Approved March 2, 1988
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

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

9:00 a.m./~~p.m.~~ on March 1, 1988 in room 529-S of the Capitol.

All members were present except:

Sen. Gannon - Excused

Committee staff present:

Bill Wolff, Legislative Research
Bill Edds, Revisor of Statutes

Conferees appearing before the committee:
Sen. James Francisco
Debbie Hinnen, American Diabetes Association
Christine Clarkin, American Diabetes Association
Ron Doole, American Diabetes Association
Bob Cochrane, American Diabetes Association
Sheryl Bussell, Board member of Diabetes Association
Ron Todd, Kansas Insurance Department
Bud Cornish, Kansas Life Association

The minutes of February 29 were approved.

The hearing began on SB 670 relating to accident and sickness insurance, concerning apportionment of assignment of risk and authorizing an offset against the premium tax of certain insurers. Sen. James Francisco testified in support of the bill which had been introduced at his request. He said the bill would allow a state insurance pool risk for individuals who do not have adequate access to health care insurance. He applauded the committee for its efforts in the past in the same area. He said at least eleven other states have pool risks and that he has a great deal of information on this. He had several pass outs for the committee to verify his testimony. (See Attachments I through VI.)

Debbie Hinnen, a diabetes nurse and representing the American Diabetes Association, testified in support of SB 670. (See Attachment VII.)

Christine Clarkin, a health professional in the field of diabetes and a volunteer for the American Diabetes Association, followed in support of SB 670. (See Attachment VIII.)

Ron Doole, a diabetic with the American Diabetes Association, followed with testimony in support of the bill. He said diabetes is not an observable problem in individuals, but none the less, important. This bill is an opportunity to take it away from numbers and put in people. There are people who cannot afford to treat their diabetes and, therefore, let it go which results in health problems. This bill will address this situation.

Bob Cochrane, American Diabetes Association, followed with further testimony in support of the bill. (See Attachment IX.)

Sheryl Bussell, an attorney from Iola and a member of the board of the American Diabetes Association, gave her support to the bill. She told the committee that she is a mother of a diabetic person and understands the need for the bill. She also teaches Kansas History and emphasizes to her students that Kansas has been progressive in many areas. She would ask in considering SB 670 that Kansas take the lead, as have several other states, and allow the Commissioner to set up this plan. She emphasized that his is not a piece of social legislation. It is not for indigents but for people who could afford insurance but cannot get it. As a mother of a diabetic she has encountered this availability problem many times.

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.

Ron Todd, Kansas Insurance Department, followed with testimony to inform the committee of the background. (See Attachment X.) He called attention to the fact that the language on the first page of the bill is existing law. He noted that the "plan" in line 78 is explained in Appendix D of his pass out. He said there are two methods of paying: (1) the state pays directly or (2) the company pays for it, but any losses on it can be offset on their annual premium. The purpose of SB 670 is to add new language on page 3 that would give the insurer the right to credit any losses against the premium tax. He then noted that, technically, new language is needed on the second sentence on line 85. As to the estimated cost of the bill, it is difficult to estimate because the Department does not know how many people will take out the plan or how many losses there will be. Their statistics show that out of 79,000 applications received, 17,000 were declined. Based upon this, if 17% (3000) of the people would come into the plan with the worst loss ratio of 150%, the cap might be $4,000,000, but he feels it will be more like $1,000,000. Mr. Todd said that it is clear that there is a need for this type of risk pool and suggested that if the committee approves the plan, there should be a resolution approving the plan rather than working the bill.

The Chairman asked if this is for individual policies and not group policies, and if the bill of yesterday excluding persons from group policies would have an affect on SB 670. Mr. Todd siad that it is just for individuals and that the other bill will not affect SB 670 except it will cut down the number of people looking for a market.

Bud Cornish, Kansas Life Association, testified to express his industry's concern regarding the language on lines 82-90 concerning the offset of the premium tax. He said the language needs clarifying work. Also, lines 63-81 indicate that the legislature was to have approval, but Mr. Cornish wondered how the legislature is going to state this approval. Mr. Cornish concluded by saying that his industry has great concerns about the mechanism of the bill with regard to the servicing carrier created and the companies being assessed what they need. He feels the offset on the premiums will be the actual fiscal cost of the bill.

With reference to page 3 of the Appendix dealing with the AIDS epidemic, Sen. Reilly asked if this is included in alternative 1 and if so, what projections are made here. Mr. Todd said AIDS is not specifically addressed, but inherent in the proposal is that it is a catastrophic plan, and they have a bill where preexisting conditions are not covered so this acts as an insulation against AIDS patients. Sen. Reilly asked further if AIDS is not included in Mr. Todd's forecast of the worst condition. Mr. Todd said the Department was trying to consider all losses that might occur. Debbie Hinnen said she has statistics on AIDS.

The Chairman asked if this is similar to automobile assigned risk plans whereby an individual can apply to the Insurance Commissioner through his agent, and the Commissioner's office would assign the risk to some company. Mr. Todd said that basically it is. Probably there will be only one serving carrier who would process it under SB 670 which makes it simpler insofar as keeping records.

The Chairman asked that the Insurance Department work on the plan and get the language to the committee as soon as possible as time is running short for working bills.

There being no further time, the meeting was adjourned.

SENATE COMMITTEE

ON

FINANCIAL INSTITUTIONS AND INSURANCE

OBSERVERS
(Please print)

DATE	NAME	ADDRESS	REPRESENTING
3-1-88			
	Rick Hunecker	420 SW 9th Topeka	KS Ins. Dept.
	Bob Cochrane	3210 E. Douglas, Wichita	Am. Diabetes Assn
	John Peterson	Topeka	Kaiser Permanente
	Sheryl A. Bussell	315 So. Washington Iola Ks	Am. Diabetes Assoc.
	Debbie Heinen	RR1 Box 135 B Augusta Ks.	Am. Diabetes Assoc
	Ken Doole	4706 W 17 St Topeka Ks.	Am. Diab. Assn,
	Christine Clarkin	1272 Medford Topeka	Am. Diab. Assoc.
	Cheryl Dillard	Kansas City	Kansas HMO Assoc.
	Jack Roberts	Topeka	BC-BS
	Wm. Pitsenbergen	"	"
	LM Cornish	"	Ks Life Assn
	Jim Yonker	Topeka	Observer

MEMORANDUM #5

AN ANALYSIS OF STATE EXPENSES ASSOCIATED WITH HIGH-RISK POOLS

High-risk pools are attractive to states (and to the federal government as well), because administrative and financial responsibility rests entirely with the participating insurance carriers. In an era when "privatization" is being advocated, and there is a perception that private management can be more efficient and less politically motivated than public programs, high-risk pools appear to offer a viable solution to the problem of uninsurance among chronically ill children.

Operational state pools, however, have not been self-supporting through premium income. This memorandum explores the reasons for the financial losses that have been incurred in various state programs and examines how existing state high-risk pools actually have been financed. It also considers alternative mechanisms for financing inevitable deficits that result from the capped premiums extended to make the insurance affordable for the average American family. It addresses four questions:

- What has been the financial experience of the operating pools?
- What have been the costs incurred by states with high-risk pool laws in effect?
- Is there a rationale for states to finance high-risk pools?
- What strategies exist for reducing pool losses?

Attachment I

A. WHAT HAS BEEN THE FINANCIAL EXPERIENCE OF THE OPERATING POOLS?

In theory, financing for high-risk pools is expected to come from premiums. Yet, in practice, claims pay-outs have exceeded premium revenues, losses to the pools have been significant, and members have had to be assessed annually. This is because of the adverse selection of individuals insured by the pools and the fact that states have sought to minimize financial barriers to enrollment by capping premium amounts.

