, the requirements of this bill become applicable, it is your responsibility to file this form for the duration of the study. All other companies must file the initial report no later than August 15, 1986 and by the 15th of each subsequent month for the duration of the study.

Very truly yours,



Fletcher Bell
Commissioner of Insurance

FB:dbah
Attachments
3098mt

1. _____ 1a. _____
Company Name Date

_____
Address

_____
City, State, Zip Code

2. _____
Month, year reported

3. Number of applicants reviewed _____

4. Number of applicants declined _____

5. Number of applicants requiring exclusion of specific health condition(s) as a requirement of issuance _____

6. Number of applicants requiring rates higher than standard as a requirement of issuance _____

7. Number of applicants regarding exclusion of specific health condition(s) and rates higher than standard as a requirement of issuance _____

8. Number of insureds covered by existing contracts terminated due to claims experience _____

9. Number of persons covered by existing contracts requiring rate increases above standard as a condition of renewal due to claims experience _____

MT:lbah
5746

Substitute for SENATE BILL No. 121

AN ACT concerning insurance; relating to apportionment or assignment of risk for accident and sickness insurance policies; amending K.S.A. 40-2111 and K.S.A. 1985 Supp. 40-19c09 and repealing the existing sections.

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

Section 1. K.S.A. 40-2111 is hereby amended to read as follows: 40-2111. *(a)* Every insurer *authorized to issue a policy of accident and sickness insurance as defined in K.S.A. 40-2201 and amendments thereto or* undertaking to transact in the state of Kansas the kinds of insurance specified in subsection (a), (b) or (c) of K.S.A. 40-901 *and amendments thereto* or subsection (b) or (c) of K.S.A. 40-1102 *and amendments thereto*, and every rating organization which makes rates for such insurance, shall at the discretion of the commissioner of insurance, cooperate in the preparation of and submission to the commissioner *and participate in* a plan or plans for the equitable apportionment among insurers of applicants for insurance who are, in good faith, entitled to such kinds of insurance, or subdivisions or combinations thereof, but who are unable to procure the same through ordinary methods~~: *Provided*, That~~. This section shall not apply to the kinds of insurance specified in K.S.A. 40-2102 and 40-2108 *and amendments thereto*.

(b) Such plan or plans shall provide:

~~(a)~~ *(1)* Reasonable rules governing the equitable distribution of risks, by direct insurance, reinsurance or otherwise, and their assignment to insurers;

~~(b)~~ *(2)* rates and rate modifications applicable to such risks which shall be reasonable, adequate and not unfairly discriminatory;

~~(c)~~ *(3)* the extent of liability which each insurer shall be required to assume; *and*

~~(d)~~ *(4)* a method whereby applicants for insurance, insureds, agents and insurers may have a hearing on grievances and the right of appeal of the commissioner.

For every such plan or plans, there shall be a governing board, to be appointed by the commissioner of insurance, which shall meet at least annually to review and prescribe operating rules, and which shall consist of the following members:

~~(1)~~ *(A)* Seven ~~(7)~~ members who shall be appointed as follows: Three ~~(3)~~ ~~of such~~ members shall be representatives of foreign insurance companies, two ~~(2)~~ members shall be representatives of domestic insurance companies and two ~~(2)~~ members shall be licensed independent insurance agents. ~~Said~~ *Such* members shall be appointed for a term of three ~~(3)~~ years, except that the initial appointment shall include two ~~(2)~~ members appointed for a ~~two (2) year~~ *two-year* term and two ~~(2)~~ members appointed for a ~~one (1) year~~ *one-year* term, as designated by the commissioner; and

~~(2)~~ *(B)* Two ~~(2)~~ members representative of the general public interest, with ~~said~~ *such* members to be appointed for a term of two ~~(2)~~ years.

