Approved February 6, 1990
Date

MINUTES OF THE House COMMITTEE ON Insurance.

The meeting was called to order by Dale Sprague at
Chairperson

3:30 xx a.m./p.m. on January 30, 89 in room 531-n of the Capitol.

All members were present except:

Committee staff present: Chris Courtwright, Research Department
Emalene Correll, Research Department
Bill Wolff, Research Department
Bill Edds, Revisor of Statutes
Patti Kruggel, Committee Secretary

Conferees appearing before the committee:

see attached list

The meeting of the Joint House/Senate Insurance Committee was called to order at 3:40 p.m., Co-Chaired by Senator Dick Bond and Representative Dale Sprague.

Sen. Bond opened discussion on the subject of Health Care Insurance Costs. He explained that the purpose of these two Insurance Committees coming together on this major issue on the affordability and availability of health care in our society is significant to begin the process of discussing what impact can be provided at state level. Sen. Bond turned the meeting over to Rep. Sprague.

Rep. Sprague directed the conferees to provide an overview of what components make up the health care delivery systems in Kansas.

Representative Jessie Branson, provided testimony (Attachment 1) relating to HB 2610 which is designed to provide incentives to small employers offering health care coverage to employees through group health insurance.

Dick Brock, Insurance Department appeared before the Committee providing information (Attachment 2)on the many steps insurers are using today to provide insurance. Mr. Brock expressed problems with underwriting that is taking place in group health insurance, contrary to the original concept of group insurance.

Next appearing was Tom Miller, Blue Cross/Blue Shield. providing testimony (Attachment 3) addressing Health Care Costs. Mr. Miller also provided testimony from the United States General Accounting Office relating to the availability and adequacy for small businesses. (Attachment 4.)

Jerry Slaughter, Kansas Medical Society testified concerning the costs and accessibility of health care insurance (Attachment 5.)

Terry Leatherman, Kansas Chamber of Commerce and Industry provided testimony (Attachment 6)supporting the removal of state insurance mandates.

MINUTES OF THE House COMMITTEE ON Insurance,

room 531-N, Statehouse, at 3:30 ~~xx~~m./p.m. on January 30, 89.

Jim Schwartz, Kansas Coalition on Health submitted testimony (Attachment 7) supporting a comprehensive reform of the health care funding and delivery system. Mr. Schwartz stressed changing the basic financial incentives and legalalities that have fueled the health care skyrocket.

Meyer Goldman, HMO expressed concern for the rising costs of health care and supports a proposal to permit subrogation on health care (Attachment 8.)

Don Cooke, Kaiser Permanente distributed testimony(Attachment 9) on the continuing escalation of health care insurance premium rates.

Next appearing was Marion Broderick, Prime Health. Ms. Broderick testified on the significant contribution mandated benefits have on rate increases (Attachment 10.)

Stan Pomeroy, Jefferson City Memorial Hospital expressed concerns on costs of employee health care insurance. Mr. Fowler offered in his testimony (Attachment 11)some alternatives to conventional health care costs.

Appearing briefly was Jerry Fuqua, USD 338 Valley Falls, Kansas. Mr. Fuqua's testimony (Attachment 12) expressed the concerns teachers are facing to the high premium costs of health insurance.

Gary Fowler, McClouth High School provided testimony (Attachment 13) suggesting alternatives which would: (1) have KPERS administer a health insurance program for all public employees; and (2) earmark funds especially for health insurance benefits for the schools.

Mick McBride, Wichita Public Schools distributed testimony (Attachment 14)explaining the benefits of self funded health plans. Mr. McBride stated that the Wichita district provides a comprehiensive health plan and claims that the self funded plan has allowed the district to achieve its goals.

Testimony was provided (Attachment 15) regarding the present health care situation in Kansas by Representative Artie Lucas and offering some recommended changes. Rep. Lucas also provided alternative plans which were included in the 1990 bid requests for the State Insurance Plan (Attachment 16.)

Written testimony by Kay Coles, KNEA was distributed (Attachment 17.)

The Committee was distributed testimony from Roger Harms, Social Worker, Wichita Regional Medical Center (Attachment 18.)

There were no other conferees wishing to testify and hearings were concluded.

The Chairman announced that the House Insurance Committee would continue discussion on health care costs at the next meeting January 31, 1990.

The meeting was adjourned at 5:30 p.m.

GUEST LIST

COMMITTEE: _____ DATE: 1/30/96

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Lisa Getz	Wichita	St. Francis Reg. Medical Center
Warren Gilbert, DDS	Topeka	KPMA
Wayne Probasco	Topeka	Ks Podiatry
Bill Pilsenbarger	Topeka	Blue Cross Blue Shield
Tom Mills	Topeka	Blue Cross Blue Shield
John Kuck	Topeka	Blue Cross Blue Shield
Don Cooke	Shawnee Mission	Kaiser Permanente
Myra L. Goldman	Kansas City	Prime Health Kans HMO Assn
Marni Broderick	Kansas City	Prime Health
Jim Oliver	Topeka	PIA
Robert J. Shanks	Winchester	Supt USD 339
Jerry K. Fuqua	Valley Falls	Supt USD 338
Jack L. Bittner	McLouth	Supt USD 342
Alan E. Pomeroy	McLouth	Teacher USD 342
Al Alexander	Wichita	Emp Legal Society
Jerry Slaughter	Topeka	KNEA
Bill Curtis	Topeka	Ks Assoc. of School Bds
Rep. Jessie Branson		Leg
L M Cornish	Topeka	Ks Life + P.C. Assn
Dick Brock	Ins Dept	
Lisa Fague	Topeka	Shanks Secretary

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REPRESENTATIVE, FORTY-FOURTH DISTRICT
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TOPEKA

COMMITTEE ASSIGNMENTS
RANKING MINORITY MEMBER: PUBLIC HEALTH AND WELFARE
VICE CHAIRMAN: COMMISSION ON ACCESS TO SERVICES FOR THE MEDICALLY INDIGENT AND THE HOMELESS
MEMBER: EDUCATION
TAXATION
STATE ADVISORY COMMISSION ON SPECIAL EDUCATION

HOUSE OF
REPRESENTATIVES

January 30, 1990

TO: Representative Dale Sprague
and Senator Dick Bond, Co-chairmen
and Members
Joint Committee on Insurance

FROM: Representative Jessie Branson
Vice Chair
Commission on Access to Health Services
for the Medically Indigent

RE: Concept embodied in H.B. 2610 which resides in the House Insurance Committee. Creates incentives for small employers (25 or fewer employees) to provide health care benefits through group health insurance.

H.B. 2610 is referred to as the "Small Employer Incentive Bill". It has been developed over the past two years by the Commission on Access to Services for the Medically Indigent. It is patterned after the Oregon law and is designed to provide incentives to small employers who would offer health care coverage to employees. H.B. 2610 does not mandate coverage -- it is entirely permissive.

Attachment 1

The Commission has received considerable testimony from local health departments, hospitals and other providers who are increasingly feeling the impact of large numbers of people who seek primary care as well as acute care services and who are uninsured. Clinics to serve medically indigent persons have cropped up around the state, particularly in the urban areas, and are largely supported by private sources.

Based upon a survey conducted by the Kansas Hospital Association in 1987 as well as national data, we know that at least 14% to 16% of the Kansas population is uninsured for health care benefits -- in other words, some 385,000 people.

Small businesses are particularly hard hit. The U.S. Small Business Administration, Office of Advocacy, made the following statement in July, 1989:

> "----the prevalence of health care coverage increases with the size of a firm -- more than 47% of all uninsured workers are employed in firms with 1-24 employees".

According to the Kansas Department of Commerce, approximately 90% of the businesses in Kansas employ 25 or fewer employees.

Further, national data indicates that 80% of uninsureds are individuals who work full or part time or are dependents of an employee. H.B. 2610 aims to alleviate the problem of lack of access to health care services for the "working poor" in Kansas.

* * * *

Following is a synopsis of H.B. 2610:

I. VEHICLE FOR OFFERING COVERAGE

a. Any two or more employers are authorized to establish a "small employer health benefit plan" for coverage of employees and dependents

b. Small employer defined:

1. Employs no more than 25 employees who do not have health insurance or are not eligible for Medicaid or Medicare.

2. Has not provided health care coverage to employees within past two years.

c. Eligible employee defined:

1. Employed an average of 17.5 hours/week and has no other health care coverage.
2. Elects to participate in plan

d. Plan must provide for a board of directors to operate the plan. May employ a director/marketer.

e. Commissioner of Insurance must assist, if requested, in establishing a plan.

II. INCENTIVES FOR EMPLOYERS

a. Plan not required to include state-mandated benefits

b. No premium tax levied on small employer

c. Employer may claim a decreasing income tax credit phased out over a five year period based on $25/mo. per employee

d. Opportunity to join with other small employers to create a plan.

III. EMPLOYER/EMPLOYEE RESPONSIBILITY

a. Part I Coverage

1. Employer shall pay premium up to $40/mo/employee
2. Employee is required to make a minimum contribution of 25% of premium or $15/mo. whichever is less. (Total premium = employer + employee contribution).
3. Part I coverage limits employees' responsibility (deductible) to no more than $5,000/yr. for employee coverage and no more than $7,500/yr. for family coverage.

b. Part II Coverage

1. Shall consist of optional benefits as designed by the plan
2. Shall reduce deductible of Part I
3. No limit on premium

IV. COST OF TAX CREDIT

a. Maximum of 10,000 employees to be covered state-wide. If maximum of 10,000 employees participate the aggregate tax credit would be $3M.

V. OTHER STATES

Eleven states have initiated, and several more are looking at, some type of demonstration program or state-wide program that utilizes a state subsidy to encourage the expansion of health insurance coverage to persons who do not have group coverage available through the workplace.

State subsidies generally take one of two forms -- either a direct subsidy to assist with the cost of the insurance or an indirect subsidy in the form of a tax credit.

Some states have taken other approaches to increasing the number of individuals and families who can have access to health insurance, such as a Medicaid "buy in" or MekiKan "buy in". Two states, Hawaii and Massachusetts have mandated employers to provide coverage, however the Massachusetts law, passed two years ago, has not been implemented.

TESTIMONY BY

DICK BROCK, ADMINISTRATIVE ASSISTANT

KANSAS INSURANCE DEPARTMENT

BEFORE THE

JOINT HOUSE INSURANCE COMMITTEE & SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE

OLD SUPREME COURT ROOM

JANUARY 30, 1990

Attachment 2

I'm fully aware of the admonition contained in the scope statement regarding this meeting which calls on conferees to confine their remarks to the cost of accident and health insurance. I recognize the need for this restriction and will adhere to it but I must tell you -- it will be difficult. Health care costs are triggering the health insurance problems we face today. Many of the steps insurers are using today that some perceive as problems and others know as problems would not be occurring if extra-ordinary innovation was not necessary to compete for good risks at competitive and, to the extent possible, affordable rates.

Underwriting and Rating Practices

One of the innovations we have seen in the past several years is a significant increase in the number of insurers who profess to write group insurance but in reality simply insure a number of individuals under one policy. I describe the practice in this fashion because, rather than evaluating the underwriting characteristics of a group as a whole, they will evaluate each individual to be insured by the group, cull out those they don't want, then issue a group policy covering those who are left. From a cost standpoint, this practice can be attractive to the group policyholder and from a competitive perspective, the insurer obviously ends up with a better risk. It is not, however, attractive at all from the standpoint of those who are left out in the cold. Some of these people may have other options such as being eligible for coverage under their spouse's group or perhaps the condition which caused their rejection from the group is not so severe as to prevent them from obtaining individual coverage of some kind. But many, many of these people will be forced to rely on the temporary continuation rights afforded under state or federal law and ultimately the conversion rights state law provides. These are not, however, a panacea because the cost of either of these alternatives is usually high and often unaffordable. As a result, many people who are individually rejected for coverage under

a group plan in which they are otherwise eligible to participate will be added to the ranks of the uninsured.

Equally troublesome is the fact that as more companies underwrite individuals into or out of a proposed group, other insurers are literally forced to do the same thing. Consequently, the practice not only spreads but the number of people who find themselves on the outside looking in quickly multiply. In 1988, the legislature addressed this issue by enacting Senate Bill No. 539 but during the course of the legislative process, the bill was amended to apply only to groups formed under the auspices of a single employer. This leaves multiple employer trusts, associations and others free to sponsor groups which can and do leave individual members and/or dependents outside the group coverage. Senate Bill No. 445 has been introduced to this session of the legislature so the vehicle providing the opportunity to revisit this issue is available.

Another practice that we are seeing more and more often is what some people refer to as tier rating. This technique consists of placing individual group members and their dependents into a separate category determined by the company's assessment of each individual's health condition and consequent loss potential. The premiums charged for coverage are then varied depending on the risk category. This is not necessarily a bad technique -- it's certainly better than simply refusing to insure those who fall in a high risk category. However, it is another movement away from the traditional group concept particularly when it is recognized that a willingness to insure people in a so-called high risk category does not at all mean the highest risks are even close to being uninsurable. But while we know what it doesn't mean, we still don't know what this segregation of risks can tell us because we don't see the underwriting standards used to place risks in a given risk category. And, even if we did, these standards would no doubt vary considerably

between companies and even between risks. Common sense tells us, however, that the different categories only mean that one category is populated with persons who are presumed to be more or less healthy than those in another category. It doesn't necessarily mean the people in any category are people we would normally consider to be in bad health.