With the exception of Connecticut's Blue Cross/Blue Shield pool, which includes many standard risk individuals, none of the high-risk insurance pools with any experience have been financially self-sufficient. After an initial start-up period, they usually have charged enrollees the maximum premium price permitted under state law and still have had to assess member insurers each year in order to underwrite losses. Assessments, although small, have been required by most pools even during their first year of operation.

While assessments may cover administrative costs that are not contributed in-kind, they primarily reflect the amount of claims expense that could not be financed from premiums. Rarely has the ratio of claims payments to premium income (usually expressed in terms of claims as a percentage of premiums) been favorable for risk pools (see Table 5.1). During the first few

Table 5.1

FINANCIAL EXPERIENCE OF HIGH-RISK POOLS

States with Operational Pools(1)	Enrollees	Claims Pay-Out Ratio	Amount Assessed Pool Members	Lost State Revenue(2)	Indirect State Cost Per Case
Connecticut					
1. Commercial pool					
1977	N/A	37	1,353	--	--
1978	N/A	72	30,441	--	--
1979	N/A	103	(3,079)	--	--
1980	N/A	100	6,977	--	--
1981	N/A	101	254,066	--	--
1982	N/A	102	403	--	--
1983	4,399	113	236,450	--	--
1984	3,479	118	577,366	--	--
1985	3,388	145	1,307,852	--	--
1986	3,101	119	1,490,387	--	--
2. Blue Cross/ Blue Shield(3)					
1977	2,501	79	--	--	--
1978	3,825	60	--	--	--
1979	5,039	77	--	--	--
1980	7,669	59	--	--	--
1981	12,646	66	--	--	--
1982	19,019	116	--	--	--
1983	27,122	100	--	--	--
1984	34,062	88	--	--	--
Florida					
1984	382	28	0	0	0
1985	651	194	0	0	0
1986	865	101	0	0	0
Indiana					
1982	41	9	53,300*	53,300	1,300
1983	2,288	108	10,601	10,601	5
1984	3,510	127	134,077	134,077	38
1985	3,276	168	3,349,079	3,340,079	1,020
1986	3,229	174	N/A	N/A	N/A

Table 5.1

FINANCIAL EXPERIENCE OF HIGH-RISK POOLS
(CONTINUED)

States with Operational Pools(1)	Enrollees	Claims Pay-Out Ratio	Amount Assessed Pool Members	Lost State Revenue(2)	Indirect State Cost Per Case
Minnesota					
1977	N/A	145	N/A	N/A	N/A
1978	N/A	136	N/A	N/A	N/A
1979	N/A	202	N/A	N/A	N/A
1980	N/A	188	N/A	N/A	N/A
1981	2,918	219	1,000,000	1,000,000	343
1982	4,250	194	3,000,818	3,000,818	706
1983	6,669	171	3,487,532	3,487,532	523
1984	9,158	152	4,795,971	4,795,071	524
1985	10,139	140	5,507,000	5,507,000	543
1986	10,439	176	9,024,228	--	--
North Dakota					
1982	78	141	49,862	49,862	639
1983	245	250	229,483	229,483	937
1984	615	232	605,367	605,367	984
1985	983	191	600,00	600,000	610
1986	1,131	217	1,527,000	1,527,000	1,350
Wisconsin					
1981	309	29	100,000	--	--
1982	977	185	1,300,000	--	--
1983	1,798	200	2,000,000	--	--
1984	1,918	149	1,700,000	--	--
1985	1,919	126	0	--	--
1986	1,965	106	N/A	--	--

N/A = Not available.

(1) Data are shown for the first year in which pool was operational for at least six months.

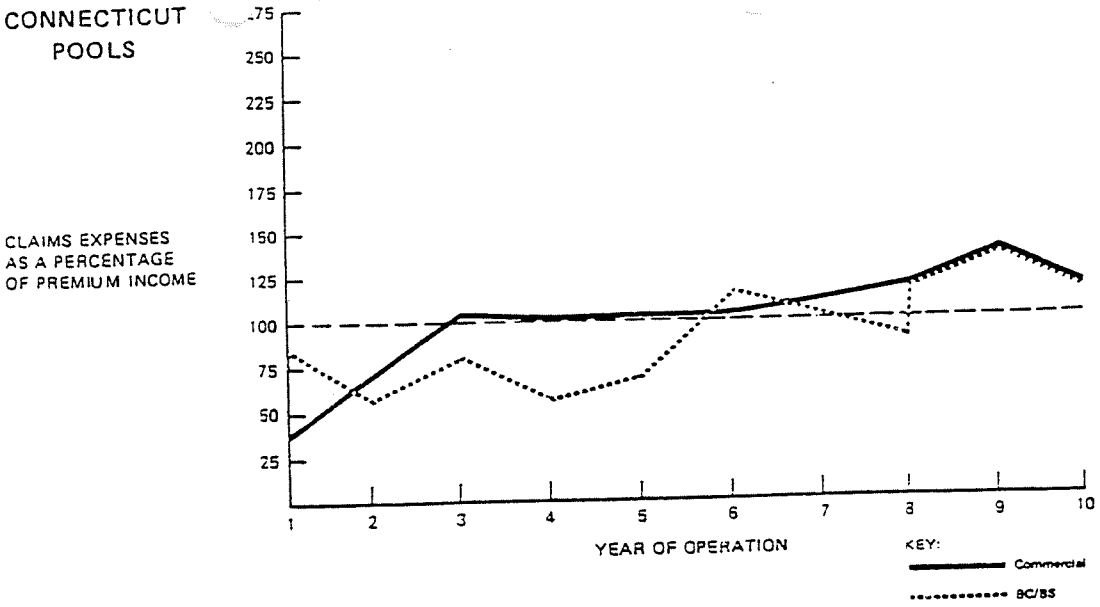
(2) From the outset, Connecticut and Wisconsin did not permit a tax credit to offset the amount of an insurer's assessment. In 1986, Minnesota discontinued its original tax credit provision.

(3) In September 1984, Blue Cross/Blue Shield of Connecticut converted to a mutual insurance company and the two existing pools were closed to new enrollees. The current pool includes both the commercial insurers and the Blue Cross/Blue Shield Plan. It is technically a new entity but actually is administered by the same carrier that administered the commercial pool.

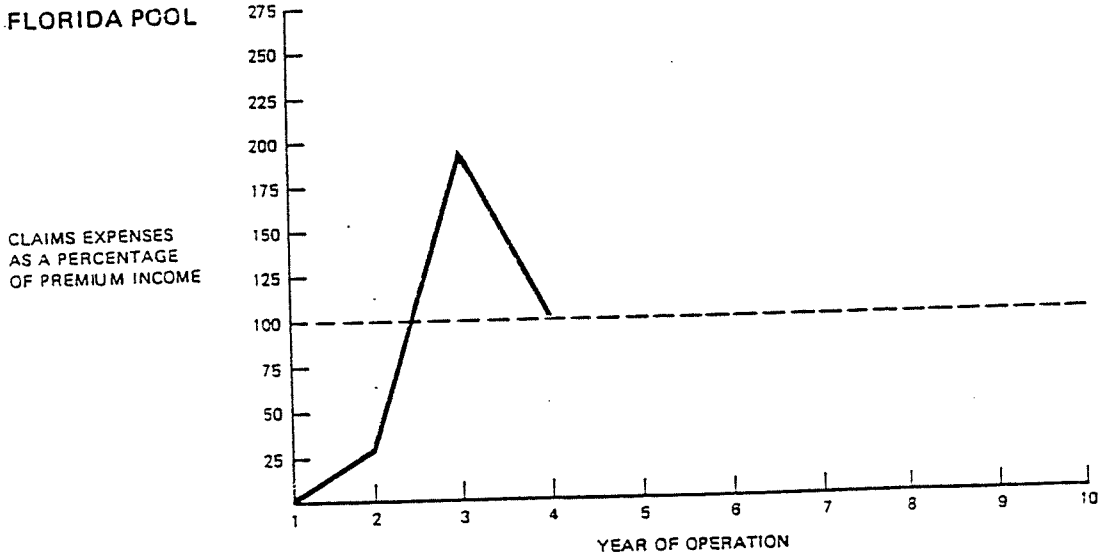
Source: Fox Health Policy Consultants, based on state pool annual reports and telephone and written communications with pool administrators and state insurance commission staff in May and June of 1987.

