Approved February 10, 1988
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by Sen. Neil H. Arasmith (Chairperson) at 9:00 a.m./~~p.m.~~ on February 9, 1988 in room 529-S of the Capitol.

All members were present except:

Committee staff present:

Bill Wolff, Legislative Research
Bill Edds, Revisor of Statutes

Conferees appearing before the committee:

Ron Todd, Kansas Insurance Dept.
Meyer Goldman, Kansas HMO Association
Jack Roberts, Blue Cross/Blue Shield

The minutes of February 3 were approved.

The hearing began on SB 537 dealing with health maintenance organizations (HMOs). Ron Todd, Kansas Insurance Department, testified in support of the bill. (See Attachment I.)

The chairman noted tht the list of requirements to be filed with the comis-sioner's office on page two of the bill includes several that are based on projections and asked if this is common. Mr. Todd answered that it is common and that this puts in writing what must be done to determine fiscal solvency. The chairman asked further for a definition of "unaudited financial statements" as it appears on line 65. Mr. Todd said these statements have not been audited by a CPA, but they give more information closer to the time being considered. The chairman had a final question as to page six as to a definition of "average monthly uncovered expenditures". Mr. Todd said this is a term defined in the HMO legislation and that it is a part of the estimated expenditure that could be left with the enrollee to pay in case of insolvency.

With regard to line 211, Sen. Karr asked why there was a big change--from $10,000 to $150,000. Mr. Todd said that this was proposed by the HMOs. He added that it was low in order to help the formation and operation of HMOs. The chairman added that also it is because HMOs have grown in size, and the financial backing is better than when they were first organized to which Mr.Todd agreed.

Staff questioned the wording on line 206 as to how the first option can ever be viable when you have the second. The wording has been changed so that it reads 5% of the same thing or twice the same thing which in reality is one option. Mr. Todd said he would leave comments on this to the conferee from HMOs. Staff also noted that Matt Lynch of the judicial branch had questioned why the language on lines 142 through 152 had been inserted. The lanuage had been deleted when the Administrative Procedures Act was passed. The inclusion of these lines will not hurt anything, but they are not necessary. Mr. Todd said this was suggested by the HMOs and agreed that they do not add anything.

Meyer Goldman, Kansas HMO Association, testified in support of SB 537. (See Attachment II.) The chairman questioned the deletion of "health care services for" on line 207. Mr. Goldman agreed that this deletion changed the intent and that it is redundant. He has no objection to going back to the original language. Staff asked if it is possible for HMOs to have uncovered expenditures other than for health care services, and Mr. Goldman siad it would be possible when they are just starting. Sen. Werts asked what the difference is between "average monthly uncovered expenditures" and "uncovered expenditures". Mr. Todd said this is found in the definition section. Staff informed the

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

committee that "uncovered expenditures" covers only the cost of health care services. With this, the hearing on SB 537 was concluded.

The hearing began on SB 538 concerning conversion coverage for Blue Cross/Blue Shiled. Ron Todd testified in support of the bill. (See Attachment III.) Staff asked if other companies can offer the same option as this one, and Mr. Todd said they can offer a very similar option.

Jack Roberts, Blue Cross/Blue Shield, testified in support of SB 538. He said BC/BS has offered this for some time and, therefore, he has no objections. The chairman asked how it has been offered if it has not been in the law. Mr. Roberts clarified that it can be offered now, but this bill requires them to offer it.

On a call for action on SB 538, Sen. Gordon made a motion that SB 538 be reported favorable for passage, Sen.Gannon seconded, and the motion carried.

Attention was returned to SB 537. Mr. Todd said the Department would need some time to work on the language regarding "uncovered expenditures". Staff said this is a defined term, but previously there were three alternatives. A discussion followed regarding the defined term. Sen. Werts asked that staff draft subsection (b) to standard KAPA language to eliminate any confusion. Staff noted that these lines can be deleted, and then it would automatically come under KAPA.

Sen. Werts made a motion to strike Section 2, Sen. Karr seconded, and the motion carried.

Mr. Todd said the Department would work on line 206. The chairman said the committee may not be able to get back to it at tomorrow's meeting, but it will if possible.

The meeting was adjourned.