Another version of tier rating works a little differently but produces quite similar results. Traditionally, insurers have combined the experience of smaller groups -- for example groups of 25 or fewer members -- and have used the combined experience of all small groups to develop community rates. It is becoming increasingly common, however, for insurers who will even write small groups to rate them on the basis of their own loss experience.

Neither of these techniques -- the tier rating or the change in rating small groups is inherently evil. In fact, they are somewhat laudable because they are an attempt to keep health insurance coverage available to as many people as possible at the lowest possible rates despite the rising cost of health care. Again, however, there are a couple of serious problems that result. First, when the new rating system is initially implemented on a group previously insured under a more traditional rating system, individual members of the group can be and have been subjected to tremendous premium increases. In addition, the fragmentation of the group obviously amplifies the adverse effect of a serious illness or accident among the group members. Obviously, insurance and actuarial principles function better when losses can be spread among a large number of risks. Thus, when a group is divided into different categories or a community of risks is reduced to a number of small groups, premiums can fluctuate rather dramatically and in this day and age, the fluctuations usually have a steep upward slant to them. This then presents an affordability problem and results in more people

joining the ranks of the uninsured despite the fact that coverage might be available. Consequently, as government grapples with the health insurance issue, the notion of requiring community rating of all groups below a certain size should be explored as one possible way to add some stability to the costs experienced by those groups who are too small to actuarially support themselves.

Along this same line, the statutes governing the regulation of fire and casualty insurance rates require the Commissioner to develop or approve a statistical plan to be used in accumulating a credible body of loss data to be used in ratemaking. This is an essential ingredient in the development of actuarially sound rates because in most lines few if any individual insurance companies produce enough data to be statistically reliable. Thus, loss data for all companies for the same kind of insurance corrects this problem yet insurers are still able to actively compete because of variable expenses, underwriting practices and so forth. No similar mechanism exists with respect to accident and health insurance. Perhaps such a mechanism is not feasible but it is a possibility which if successful could produce a much more valid body of data to use as a basis for rates.

While still on the subject of small groups, reports on a 1987 analysis by the Employee Benefits Research Institute indicates that, of the 37 million uninsured in this country, 85% of those under age 65 are workers or members of a workers family. This means, it seems to me that a significant portion of the uninsured population is in that position either because their spending priorities don't include health insurance or they simply can't afford health insurance. We also must remember that, as I understand it, the 37 million uninsured number that is widely used and accepted, includes a great many people -- probably millions -- who have health insurance may not have coverage for a major problem like

heart disease because of an exclusion rider attached on the basis of prior medical history or the coverage is simply inadequate to accommodate a serious illness or accident. This large number of working uninsureds should encourage this session of the legislature to seriously consider House Bill No. 2610 which has been developed and recommended by the Commission on Access to Services for the Medically Indigent and Homeless chaired by Senator Ehrlich. Though not a panacea and perhaps even in need of considerable work, this bill is intended to encourage and assist employers in providing at least minimal health insurance coverage to employees. If the uninsured problem is to be solved at all, it certainly won't be solved overnight and a single state probably can't do all that must be done. But we can take some small steps forward and House Bill No. 2610 is one way to do it.

However, even House Bill No. 2610 permits employees and/or dependents to be excluded from the group because of a health condition or conditions. So, once again, we are confronted with the problem of how to help people who cannot obtain accident and sickness insurance in the voluntary insurance market.

Risk Pools

As many of you will recall, legislation has been considered or proposed several times in recent years -- most of them developed and all of them supported by the Insurance Department -- which would address the concerns of at least some of the uninsured and uninsurable 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, no support developed, and it was not presented for legislative consideration.

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 which provided for establishing of a pooling mechanism and the health care cost containment provisions as separate bills but neither was 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 but not enacted.

One of the greatest obstacles to more favorable legislative consideration of these earlier proposals seemed to be our inability to demonstrate a need for a facility that would make insurance available to persons unable to obtain adequate accident and sickness insurance protection in the normal insurance market.

This obstacle seemed to be addressed by legislation enacted in 1986. In 1986, Substitute for Senate Bill No. 121 was enacted, which 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 during a given period of time.

The reporting period we prescribed was July 1, 1986 to June 30, 1987. During this period, companies reported processing 79,230 applications for individual accident and health insurance policies of which 5.14% were declined. Of those not declined, almost 17% were issued with health restrictions (riders) i.e. coverage was excluded for a particular

condition or conditions -- or written at substandard rates. In addition, Blue Cross and Blue Shield of Kansas, Inc., the company which reported the largest number of applicants, 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. Finally, the grim and growing 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 was 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 -- although we doubt it -- or may have later secured group coverage. Of those rejected, we do not know how many could afford insurance at standard rates but could not afford to participate in a risk pool. On the other hand, we do 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 compiled tells us little more than the frequency of adverse underwriting decisions during a one year period. Nevertheless, we do now know with absolute certainty that a very significant 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. Unfortunately, we did not keep track of them but over the years we have had a number of reports -- many from legislators on behalf of a constituent -- of people who have lost their homes, farms and businesses due to an inability to pay their medical bills because insurance was not available. We are

continuing to hear from people who cannot obtain adequate accident and health coverage and the frequency of such contacts is increasing.

On the other hand, we are also aware of the legitimate concerns about the potential quicksand effect of health risk pools. If a pool is established, it will, of course, by design, provide health insurance coverage to persons who cannot obtain it anyplace else. By doing so, it is obvious that the cost of such coverage will be extremely high and the pool will not be economically self-sustaining -- such pools invariably pay out more in benefits than they take in as premiums. As a result, pool losses must be subsidized from some source. If no external subsidy is provided, the insurers comprising the pool will have no alternative but to fund the losses and the only place they can generate the revenue to do this is from the premiums paid by their own accident and sickness insurance policyholders. This then will drive premiums up for policies written in the voluntary market which, in turn, can drive more people into the uninsured ranks because they can no longer afford the coverage.

If a public subsidy is used, such as a premium tax offset, the state is exposing itself to an obligation which can become quite onerous and, equally important, one which can become almost impossible to back away from. For these reasons, a health risk pool, even though it is an extremely desirable tool, must be developed with a great deal of caution and a good understanding of the long range overall impact it can and will have in a variety of areas.

Rate Regulation

Rate regulation is often mentioned as a means of achieving stability, if not reductions, in accident and sickness insurance rates. Conceivably,

there is merit to this possibility particularly with regard to new rating/underwriting techniques which can have the transitional impact experienced with the introduction of tier rating as mentioned earlier. There are, however, some offsets. In the first place, it must be remembered that tier rating has been introduced as a way to continue providing insurance to as many people as possible by varying the premium charge depending on the health condition of individual insureds. A valid analogy can be drawn between this practice and automobile liability insurance. In automobile liability insurance most insurers use a merit rating or safe driver plan whereby persons with more accidents and moving traffic violations pay more than otherwise comparable drivers in the insured population. When merit rating or safe driver plans were introduced in the early '60s, premium adjustments as a percentage increase or decrease were probably as dramatic for some persons. However, the magnitude of accident and health insurance premiums makes adjustments in this area far more troublesome for far more people than was experienced in the auto insurance arena. Obviously, a rate regulatory law could be crafted in such a way that tier rating or other similar innovations could be prohibited or their use restricted. Whether the end result would be good or bad for the insured groups affected is, however, the real question because the application of artificial impediments to otherwise rational rating plans can and do often result in cancellations, nonrenewals and refusals to write coverage at all. In other words, rightly or wrongly, insurance companies can exercise significant leverage simply by withdrawing from the marketplace.

On the other hand, rate regulation can have a significant psychological impact on the insuring public simply by having the knowledge that insurers cannot charge any price they so choose because their rates are subject to review by an independent state agency, must meet certain prescribed standards and must be based on information supporting or

justifying the premiums charged. In addition, the presence of rate regulatory requirements can have an effect on insurance company management decisions because new rates or new rating techniques cannot simply be developed and used. Rather, they must meet prescribed standards. And the knowledge that they will be reviewed by those responsible for administration of the rate regulation act can retard precipitous action.

However, some indication of how and how much accident and sickness insurance rate regulation would impact consumers can be gained by looking at the market served by Blue Cross and Blue Shield. These organizations have been subject to a prior approval rate regulation law since 1972 and the authority granted the Commissioner of Insurance under this law has frequently resulted in the disapproval of rate requests in their entirety or the approval of rates lower than originally requested. Nevertheless, the rates charged by Blue Cross and Blue Shield have displayed the same inexorable climb upward as those charged by other insurers. In addition, groups and individuals insured by Blue Cross and Blue Shield have not avoided the problems associated with increasing premiums and/or decreasing benefits. Many school districts and the State of Kansas employee group are obvious examples.

In addition, it should be noted that the authority granted the Commissioner of Insurance under the 1972 Blue Cross and Blue Shield rate regulation act has been significantly restricted by a 1980 decision of the Kansas Supreme Court. Of particular interest in today's environment is the Court's finding that the Commissioner cannot question the establishment of rating classes by Blue Cross and Blue Shield nor can the Commissioner require any group or class to subsidize any other group or class. This part of the decision would directly prevent the Commissioner from doing very much with or to tier rating proposals under the current

statutory language used in the Blue Cross and Blue Shield rate regulation act.

Therefore, if accident and sickness rate regulation is to be considered for direct application to individual and group or blanket policies issued by traditional insurance companies, the 1980 Supreme Court decision should be carefully considered by the authors of any legislative proposal. In addition, any such proposal should take into account the fact that many group accident and health contracts are developed through negotiations between organized labor and employers, employers and insurers or between other parties. Finally, many group health insurance contracts covering Kansas residents are effected outside the state and governed by the laws of the state where the contract is entered into. Some Kansas laws concerning certain accident and health insurance subjects have been drafted to apply on an extraterritorial basis. Whether this could be done, how it could be done and its constitutional implications should also be considered during the drafting process of any rate regulation legislation.

Mandated Benefits

It just so happens that one of the Kansas statutes that requires extraterritorial application deals with certain mandated benefits and no discussion of current health insurance concerns would be complete without some thought being given to this subject. Before we talk about specific mandates, you should be aware of two general points. First, there are two types of statutes that are generally categorized as mandated benefits. The first, of course, are those statutes which prescribe and mandate the inclusion of coverage in an accident and health insurance policy for a specific condition or event. The second are those statutes,

sometimes referred to as equality statutes, which require insurance contracts to pay for covered services when provided by a specified practitioner or one of a general class of practitioners.

In the first category -- and these aren't in any particular order but will generally follow the chronological pattern of their enactment -- we have K.S.A. 40-2,102 which mandates "sick" baby care from the moment of birth. There is some confusion about this because most policies also pay for the newly born baby's well-care but the mandate is for injury or sickness including congenital defects and birth abnormalities. Next is 40-2,105 which mandates coverage for alcoholism, drug abuse or nervous or mental conditions by requiring benefits for a specified number of days of inpatient treatment and a minimum dollar amount for outpatient treatment. Finally, K.S.A. 1988 Supp. 40-2230 is a quasi mandate in that coverage must be provided for mammograms and pap smears <u>if</u> laboratory or x-ray services are covered. When we talk about mandates, we usually think about a long list of costly benefits so you may be surprised by the fact that only 3 pertain directly to benefits.

The second category is longer -- those statutes which require payment for covered services when performed by particular providers include K.S.A. 40-2,100 which names optometrists, dentists, and podiatrists; K.S.A. 40-2,101 which requires equal treatment for all providers licensed under the Kansas healing arts act (services performed by a chiropractor are affected by this statutory mandate); K.S.A. 40-2,104 requires reimbursement for services performed by a licensed psychologist if the service is covered by the contract -- which it probably is because of K.S.A. 40-2,105 which mandates coverage for nervous or mental conditions; K.S.A. 40-2,114 applies to licensed specialist social workers -- This one is presumably also affected by the mandate for nervous and mental condition coverage.

Finally, K.S.A. 40-2,103 is one of the extraterritorial provisions which makes the provisions relating to persons licensed under the healing arts act, optometrists, podiatrists, dentists, psychologists, social workers and benefits for injured or sick newly born children applicable to Kansas residents and people employed in Kansas even if the contract under which they are insured is issued or delivered outside the state.

While not normally thought of as a mandated benefit, K.S.A. 40-2209(D) requires all group policies to provide certificate holders 6 months continuation of coverage under the group program following the individual's termination from the group and/or a conversion policy meeting specified minimum standards unless certain conditions apply such as eligibility for other similar group coverage, eligibility for medicare, etc. Subsequent to enactment of this law, a federal law was enacted which also requires continuation of group coverage for a specified period of time which applies to employers with 20 or more employees.

With one exception, and not counting the continuation and conversion law, each of the mandates was sponsored and supported by the health care providers affected. The lone exception was the quasi mandate regarding mammograms and pap smears. In this case, consideration of the legislation was initiated by the Kansas chapter of the American Cancer Society. In many cases, of course, the legislative effort was applauded and supported by others but I think it's fair to say they were encouraged to do so by the original sponsors. This does not at all mean the legislation is automatically flawed or shouldn't have been enacted because of the process used to generate legislative action. This is a normal process. We are all accustomed to it. And, it works pretty well.