Figure 1

CONNECTICUT POOLS



FLORIDA POOL



INDIANA POOL

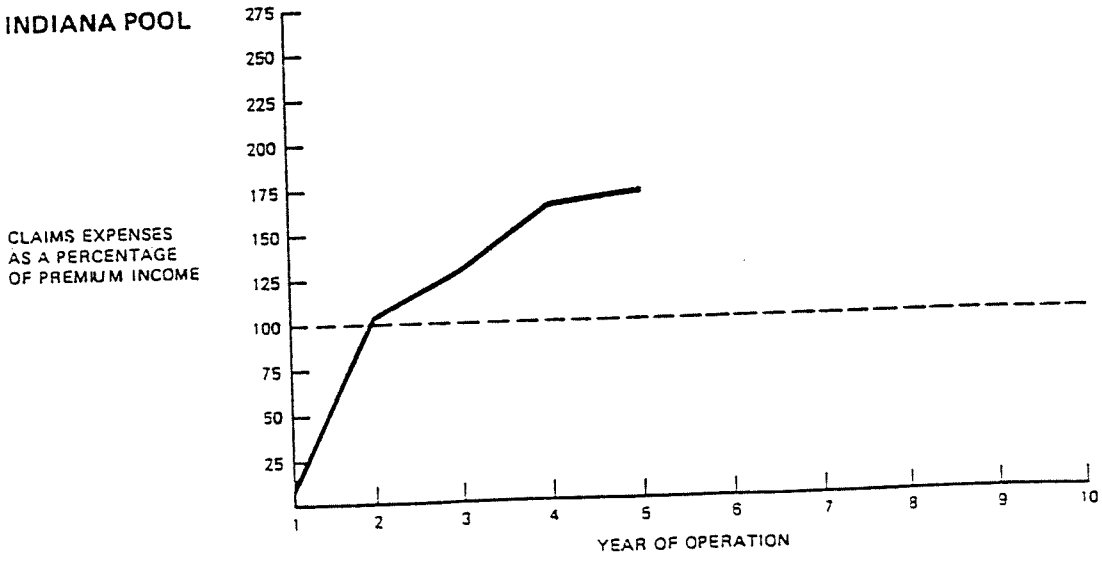
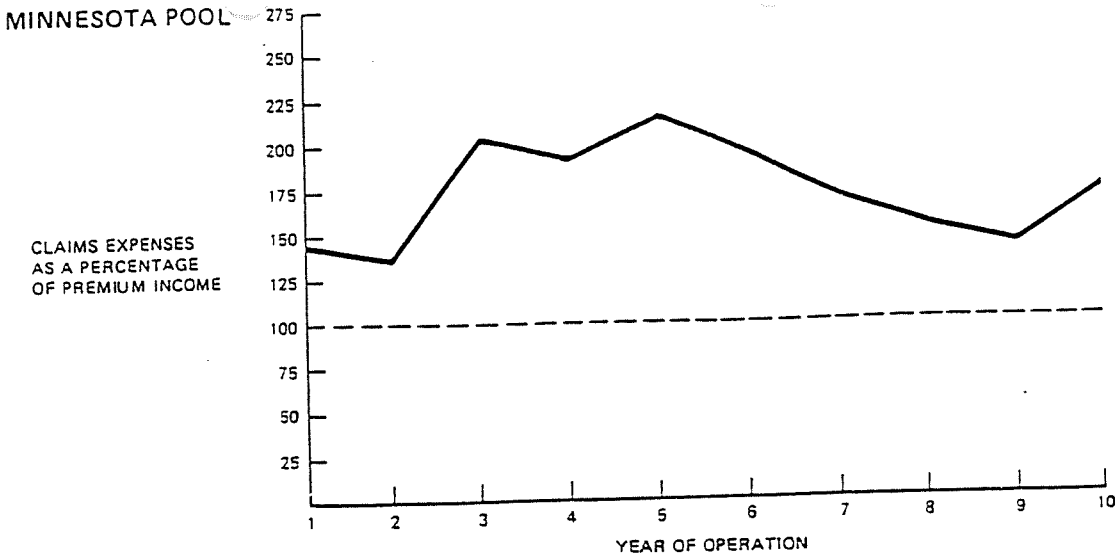
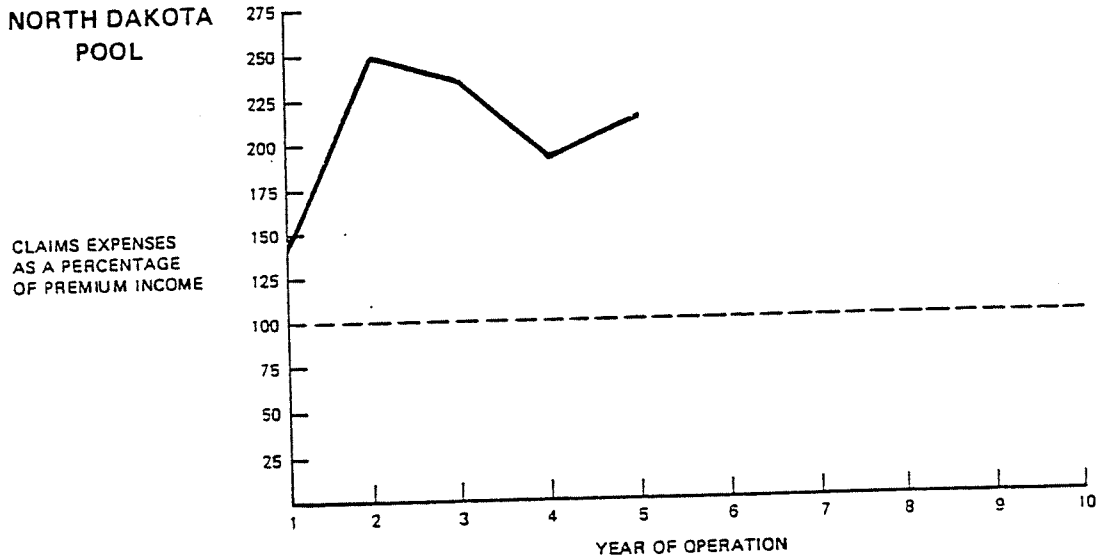
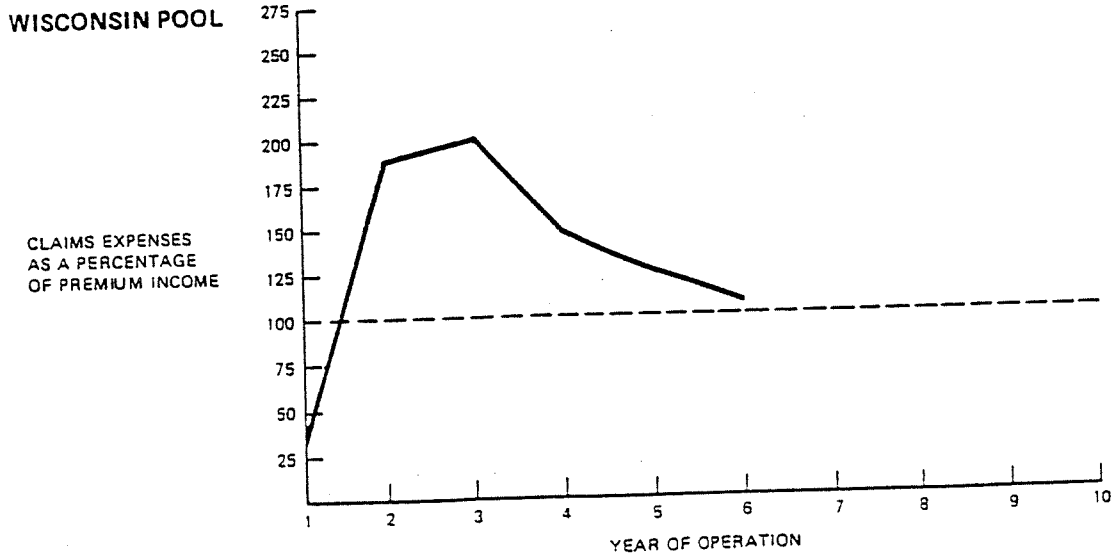