(c) With regard to accident and sickness insurance, prior to the implementation of a plan under this section: (1) Every insurer shall report to the commissioner at such time as the commissioner may require, on a form prescribed by the commissioner, information concerning each instance of declination of insurance coverage, termination of insurance coverage and offering to insure at higher than standard rates, with respect to the type of insurance proposed to be provided under this section; (2) the commissioner shall report to the governor and to the legislature, no later than the commencement of the 1988 regular session of the Kansas legislature, data obtained under the provisions of this section along with a proposed plan, including an analysis of the cost impact thereof, developed in accordance with this section; (3) the legislature shall have an opportunity to review the data and comment on whether there is a need for implementation of the plan; and (4) approval by the legislature must be obtained.

Sec. 2. K.S.A. 1985 Supp. 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 K.S.A. ~~1984~~ *1985* Supp. 40-2,116 and 40-2,117 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, *40-2111 to 40-2116, 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. 3. K.S.A. 40-2111 and K.S.A. 1985 Supp. 40-19c09 are hereby repealed.

Sec. 4. This act shall take effect and be in force from and after its publication in the statute book.

I hereby certify that the above BILL originated in the SENATE, and passed that body

_____

SENATE concurred in
HOUSE amendments _____

_____
President of the Senate.

_____
Secretary of the Senate.

Passed the HOUSE
as amended _____

_____
Speaker of the House.

_____
Chief Clerk of the House.

APPROVED _____

_____
Governor.

APPENDIX B

KANSAS INSURANCE DEPARTMENT
ACCIDENT & HEALTH DIVISION
BULLETIN 1986-22 REPORTING FORM
ADVERSE UNDERWRITING STUDY REPORT
7/86 TO 6/87

NUMBER OF REPORTS TABULATED	1,615
NUMBER OF APPLICANTS REVIEWED	79,230
NUMBER OF APPLICANTS DECLINED	4,069
NUMBER OF APPLICANTS REQUIRING EXCLUSION OF SPECIFIC HEALTH CONDITIONS AS A REQUIREMENT OF ISSUANCE	9,061
NUMBER OF APPLICANTS REQUIRING RATES HIGHER THAN STANDARD AS A REQUIREMENT OF ISSUANCE	1,957
NUMBER OF APPLICANTS REQUIRING EXCLUSION OF SPECIFIC HEALTH CONDITIONS AND RATES HIGHER THAN STANDARD AS A REQUIREMENT OF ISSUANCE	495
NUMBER OF INSUREDS COVERED BY EXISTING CONTRACTS TERMINATED DUE TO CLAIMS EXPERIENCE	297
NUMBER OF PERSONS COVERED BY EXISTING CONTRACTS REQUIRING RATE INCREASES ABOVE STANDARD AS A CONDITION OF RENEWAL DUE TO CLAIMS EXPERIENCE	1,072

APPENDIX C

Blue Cross
Blue Shield
of Kansas

1133 Topeka Avenue
P.O. Box 239
Topeka, Kansas 66629

October 14, 1987

Richard G. Huncker
Accident and Health Supervisor
Kansas Insurance Department
420 Southwest Ninth Street
Topeka, KS 66614

RE: ADVERSE UNDERWRITING DATA

In response to our conversation of September 28, 1987, we are forwarding the following data in regard to individual underwriting. We hope that this information is helpful.

For the period January 1, 1987 through June 30, 1987, we recorded a total of 9622 applicants in our Non-Group and Farm Bureau categories of business. Or those, a total of 1,897 memberships were ridered for at least one condition.

Of the 1,897 memberships which were ridered, a total of 849 were terminated within sixty-one days of the effective date. A breakdown of the reasons for which those memberships were terminated appears below:

	Reason	Total Number
1)	By request, no reason given	265
2)	Transferred to another membership number	27
3)	Transferred to another group number	21
4)	Changed to another category of business	27
5)	Cancelled due to returned check	2
6)	Cancelled for non-payment of dues	471
7)	Cancelled to commercial coverage	3
8)	Transferred to HMO Kansas	1

USA

In addition to the reasons listed above, we find that 32 memberships which had been cancelled were undergoing reinstatement or other maintenance transactions at the time this data was compiled.

As you will remember, on May 15, 1987, we reported figures for the period July 1, 1986 through December 31, 1986. Of a total of 10,099 applicants, we reported a total of 1,892 memberships which were ridered. Of those ridered memberships, 786 were cancelled within sixty-one days of the effective date.