Nevertheless, one recent study ("State Mandated Benefits and the Smaller Firm's Decision to Offer Insurance", Gail A. Jensen, University of Illinois at Chicago and Jon R. Gabel, Health Insurance Association of America, March 1989) estimates that mandated benefits are responsible for 16% of the small businesses who do not provide a health insurance plan for employees. Ironically, one of the mandates viewed as the most onerous are the continuation and conversion laws. The study did not explore the trade-off that would almost certainly result if the continuation and conversion laws were repealed but it's obvious that, even though such repeal would presumably encourage more employers to offer a group plan which would decrease the total number of uninsureds, the repeal would leave a number of uninsurables without insurance and no way to obtain it.

Summary

Any discussion of accident and sickness insurance problems and concerns could continue indefinitely. As noted a time or two in the above testimony, the remedy for one problem sometimes creates other problems. This obviously makes the end result difficult to measure. But one thing is abundantly clear and that is we are in a situation where everyone must give up something. Insurance companies have a public policy responsibility to help resolve existing problems rather than create new ones. Employers are already being required to bite the bullet on health insurance costs and they must accept the fact that no end is in sight. Employees, association members and other insureds must realize that the days of low deductibles, little or no copayment requirements and unfettered freedom to seek medical attention from any provider desired at any time are over. Those marketing health insurance either as a vocation or as a group policyholder must understand that the ability to tailor a

group health insurance policy to their individual, self-interest specifications is a burden the insured population can no longer afford. Insurance regulators must know they will continue to be required to make unpopular decisions. And legislators need to realize that our health care delivery system will consume every dollar directed to it. Consequently, if we can alleviate some of the insurance problems today or tomorrow or next month we will have been productive but the world of medicine can deliver more than we can ever pay for so there is no way to create an insurance system that can meet this kind of open-ended financial appetite.

This doesn't mean we are defeated. I've mentioned a number of areas that are at least deserving of consideration. Prohibit individual underwriting of group and blanket policies as proposed by Senate Bill No. 445; require all non-merit rated groups to be rated on a community basis; revisit mandated benefits; explore the possibility of a central source of statistical gathering and analysis for accident and sickness insurance similar to that used in fire and casualty insurance; take at least one more look at a risk pool mechanism; and review House Bill No. 2610 as a tool to further encourage the formation of employer/employee groups. The one obvious possibility I haven't mentioned is some kind of statewide mandate for employer sponsored coverage. Hawaii has had a plan of this nature for some time. Massachusetts enacted one but, as I understand it, much higher than expected costs and the state's financial condition have prevented implementation. California, New York, District of Columbia and Washington have at least considered legislation of this nature but I don't know the outcome. Despite this activity, it seems to me this is an option that should not even be considered until all other efforts have failed. Through the exploration of the areas I've noted and probably other ideas I haven't mentioned, we can and we must endeavor to make the

Kansas health insurance environment as efficient and accessible as possible.

JOINT HOUSE-SENATE INSURANCE COMMITTEE MEETING
3:30 P.M., January 30, 1990

TESTIMONY BY BLUE CROSS AND BLUE SHIELD OF KANSAS

Thank you Mr. Chairman and Members of the Joint House-Senate Insurance Committee for providing us with this opportunity to make some brief statements on the subject of the cost of health care insurance.

My name is Thomas L. Miller. I am the new President Elect for Blue Cross and Blue Shield of Kansas. I will become President on March 1, 1990.

I would like to respond briefly to each of the topics as indicated in the Scope statement.

1) How is insurance coverage for accidents and sickness made available (individual or group policies, government programs, employee sponsored, self-insurance).

At Blue Cross and Blue Shield of Kansas we have four classes of business including:

Direct Enrolled - These are individual policies available with a health statement. These products include Afford-a-Care and Farm Bureau. Some individuals may have certain medical conditions ridered out based on the health statement.

Conversions - These are individual policies available for those that have been covered under a group policy and is available whenever a person is no longer employed by a group. These individuals may enroll under the conversion class without any restrictions on existing health conditions but must have completed their pre-existing waiting period.

Individuals covered under Farm Bureau may also convert but any restrictions they have under Farm Bureau coverage would continue with them under the conversion coverage.

Groups - These are group policies that are available to

(1) Employer groups of five or more employees
(2) Members and their employees who belong to an association that sponsors Blue Cross and Blue Shield of Kansas coverage
(3) Members and their employees who belong to a Chamber of Commerce that sponsors Blue Cross and Blue Shield of Kansas coverage.

Under the current Senate Bill 704, employees in groups of under 20 are eligible for continuous coverage in the group for 6 months if they terminate group coverage. Under Comprehensive Omnibus Budget Reconciliation Act (COBRA), for groups of 20 or more the employees are eligible for 18 months of continuous coverage and dependents for 36 months of continuous coverage under their group policy after they leave the group.

Attachment 3

Complementary Coverage - These are policies available for those individuals covered under Medicare that want to purchase coverage to fill some of the gaps in Medicare coverage. They may enroll individually in Plan 65 or Plan D (if disabled under age 65) as soon as they are eligible for Medicare coverage. There are no waiting periods or restrictions. They must enroll as soon as they are eligible or during an open enrollment period of March, April, or May each year.

If a person is covered through a group and is eligible for Medicare coverage they may enroll under Medicare exclusion and receive coverage at the same level as those under age 65 enrolled in the group plus any Medicare services that may exceed the groups coverage. The enrollment rules are the same as for all ages in the group.

Other programs currently available through the State and Federal government includes Medicare, Medicaid, and MediKan. Blue Cross and Blue Shield of Kansas administers only Medicare.

Following the Employer Retirement Income Securities Act (ERISA), many larger employers decided to self-insure. They have designed their own package of benefits since under ERISA mandated benefits are not required to be included in the coverage. Some of these self-insured employers enroll with Blue Cross and Blue Shield of Kansas for claims administration. The employer assumes the risk of the program.

2) What types of coverages are available and why?

We have both group and non-group type coverages available to accommodate both those desiring coverage through an employer (group) and for those desiring individual coverage (non-group).

These policies include multiple options of deductibles, shared pays, and co-pays.

We have traditional coverages that allow freedom of choice of providers.
We have managed care coverages available that requires the individual to seek care through a primary care physician to receive the maximum benefits.
We also have a Health Maintenance Organization that in general requires those enrolling to seek their care through a Primary Care Physician in order to receive any benefits.

We have recently introduced coverage available for long term care for both institutional and custodial care and home health services.

These coverages are available to give the insuring public the maximum product flexibility when choosing their health care insurance.

In general, the more restrictive the coverage is for receiving benefits the lower the cost. This means HMO's provide the most benefits at the lowest cost because the patient is restricted to seeking care through one primary care physician. This physician then may refer the patient to specialists as needed.

3) To whom coverage is not available and why?

Anyone can enroll in Blue Cross and Blue Shield of Kansas coverage. However, there are individuals that are not eligible for group coverage through an association, a Chamber of Commerce, or an employer group. Individuals that are not eligible through a group and have a health condition may have exclusion riders applied which may make the coverage undesirable since the coverage will be limited to those conditions that have not been ridered.

Health statements are required on individuals enrolling in non-group coverage in order to keep the price of individual coverage competitive with other insurance companies offering individual policies.

4) What are the factors that increase premiums charged for coverage?

There are many many reasons why premiums increase but we wish to mention only a few today.

First, the number of uninsured people that receive care and cannot pay for the services is increasing. Most of this expense ultimately is included in charges made by providers and billed to those who have insurance to offset the providers loss.

Second, adverse selection which is created by individuals who are quote "healthy" and take individual coverage at a cheaper rate than the group's rate. This results in fewer people covered in the group but with little or no expense removed. Thus those left in the group must pay more because there are fewer people to spread the cost over. This is why insurers are becoming more restrictive on quotes to meet their underwriting requirements.

Third, as the charges made by the providers for services increases, so must the premium be increased to pay for this increased cost.

Another big factor is the number of services being sought and provided to those covered by insurance. This use of services has been increasing at an alarming rate and the insurance premium must be increased in order for the insurers to have the funds necessary to pay for these increased services.

Fourth, new medical technology is expensive which impacts the price per service that providers bill to insurers.

Fifth, the population on the average is aging and as we age the need for health care services increases on the average. This in turn results in the need for higher insurance premiums in order for insurers to pay for the increase in services being provided.

I have provided you with a laundry list of items contributing to the ever-increasing costs of health care but there is not enough time available during today's meeting to explore the impact of each of these items. It is our hope that the Committee will allow sufficient time in a crowded agenda to fully explore the nature of this very complex problem.

We are convinced that piecemeal attempts to address the cost of health care will not prove effective. The complexity of the issue does not lend itself to simple solutions. If we are going to impact the cost problem, we are going to have to address the total health care financing and delivery system or the non-system as it exists today.

5) How do mandated benefits affect health insurance premiums and how can these increases be mitigated?

Each mandated benefit expands the coverage that must be offered by insurance companies. This in turn increases the amount of premium that must be charged.

Mandated benefits have also caused some larger groups to decide to go to self-insurance in order to avoid providing coverage for some of the mandated benefits.

Mandated benefits have added to the cost of health insurance but there are many reasons for the escalating cost. Taking action to rescind mandated benefits will reduce the premiums required but will not solve the cost problem.

6) Discuss research and development of alternative to conventional health and accident insurance.

There are currently many groups and commissions studying this subject both at the national and state level.

Locally, we have two such organized groups, the Kansas Employees' Coalition on Health Care and the soon to be announced, Governor's Commission. Each of these entities will be producing reports describing the current environment and offering alternative proposals. It is our belief that the consensus of opinion on potential solutions to the health care cost problem that we are lacking today will start to build as these groups devote a greater amount of time, energy and compromise to their efforts.

It will not be an easy process, but it will be beneficial. We, at Blue Cross and Blue Shield, stand ready to provide assistance to any or all groups seeking a rational approach to this most difficult problem.

United States General Accounting Office

GAO

Testimony

For Release
on Delivery
Expected at
10:00 a.m. EDT
Monday
October 16, 1989

HEALTH INSURANCE: Availability and Adequacy for Small Businesses

Statement of
Mark V. Nadel, Associate Director
for National and Public Health
Issues

Before the
Subcommittee on Health and
the Environment
Committee on Energy and Commerce
House of Representatives

Attachment 4

Summary

Small businesses are having an increasingly difficult time offering health insurance which meets the needs of their employees. This is the result of rapidly increasing costs of health care and changes in the insurance market, especially the use of strict underwriting standards by insurers.

About half of small businesses with less than ten employees do not offer health insurance coverage to their employees, with cost being the primary reason cited for not doing so.

Compared with larger companies, small ones have been particularly hard hit by several closely related factors, including:

--the inability to spread risk over a large number of employees and the consequent greater chance that just one or two employees with serious illnesses will lead to huge premium increases,

--the increase in the use of insurance premiums that are based on the experience of individual companies (experience rating) rather than the broader community (community rating).

--competition among insurers for businesses that present lower risk, and consequent higher costs for businesses with worse experience.

Insurance pricing mechanisms also constitute a major problem for small business. This market is characterized by businesses frequently changing or otherwise leaving their insurance companies, a process known as "churning." While many small businesses simply go out of business, others periodically choose new insurers who offer lower rates. This competition may eventually exclude some employees, however, because insurers may use medical underwriting criteria to exclude employees with preexisting conditions (including illnesses developed under coverage of the previous insurer). Culling out less healthy employees makes the initial costs for a small business policy relatively low. From the second year onward, however, the firm's employees begin to develop illnesses that are covered, leading to higher costs for the insurers and higher premiums, and shopping for a new insurance company again. The net result is a reduction in the effective amount of health insurance coverage.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss problems which small businesses have in providing health insurance to their employees. Because of the concern that restrictive changes in health insurance plans by both small and large firms may increase the numbers of Americans who lack adequate health insurance, you and Chairman Dingell asked us to begin an examination of the major health policy initiatives being adopted by the private sector. That study is currently under way. Today's focus is on small business, and we will provide some preliminary findings on the problems that employees of small businesses face in obtaining adequate and affordable health insurance coverage. While all firms are having problems with rapidly rising health care costs, our preliminary findings indicate that the workings of the small business insurance market create unique problems for small firms that exacerbate the impact of rising costs affecting firms of all sizes.

As the Committee is well aware, health care costs have been increasing rapidly. These increases in health costs have led to more than an eight-fold increase in business health spending between 1970 and 1987. Such rising health costs have adversely impacted firms of all sizes. But small firms and their employees have been particularly hard hit. A National Association of Manufacturers survey found that 1988 health care costs for firms with less than 25 employees increased by 33%--- a rate of

increase one and a half times the rate experienced by the nation's largest firms.