Figure 2


MINNESOTA POOL
CLAIMS EXPENSES AS A PERCENTAGE OF PREMIUM INCOME
275
250
225
200
175
150
125
100
75
50
25
1
2
3
4
5
6
7
8
9
10
YEAR OF OPERATION


NORTH DAKOTA POOL
CLAIMS EXPENSES AS A PERCENTAGE OF PREMIUM INCOME
275
250
225
200
175
150
125
100
75
50
25
1
2
3
4
5
6
7
8
9
10
YEAR OF OPERATION


WISCONSIN POOL
CLAIMS EXPENSES AS A PERCENTAGE OF PREMIUM INCOME
275
250
225
200
175
150
125
100
75
50
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1
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10
YEAR OF OPERATION

years of operation, pay-out ratios varied considerably from pool to pool. In general, though, most of the pools seem to end their first or second year with ratios somewhere between 100 to 200 percent. By the third year's end, ratios for half the pools have reached or exceeded 200 percent. Then, in the fourth and succeeding years, the pools' pay-out ratios tend not to differ quite as widely and to remain, with some fluctuation, in the general vicinity of 125 to 175 percent.

Historic differences in pay-out ratios from one pool to another seem to be accounted for largely by differences in premium and benefit structures. The Florida and commercial Connecticut pools, in which premium revenues have kept better pace with claims expenses, are the only pools that have required a 12-month waiting period for pre-existing conditions. In addition, their premium rates and deductibles tend to be higher than those of the pools with expenses greatly exceeding their income.

As the pools with poor pay-out ratios have grown in enrollment, annual deficits have reached several million dollars. This sometimes has triggered major plan restructuring. The Wisconsin pool, for example, had been in effect for not yet three years when, in June 1983, its claims pay-out ratio had reached 200 percent. Assessments in amounts totaling $2 million had to be made, despite the fact that members had been assessed

approximately $1 million just seven months earlier. Although Wisconsin's lawmakers stood opposed to providing commercial insurers a tax credit, they moved to extend the waiting period for coverage of pre-existing conditions from 30 days to six months; increase the maximum annual liability of enrollees from $1,000 to $2,000; and raise premium prices from 130 to 150 percent of standard rates.

B. WHAT HAVE BEEN THE COSTS INCURRED BY STATES WITH HIGH-RISK POOL LAWS IN EFFECT?

Lawmakers in nearly all of the states with high-risk pool statutes have chosen to permit pool members to take a tax credit equal to the amount of their pro rata assessment. This policy has resulted in significant losses in state revenue. In addition, the legislature in one state (Wisconsin) has elected to offer enrollees an income-adjusted premium which has required a relatively small line item in that state's annual budget.

The tax credit -- which may be applied against either premium or income tax liability -- has been incorporated so widely into the risk-pool scheme because of equity issues raised by the insurance industry. Since self-insured plans are not required to participate in the pools and share in their losses, Blue Cross/Blue Shield plans and commercial insurers bear a disproportionate share of the cost associated with insuring the high-risk population. Insurers argue that if they are forced to raise premiums as a means of offsetting their risk-pool

assessments, then large and medium employers will have further reason to self-insure, inevitably reducing the base on which to finance high-risk pool operations.

In states that allow tax credits, indirect subsidies have grown considerably as the number of insured has increased. After three years with high-risk pool legislation in effect, the amount of annual revenue lost to the state is likely to run well over a million dollars, as Table 5.1 shows. In Minnesota, where enrollment reached more than 10,000 in the pool's ninth year of operation, indirect costs to the state amounted to just over $5.5 million.

On a per capita basis, indirect state costs typically run approximately $600. The year that Minnesota's revenue losses surpassed the five million dollar mark, for example, its indirect per case costs were, on average, $543.

The income-adjusted premium subsidy is intended to assist the many eligible low-income individuals in purchasing high-risk pool coverage. This policy, of course, requires a direct outlay of state funds.

Wisconsin, which is the only state to institute a premium subsidy program, expended about $171,000 in fiscal year 1986, the first full year that the program was in effect. Subsidies were

provided to just under a third of the pool's policyholders, at an average cost of $285 per recipient. Current premium reductions ranged from 33 to 17 percent, depending on an individual's income.

C. IS THERE A RATIONALE FOR STATES TO FINANCE HIGH-RISK POOLS?

The primary rationale for state subsidization of high-risk pools is the longstanding role that states have played in helping to pay the health care costs of the uninsured, underinsured, and other special need populations. Another rationale is the states' responsibility to structure public policies so that taxes or assessments are imposed equitably.

State support for high-risk pools is not without precedent. States have played a major role in financing any number of programs designed to extend access to appropriate health care services, particularly among low-income and high-cost populations. State-only Medicaid programs, indigent care programs, uncompensated care programs, and special grants to maternal and child health providers are among the various types of programs that receive state funds.

States recently have moved to expand their health care financing role for vulnerable groups in society in part because of certain perceived benefits. Improvements in the health and

functional status of infants and children is one such benefit. Relief for families who otherwise would be ruined financially by exorbitant medical bills is a second. The assured financial viability of hospitals and other providers that disproportionately serve the poor and other uninsured and underinsured populations is a third.

Aside from the precedents for a state role in high-risk pool financing, however, states have a basic obligation to assure that its policies treat all health care payers fairly. All but three of the states with mandatory pools have been responsive to the insurance industry's charge that requiring conventional insurers alone to finance risk-pool losses is competitively unfair and likely to fuel the movement to self-insurance which, in turn, would reduce not only the base on which to finance a high-risk pool but the amount of a state's premium tax revenue as well. Asking insurers to finance risk-pool deficits may become even less politically feasible in the future.

D. WHAT STRATEGIES EXIST FOR REDUCING POOL LOSSES?

Aside from lifting premium caps and cutting back on benefits, there essentially are two ways in which high-risk pool losses might be reduced. One is for pools to manage their medical spending more effectively. The other is for the pools to broaden their enrollment so that low- as well as high- risk individuals can participate.

1. Better Management of Medical Spending

The existing pools operate like traditional commercial plans, playing little or no role in how services are used or which providers are selected. Yet there is some reason to believe that greater involvement in case management, utilization control, and selective contracting could produce a more favorable financial picture for high-risk pools.