Compiling that data with data extracted for the period January 1, 1987 to June 30, 1987 results in the following totals for the period July 1, 1986 through June 30, 1987:

Total applicants	-	19,721
Ridered memberships	-	3,789
Cancelled	-	1,635

We hope that this information is helpful. If you have any further questions, please feel free to contact us.

Barbara Casto

BARBARA CASTO, Manager
Special Services
Customer Service Center

TF
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cp50/01o

APPENDIX D

KANSAS HEALTH INSURANCE POOLING MECHANISM

Section 1. Definitions.

1. "Pool" means the Kansas Health Insurance Pool.

2. "Board" means the Board of Directors of the pool.

3. "Insured" means any individual resident of this state who is eligible to receive benefits from any insurer as defined in this section.

4. "Insurer" means any insurance company, health maintenance organization, and non-profit hospital and medical service company authorized to transact business in this state.

5. "Insurance arrangement" means any plan, program, contract or any other arrangement under which one or more employers, unions or other organizations provide to their employees or members, either directly or indirectly through a trust or third party administrator, health care services or benefits other than through an insurer.

6. "Health insurance" means any hospital and medical expense incurred policy, and nonprofit health care service plan contract. The term does not include insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

7. "Medicare" means coverage under both part A and B of Title XVIII of the Social Security Act, 42 USC 1395, et seq as amended.

8. "Physician" may be defined by including the words "duly qualified physician" or "duly licensed physician". An insurer using these terms shall recognize and accept, to the extent of its obligation under the contract, all providers of medical care and treatment when these services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

9. The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

a. be an institution operated pursuant to law; and

b. be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and

c. provide twenty-four (24) hour nursing service by or under the supervision of registered graduate professional nurses (R.N.'s).

The definition of the term "hospital" may state that such term shall not be inclusive of:

a. convalescent homes, convalescent, rest, or nursing facilities; or

b. facilities primarily affording custodial, educational or rehabilitory care; or

c. facilities for the aged, drug addicts or alcoholics; or

d. any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.

10. "Plan of operation" means the plan of operation of the pool, including articles, bylaws and operating rules, adopted by the board pursuant to §2 of this pooling mechanism.

11. "Benefits plan" means the coverages to be offered by the pool to eligible persons pursuant to §6 of this pooling mechanism.

12. "Department" means the Kansas Insurance Department.

13. "Commissioner" means the Kansas Insurance Commissioner.

14. "Member" means all insurers participating in the pool.

Section 2. Operation of the Pool.

1. A non-profit entity to be known as the Kansas Health Insurance Pool, will be established for the purposes of implementing this pooling mechanism. All insurers providing health plan benefits in this state on and after the effective date of this pooling mechanism shall be members of the pool.

2. The Commissioner shall appoint members of the governing board as specified in K.S.A. 40-2111. The Commissioner shall give notice to all insurers of the time and place for the initial organizational meeting.

3. If, within sixty (60) days of the organizational meeting, the administering insurer has not been appointed by the Board, the Commissioner shall appoint an administering insurer.

4. The Board shall submit to the Commissioner a plan of operation for the pool and any amendments thereto necessary or suitable to assure the

fair, reasonable and equitable administration of the pool. The Commissioner shall, after notice and hearing, approve the plan of operation provided such is determined to be suitable to assure the fair, reasonable and equitable administration of the pool, and provides for the sharing of pool gains or losses on an equitable proportionate basis. The plan of operation shall become effective upon approval in writing by the Commissioner consistent with the date on which the coverage under this pool mechanism must be made available. If the pool fails to submit a suitable plan of operation within 180 days after the appointment of the board of directors, or at any time thereafter fails to submit suitable amendments to the plan, the Commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this section. Such rules shall continue in force until modified by the Commissioner or superseded by a plan submitted by the pool and approved by the Commissioner.