Probably the most important effect of rising costs is the inability of a substantial number of employees of small firms to obtain group health insurance. The smaller the firm, the less likely it is to offer health insurance. A recent Small Business Administration (SBA) study indicated that only 46 percent of businesses with less than 10 employees offered health coverage. In contrast, according to SBA almost all businesses with 100 or more employees offered health insurance. Almost half of the working uninsured are employed by businesses with fewer than 25 employees. Of the 8.2 million uninsured private wage and salary workers in 1984, 3.9 million were employed by a firm with fewer than 25 employees.

Erosion of the Small Business Health Insurance Market

Problems with the cost and availability of insurance are in large part consequences of the nature of the small business health insurance market. A confluence of factors is leading to the erosion of the health insurance market for small employers. These factors include:

-- the inability to spread risk over a large number of employees,

-- the decline of the availability of community rated health insurance products,

-- competition among insurers to offer coverage only to the best risks.

Insurance is used to spread risk. It is probable that in a sizable population, relatively few people will incur substantial health care costs. The losses of these few are shared among many, as covered individuals (or their employers) make regular payments into an insurance fund from which payments can be made. Small firms, because they are insuring only a few individuals, are less able to take advantage of this pooling of risks. Therefore, when insurance premiums are based on the experience of individual small companies, those companies with even a single employee with high costs can be adversely affected because of their small risk pool.

In the past this dilemma has been avoided through a system known as community rating--a mechanism for spreading risks more broadly. Under community rating the premium is based on the average cost of actual or anticipated health care used by all subscribers in a particular geographic area, industry, or other broad grouping and does not vary for subscribers within each grouping. Therefore, an individual firm's premium generally is not further adjusted for such variables as its own claims experience or the health status of individual workers. Blue Cross plans in most states have traditionally provided community rated plans available to small firms.

Greater competition in the insurance marketplace has led to the erosion of community rating. Commercial insurers were able

to select from the community pool small businesses who were better risks and offer lower rates, thereby raising the rates for the higher risk firms remaining in the pool. As commercial insurance companies continued to siphon off the firms with the lowest expected health costs, the ability to spread risks in community rated plans diminished. As a result, community rated health insurance products became less available. Even Blue Cross/Blue Shield plans have had to reduce the extent of community rated health insurance. Risk pools have become increasingly narrow as insurers attempted to take the better risks and base premiums on the expected utilization of a small risk group. This in turn has adversely affected those small firms whose employees have had higher than average medical costs.

Restrictive Underwriting Practices

Small businesses are currently in a market where some insurers are attempting to move costly industries, firms or individuals out of their pool through restrictive underwriting practices.[1] Medical underwriting often results in the exclusion of some employees from coverage if they have preexisting conditions such as cancer, diabetes, heart disease or other high cost illnesses. In some cases such individuals may be denied any coverage, and in other cases only the specific preexisting

[1]Underwriting generally refers to insurance companies' criteria and decisions as to which risks to accept or exclude from coverage.

condition is excluded. This underwriting may also limit the coverage available to spouses and dependents of the employee.

Another underwriting practice employed by some insurers of small firms is to exclude selected types of businesses. Among the many types of businesses that various insurers exclude are taxi companies, taverns, roofing companies, hair stylists, and medical offices. The exclusions, however, vary widely among insurance companies.

Even when a firm and its workers have health insurance, they may still be affected by their insurance company's underwriting practices. Policies are written for a set time and at the end of that term some insurance companies may subject covered individuals to medical underwriting criteria. This practice, known as "renewal underwriting" can result in exclusion of coverage for any person who has developed an expensive medical condition while he or she is insured.

Turnover, Pricing, and Underwriting

Because of the factors discussed above, workers in small businesses may face particular problems when their employers change insurance companies or when they change employers.

Rapid turnover of the firms insured by an insurance company, known as "churning," is a fact of life in the small business health insurance market. Based on our discussions with several companies who provide insurance to small businesses, it appears that about a third of the insured firms leave these insurance

companies or are not renewed each year. A large number of small firms fail and go out of business. Others shop for better price and/or service.

Insurers told us that one of the major contributors to churning is durational rating or the "wear off of underwriting." Because of medical underwriting and preexisting condition exclusions, first year costs for a small business policy are considerably lower than the costs for subsequent years. In the second and subsequent years some preexisting condition exclusions expire and the covered population begins to develop new conditions leading to higher costs. Higher costs generate the need for rising premiums. In the face of these higher premiums, many small businesses respond by seeking a new insurer who will offer them a lower first year rate. Problems for employees will arise if they had a serious illness or even a pregnancy which began under the lapsing insurance contract. These employees may well find themselves excluded from necessary coverage under the new insurance company.

Similar problems occur for workers who are changing jobs or who have recently lost their job. Providing transitional coverage is another important issue for small business. They have higher labor force turnover rates and longer waiting periods before health coverage begins than larger firms do. Further, at termination of employment small firm employees usually do not have the option of continuing their health insurance coverage at group rates. For firms with 20 or more employees, the

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that employers offering health insurance benefits offer employees separating from the firm (other than for gross misconduct) the option of continuing health coverage for up to 18 months. For such employees electing this option, the premium will be no higher than 102 percent of the group rate, payable by the employee.

Conclusions and Potential Policy Options

In conclusion, Mr. Chairman, our preliminary work has indicated that in many instances workers in small businesses are uninsured or underinsured due to financial pressures on their companies compounded by the nature of the small business health insurance market.

Insurance experts we consulted suggested a number of potential policy options to lessen problems in the small business health insurance market. These include:

-- encouraging or requiring greater use of community rating,

-- extending COBRA continuation of coverage to firms with less than 20 employees,

-- encouraging portability of health insurance benefits,

-- eliminating pre-existing condition clauses,

-- guaranteeing renewability of insurance policies for all covered individuals,

-- having the government assume the role of reinsurer/risk taker, perhaps through subsidy to a risk pool.

Some of these ideas have been tried. In recent years, industry groups and state governments have attempted to deal with the problem by creating multiple employer trusts (METs) and state assigned risk pools. These have met with mixed success. In state risk pools coverage has been limited, prices have escalated, and the pools have run deficits. Some METs have gained advantages of economies of scale. However, many still use medical underwriting and some have been subject to adverse risk pool selection.

One attempt to study potential solutions is a series of 15 demonstration projects instituted by the Robert Wood Johnson Foundation. These projects target uninsured small firms with wage rates lower than the national average. The goal of the demonstrations is to determine whether lower cost insurance products, with or without premium subsidies, can be marketed successfully to small firms. It is too early to assess these projects.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions that you or members of the Committee may have.

KANSAS MEDICAL SOCIETY
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January 30, 1990

TO: House Insurance Committee
Senate Financial Institutions and Insurance Committee

FROM: Jerry Slaughter
Executive Director

SUBJECT: Joint Hearings on Cost of Health Care Insurance

The Kansas Medical Society appreciates the opportunity to offer comments on the subject of health care insurance generally, and more specifically the issues of cost and accessibility.

The discussions surrounding availability and affordability of health care are not new, but are certainly more pronounced in recent times. Additionally, cost and access considerations are frequently interrelated.

In fact, one cannot adequately evaluate the problem of cost and access to care without taking a comprehensive look at the whole system. Every change that is imposed upon the health care system will have some resultant effect. For example, mandating benefits extends health care services to populations who might not otherwise have access to such services, but there is a corresponding cost. Another example is differential reimbursement rates in federal programs which discriminate against rural providers of care, thus providing disincentives for health care personnel and institutions to develop in rural areas.

The economic system in which health care is delivered in our country is unlike almost any other. The "consumer" (patient) is seldom the payor, as the overwhelming majority of care is purchased by third parties, whether they be health insurers, self-insured employer groups, government, etc. As government has become a larger purchaser of health care, it has discounted payments to providers in an effort to contain costs, which has resulted in enormous cost transfers to other payors in the private sector.

The growth of alternatives to traditional indemnity insurance, such as HMOs, PPOs and the whole array of "managed care" health plans have also had an effect. While some subsets of our population have benefitted from these alternatives, it can be argued that costs for the rest of the population have increased, as the base of population left in traditional plans has shrunk, making the risk-sharing pool smaller.

Attachment 5

What about our ability to pay for advancing technology? Certainly, technology has been one of the key factors which have driven up health costs in recent years. However, technology has made it possible to extend lives and save lives where just a short time ago there was no hope. Add to this the demographic trends in our country which show a rapidly growing aged population, and one can only guess at the impact a graying America will have on an already technology-intensive health care delivery system.

Some argue for expenditure limits and rationing of health care through some national or regional plan. As an academic exercise the concept seems fairly straightforward and simple. Yet to implement such a system in contemporary American culture where expectations and demands are high for access to a pluralistic system, and one can readily see that implementation of such a concept would be difficult, if not impossible.

We applaud the efforts of both committees to begin looking at our health insurance system on a broader scale. If you are looking for quick fixes or simple solutions, you simply will not find any. Countless study commissions and organizations countrywide for years have been wrestling with the difficult problems which surround the delivery of health care in our country. There are many scapegoats that can be targeted, but in truth, there are not any culprits who can shoulder the entire blame for the cost and access problems which surround our health insurance system. The problems are systemic, and have developed over several decades in an environment of the mixed messages which come from alternating incentives created by government regulation and market forces.

It would be impossible in one afternoon to cover fully the various aspects of the problem which faces our health care insurance delivery system. Our comments above are not intended to be complete or inclusive, but just one perspective on a very small part of the system. We suggest, and hope, that the committee will take a deliberate and focused look at the whole system as it operates in our state. At the very least, it will help to raise the level of understanding and awareness of the problem, as well as beginning a much needed dialogue on alternatives and solutions. We welcome the opportunity to participate in your continuing discussions, and pledge our cooperation in your efforts. Thank you for considering our comments.

JS:nb

LEGISLATIVE TESTIMONY

Kansas Chamber of Commerce and Industry

500 Bank IV Tower One Townsite Plaza Topeka, KS 66603-3460 (913) 357-6321

A consolidation of the
Kansas State Chamber
of Commerce,
Associated Industries
of Kansas,
Kansas Retail Council

January 30, 1990

KANSAS CHAMBER OF COMMERCE AND INDUSTRY

Testimony Before the

Joint House/Senate Insurance Committee

by

Terry Leatherman
Executive Director
Kansas Industrial Council

Mr. Chairman and members of the Joint Committee:

My name is Terry Leatherman. I am Executive Director of the Kansas Industrial Council, an arm of the Kansas Chamber of Commerce and Industry. Thank you for this opportunity to address the topic of the spiraling cost of health care insurance.

The Kansas Chamber of Commerce and Industry (KCCI) is a statewide organization dedicated to the promotion of economic growth and job creation within Kansas, and to the protection and support of the private competitive enterprise system.

KCCI is comprised of more than 3,000 businesses which includes 200 local and regional chambers of commerce and trade organizations which represent over 161,000 business men and women. The organization represents both large and small employers in Kansas, with 55% of KCCI's members having less than 25 employees, and 86% having less than 100 employees. KCCI receives no government funding.

The KCCI Board of Directors establishes policies through the work of hundreds of the organization's members who make up its various committees. These policies are the guiding principles of the organization and translate into views such as those expressed here.

Attachment 6

The health care crisis in this country is a multi-dimensional problem, where the individual dimensions seem to feed a vicious circle which compounds the problem. The circle starts with the soaring cost of health care services and insurance. Those costs contribute mightily to having 37 million Americans, including a half million Kansans without insurance coverage. When the uninsured become ill and need medical care, the bills go unpaid. Because doctors and hospitals need to recoup those costs, their charges are increased to insured patients. Those additional charges force insurance companies to increase insurance premiums. The circle is complete when those premium increases force more people to drop their coverage and join the growing ranks of the uninsured in America.

Employers become involved in this issue because most Kansans become insured at the workplace. 85% of Kansans have health care insurance coverage. 68% of those Kansans are insured through employer sponsored programs. Also, insurance costs are increasingly becoming a major portion of the business' bottom line. Private health care insurance plans cost $1,700 per employee/per year nationwide. In many cases, an employer pays a dollar an hour, every hour, to insure the health of an employee.

While it is easy to identify the problem, it is much more difficult to solve the problem. However, I will mention two proposals which could help the marketplace curb insurance costs and encourage small employers to provide health care insurance to workers.

The first proposal would be to remove all mandated benefit programs from state law. The passage of each mandated benefit may have been well-intentioned, but the end result has been to add to that vicious circle of spiraling costs. According to a National Center for Policy Analysis report from last February, "as many as one out of every four uninsured people, or about 9.3 million Americans, lack health insurance because of expensive mandated benefit provisions in state law." By removing mandated benefits, two positive results should be achieved. First, and most important, more Kansans should be able to afford a basic insurance policy, which pays for needed services from a doctor or hospital. Second, many Kansas employers will choose to continue offering mandated programs

voluntarily in order to retain their employees. Because employees care about the benefits they receive from their employer, and because a business' success depends on a qualified workforce, truly needed 'mandated' benefits will become voluntary benefits in many cases.

The second proposal would be for the state to encourage small employers to begin offering health care insurance to workers, through programs like the one contained in HB 2610. Small employers hold the key to having the Kansas workforce covered by health care insurance. That's because virtually all large employers offer workers health care insurance, but only 46% of the businesses with less than ten employees have health care insurance programs. HB 2610 recognizes that small employers are not offering insurance to workers because of high costs. HB 2610 would allow small employers to band together into health care associations, would allow insurance to be written to these small businesses without state mandates and would offer tax incentives to encourage the small businessman and woman.