Case management of the highest cost claims is becoming a more commonplace component of risk-pool administration, but routine case management of the majority of beneficiaries has never been tried. Given the very adverse selection of individuals covered by the pools, though, it would seem that some cost savings could be achieved through appropriate case management services. Indeed, what few studies of case management demonstrations exist suggest that while case management may yield only modest savings for the general population,1/ it may result in dramatic cost savings for children with special health care needs. A Florida study found that following the introduction of case management services, average subsequent expenditures for low-income children with severe chronic conditions were only

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1/ Deborah Freund and Edward Neuschler, "Overview of Medicaid Capitation and Case Managed Initiatives," Health Care Financing Review, 1986 Annual Supplement, pp. 21-29.

slightly more than a third of the expenditures for a comparable child population who did not receive the service.[2/]

Case management costs, of course, also vary with the health status of recipients. For a generally healthy population, the case management service usually entails prior authorization by a primary care physician for all inpatient care and specialty care referrals. This could be purchased for as little as $36 per enrollee per year.[3/] For a chronically ill child population, case management should involve developing a health care plan in consultation with family and providers; arranging, coordinating, and monitoring services; training family members; providing psycho-social support; and assuring communication with education and social service agencies. The cost of this type of case management could range from $75 for the typical cases to $375 for cases that are very complex.[4/]

Utilization control is comprised essentially of preadmission screening and continuing medical necessity review, and retrospective cost analysis. It could be employed by high-risk pool administrators as another cost reduction mechanism, but

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2/ Steve Freedman and Patricia Pierce, Comprehensive Health Care Case Management: A Demonstration, in press.

3/ Freund and Neuschler.

4/ Josephine Gittler and Milo Cotton, Community Based Case Management Services for Children with Health Case Needs, National Maternal and Child Health Resources Center, 1987.

has not as yet. The utilization review literature -- while focusing almost exclusively on HMOs -- indicates that efficient utilization practices can produce significant savings. In a major study of the Puget Sound HMO, researchers report that per recipient expenditures for all health care services were 28 percent less for plan enrollees than for a comparable non-enrollee population. Most of the savings is attributed to lower hospital utilization.5/ Both this HMO study and a nationwide study of Kaiser Permanente found that appropriate utilization controls reduce hospital admissions by as much as 40 percent.6/

Such high-impact utilization review programs, however, are probably rare outside of an HMO setting. A highly successful pre-admission certification program run by Blue Cross/Blue Shield of North Carolina, for example, reports an average annual decrease in inpatient hospital admissions that is 12 percent greater for enrolled groups than for nonenrolled groups.7/ Audit results of three utilization review systems currently in use by Fortune 500 employers indicate that, on average, about 30 percent

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5/ Willard Manning, et. al., A Controlled Trial of the Effect of a Prepaid Group Practice on the Utilization of Medical Services, RAND, 1985.

6/ Harold Luft, Health Maintenance Organizations: Dimensions of Performance, John Wiley and Sons, 1981.

7/ Unpublished data from the National Blue Cross and Blue Shield Association, Chicago, Illinois.

of hospital days that are approved, in fact, may not be medically necessary.8/

Clearly, the most dramatic utilization review findings tend to focus on HMO populations which consist of generally healthy workers and their families. Whether the same significant cost savings would be reported for a chronically ill child population is not clear. It could be that because of their greater than average utilization of hospital services, even more substantial savings could be achieved. On the other hand, perhaps much of the inpatient care provided to these children may not be discretionary.

Rate negotiation is a third cost control mechanism available to high-risk pool administrators. Various approaches are being tried with apparent success by both public and private payers. Preliminary analysis indicates that Medicare's prospective payment system for hospitals has enabled the program to achieve a 1.12 day decrease in average length of stay.9/ Evidence from the Medi-Cal experience with selective hospital contracting also suggests substantial savings: estimates show that the state saved

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8/ Arnold Milstein, et. al., "Gauging the Performance of Utilization Review," Business and Health, February 1987, pp. 10-12.

9/ Susan Des Harnais, et. al., "The Early Effects of the Prospective Payment System on Inpatient Utilization and Quality of Care," Inquiry, Spring 1987, pp. 7-16.

between $140 and $165 million in year one, and between $218 and $236 million in year two.10/

Eager to institute their own discount rate programs, and at the same adopt some of the cost containment features of HMOs, private payers have begun moving rather rapidly into preferred provider organization (PPO) arrangements. Under such arrangements, a network of hospitals, physicians, or other providers agree to deliver services to beneficiaries at a discounted rate and promise to comply with utilization review in exchange for prompt payment and the hope of an increased share of the health care market. Beneficiaries are given financial incentives to use the PPO providers. The incentives are in the form of reduced deductibles and coinsurance fees. Fifty commercial insurers and 54 Blue Cross/Blue Shield plans had entered into preferred provider arrangements by October 1987.11/ Taking into account self-insured plans as well, approximately 32 million individuals are presumed to be eligible for PPO services.12/

10/ Richard Curtis and Ian Hill, Affording Access to Quality Care: Strategies for Medicaid Cost Management, National Governors' Association, 1986.

11/ Unpublished data from the Health Insurance Association of America and the Blue Cross and Blue Shield Association.

12/ Unpublished data from the American Association of Preferred Provider Organizations.

PPOs have not been in existence long enough to be evaluated fairly. To date, there is conflicting evidence as to whether the health status of PPO users is similar to that of nonusers.13/ Moreover, savings to third party payers as yet have not been documented satisfactorily. One study of a large employer group concluded that per capita charges for strong PPO users were only one-half to one-third those for nonusers, but found that strong PPO users were younger and healthier and had fewer chronic illnesses than other employees.14/

To be successful with a chronically ill child population, a PPO organization would need to include the wide range of pediatric specialists and tertiary care centers involved in the management and treatment of chronic childhood conditions. Families of children with special medical problems generally have well-established physician relationships that modest economic incentives are not likely to disturb. More important, without extensive experience serving these children and their families, providers may not be capable of furnishing state-of-the-art medical care and understanding the various ancillary therapy and support services that frequently are needed in order to avoid a

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13/ See Paul Ginsberg, et. al., "Who Joins PPO?," Business and Health, February 1987, pp. 36-38; and James A. Hester, "Real Life Lessons from a PPO Plan," Business and Health, July 1987, pp. 23-28.

14/ Hester, 1987.

subsequent hospitalization and ensure the child's optimal functioning.

2. Broader Pool Enrollment

High-risk pool losses essentially are the result of capped premium rates for a population that, by definition, has greater than average health care expenses. Broadening a pool's enrollment to include low- as well as high- risk individuals, therefore, should improve its financial results significantly.

Connecticut's risk-pool experience appears to bear this out. Connecticut has the only high-risk pool statute that has no illness or rejection requirements for enrollment and its two original pools -- one operated by Blue Cross/Blue Shield (BC/BS) and one operated by commercial insurers -- are the only experienced pools that have not faced substantial deficits. The Connecticut BC/BS pool, in fact, stands out as the only pool that has been financially self-sufficient, showing a respectable profit in all but one of its eight years of operation.

The greater financial success of the BC/BS pool apparently was attributable to the number and composition of its subscribers. At least four times as many individuals were enrolled in the BC/BS pool as in the commercial pool. Moreover, most of the enrollees were standard health insurance risks seeking interim coverage. The BC/BS pool was able to attract so

many relatively young and healthy people because its underwriting policy had been to broaden the pool's risk composition by permitting year-round open enrollment for high-risk coverage while regular policy enrollment was allowed during only two months of the year. The commercial pool's enrollment was more restricted because individual company agents tended not to refer good insurance risks to the high-risk pool for coverage.

E. ARE THERE ALTERNATIVE RISK-POOL FINANCING MECHANISMS THAT WOULD NOT RESULT IN LOST STATE REVENUE?

There are several ways in which states could generate funds to support a high-risk pool directly. Mechanisms could be designed that would spread the cost across all health care payers, all employers, or even all state residents. Like the tax write-off policy, none of these financing approaches places an unfair burden on any particular segment of health care payers. Interestingly, though, they lack what may be the most politically useful feature of the tax credit, namely, the avoidance of a direct line item in the state budget.