5. In its plan the Board shall,

   a. Establish procedures for the handling and accounting of assets and monies of the pool.

   b. Select an administering insurer in accordance with §4 of this pooling mechanism.

   c. Establish procedures for the collection of assessments from all members to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made. The level of payments shall be established by the board, pursuant to §5 of this pooling mechanism. Assessment shall occur at the end of each calendar year. Assessments are due and payable within 30 days of receipt of the assessment notice.

   d. Develop and implement a program to publicize the existence of the plan, the eligibility requirements, and procedures for enrollment, and to maintain public awareness of the plan.

6. Powers and Authority of the pool. The pool shall have the specific authority to:

   a. Enter into contracts as are necessary or proper to carry out the provisions and purposes of this pooling mechanism, including the authority, with the approval of the Insurance Commissioner, to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

   b. Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against pool members;

c. Take such legal action as necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

d. Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas and any other actuarial function appropriate to the operation of the pool. Rates shall not be unreasonable in relation to the coverage provided, the risk experience and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claims costs and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices.

e. Assess members of the pool in accordance with the provisions of this section, and to make advance interim assessments as may be reasonable and necessary for the organizational and interim operating expenses. Any such interim assessments to be credited as offsets against any regular assessments due following the close of the fiscal year.

f. Issue policies of insurance in accordance with the requirements of this pooling mechanism.

g. Appoint from among members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design, and any other function within the authority of the pool.

h. Establish rules, conditions and procedures for reinsuring risks of pool members desiring to issue pool plan coverages in their own name. Such reinsurance facility shall not subject the pool to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers.

Section 3. Eligibility.

1. Any individual person, who is a resident of this state shall be eligible for pool coverage, except the following:

a. persons who have on the date of issue of coverage by the pool, coverage under health insurance or an insurance arrangement.

b. any person who is at the time of pool application eligible for health care benefits under any state Medicaid law.

c. any person having terminated coverage in the pool unless twelve months have lapsed since such termination.

d. any person on whose behalf the pool has paid out $1,000,000 in benefits.

e. inmates of public institutions and persons eligible for public programs.

2. Any person who ceases to meet the eligibility requirements of this section may be terminated at the end of the policy period.

3. Any person whose health insurance coverage is involuntarily terminated for any reason other than nonpayment of premium and who is not eligible for conversion, may apply for coverage under the plan. If such coverage is applied for within 60 days after the involuntary termination and if premiums are paid for the entire coverage period, the effective date of the coverage shall be the date of termination of the previous coverage.

Section 4. Administering Insurer.

1. The board shall select an insurer or insurers through a competitive bidding process to administer the pool. The board shall evaluate bids submitted based on criteria established by the board which shall include:

   a. The insurer's proven ability to handle individual accident and health insurance.

   b. The efficiency of the insurer's claim paying procedures.

   c. An estimate of total charges for administering the plan.

   d. The insurer's ability to administer the pool in a cost efficient manner.

2. a. The administering insurer shall serve for a period of three (3) years subject to removal for cause.

   b. At least 1 year prior to the expiration of each 3 year period of service by an administering insurer, the board shall invite all insurers, including the current administering insurer, to submit bids to serve as the administering insurer for the succeeding 3 year period. Selection of the administering insurer for the succeeding period shall be made at least 6 months prior to the end of the current 3 year period.

3. a. The administering insurer shall perform all eligibility and administrative claims payment functions relating to the pool.

   b. The administering insurer shall establish a premium billing procedure for collection of premium from insured persons. Billings shall be made on a periodic basis as determined by the board.

c. The administering insurer shall perform all necessary functions to assure timely payment of benefits to covered persons under the pool including:

1. Making available information relating to the proper manner of submitting a claim for benefits to the pool and distributing forms upon which submission shall be made.

2. Evaluating the eligibility of each claim for payment by the pool.

d. The administering insurer shall submit regular reports to the board regarding the operation of the pool. The frequency, content, and form of the report shall be as determined by the board.

e. Following the close of each calendar year, the administering insurer shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the board and the department on a form as prescribed by the Commissioner.

f. The administering insurer shall be paid as provided in the plan of operation for its expenses incurred in the performance of its services.