By removing state insurance mandates and providing incentives to small business to offer health care insurance, there is no doubt that more Kansans would obtain health care insurance. That would mean Kansas hospitals and doctors would perform less 'charity medical care,' and would not need to pass those costs on to insurance providers. Hopefully, that would halt the vicious circle of ever increasing health care insurance costs.

Once again, thank you for the opportunity to address this critical issue. I would be happy to attempt to answer any questions.

Kansas Employer Coalition on Health, Inc.
1271 S.W. Harrison • Topeka, Kansas 66612 • (913) 233-0351

Kansas Employer Coalition on Health, Inc.
Testimony to House-Senate Insurance Committee
January 30, 1990

by James P. Schwartz Jr.
Consulting Director

Ladies and Gentlemen:

I am Jim Schwartz, consulting director for the Kansas Employer Coalition on Health. The coalition is 100 plus companies across the state who share a concern about the soaring cost of health care provided to employees.

I wish to convey to you sincere thanks on the part of employers in this state for coming together today to grapple with this complex and frustrating issue. After struggling (largely in vain) for the past decade to moderate health insurance costs, employers increasingly welcome a broader-based approach to dealing with the problem. That broader base, in the view of most knowledgeable employers, includes an important role for government.

Last week I attended a conference in Washington, D.C., hosted by the Washington Business Group on Health and the National Association of Manufacturers, on a range of topics dealing

with employer-sponsored health insurance. Ninety percent of the conference was devoted to proposals for comprehensive reform of the health care funding and delivery system.

The message I took from that emphasis is that players in the health care system are placing less emphasis on micro-economic solutions and more emphasis on macro-economic solutions. We're no longer pinning our hopes for solving the crisis on changes in deductibles or on restrictions on length of stay. Instead we're stressing changes in the basic financial incentives and legal underpinnings that have fueled the health-care skyrocket.

That's not to say we're no longer interested in front-line cost-containment tactics. We are – at least as long as the current rules apply. It's just that we're painfully aware that poking at the health care balloon just provokes it to expand in some new direction. What we need is a solution that encompasses the whole balloon and contains it, with consensus about quality, access, costs, and ethics.

For over two years this coalition has attempted to come up with some private sector leadership on the subject of care for the uninsured. Our fledgling efforts constantly ran smack into the problem of exacerbating costs. Then, through a concerted effort by one of our committees during the past year, we came to realize that the problems of access, cost, and quality are all ultimately related. Whenever we addressed any one of these issues, the others were quickly drawn into the debate. So, we came to see that any proposal that would deal substantially and permanently with any one of these problems must also deal comprehensively with the others.

After studying every domestic and foreign proposal we could get our hands on, our committee finally created a

constellation of recommended reforms for the health-care funding and delivery systems. Our board will hear the committee's presentation this Thursday. I expect the board to authorize widespread distribution of the proposal for comment. When that happens, I'd be delighted to return to present it to you in person. It is the finest work this organization has ever spawned in its seven-year history. It is an evolutionary proposal that leaves substantial roles for all the current players. It minimizes the role of direct government regulation and could be implemented on either a state or national level.

For now, let me suggest that short-term fixes (like mandate repeal and subrogation) be entertained in earnest, but that long-term reform be embarked upon with no less vigor. The word I get from Washington is that the federal government is looking to the states for successful experiments on comprehensive reform. Our meeting here today suggests that we may finally have the will, the urgency and the ability to deal constructively with a deeply troubled system.

I'd be happy to respond to questions.

K A N S A S H M O A S S O C I A T I O N
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TESTIMONY OF MEYER L. GOLDMAN
BEFORE JOINT COMMITTEE ON HEALTH CARE COSTS

31 January 1990

Thank you for this opportunity to speak. I am Meyer L. Goldman of Kansas City, president of the Kansas HMO Association and a representative of Prime Health, Kansas City's largest, and Kansas' oldest health maintenance organization.

We appreciate the systematic and deliberate manner in which your committee is approaching the difficult problem caused by escalating health care costs. The issue is complicated. There is no single solution, nor will the entire problem be solved at the State level. Yet we believe there are substantial steps that can be made through public and private efforts within Kansas.

The presentation a few minutes ago of Richard Brock of the Department of Insurance was comprehensive and directed specifically at principal issues. Many of his points are included in our own programs. We commend it to you for careful study.

The concept of the health maintenance organization includes a strong cost-control component. Within the industry we often refer to ourselves as "health management organizations", because it is through careful management of care that we try to achieve both health maintenance and healing. To be of high quality, care must be accessible, delivered by competent professionals, and appropriate to the needs: neither too little nor too much. HMOs use management techniques to develop a health care system.

The rapid growth of managed care organizations, and particularly HMOs, testifies to the acceptance of this approach by consumers. Every HMO subscriber belongs to the plan by his or her own choice. The HMO has been selected in preference to whatever alternate plan is offered. And the subscriber has an opportunity at least once a year, in an "open enrollment period," to express approval or disapproval by remaining in the plan or changing.

While HMOs provide far broader protection than traditional indemnity plans - particularly in the areas of preventive medicine - at relatively modest costs, they are not immune to inflationary pressures of the health care industry. Typically our rates increase more slowly than those of other kinds of plans, but they do increase. And that worries us as much as it worries you.

Many of the prices are beyond local control. Development of new technology adds cost whatever the delivery system. Care must be used that the new technology is used appropriately. Health care is a labor-intensive industry, and its employees include a wide variety of highly-trained people.

There are, however, some steps that, on the State level, could deter the constant excessive cost increases that we are experiencing. The Kansas HMO Association is supporting Senate Bill 396, to permit subrogation of health care claims. Passage of this bill would permit HMOs and insurors to recover from third parties the cost of any care for which their actions are responsible. It would reduce the share of cost that must be paid by the subscriber or an insuror. We believe passage of this bill is in the interests of cost control.

You have already heard about the effect of mandates. Every form of care required by State mandate, and every mandated extension of provider services increases the cost to the individual. While many of the services mandated by law are routinely provided by HMOs we experience increased cost with every mandate. The cost is shared by all subscribers, whether or not the mandated service is appropriate for him or her. We recommend a careful look at the mandates presently operating, and a legislative policy of reducing present requirements and restricting new ones.

Mandates have other harmful effects. Mandates established by State law have no effect on self-insured or multi-employer plans established under ERISA or the Taft-Hartley Act. Already more than half the plans in Kansas are self-insured and exempt from state requirements. When our costs are increased, there is added incentive for employers to consider self-insurance.

Also the increased cost tends to reduce participation in plans. Most employer plans require the employee to pay part of his or her own protection, and part or all of the protection for dependents. Each cost increase causes some additional employees to drop their protection. This is part of the reason that so many employed people or their dependents are in the uninsured category.

We have a direct concern in the development of plans to provide protection for our presently unprotected citizens: unrecovered cost of hospital and medical care for these people is borne mainly by those who are protected, because the unrecovered cost is included in rates. Therefore, as well as our natural concern for the welfare of citizens, we have more motive for helping develop practical programs to extend health care protection to all Kansans.

One other point. We believe we are contributing substantially to cost control through our managed care approach. I would commend to you testimony documented in hearings in 1988 before the Subcommittee of Education and Health, Joint Economic Committee of the Congress of the United States. The testimony reveals the large waste that is occurring because of duplication, unnecessary

procedures and lack of coordination in health care. When considering a State program of protection of the uninsured, we believe provisions should be made to use the knowledge developed in managed care techniques to conserve funds and limit costs.

Our members strongly commend and support your efforts. We will be glad to assist in any way we can. Please call on us.

Thank you.

Testimony Before Joint House/Senate Insurance Committee

January 30, 1990

Chairman Bond and Chairman Sprague, members of the joint Committee. Thank you for the opportunity of addressing the Committee this afternoon. My name is Don Cooke; the Health Plan Manager for Kaiser Permanente in Kansas City.

Kaiser Permanente may or may not be a familiar name to you. We are the nation's largest and most experienced privately funded provider of health care. We operate as a not-for-profit Health Maintenance Organization, providing health care coverage and care for over 6 million people in 16 states. Our almost 50 years of experience provide us a unique base for understanding and impacting cost effective health care delivery.

We have operated in the Kansas City area since 1985, when Kaiser Permanente expanded to it's twelfth "Region", or geographic area location. When we merged Kansas City Health Care into Kaiser Permanente in August 1985, there were 9,800 Kansas City area citizens receiving care from that organization, utilizing two medical offices and one hospital - Kansas University Medical Center. Since then, we have opened another four medical offices, and have contracted with a second hospital. Our membership is now over 40,000 members. The total book value of our assets in the Kansas City area is over $7,500,000, and we now employ over 200 support staff and our medical group consists of 36 full time primary care physicians with over 450 specialists available in a referred basis.

As I understand your interests here today, you are concerned with the continuing rapid escalation of health care insurance premium rates. So are we. We have been proud of our ability to contain costs. In the period from 1986 through 1989, the Kansas City Region of Kaiser Permanente has been able to hold our annual rate increase to an average of 4.5% per year. In 1990, this changed to 19.5%, with specific groups, such as the State of Kansas employee group receiving a 24% increase. This change occurred because of increases in the cost of providing medical care, and because of our need to accelerate our facility construction plans, a situation caused by our rapid growth.

Medical care costs <u>are</u> rising rapidly. All of us have become used to receiving what we might call "Cadillac Medicine". The advent of such esoteric procedures as bone marrow transplants, human growth hormone for dramatically undersized infants, fertility treatment, and lithotripsy and cat scans have led all our population to expect only the best, and to expect every heroic measure to be provided almost instantly. As I listen to the concerns expressed by our members in Kansas City, the most frequent expressions I hear are "I want it now". I believe we have come to expect "fast food" medicine. As we all know, instant service costs

money. We at Kaiser Permanente are doing our best to maintain a reasonable balance between the true medical needs of our patients, containing the cost of providing quality care, and the population's perception of acceptable access to medical care. It's a tough balancing act.

I'd like to talk briefly about how we decide what our premiums will be. Our dues rates are established to cover our costs, although we have not yet reached the "breakdown point" in our Kansas City Region. As a not-for-profit organization, we project the total cost of serving our members in the following year, including the full cost of expected hospitalization, outpatient routine and specialty care, and prescription medications. We include a factor for facility expansion and maintenance, and the routine overhead of doing business. If we take in more than we expect in dues, and/or pay out less in costs, the excess is carried forward into the next year in the form of reduced rates. As the result of faster than anticipated growth over the past 18 months, we have accelerated our facility construction plans. This has added extra pressure on our financial situation, creating the need to generate additional capital expenditures.

What can we all do to help? First, somehow, the public must come to realize that there are some limits as to what medical care can do. It's still an inexact science, still dependent on a physician's ability to diagnose, even with sophisticated technology.

The other areas, which are under your consideration, include allowing us to use subrogation as a means to lower our costs, and to consider the impact of mandated coverages on us.

Subrogation is the process of allowing us to collect for the care we provide a member, when the reason for that care is the action of an insured third party. Estimates place the value of subrogation at 1 to 5% of total revenue, per year, depending on the vigor with which it is pursued. Legislatively mandated coverages, such as the mental health and substance abuse mandate passed by the Kansas legislature several years ago, put upward pressure on health care costs. That one mandate raised our rates approximately 2%. At the same time, it added pressure on employers to self insure their health care benefits plans, effectively removing large employers from the pool of companies paying premium taxes and mandated benefits. Remove our flexibility in providing what employers demand, and you remove our ability to provide benefits to a broad based constituency.

Kaiser Permanente is already virtually the only Health Maintenance Organization providing Direct Pay - or Non-Group - enrollment in the Kansas City area. As you may know, Direct Pay means that individuals can join our plan without being employed by a group offering our plan. This allows self employed, retired, and small employer groups to be enrolled in our plan, at costs equivalent to those paid by major employers. Please help us maintain this

community feature by helping maintain a "level playing field".

Thank you. I'd be happy to answer any questions.

DC/id
01/29/90

KAISER PERMANENTE

Fact Sheet

January 1990

KAISER PERMANENTE

* is Kansas City's largest group-practice health maintenance organization, serving almost 36,000 members in the seven-county Kansas City metropolitan area.

* owns and/or operates six medical offices in Gladstone and Kansas City, Missouri, and Overland Park, Mission and Kansas City, Kansas.

* includes the Permanente Medical Group of Mid-America, P.A., whose sole function is to provide and/or arrange medical care for Kaiser Permanente members. The Permanente Medical Group currently includes almost 35 physicians and continues to expand to meet the needs of our growing membership. In addition, 400 specialty physicians affiliated with St. Luke's Hospital and the University of Kansas Medical Center are available to members upon referral by their Kaiser Permanente physician.

* is the largest and most experienced health maintenance organization in the United States, serving more than 6 million members in 16 states, including California, Colorado, Connecticut, Georgia, Hawaii, Kansas, Maryland, Massachusetts, Missouri, New York, North Carolina, Oregon, Texas, Virginia and Washington, and the District of Columbia.