Spreading the pool's losses across all health care payers could be easily accomplished if the federal ERISA law were amended. Then states would have the authority to require that all payers -- including HMOs and the self-insured -- participate in a risk pool and share equitably in its losses.

Absent this possibility, states could institute a hospital bed tax that indirectly would affect at least all private parties paying for hospital services. (Medicare and Medicaid probably could not be expected to accept this additional charge.) Under this approach, states would assess hospitals up to a certain percentage of their patient revenues. A hospital bed tax already has been used in several states to finance assistance for hospitals providing the bulk of uncompensated care, and in one state to support Medicaid expansions, but it has not yet been used to fund a high-risk pool. Utah, however, did consider risk pool legislation that would have been financed by a tax on both hospital and physician services.

Pros: The hospital bed tax treats all health care payers equally and circumvents the problem of identifying the self-insured.

Cons: The tax has the effect of penalizing the sick and their insurers. It also places a burden on hospitals who serve the high risk.

Spreading the pool's losses across all employers is another approach that forces the financial participation of HMO and self-insured plans. States could impose a special tax on employers and provide that this tax could be offset by the amount of premium tax that had been built into an employer's premium charges. In this way, the state would collect new revenue primarily from companies with self-insured or HMO plans. These

funds could be combined with a portion of the state's premium tax revenues to finance high-risk pool losses equitably.

A provision that was struck from the 1986 budget reconciliation legislation but will be offered again this year would have encouraged the establishment of state mandated pools funded largely by taxes levied on employers with self-funded group health plans. The states, however, appear not to have given this financing option any serious consideration.

Pros: A employer tax that allowed a credit for premium taxes offers an equitable way to finance high-risk pools.

Cons: The administration of an employer tax with premium tax credits may be difficult.

A substantially different financing approach would be to place partial responsibility for the disabled population's care with the general public by imposing a special excise tax on cigarettes, alcohol and other items that adversely affect health. No state as yet has proposed an excise tax to generate revenue for a risk pool. Several, however, have proposed to implement an excise tax to finance other types of health care reimbursement programs. Maine, for example used a cigarette tax to finance its catastrophic health expense program.

Pros: It penalizes individuals who are engaged in risk-taking behaviors and, therefore, more likely to use the health care system in the future.

Cons: A new or increased excise tax would be difficult to enact because of the strong opposition that would be marshalled by the affected industry.

F. WHAT OPTIONS EXIST FOR A FEDERAL ROLE IN THE FINANCING OF HIGH-RISK POOLS?

There are three obvious ways that the federal government might play a role in risk-pool financing. It could provide to states either 1) incentive grants to cover start-up costs for newly created pools or 2) operational grants essentially to cover all or part of a risk pool's losses. In addition, the federal government could authorize states to use federal Medicaid matching funds to subsidize premiums and coinsurance expenses for certain financially eligible children. To be supported politically, however, these initiatives probably would have to include a funding strategy that would generate new sources of revenue.

Federal legislation to provide incentive grants for states to establish high-risk pools has been introduced by Senator Durenberger. The proposed legislation would define the organizational, eligibility, and benefit features of a qualified risk pool and make grant funds available to states with newly created pools that meet the specified criteria. States with high-risk pools already in operation could apply for a grant to develop other mechanisms that would furnish affordable private coverage to the uninsured.

Legislation to provide states with mandatory high-risk pool program grants to cover all or part of their operating losses also could be developed. Under such a scheme, the federal government would assume responsibility for sharing the burden of subsidizing the on-going costs associated with covering an otherwise medically uninsurable population. Such funds possibly could be used to subsidize premium charges for low-income applicants to the pool as well as to underwrite losses.

A very different way in which the federal government could become involved in financing high-risk pools is through the Medicaid program. The Title XIX statute could be amended to extend optional Medicaid eligibility to high-risk children whose family income is at or below a certain standard (perhaps 200 percent of poverty) and to authorize states to use Medicaid funds to pay for these children's premium and cost-sharing charges on a sliding-scale basis. The idea of offering low- and moderate-income individuals without health insurance protection a subsidy toward the purchase of private coverage is gaining increased attention by the states. Washington State recently enacted a major package of health insurance programs which included a premium subsidy for individuals and families with incomes up to 200 percent of poverty to purchase a state-sponsored group plan.

Congress currently is considering a proposal to establish a sliding-scale premium arrangement for the Medicaid program itself. Permitting states to determine whether newly eligible children should be offered the opportunity to "buy-into" Medicaid or "buy-into" private coverage could be left to the states. Among the issues that states might want to take into account, if given such an option, are the impact of private vs. public coverage on the program's acceptability to families, the child's access to appropriate providers, and the provider's ability to secure reasonable reimbursement.

Finance

POOL FUNDING

NOTE: In theory, state health pools are designed to pay for themselves through premiums charged to the policyholders. However, due to the premium caps placed on all state pools and the fact that most individuals using the state plans are high risk, the pools will undoubtedly face a loss after paying out claims.

In the early years of state health pools, there were only a couple of options for paying this loss. However, in the last couple of years, several states have begun to explore alternative funding mechanisms.

Because of Federal Law (The Employment Retirement Income Security Act, known as ERISA) self-insurers are not required to become members of a state pool, therefore are not assessed any of the cost. In addition, all state pool legislation allows abatement of assessment if the payment of the assessment would endanger the ability of the member to fulfill his contractual obligations. Also, assessments that are less than an amount determined by the board to justify the cost of collection shall not be considered.

	STATE	SOURCE
	ALASKA	Assessment of losses to participating insurers.
	ARIZONA	Assessment with credit applied against premium tax and income tax. Use formula of approximately 20% per year.
	CALIFORNIA	The state has created a start-up fund of $250,000. Future losses will be paid by taxes on employers.
	COLORADO	Assessment with credit applied against premium tax and income tax.
*	**CONNECTICUT**	**Assessment of losses to participating insurers.**
*	**FLORIDA**	**Assessment with credit applied against premium tax and income tax. Maximum assessment of 1% per year on premiums or greater than premium tax. Use formula of approximately 20% per year for offset.**

Attachment II

	GEORGIA	Assessment of losses to participating insurers.
*	**ILLINOIS**	**The state will recoup any deficit incurred under the plan through appropriations made by The General Assembly.**
*	**INDIANA**	**Assessment with credit applied against premium tax and income tax. Also allowed to increase rates to offset assessment.**
*	**IOWA**	**Assessment with credit applied against premium taxes, income taxes or revenue at the rate of 20% per year over a five-year period.**
	KANSAS	To Be Determined By The Board.
	LOUISIANA	Assessment with credit applied against premium tax.
*	**MAINE**	**Assessment through a maximum .0015% tax on hospital patient service revenue.**
*	**MINNESOTA**	**Assessment of losses to participating insurers. Prior to 1987, a tax credit was allowed towards the assessment.**
	MISSISSIPPI	Assessment with credit applied against other taxes paid.
	MISSOURI	Assessment with credit applied against premium tax.
*	**MONTANA**	**Assessment with credit applied against premium tax.**
*	**NEBRASKA**	**Assessment with credit applied against premium tax.**
*	**NEW MEXICO**	**Assessment to participating insurers. A 30% credit will be allowed only on any amount exceeding $75,000 yearly.**
	NEW YORK	Assessment of losses to participating insurers.
*	**NORTH DAKOTA**	**Assessment with credit applied against premium tax and income tax.**
	OHIO	Losses paid by state general funds.