Section 5. Assessments.

1. Following the close of each fiscal year, the pool administrator shall determine the net premiums (premiums less administrative expense allowances), the pool expenses of administration and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. Health insurance premiums that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments.

a. Each insurer's assessment shall be determined by multiplying the total cost of operation by a fraction the numerator of which equals that insurer's premium and subscriber contract charges for health insurance written in the state during the preceding calendar year and the denominator of which equals the total of all premiums, subscriber contract charges written in the state during the preceding calendar year.

2. If assessments exceed actual losses and administrative expenses of the pool, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" include reserves for incurred but not reported claims.

3. a. Each member's proportion of participation in the pool shall be determined annually by the board based on annual financial

statements and other reports deemed necessary by the board and filed by the member with it.

b. Any deficit incurred by the pool shall be recouped by assessments apportioned under subsection (1) of this section by the board among members.

4. The board may abate or defer, in whole or in part, the assessment of a member if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. In the event an assessment against a member is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in subsection (1) of this section. The member receiving such abatement shall remain liable to the pool for the deficiency for 4 years.

Section 6. Minimum Benefits - Availability.

1. The pool shall offer major medical expense coverage to every eligible person who is not eligible for Medicare. Major medical expense coverage offered by the pool shall pay an eligible person's covered expenses, subject to limits on the deductible and coinsurance payments authorized under paragraph (4)(d) of this section, up to a lifetime limit of $1,000,000 per covered individual. The maximum limit under this paragraph shall not be altered by the Board, and no actuarial equivalent benefit may be substituted by the Board.

2. Covered Expenses -- Covered expenses shall be the prevailing charge in the locality for the following services and articles when prescribed by a physician and determined by the pool to be medically necessary.

a. Hospital services.

b. Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than mental or dental, which are rendered by a physician, or by other licensed professionals at his direction.

c. Drugs requiring a physician's prescription.

d. Services of a licensed skilled nursing facility for not more than 120 days during a policy year.

e. Services of a home health agency up to a maximum of 270 visits per year.

f. Use of radium or other radioactive materials.

g. Oxygen.

h. Anesthetics.

i. Prostheses other than dental.

j. Rental of durable medical equipment, other than eyeglasses and hearing aids, for which there is no personal use in the absence of the condition for which is prescribed.

k. Diagnostic X-rays and laboratory tests.

l. Oral surgery for excision of partially or completely unerupted, impacted teeth or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

m. Services of a physical therapist.

n. Transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition.

o. Services for diagnosis and treatment of alcoholism, drug abuse or nervous or mental conditions shall be covered in the manner prescribed in K.S.A. 40-2,105.

3. Exclusions -- Covered expenses shall not include the following:

a. Any charge for treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or a congenital bodily defect to restore normal bodily functions.

b. Care which is primarily for custodial or domiciliary purposes.

c. Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician.

d. That part of any charge for services rendered or articles prescribed by a physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality or for any charge not medically necessary.

e. Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual providing the services or articles.

f. Any expense incurred prior to the effective date of coverage by the pool for the person on whose behalf the expense is incurred.

g. Dental care except as provided in subsection (3)(1) of this section.

h. Eyeglasses and hearing aids.

i. Illness or injury due to acts of war.

j. Services of blood donors and any fee for failure to replace the first 3 pints of blood provided to an eligible person each policy year.

k. Personal supplies or services provided by a hospital or nursing home, or any other nonmedical or nonprescribed supply or service.

4. Premiums, Deductibles, and Coinsurance.

a. Premiums charged for coverages issued by the pool may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage.

b. Separate schedules of premium rates based on age, sex, and geographical location may apply for individual risks.

c. The pool shall determine the standard risk rate by calculating the average individual standard rate charged by the five largest insurers offering coverages in the state comparable to the pool coverage. In the event five insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Initial rates for pool coverage shall not be less than 150% of rates established as applicable for individual standard risks. Subsequent rates shall be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein. In no event shall pool rates exceed 200% of rates applicable to individual standard risks. All rates and rate schedules shall be submitted to the Commissioner for approval.

d. The pool coverage defined in Section 6 shall provide optional deductibles of $1,500 or $3,500 per annum per individual, and coinsurance of 20%, such coinsurance and deductibles in the aggregate not to exceed $5,000 per individual nor $7,500 per family per annum. The deductibles and coinsurance factors may be adjusted annually according to the Medical Component of the Consumer Price Index.