SENATE COMMITTEE

ON

FINANCIAL INSTITUTIONS AND INSURANCE

OBSERVERS
(Please print)

DATE	NAME	ADDRESS	REPRESENTING
9 Feb	Rosa Ray Goldman	KCMO	
	Maysu L. Goldman	KCMO	Kansas HMO Association
	Ron Todd	Topeka	Ins. Dept.
	Jack Roberts	"	BC-BS
	L M Cornish	"	Ks Assn P/C Cos
	Jim Hola	Wichita	Ks C.U. League
	Harry Humphrey	Topeka	KMHA
	Amy Apitz	Topeka	KMHA
	John Peterson	Topeka	Kaiser Permanente
	Larry Magill	"	IIAK

Explanatory Memorandum For
Legislative Proposal No. 3 — SB 537

The statutes governing the formation, operation and regulation of health maintenance organizations (HMO's) were first enacted in 1974 and are found in Article 32 of Chapter 40, Kansas Statutes Annotated. With few exceptions, these statutes have not been materially changed since their enactment even though HMO's have evolved so they have different organizational structures, different backgrounds, different profit motives and so forth. Legislative Proposal No. 3 was primarily developed by the Kansas HMO Association to clarify provisions of existing law that are lacking in specificity such as documentation of fiscal solidity. Also such clarification will result in the removal of inconsistencies that result from differing HMO organizational structures, specifically staff or group model as opposed to independent practice associations. In addition, the minimum deposit requirements for new and existing HMO's has been increased from $10,000 to $150,000 with a transition period provided to facilitate compliance.

Attachment I

M E Y E R L . G O L D M A N

444 Westover Road, Kansas City, Missouri 64113 816 361-3928

Testimony on Senate Bill 537, 9 February 1988

On Behalf of Kansas HMO Association

I am Meyer L. Goldman, of Prime Health, Kansas City, a health maintenance organization serving more than 20,000 Kansas residents. I am also secretary-treasurer of the Kansas HMO Association, an organization of 12 health maintenance organizations with more than 200,000 subscribers in the state.

I want to express the Association's wholehearted support of Senate Bill 537, a measure that strengthens and brings up to date Kansas statutes governing health maintenance organizations. We believe the proposal will give additional protection to those Kansans who choose our form of health care delivery, increase the stability of a growing industry, and thereby contribute to efforts to control escalating health care costs through effective, constructive competition among providers.

Attachment II

SB 537 amends the original Kansas HMO Act, adopted a number of years ago under circumstances different from today. At that time HMOs were new to our region: Prime Health, the first HMO serving Kansans, began operating in 1976. It was the 23rd HMO in the United States to receive Federal Qualification.

The number of HMOs in Kansas is increasing, and the number of their subscribers has grown each year, usually by double-digit proportions.

HMOs today take many different forms, some of which did not exist in 1976. HMOs have certain things in common: all of them provide direct health care rather than reimbursement for expenditures. Most of them provide substantially more comprehensive services than indemnity plans, and by their nature share the subscriber's interest in maintenance of good health and early detection of conditions before they become serious. All of them require subscribers to use selected providers. Their operations are monitored: by the state, and by the Federal Government for those Federally qualified or with Medicare contracts.

They differ widely in their structure. Some offer services through HMO-operated health care centers, using physicians who are full-time employees of the HMO, or who comprise a medical group that contracts with the HMO. Others provide services in the offices of the affiliated physicians. The first are known as staff

or group model HMOs. The second are known as Independent Practice Associations (IPAs.)

SB 537 recognizes the differences in these methods of operation, and provides effective and workable regulation of all types. It clarifies the regulation to assure financial stability of HMOs, and increases the statutory requirement for deposit of funds to assure payment of expenses.

The bill provides an orderly method for appeal and review of decisions of the Commissioner of Insurance pertaining to denial, suspension or revocation of a certificate to operate in Kansas, and adds provisions to clarify the contracts between HMOs and their subscribers, for the subscribers' protection.

The changes are not radical, but I believe they are important. Our association urges their adoption. Thank you for this opportunity to testify. I will be glad to try to answer any questions you may wish to ask.

Explanatory Memorandum For Legislative Proposal No. 6 SB 538

This proposal would require all mutual nonprofit hospital and medical service corporations doing business in this state to offer an additional conversion option to persons who are terminated from a group accident and sickness contract. The conversion option presently required entitles terminated group members to adequate coverage but the cost is quite high. The additional option that would be required by enactment of Legislative Proposal No. 6 would still permit the terminated group members to obtain meaningful insurance protection but the deductible and copayment provisions would enable them to do so at a lower cost.

Attachment III