*	**OREGON**	**Assessment with credit applied against other taxes paid.**
	SOUTH CAROLINA	Assessment with credit applied against premium tax and income tax.
	SOUTH DAKOTA	Assessment with credit applied against premium tax. Use formula of approximately 20% per year write-off.
*	**TENNESSEE**	**Assessment of losses to participating insurers with credit applied against premium tax.**
	TEXAS	Assessment of losses to participating insurers.
	UTAH	To Be Determined.
	VERMONT	Assessment of losses to participating insurers.
*	**WASHINGTON**	**Assessment with credit applied against other taxes paid.**
	WEST VIRGINIA	Assessment with credit applied against premium tax.
*	**WISCONSIN**	**Assessment of losses to participating insurers plus special fund created by state to subsidize premiums for low-income policyholders.**

*** Highlighted states have existing plans.**

Compiled by Communicating for Agriculture

July, 1987

AGENT & ADMINISTRATOR FEES

AGENT FEES: Agent fees are the dollar amount provided to a licensed insurance agent within a state for enrolling an individual in the state health plan. Several states spell out the amount within the statute, however most of the fees are set by the plan Board of Directors. Only those states with existing plans are shown here.

CONNECTICUT	**Agent Referral Fee - $20**
FLORIDA	**Agent Referral Fee - $75**
INDIANA	**Agent Referral Fee - $25**
IOWA	**Agent Referral Fee - $25**
MINNESOTA	**Agent Referral Fee - $50**
MONTANA	**Agent Referral Fee - $25**
NEBRASKA	**Agent Referral Fee - $25**
NORTH DAKOTA	**Agent Referral Fee - $25**
TENNESSEE	**Agent Referral Fee - $50**
WISCONSIN	**Agent Referral Fee - $35**

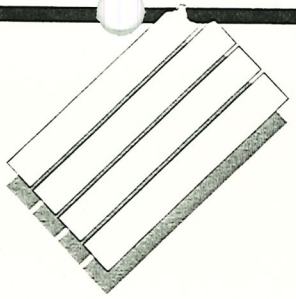
ADMINISTRATOR FEES: Administrator fees are the dollar amount provided to the carrier handling all administrative functions for the state plan. The administrator is usually awarded a contract for a period of three to five years to provide premium collection and benefit payments, as well as provide the Board with needed monitoring and data collection.

Most state plans provide for the Administrator to be paid out of either a percent of the premiums collected or a percent of the claims audited or paid. Much of this information can be obtained directly from the administrator, however the following states specifically spell out the maximum amount to be paid for administration of the plan.

MINNESOTA	**Administrator Fee - 12 1/2% of Premium Maximum**
MONTANA	**Administrator Fee - 12% of Premium Maximum**
NORTH DAKOTA	**Administrator Fee - 12 1/2% of Premium Maximum**

Compiled by Communicating for Agriculture
July, 1987

Francisco



4. CREATE AN ENVIRONMENT IN WHICH INSURANCE IS AFFORDABLE FOR ALL WORKING PEOPLE.

National data suggest that one-half of the uninsured – some 170,000 to 240,000 in Kansas – are working people and their dependents. We need to make it possible for those people to have health coverage for themselves and their families at a reasonable price.

Many of these people work for small businesses which find it difficult to obtain or afford health plans for their employees.

A statewide risk pool should be established for those who cannot access health insurance due to pre-existing conditions. Employers should be encouraged to provide adequate access to health insurance for their employees.

Attachment III

Kansas

STATE OF KANSAS

EDWARD F. REILLY, JR.
SENATOR, THIRD DISTRICT
LEAVENWORTH AND JEFFERSON COUNTIES
430 DELAWARE
LEAVENWORTH, KANSAS 66048-2733
913 682-1236

TOPEKA

COMMITTEE ASSIGNMENTS
CHAIRMAN FEDERAL AND STATE AFFAIRS AND INSURANCE SUBCOMMITTEE
VICE CHAIRMAN ELECTIONS
MEMBER CONFIRMATIONS
FINANCIAL INSTITUTIONS AND INSURANCE
PUBLIC HEALTH AND WELFARE

SENATE CHAMBER

February 11, 1986

NEWS RELEASE

Representative Rex B. Hoy
Republican, 24th District
Room 112-S
Statehouse
Telephone: 296-7664

Senator Edward F. Reilly, Jr.
Republican, Third District
Room 254-E
Statehouse
Telephone: 296-7372

It was announced today that the Insurance Subcommittee of the Senate Financial Institutions and Insurance Committee, chaired by Senator Edward F. Reilly, Jr., and a Subcommittee of the House Insurance Committee, chaired by Representative Rex B. Hoy, would begin hearings on Tuesday, February 18, 1986, at 8:00 a.m., in Room 254-E of the Statehouse to discuss matters relating to the insurance industry, availability of insurance and cost of insurance. The chairmen of the two committees reported that the hearings would not be limited to any specific type of coverage but would concentrate on all aspects of insurance and its availability.

It was announced by Representative Hoy and Senator Reilly that the purpose would be to formulate some thoughts and ideas to present to the full House and Senate Committees concerning the future of insurance availability in Kansas and whether or not the 1986 session of the legislature needs to introduce specific legislation to enhance that availability and protection for the Kansas public.

The first meeting of the Subcommittees on Tuesday, February 18, will concentrate on an introduction of the problem by staff and representatives of the Insurance Department and other interested parties who wish to be heard concerning the issue. The hearings will continue on Thursday, February 20, at 8:00 a.m., in Room 254-E, and Tuesday, February 25, at 8:00 a.m., in Room 254-E, in the Statehouse. Anyone interested in appearing may contact Mr. Bill Wolff, Research Department, Statehouse, 296-3181, who is a committee staff member.

Wed. Feb. 26, 1985
Attachment IV

Kansas

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

1350 East Touhy Avenue, Suite 380W Des Plaines, IL 60018 312/297-1490 Telecopier 312 297-6295

Attachment IV

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
H00% 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.

Francis

KANSAS HOSPITAL ASSOCIATION

news release

Jan. 22, 1988

FOR MORE INFORMATION CONTACT:
Barbara Schoof Conant
Director of Public Information
(913) 233-7436

RE: HOSPITALS PROPOSE SOLUTIONS TO THE PROBLEM OF MEDICAL INDIGENCY

FOR IMMEDIATE RELEASE

TOPEKA -- In response to a growing population of medically indigent which is straining the state's health care system, the Kansas Hospital Association is proposing a set of solutions that include expansion of the state's Medicaid eligibility requirements. According to the Topeka-based KHA, hospitals across the state are trying to maintain a delicate balance between their mission of providing access to health care with the principles of sound business.

A recently released "Report on Health Care for the Indigent," shows that the KHA estimates as many as 25 percent of Kansans may be without any kind of public or private health care coverage. Contributing to that high total is the current Medicaid maximum eligibility levels which have been set at 50 percent of the federal poverty level or at an annual income of just above $5,000.

The Kansas Medicaid program covers approximately 212,000 recipients, or 38 percent of the more than 500,000 Kansans who

P.O. Box 2308 • 1263 Topeka Avenue • Topeka, Kansas 66601 • (913) 233-7436

Attachment VI

live in households with annual incomes below $10,000.

It is estimated that as many as 330,000 people live in households with no health care coverage and another 150,000 in households where only some of the members were covered. This estimate totals 480,000 Kansans, or 15 percent to 25 percent of the state's population.

"This situation places hospitals in a no-win dilemma," said Donald A. Wilson, president of the KHA. "Hospitals are struggling with balancing their resources and obligations to the community and other nonindigent patients with the mission of providing health care to all patients regardless of ability to pay. "

In addition, the community does not receive the benefits of hospital investments, Wilson explained. For example, the hospital may be unable to purchase new equipment and or implement new methods of care that might otherwise have been available if payment had been received for all of the health delivered.