* is a direct provider and financier of comprehensive health care, not an indemnity insurance company. Kaiser Permanente is substantially different from other health maintenance organizations that contract for care with individual physicians.

* is a not-for-profit corporation whose financial capability is assured by the national organizations, Kaiser Foundation Health Plan Inc. and Kaiser Foundation Hospitals, which are headquartered in Oakland, Calif.

* is an active corporate citizen. Community service projects include such things as the following: sponsoring "Professor Bodywise and His Traveling Menagerie," a live theatre production for elementary school children that promotes good health and safety; serving as a corporate sponsor of "Harmony in a World of Difference," a program designed to promote racial equality in the Kansas City area; co-sponsoring with the Boy Scouts of America an annual food drive called "Scouting for Food," which helps provide food for needy families and the homeless.

* was founded by industrialist Henry J. Kaiser and Dr. Sidney Garfield. The pair demonstrated the viability of pre-paid group practice health care on projects such as the Los Angeles Aqueduct and Grand Coulee Dam, and during World War II, in the construction of the Liberty Ships. Kaiser Permanente opened to community enrollment in 1945.

* For more information contact **Cheryl Dillard**, government and community relations manager, (913) 722-8484.

Kaiser Foundation Health Plan of Kansas City, Inc.
6900 Squibb Road, Suite 201 Shawnee Mission, Kansas 66202 (913) 722-8400

The New York Times
Business

Why Kaiser Is Still the King

As the nation's health bill soars, companies and employees are flocking to the low-cost H.M.O.

By GLENN KRAMON

OAKLAND Calif.

KATHY ADAMS looked down at her 4-week-old son, born two months prematurely, and remembered the weeks of medical care he received under the Kaiser Permanente Medical Care Program, from the intensive-care ward to the doctor's office. "Emotionally and medically," she said, "they were top notch."

Then she thought of the bill — or, rather, the lack of one. "I have friends who have had babies in other hospitals who are still paying the bills three years later," said Ms. Adams, a social worker at Alternative Family Services, one of the many employers to offer the Kaiser health plan.

Kaiser, a health maintenance organization that gets a fixed fee for each member no matter how much care is provided and that keeps costs low, has its critics. But at a time when the nation's health-care bill is soaring and when companies are asking employees to pay more of the cost, people like Ms. Adams are swelling Kaiser's enrollment so fast that applicants are being turned down for lack of room.

Kaiser is now by far the largest H.M.O. in the country, with six million members. And in a period of growing competition and industry shakeout among all types of health-care plans, Kaiser has also won a new respect for its stability and for apparently controlling costs without sacrificing quality.

Indeed, Kaiser is now seen by some as a model for health plans of the future. "We as a nation would be much better off if we had a lot more of our care delivered by organized systems like Kaiser," said Alain C. Enthoven, management professor at the Stanford Business School and a well-known specialist in health care. "My only regret about Kaiser is that we don't have several dozen more of them. It would be better if there were strong competitors," said Professor Enthoven, who is a consultant to Kaiser.

But as successful as Kaiser is, competition from other health plans, including prepaid plans that allow patients a bigger choice of doctors and better service, has forced it to change in some respects. And some inside and outside the program worry that these changes may raise Kaiser's costs and cause it to stray from its winning formula.

Already, Kaiser plans to adjust rates for some employers that argue that their employees cost less to serve — something Kaiser has traditionally not done. It also has begun advertising for the first time, with a smooth television, radio and print campaign ("Good People. Good Medicine") that personalizes the program's physicians.

Kaiser is even experimenting with allowing members to use outside doctors. Many physicians at Kaiser fiercely oppose such a move, worried that it will compromise the tightly knit group practice that makes Kaiser successful in controlling costs and looking after quality.

Another problem is that Kaiser has not been immune to the general health-care industry's soaring costs. While it remains the least-expensive plan offered by most employers, it had to increase its rates 11 percent systemwide this year, more than twice the rate of the previous three years, and it expects a rise of more than 15 percent for next year.

And there is uncertainty about whether Kaiser can make its newer operations elsewhere as popular and cost-effective as its established California groups.

But if anyone has a chance to make it, it is Kaiser. So big has it become that if the nonprofit Kaiser

Continued

Fully Busy' Surgeons

Paying doctors a fixed amount no matter how many services they provide rather than a fee for every service performed discourages unnecessary and inappropriate services, Professor Enthoven said.

"They match the resources used to the needs of the population served," he said. "They hire specialists in numbers just enough to keep them fully busy, which means they can make a good living at a low cost per case. All their neurosurgery in northern California is done at one of their 14 medical centers by a team of eight surgeons. Those doctors have full operating schedules; it's well-documented that practice makes perfect."

Indeed, Professor Enthoven said, Kaiser "won't do a procedure like open-heart surgery until it can do it in a high-volume way that assures proficiency. They would contract it out to a high-volume producer until they are ready to do it at high volume themselves." By contrast, he said, many hospitals do fewer than the number of operations thought to be required for proficiency by medical societies and health departments. "And because they do not have a high volume, they charge more per case," he said.

Kaiser says another reason its costs stay down is that its hospitalization rate is relatively low. In 1987, it had 387 hospital days per 1,000 members, compared with an average 650 days for fee-for-service health plans. In addition, its huge size permits it to negotiate lower purchase prices.

The program also has pioneered the appropriate use of less costly care — like home nursing care and the use of nurse practitioners and physician's assistants to perform tasks like routine physicals, said Dr. Paul D. Lairson, the liaison with the physicians who work at Permanente.

Finally, Kaiser has also been successful because it can attract good doctors, advocates say. In fact, in some specialties and regions the competition for jobs is intense. "We try to pay our doctors over a lifetime fairly close to what they would make in standard practice," Dr. Lairson said. Starting pay is at least $60,000 and the average physician makes a six-figure salary, with raises based on specialty, seniority and merit.

"They won't make $400,000 a year, but there are benefits like having someone else on at night and regular days off, sick-leave benefits and a retirement program," Mr. Vohs said.

Fiddling With a Formula

But even with its success, Kaiser is under pressure to change in the face of increasing competition. It has increased the ratio of physicians to members, to 1 to every 770 from 1 to 1,000 in 199 Mr. Vohs said. In the Bay Area, it has also opened satellite offices more convenient to many members. It now offers primary care during evening hours at some centers.

It has also begun to help patients choose their own physicians andimproved a phone system notorious for tie-ups. "Competition has been good for us," said Robert M. Crane, a senior vice president at Kaiser.

But there are also changes Kaiser is making reluctantly, fearing that they will undermine the plan's basic philosophy. It is being forced to alter the way rates are set. Historically, Kaiser based its rates on its costs of serving an entire community of l ser members, which means that t.. costs of expensive patients are spread across a broad base. Now, many employers argue that the average cost of caring for their employees is lower than that of the community and that they no longer want to subsidize other people.

So Kaiser is proposing a compromise. Beginning in 1990 it will reduce or increase the rates of large groups depending on their costs, but by no more than 5 percent a year. But "we will also continue a subsidy for those individuals and small groups who can't get insurance or only very expensive insurance," Mr. Crane said.

Perhaps the most difficult change being studied involves how to respond to the growing variety of competitors that boast of a much greater choice of physicians than is offered at H.M.O.'s like Kaiser. Though it has long been committed to the group practice concept, Kaiser has begun experimenting with allowing members in Bakersfield, Calif., to use outsideKaiser for primary care,though they pay extra when they do so.

Whether Kaiser can stand up to health-care inflation is another question. Other kinds of medical plans have raised their rates sharply, so Kaiser can, too. Higher rates enable it to make improvements that make it more competitive with plans that emphasize service. It can further increase the ratio of physicians and nurses to members, for example.

But Professor Enthoven of Stanford worries that in trying to make itself more attractive, Kaiser will sacrifice some cost-effectiveness, increase its rates, and become less of the health-care model that it is now. ■

'YOU HAVE TO KNOW **HOW TO USE THE SYSTEM'**

IN its earlier days, the Kaiser health care program was sometimes dismissed as assembly-line medicine. But recent interviews with 17 Kaiser patients of many ages outside the program's hospitals in San Francisco and Redwood City, Calif., found overwhelming enthusiasm for the system.

"Kaiser got a real bad rep years ago because waits were longer and it was harder to choose your own doctor," said Janet Nuñez of Campbell, Calif. "But it's improved. If it were bad, I would change plans."

Virtually everyone was pleased with the ability of the doctors, noting that, as in any program, there are good ones and bad ones.

While the San Francisco hospital in particular seemed crowded — for example, 31 people were waiting in line at the specimen collection station — almost everyone interviewed denied that waiting times were long enough to bother them.

"You just have to know how to use the system," said Mary Stanisich of Burlingame, Calif. That includes selecting the right physician to guide you through the system, she said.

The patients emphasized that Kaiser may not be the right place for those who want to be babied. "If you are truly sick and need care, you can get it. But otherwise it's a lot like the Army — they won't give you much time," said a Palo Alto man.

Indeed, a Kaiser plan can have shortcomings. Coverage of mental health and substance-abuse treatment is sometimes not as extensive as that offered by more conventional plans. And a San Francisco physician at Kaiser, who asked that her name not be used, said waiting times can be too long, appointments can be hard to get and that doctors often do not have enough time to spend with each patient. Kaiser executives concede that membership has grown so fast that it is sometimes hard to keep up.

The one patient who was critical of Kaiser among those interviewed complained that "you have to be a fighter to get what you want, and when you're sick that's not easy. You can get lost in the system."

But many other patients interviewed said they found the same to be true in non-Kaiser systems. The low out-of-pocket cost at Kaiser, they said, made up for the inconveniences.

STATEMENT BEFORE THE JOINT HOUSE-SENATE COMMITTEE ON INSURANCE

Marion P. Broderick
Senior Vice President of Marketing
Prime Health Kansas City, Inc.
January 30, 1990

Attachment 10

Thank you for the opportunity to address the Joint House-Senate Insurance Committee on the subject of health care insurance cost increases--a problem which has grown to crisis proportions in the State of Kansas and across the nation.

Prime Health of Kansas City is a Health Maintenance Organization licensed by the States of Kansas and Missouri. Prime Health provides medical cost protection and health care services to more than 80,000 people in the greater Kansas City metropolitan area. Our Plan was developed in 1976 with the support of local business, labor and community representatives who felt that an alternative to conventional health insurance was needed in Kansas City.

Prime Health presently offers several benefits options, all of which provide comprehensive coverage. All members enjoy 100 percent coverage for: well-baby and well-child care, including immunizations; pre- and post-natal care; and routine physical exams. Some benfits packages include small copayments for physician office visits and/or hospital care. Ninety-seven percent of all Prime Health members have prescription drug coverage with a modest copayment of $3.00 or $5.00. No deductibles apply nor is coverage waived or delayed for pre-existing conditions.

Despite the comprehensive level of benefits, Prime Health's rates are very competitive with those of competing insurers and HMOs in our market.

Prime Health is able to provide comprehensive benefits at competitive rates for two reasons: (1) our organizational structure allows us to investigate cost problems and devise programmatic solutions; and (2) our membership is large enough for us to subject cost problems to a make-or-buy analysis.

Prime Health is a mixed model HMO. Eighty percent of our members receive care at one of six medical centers located throughout the Kansas City metropolitan area. Primary care physician specialists in these centers are employed by Prime Health and devote their entire practices to members of the HMO. Twenty percent of our members receive primary care from independent physicians who contract with Prime Health as part of our community networks. Prime Health networks are intentionally kept small to ensure a level of physician communication and commitment comparable to that found within our medical group.

The power of Prime Health's organizational structure and its membership base to influence cost effective health care is exemplified in the development of our out-patient substance abuse program nearly three years ago. Prime Health experienced significant increases in drug and alcohol treatment utilization in 1985-1986. Our practice of treating patients in the most appropriate and cost-effective setting was thwarted in the area of substance abuse treatment because out-patient programs were virtually nonexistent in the Kansas City area.

We developed our own comprehensive, out-patient substance abuse treatment program. Our inpatient utilization for drug and alcohol abuse in 1989 was half that of 1988, and total treatment costs were significantly lower. Equally important, the success rate of patients in our outpatient program is comparable to, or better than, published statistics for inpatient programs.

The ability of Prime Health's organizational model to manage health care resources could imply that we are immune to the problem of health care cost inflation. That is not the case. After very moderate rate increases in the mid-1980's,

Prime Health's premiums increased 10 percent from July 1987 to June 1988, 14 percent from July 1988 to June 1989, and are increasing 15 percent in our current fiscal year ending June 1990. While these increases seem low compared to those of conventional insurers, they do exceed the overall inflation rate.

There are some factors of particular interest to this committee which influence these cost increases. I would like to touch on a few of these briefly. In our experience, mandated benefits do contribute significantly to cost increases. Because Prime Health operates both in Kansas and in Missouri, we meet two different sets of benefits mandates.

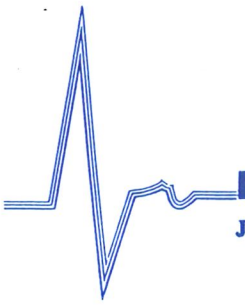
Within two years of mandated higher coverage for inpatient mental health and substance abuse in Missouri, our actual discharge rate doubled. In the first 18 months after higher coverage for inpatient mental health in Kansas was mandated, total discharges for substance abuse and mental health increased 30 percent.