5. Pre-Existing Conditions.

Pool coverage shall exclude charges or expenses incurred during the first twelve months following the effective date of coverage as to any condition, which during the six month period immediately preceding the effective date of coverage, (i) had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment or (ii) for which medical advice, care or treatment was recommended or received. Such pre-existing condition exclusions shall be waived to the extent to which similar exclusions, if any, have been

satisfied under any prior health insurance coverage which was involuntarily terminated; provided, that application for pool coverage is made not later than thirty-one (31) days following such involuntary termination and, in such case, coverage in the pool shall be effective from the date on which such prior coverage was terminated.

6. Nonduplication of Benefits.

Benefits otherwise payable under pool coverage shall be reduced by amounts paid or payable through any other health insurance, or insurance arrangement, and by all hospital and medical expense benefits paid or payable under any worker's compensation coverage, automobile medical payment and by any hospital or medical benefits paid or payable under or provided pursuant to any state or Federal law or program except Medicaid.

Section 7. Complaint and Grievance Procedure.

1. Purpose. The Pool recognizes that from time to time participants may encounter situations where the performance of the Pool does not meet their expectations. When this occurs, the participant may wish to call the matter to the attention of the Board of Directors of the Pool. It is the policy of the Pool to promptly and fairly consider all complaints and grievances of its participates. The procedure outlined in this Section is established to define and assure this policy.

2. Definitions. For the proposes of this Complaint and Grievance Section, the following terms and their definitions apply:

a. Complaint means a relatively minor verbal or written expression of concern about a condition in the Pool's operation which may be resolved on an informal basis.

b. Grievance means a more serious written expression of concern about the Pool's operation or a complaint which has not been resolved to the participant's satisfaction. Both situations require a formal response by the Pool, including a thorough investigation and appropriate answer to the participant.

c. Participant means applicants for insurance, insureds, agents and insurers.

3. Procedure for Filing a Complaint or Grievance.

a. A complaint may be directed to the Pool by the Participant by telephone, in person, or in writing expressing the details of the participant's concern. Complaints will be handled by the Pool complaint/grievance coordinator who may involve other staff members of the Pool or providers of care in making the determination. The objective is to handle the complaint as quickly and as courteously as possible. If the participant does not receive prompt resolution, or wishes to express his

concern to a higher level of authority, he may file a written grievance with the Pool.

b. A grievance is to be submitted to the Pool by completing the Grievance Form available from the Pool's office. This form should be filed within 90 days after the incident occurred. The participant must sign the form acknowledging that all incidents are accurately described.

Upon receipt of the Grievance Form, the Pool will conduct a thorough review of the situation. A response to the participant's grievance will be prepared and the participate will be notified of the Pool's decision in writing. If the solution is satisfactory, the matter ends.

If the solution is not satisfactory to the participant, he may within 30 days submit a written request for review by the Grievance Committee of the Board of Directors of the Pool. The request for review must state the participant's reason for appeal, including his reason for dissatisfaction with the first grievance response. The Committee will be convened within 30 days after receipt of the appeal. The participant who submitted the appeal will be invited to appear before the Committee to explain his position. The Committee will review all previous findings of the Pool. The participant will be notified of the Committee's decision within 15 days after the date of the Committee review.

c. If any party involved is not satisfied with the decision of the Board of the Pool or its committee, he may pursue normal remedies of law including a right of appeal to the Commissioner of Insurance. Prior to the institution of any legal proceeding or suit against the Pool the foregoing "Complaint" and "Grievance" procedure shall be utilized by any party alleging a claim against the Pool. In all events, such suit or proceeding must be commenced not later than five (5) years after the date the notice of final determination under the grievance procedure is transmitted to such party.

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