"The average person assumes that care for the medically indigent is fully funded through taxes or through the local public hospital," Wilson said. "State and federal programs may be publicized as a drain on budgets, but their limitations to the public go unnoticed."

KHA recognizes that the problems associated with indigent care are diverse and will require multiple solutions. It proposes a five-point plan to help alleviate the problems associated with providing care to the medically indigent:

o The Kansas Legislature should be encouraged to recognize

the provision of medical care services as a priority in the budget allocation process. Both public health programs funded through the Department of Health and Environment and medical assistance programs funded through the Department of Social and Rehabilitation Services should be considered priorities.

o The Kansas Medicaid program should take full advantage of new federally matched OBRA 1986 provisions expanding eligibility to pregnant women and to children under five and allowing separation of cash and medical assistance programs for certain groups.

o The Medicaid program should directly compensate hospitals who serve large numbers of Medicaid recipients. Hospitals documenting large amounts of Medicaid should be considered "disproportionate share" hospitals.

o A statewide risk pool should be established for those who cannot access health insurance due to pre-existing conditions.

o Employers should be encouraged to provide adequate access to health insurance for their employees.

"If providing health care to all Kansans, regardless of their ability to pay, is our goal, then the cost is society's responsibility. We believe that those costs should be spread equitably over as broad a base as possible," Wilson said.

The results of the KHA's study into the problem of the medically indigent and its proposed solutions are available on request to the Kansas Hospital Association, P.O. Box 2308, Topeka, KS 66601.

--30--

DIABETES TREATMENT CENTER
AT ST. JOSEPH MEDICAL CENTER

3600 East Harry Street/Wichita, Kansas 67218
316/689-6080

March 1, 1988

TESTIMONY FOR SENATE COMMITTEE
ON FINANCIAL INSTITUTIONS AND INSURANCE

Senator Neil Arasmith, Chairman:

Mr. Chairman and Members of the Committee:

As a health care provider in the State of Kansas, I see many people with chronic illnesses, particularly those in my field with diabetes who are unable to obtain health insurance. I support Senate Bill # 670, introduced by the Committee on Public Health and Welfare. Pooled Risk Health Insurance is a need that has been documented by Commissioner Fletcher Bell's Report to the 1988 Legislature. Pooled Risk would guarantee availability of adequate health insurance to all individuals, regardless of their physicial condition.

Fifteen states now have access to health insurance risk pools for their high risk individuals. Risk pools do not eliminate all barriers to the availability of health insurance, because premiums through pools are expensive. However, the principle that everyone has the opportunity to purchase health insurance is a very important one.

I respect the great amount of time and effort that has gone into the Insurance Department's assessment of the Kansas' need. The plan they are proposing is a strong statement of their support of this issue.

The need that was testified to two years ago is still felt by those of us working in a grass roots area. I urge your support of this bill.

Respectfully submitted,

Deborah Hinnen

Deborah A. Hinnen RN MN CDE
Program Manager

Assistant Clinical Professor
University of Kansas
School of Medicine-Wichita

DAH:dm
INS#1:024

Attachment VII

MEMBERS OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE

MARCH 1, 1988

As a health professional working with people with the chronic disease of diabetes, and as a volunteer serving with the American Diabetes Association, Kansas Affiliate, I would encourage you to lend your support to Senate Bills 670 and 674. The January 1988 report from the Kansas Insurance Department on the need for a high risk pool covering catastrophic illness provides ample evidence of the existence of such a need. The pooled risk plan for health insurance is needed now, the benefits of this plan are far greater than the potential costs of failure to enact legislation.

Christine Clarkin RNC, CDE

CHRISTINE CLARKIN, RNC, CDE
COORDINATOR, DIABETES LEARNING CENTER
STORMONT VAIL REGIONAL MEDICAL CENTER
TOPEKA, KANSAS

PRESIDENT-ELECT
KANSAS AFFILIATE,
AMERICAN DIABETES ASSOCIATION

Attachment VIII

American Diabetes Association®
Kansas Affiliate, Inc.

3210 East Douglas
316-684-6091
WATS 1-800-362-1355
Wichita, Kansas 67208-3309

TESTIMONY OF ROBERT J. COCHRANE, EXECUTIVE DIRECTOR
AMERICAN DIABETES ASSOCIATION-KANSAS AFFILIATE, INC.

Mr. Chairman, Members of the Committee,

My name is Robert Cochrane. I am the Executive Director of the American Diabetes Association-Kansas Affiliate, Inc. For the past several years, the ADA has worked to promote the establishment of pooled risk health insurance for Kansans. We are very pleased to see the bill before you today.

When hearings were last held on this issue, representatives from several other health organizations joined us in supporting risk pools. The American Kidney Foundation, the Epilepsy Foundation, and the Deaf and Hard of Hearing Association presented substantial information supporting this effort. The American Cancer Society has a national policy endorsing the concept of risk pools, although the Kansas organization has not had time to review this specific proposal. In fact, at least 25 national voluntary health organizations, all members of the Coalition for Health Insurance Availability, have endorsed the concept of health risk pooling.

The widespread support for health risk pools should not be surprising. As is clear from the Report of the Insurance Commissioner, a very large number of Kansans would like to purchase health insurance, could afford to

Attachment IX

purchase health insurance, but cannot do so because of health problems they have. In our office, we frequently receive calls from people who are searching for an insurance company who will issue a policy which will cover the expenses related to their diabetes. Unfortunately, we can offer little help. As the report clearly shows, people with chronic health problems are routinely turned down, or the existing condition is excluded from coverage.

Pooled risk health insurance is not a new concept. It would not put Kansas on untried, untested ground. Ten other states have already implemented similar programs, and some have been in operation for nearly twelve years.

The American Diabetes Association supports the Report of the Insurance Commissioner and Senate Bill 670. We hope that you will act favorably on it so that Kansans who need, want, and can afford health insurance will be able to purchase it.

Todd

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

Attachment X

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

1350 East Touhy Avenue, Suite 380W Des Plaines, IL 60018 312/297-1490 Telecopier 312 297-6295

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

State	Deductibles	Stop Loss Indiv.	Stop Loss Fam.	Maximum	Pre-existing Define	Pre-existing Wait	Pre-existing Waiver?	Med. Supp.
80% Conn.	400;1,000;1,500	2,000	4,000	$1 Mill.	6 mo.	12 mo.	No	No
150% 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
158% 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
1400% 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
158% Tenn.	500 2,000	1,500 2,500	2,500 3,500	500,000	6 mo.	6 mo.		Yes
158% 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 EXPERIE E DATA ($1,000's) FOR CALENDAR EAR 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	~~105~~ 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

	Page
I. Issue	1
II. Background	1
III. Data	2
IV. Options	3
Alternative I	
Alternative II	
V. Recommendation	3
VI. Proposed Plan	4
VII. Legislative Considerations	4
A. Subsidizing Pool Losses	
B. Collective Action	
C. Effective Date	
VIII. Conclusion	6
IX. Appendices	8

Accident and Health Risk Pool Report

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

ERAL BUSINESS
OR
N 65 CLAIMS
In Topeka
913 232-1000
In-State
1-800-432-0216
Out-of-State
1-800-468-1216

AIMS OR MEMBERSHIP
In Topeka
913 232-1622
In-State
1-800-432-3990

TATE EMPLOYEES
In Topeka
913 234-0495
In-State
1-800-332-0307

BOEING EMPLOYEES
1-800-223-0529

FEDERAL EMPLOYEES
In Topeka
913 232-3379
In-State
1-800-432-0379

FARM BUREAU MEMBERS
In Topeka
913 233-3276
In-State
1-800-332-0079

MEDICARE BENEFICIARIES
In Topeka
913 232-3773
In-State

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. Of 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

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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

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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)(l) 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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