HMOs do not escape other forces that drive premium increases. Malpractice costs are significant, both in premiums paid for malpractice coverage and in the added costs of defensive medicine. Advances in medical technology and the development of new drugs add to the total.

Prime Health is eager to work with you to further examine this problem and perhaps devise some solutions. We do ask, however, that the demonstrated ability of HMOs to contain costs not be undermined by these solutions.

"We care for . . .

those You care for."



JCM

JEFFERSON COUNTY MEMORIAL HOSPITAL
AND GERIATRIC CENTER

GAROLD J. FOWLER, ADMINISTRATOR

January 30, 1990

TO: Joint House - Senate Insurance Committee

FROM: Garold J. Fowler, Administrator

RE: Cost of Employee Healthcare Insurance

I would like to thank my representative Joann Flower by keeping me abreast of the important issues being investigated by the legislators of our fine State of Kansas, and to this most prestigious group for allowing me the opportunity to address one of the most important issues in the rising costs of employee benefits. That issue, ladies and gentlemen, is employee healthcare insurance.

What would you do if your salary was going to be cut just a little over 17%, when your gross income was approximately $9,780/year? What would you do as an employer if your employee insurance benefit line item was going to increase by 46.5% ? You would do what I did ..... I looked for another insurance plan with a higher deductible which included looking for another insurance provider.

One problem that existed as we conducted our search was the limited amount of time for another company to give us a quotation. We had less than 60 days until our new rates would go into effect. A lot of factors go into the actual quote from a new insurance company, and it is customary for an employer to allow at least 90 days for this quote. After several phone calls and a few presentations we did find a company willing to insure our employees. This company (I'll refer to as Company B) offered a lower premium with a higher deductible. It was decided to switch our employee health insurance from our existing company (I'll refer to as Company A).

As it came down to the deadline to inform Company A of the decision to terminate our contract, I discovered several factors that would cause Company B not to approve our employee insurance plan. Even if they did approve the plan, the rates would increase.

Attachment 11

R.R. 1 Box 1 • Winchester, Ks. 66097 • Hospital 913-774-4340 • Geriatric Center 913-774-4730

It was decided to stay with Company A, and take a higher deductible. Even with this higher deductible the above mentioned employee's salary cut would still be 11.9%, and the employee benefit line item would increase 31.5%.

The employee health insurance at Jefferson County Memorial (JCM) is available to all employees. The insurance benefit offered is based upon the number of hours worked. If the employee works from 20 to 32 hours/week JCM pays 5% to 50% of the premium respectively. The type of coverage available for 1990 is attached. Please refer to this benefit summary page. Various factors can cause the premiums to increase. One of the factors which increased our premiums in the past year was the claims paid for our subscriber's healthcare costs.

I can offer three alternatives at this time to conventional healthcare costs. These alternatives are listed according to my personal priority. The first two alternatives offer the least amount of financial risk to JCM.

1. Merging of all Hospitals in Kansas into one group. This could also be broken into two groups according to the urban/rural classification. This could be done by a large Company such as Blue Cross and Blue Shield. This is presently done with federal employees.

2. Offering a choice of insurance plans. Presently, all our employees have to take the same policy.

   Explanation: A 55 year old employee with no children may not need the maternity benefit, but would want the Mammography coverage. A 20 year old may want just the opposite.

3. Providing self-insurance is an alternative. However, this could impose a higher financial risk.

Again I would like to thank you for allowing me to give testimony to this very important issue that faces Jefferson County Memorial Hospital, Inc. and Geriatric Center as well as all employers of this great State of Kansas.

BENEFIT SUMMARY

FOR

JEFFERSON COUNTY MEMORIAL HOSPITAL

Sample of Health Benefits:

Hospital	Office Visits
Surgery	Newborn Care
Anesthesia	Physical Medicine
Maternity-Single/Family	Medical Equipment
X-Ray	Ambulance
Laboratory	Routine Physicals
Eye Examinations	

$1,000,000 Individual Lifetime Maximum.

Deductible: $300 Maximum of two deductibles per family.

Co-Insurance: 80%
When subscriber's 20% reaches $1000 in a contract year, eligible services will be covered at 100% for remainder of the contract year. The family's 20% maximum is $2000.

Dependents to age 23 or marriage.

In-Patient Nervous & Mental Benefits - Limited to 30 days.

Out-Patient Psychiatric Rider - $1,000 Maximum.

Accidents are subject to deductible or co-insurance.

Stand Alone Drug Program: Generic Drugs are subject to a $3.00 deductible. Name Brand Drugs are subject to a $5.00 deductible.

Dental:

No Deductible - Payment at 100%

Oral Exams	Cleaning
Root Canals	X-Rays
Simple Extractions	Fillings
Emergency Treatments	Anesthesia
Repair of Dentures	Periodontal Work

No Deductible - Payment at 50%

Space Maintainers	*Inlays
Oral Surgery	*Crowns
Removal of Root Tip	*Dentures
	*Bridges

Monthly Health & Dental Rates	Traditional
Single	$255.24
Family	$558.58

*Subject to a 240-day waiting period.
The above rates are based on a 1/1/90 renewal date.

Unified District No. 338

VALLEY FALLS PUBLIC SCHOOLS

VALLEY FALLS, KANSAS 66088

GERALD D. McCLURE, Principal
Valley Falls High School
913 - 945-3411

RANDY L. FREEMAN, Principal
Valley Falls Grade School
913 - 945-3532

JOHN MARYE, A.D.
913 - 945-3532

JERRY K. FUQUA, Superintendent
913 - 945-3259

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January 30, 1990

Joint House and Senate Committee on Insurance.
Representative Dale Sprague Senator Richard Bond

BC/BS Insurance cost for U.S.D. #338

As with most schools in the state of Kansas, our school has seen a large increase in health premium costs for our group. We have had to increase our deductable significantly in order to hold the premium down to an affordable level for our employees.

The following figures show the increase for our school for the past five years in both premium and employee deductable amounts.

Year	Monthly Family Premium	Deductable Amount
1985-86	$204.46	100
1986-87	250.95	100
1987-88	291.26	500
1988-89	312.33	500
1989-90	338.65	2000

If we had kept the same plan for 1989-90 that we had in 1988-89, our family monthly premium would be $459.09. This would have been an increase of $1,645.00 or a 40% increase a year in insurance premiums. Our teacher salary increase for the year was $1200.00 which represented a 6% increase.

If we had kept the $500 deductable plan at $459.09 per month, our beginning teacher with a family would be paying $5,473.00 a year for insurance. This would represent over 26% of their salary for health insurance. By going with a higher deductable their annual cost for health insurance is still 20% of a beginning teacher salary.

For my district, health insurance cost is the biggest concern we have. We also know this is a problem with other school districts state wide. School have collectively sought a solution to high premium cost for health insurance, but as yet, no answers are available. We were glad to see a bill introduced last week to strike the exclusion in Kansas Municipal Funded Pool Act which prohibits pooling for health insurance. This may be the tool that will eventually help health care cost.

We want to thank this joint committee of the House and Senate for looking into the health insurance issue.

Attachment 12

Jerry K. Fuqua

GENERAL BUSINESS
OR
PLAN 65 CLAIMS
In Topeka
913 291-7000
In-State
1-800-432-0216
Out-of-State
1-800-468-1216

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

STATE 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
1-800-432-3531

Blue Cross and Blue Shield
of Kansas
1133 Topeka Boulevard
P.O. Box 239
Topeka, Kansas 66629-0001

Current

TO: Mr. Jerry Fuqua
USD 338

FROM: Mark D. Isley

SUBJECT: November Renewal Rates $500 deduct 50-50 share payment

Traditional

Monthly Rates:	Single	Family	MER(Over 65)
Current Rate:	$144.68	$318.97	$ 91.58
Rate Effective:	$206.45	$456.09	$134.27
Total Rate Adjustment:	+$ 61.77	+$137.12	+$ 42.69

Choice Care

Monthly Rates:	Single	Family	MER(Over 65)
Current Rate:	$141.80	$312.33	$ 91.58
Rate Effective:	$199.57	$440.23	$134.27
Total Rate Adjustment:	+$ 57.77	+$127.90	+$ 42.69

12-2

TOPIC: High cost of health insurance, especially as it affects schoolteachers
CONFEREE: Stan Pomeroy, teacher at McLouth High School, USD 342

STATEMENT OF PROBLEM:

Is it in the best interest of Kansas schoolchildren to have teachers who are without health insurance coverage? We teachers at McLouth fear that more and more teachers are tempted to go without health insurance due to the skyrocketing costs.

EVIDENCE OF PROBLEM: The following are the health insurance costs at McLouth USD 342:

1987-88 monthly cost	1988-89 monthly cost	1989-90 monthly cost
Single: $83 (80% coinsurance)	Single: $111 (80% coinsurance)	Single: $165 (80% coinsurance)
Family: $203	Family: $247	Family: $355

To make matters worse, the above monthly premium costs would have risen even higher had we not raised our deductible. In 1987-88 the single deductible was $100; not it is $300. In 1987-88 the family deductible was $300; now it is $1,000!!

And we <u>have</u> shopped around for the best deal possible. In 1987-88 our carrier was Principal Mutual. This year it is Blue Cross/Blue Shield.

POSSIBLE SOLUTIONS:

1. Have KPERS administer a health insurance program for all public employees of Kansas. This would broaden the covered group enough so that huge increases would be less likely to occur. (McLouth got socked with big increases partly due to a stroke and a back surgery we had in our small group the same year.)

2. Earmark some funds especially for health insurance benefits for the schools. We teachers know money is especially tight this year. I personally could accept not having a pay raise if I knew that health insurance would not ensure that I took home <u>less</u> in my paycheck than I did the year before!

Risk Management Department

WICHITA
PUBLIC SCHOOLS

Testimony of L.A. 'Mick' McBride before the Joint House-Senate Insurance Committee on January 30, 1990.

Mr. Chairman, members of the Committee, I am Mick Mcbride, Supervisor of Risk Management for Unified School District No. 259 in Wichita, Kansas. My duties include supervision of the district's insurance and risk programs. Thank you for allowing me to appear before you today.

The Wichita district provides a comprehensive health plan for all employees working half-time or more in a permanent position and for retirees through the attained age of 65. The district has designed this program to provide protection for the catastrophic loss as opposed to paying for routine, elective health care. The plan includes coverage for in-hospital care, out-of-hospital care, nervous and mental care, chemical dependency treatment, and dental care. During the last two years coverage for several preventive care examinations have been added to the plan with the hope that an investment in employee health today will save money in the future. The plan does provide coverage for benefits mandated by the State of Kansas and the Federal Government. The cost of this plan is a part of the salary benefit package offered by the district to it's employees and is subject to the budget authority limits placed on the district. Because of this the district is very interested in cost containment.

A good health benefit helps the district hire and retain a quality work force. In order to offer a good health plan and in an attempt to gain control over the actual benefit offered and the cost of that benefit, the Wichita district established a self fund health plan in 1981 for the district's administrative and classified employees. The teacher group opted to continue with a fully insured plan until 1988 when a self funded plan was established for that group. We believe the self funded plan has allowed the district to achieve it's goals.

The self funded plan added a dental benefit that had not been available previously. Claim payment services were brought to Wichita, which allowed an employee to talk face-to-face with the person that processed the claim. All eligible employees were

Administrative Center • 217 North Water • Wichita, Kansas 67202

automatically enrolled for family coverage which was fully paid by the district. Payroll deductions for premiums were not required. The district purchased claim payment services and stop loss insurance to guarantee the financial stability of the plan but premiums were paid to the self fund plan instead of to an insurance company. This allowed the plan to accumulate reserves and to earn interest on the accumulation which were credited back to the plan.

The wichita district has made a strong commitment to providing quality benefits to it's employees and the self funding mechanism is the preferred system to use to provide these benefits. A self funded health plan was started in 1981 followed by a self funded short term disability plan in 1985 and a self funded worker's compensation plan in 1987. However, self funding health insurance is not the final solution to the problems associated with health care in Kansas. It does not curb medical inflation, the cost of medical technology, or cost shifting. However, it is a mechanism that allows an employer to minimize it's dependance on an insurance company and ever increasing premium rates. It allows the employer to work closely with employees on a benefit plan design that provides necessary coverage at a cost that is acceptable. It allows the employer to utilize accumulated reserves to avoid the ups and downs caused by the cyclical nature of the insurance industry. It aids in the budgeting process for the school district.

In summary, we would urge you to continue to allow school districts to self insure health insurance benefits. We are opposed to mandated first dollar health benefits because of the potential adverse cost consequences. We are opposed to taxing health insurance benefits because in many respects the cost of health care and thus the health insurance benefit is beyond the control of the district. We would like to have the ability to establish cost containment programs for workers' compensation plans the same as have been established for health insurance plans. Finally, we hope that when the question is asked, the Committee will agree that school districts should be allowed to expand the self funding mechanism into other areas where the experiences discussed here may also be received.

UNIFIED SCHOOL DISTRICT NO. 259
PREMIUM HISTORY

	TEACHER PLAN BLUE CROSS/BLUE SHIELD		ADMINISTRATIVE/CLASSIFIED SELF FUNDED PLAN
	SINGLE	FAMILY	FAMILY
1981/82	82.20	197.26	100.00
1982/83	89.63	210.99	100.00
1983/84	93.29	218.01	125.00
1984/85	92.54	219.21	160.00
1985/86	95.14	226.18	176.00
1986/87	95.14	226.18	184.00
1987/88	103.70	237.49	190.00
	SELF FUND PLAN EFFECTIVE		
1988/89		160.00	200.00
1989/90		176.00	215.00

STATE OF KANSAS

ARTIE LUCAS
REPRESENTATIVE, FORTY-NINTH DISTRICT
DONIPHAN COUNTY AND PARTS OF
BROWN, ATCHISON AND
JACKSON COUNTIES
608 E. VIRGINIA
RT. 1, BOX 170A
HIGHLAND, KANSAS 66035

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
MEMBER: ELECTIONS
ENERGY AND NATURAL
RESOURCES
TRANSPORTATION

THANK YOU MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE FOR THE OPPORTUNITY TO SPEAK TO YOU ON THIS ISSUE. JUST AS IT IS MY RESPONSIBILITY AS AN INDEPENDENT INSURANCE AGENT TO PROVIDE THE NECESSARY SERVICES TO MY CLIENTS AT A PRICE THEY CAN AFFORD, SO IT IS OUR RESPONSIBILITY AS SENATORS AND REPRESENTATIVES TO SEE THAT NECESSARY SERVICES ARE PROVIDED AT AN AFFORDABLE PRICE TO OUR CONSTITUENTS.

HEALTH CARE IS NO EXCEPTION. WE ARE SEEING, ACROSS THE STATE, THE AVAILABILITY OF HEALTH INSURANCE AT A REASONABLE PRICE BECOMING SO SCARCE AS TO BE NON EXISTANT. WHEN I HEAR OF SCHOOL DISTRICTS SUCH AS USD 501 HERE IN TOPEKA PAYING OVER $530 A MONTH FOR A FAMILY PLAN OR CITIES SUCH AS FT. SCOTT NO LONGER PROVIDING GROUP INSURANCE PLAN FOR THEIR EMPLOYEES DUE TO PREMIUMS GOING TO $600 A MONTH, I HAVE TO QUESTION WHETHER WE ARE TRULY PROVIDING FOR OUR CONSTITUENTS NEEDS.

THESE ARE BUT A FEW OF THE EXAMPLES AND RAISE MANY QUESTIONS REGARDING THE PRESENT HEALTH CARE SITUATION IN KANSAS.

WHY ARE THE KANSAS INSURANCE STATUTES SO RESTRICTIVE AS TO PENALIZE KANSANS. I AM NOT IMPLYING THAT THE INSURANCE COMMISSIONERS OFFICE IS INTENTIONALLY DOING IT, BUT THE APPEARANCE IS THAT THEY ARE FAVORING BLUE CROSS/BLUE SHIELD IN THE WAY THEY ARE INTERPRETING STATUTES.

Attachment 15

THE RELATIONSHIP BETWEEN BLUE CROSS/BLUE SHIELD HAS HISTORICALLY BEEN ONE THAT APPEARS TO HAVE SUCCESSFULLY LIMITED COMPETITION IN MANY AREAS.

THEY ARE ALLOWED TO OPERATE AS A FULLY INSURED COMPANY WHEN IN REALITY THEY ARE A PREPAID MEDICAL PLAN.

WHY HAS BLUE CROSS/BLUE SHIELD BEEN THE ONLY BIDDER FOR THE STATE EMPLOYEE BENEFIT PLAN SINCE 1978?

HOW IS IT BLUE CROSS/BLUE SHIELD CAN REDUCE THEIR RATES TO MEET COMPETITIONS RATES BY 10's OF THOUSANDS OF DOLLARS AND YET REQUEST RATE INCREASES THROUGH THE INSURANCE COMMISSIONER.

WHY IS IT THAT PROGRAMS OPERATING IN STATES THROUGHOUT THE COUNTRY ARE NOT ACCEPTABLE IN KANSAS COSTING CITIES AND COUNTIES IN KANSAS 100's OF THOUSANDS EXTRA BECAUSE OF OUR INTERPRETATION OF THE FEDERAL ERISA LAWS.

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HOUSE OF
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RESOURCES
TRANSPORTATION

Recommendations of Rep. Lucas to Joint Insurance Committee

on January 30, 1990:

1) Introduce legislation regulating Third Party Administrators:

requiring
- Liscensure by Kansas Insurance Commissioner
- Specific Bonding and Errors and Omissions Limits
- Payment of a Certification fee (Premium Tax) on all self-funded insurance plans administered in Kansas.

2) Review the Federal ERISA Laws dealing with Multi-Employee and Association Benefit Group Trust

3) Review KSA 40-2222 proposed amendment (see attached)

STATE OF KANSAS

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TRANSPORTATION

AN ACT relating to insurance, concerning the jurisdiction of the commissioner of insurance, amending K.S.A. 40-2222 and repealing the existing section.

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

Section 1. K.S.A. 40-2222 is hereby amended to read as follows: 40-2222. Any person or other entity which provides coverage in this state for medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric expenses, whether such coverage is by direct payment, reimbursement, or otherwise, shall be presumed to be subject to the jurisdiction of the commissioner of insurance unless the person or other entity conclusively shows by submission of an appropriate certificate, license or other document issued by a governmental agency that it is subject to the jurisdiction of an agency of this state or the federal government. Any entity that has obtained recognition of its exempt status under Section 501(c)(9) of the Internal Revenue Code shall be considered to be subject to the jurisdiction of an agency of the federal government and shall not be subject to the provisions of Chapter 40 of the Kansas Statutes Annotated or of the jurisdiction of the commissioner of insurance provided that such entity files satisfactory proof with the commissioner that it is covered by stop loss or excess insurance issued by an insurer subject to the jurisdiction of the commissioner for claims expense substantially in excess of anticipated contributions by or on behalf of individuals covered by the entity.

Sec. 2. K.S.A. 40-2222 is hereby repealed.

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

15-4

XIV. ALTERNATIVE PLANS TO BE BID

A. Interested parties are invited to submit proposals on statewide medical insurance plans conforming to the following basic provisions:

Benefits described as "Traditional" in the "Group Certificate/Booklet (12/88)" provided as Exhibit I, excluding "Part IV - Dental Care Program" and excluding "Part IV - Prescription Drug Program"; a fully insured plan with premium rates as structured for current categories. (Use Rate schedule HCC-90).

B. In addition to submitting proposals on the preceding basis, responders are asked to elaborate on the following:

1. Discuss procedural and other practical aspects of incorporating a higher premium for tobacco users within the rate structure.

2. Developing utilization review programs for
   a) outpatient medical care
   b) mental health, drug and alcoholic treatment
   d) chiropractic care

C. Use Rate Schedule HCC-90-D in submitting a proposed statewide dental insurance plan consistent with Part IV, Exhibit I, (Group Certificate/Booklet).

D. Use Rate Schedule HCC-90-E in submitting a proposed statewide outpatient prescription drug plan consistent with Part IV, Exhibit I, (Group Certificate/Booklet).

E. The Commission will also consider bids for alternative plan provisions, in particular PPO or SRO similar to benefits described as "Blue Select" in the "Group Certificate/Booklet (12/88)" provided as Exhibit I.

XV. REPORTING REQUIREMENTS

Outlined on the following page is a list of reports the State requires along with the scheduled dates as to when the reports will be supplied. If the selected carrier is unable to furnish any of these reports within ten (10) working days of the due dates, the carrier is charged a penalty of $1,000 for each report that is late and an additional $1,000 penalty for each ten (10) working days thereafter that the report is late. The various reports should be broken down between medical and dental.

Mike Samuelson (Groups)

1) Newman Hospital Emporia, Ks
Personal Director Ron Larrison

I was told by Mr Larrison we were by far under BC/BS Bid for the Group Health Insurance Program at Newman Hospital On the day before Mr Larrison was to make his presentation to the Board of Directors BC/BS came back in and lowered their Bid. @ 120,000
5 years

2) Cherokee County Gov't
County Clerk Maurice Soper

BC/BS had submitted their proposal to Cherokee county for next year they were 168.65 single + 365.70 family. We were again alot lower at 126.92 + 333.53 which amounted to (year) → 41,721.48 in savings to the county. BC/BS once again on the final day decided to lower their rates to around 285.00 per family I was told by Mr Soper. @ 70,000

12/21/89

Jim —

JOHN - Garrison called City of Pittsburg - they renewed with BC/BS — they reduced their renewals rate by $42.00 (Equalled our Rate)

Sorry Guy

RURAL WATER DISTRICT HEALTH PLAN

	BC/BS	RWD	ANNUAL SAVINGS
Kinsley	45,984	34,800	11,184
Baldwin	105,336	77,688	27,648
Wamego	66,060	60,924	5,136
Oakley	139,152	83,616	55,536
Brown County	157,140	86,400	70,740
Doniphan Dounty	178,464	126,720	51,744
BRB	216,406	179,174	37,232

GROUPS THAT WOULD HAVE REALIZED SAVINGS ON RURAL WATER DISTRICT HEALTH PLAN

City of Council Grove
City of Centralia
City of Lebanon
City of Thayer
City of Nickerson
Osage City
City of Harveyville
City of Toronto
Elk City
City of Burr Oak
City of Parsons
City of Whitewater
City of Peabody
City of Peru
Wallace County

KAN[illegible]-NATIONAL EDUCAT[illegible]N ASSOCIATION / 715 W. 10TH ST[illegible]ET / TOPEKA, KANSAS 6661[illegible]6

Written testimony submitted by
Kay Coles
Kansas-NEA
House and Senate Insurance Committees
January 30, 1990

Mr. Chairman and members of the House and Senate Insurance Committees, we thank you for allowing us an opportunity to address the issue of health insurance premium costs.

For educational employees throughout Kansas, the issue of health insurance costs is paramount. Premiums have increased dramatically in recent years and the spiraling expenses show no indication of easing.

Many Kansas-NEA members find their take home pay decreasing due to rising health insurance premiums and the higher deductibles that many school districts have been forced to establish. In several of our local associations, members have found their salary increases completely eaten up by increased health insurance costs. This is an issue of grave concern to all.

Kansas-NEA has formed an internal Task Force to look at health care and health insurance issues and we will be examining ways to best deal with these problems.

An informal survey taken by our association reveals the extent of this problem. Attached you will find a summary of our survey results. Of particular concern to us are the percentage increases you will find in the third column on the attached page (Attachment #1).

These percentage increases represent the health insurance premium increases in ONE YEAR. If these trends continue we will find that everyone's best efforts to increase the salaries of our state's teachers will fail.

We cannot pretend to have the answers or solutions to this extensive and complex problem. However, when looking at the soaring costs of health insurance, we must, by necessity refer to the increasing costs of health care.

Information provided by Albert Jones, President of Employee Benefits, Inc. in West Lebanon, N.H. is highlighted below. Mr. Jones, in speaking to a NEA conference on health care provided data on the causes, and how much they contribute to, the sizable increases in health care costs nationwide:

16% due to utilization.
20% due to advanced technology and catastrophic cases.
1.4% due to malpractice settlements/insurance.
32.6% due to medical inflation.
29.5% due to cost shifting.

Attachment 17

Telephone: (913) 232-8271

Although we do not have the definitive solution on how the problem of health insurance premiums should be solved, we would offer the following suggestions for your committees to review during deliberations in the 1990 session:

*Any remedies must focus not only on the user, but also on the provider. While high usage can drive up premiums, we have seen many instances where significant premium increases could not be attributed to usage. Looking at the whole picture -- the roles of users and providers -- might provide clues toward solutions.

* Requirements that school districts provide a minimum level of health insurance for employees. While this remedy also has its attendant problems, a minimum level of insurance has the potential of helping keep premium costs down. If everyone were provided the same minimums, health insurance providers might be more willing to write affordable policies.

* Health care cost controls, although not specifically what the committees are looking at today, are important to the overall issue of health insurance premiums. Reinstituting certificates of need might aid in controlling health care costs, as would a review of why some hospitals charge $25 for an aspirin, or charge high fees for a "special diet" that consists of toast and water.

* We would urge the state to examine establishment of a catastrophic health insurance plan -- paid for by the state -- for all Kansans. We have found that small groups are particularly hard hit by one or two catastrophic cases, sending premiums soaring.

* Of benefit to employees would be a requirement that employers pick up more of the cost of health insurance premiums. School districts are pushing more and more of the health care cost responsibility to employees. Deductibles of $800 to $1,000 and even $2,000 are becoming more common, forcing more out-of-pocket costs for employees. Similarly, teachers are being asked to pay a greater share of the cost for health insurance premiums.

* The committees might examine the potential of a statewide health care plan which would provide medical coverage for all Kansans. Such a mini-nationalized health care plan might provide impetus for adoption of much-needed national health care.

It is our desire to work with these committees to address this issue of grave importance to our members. We will share information with you as it becomes available to us and we look forward to the opportunity to work together.

We thank you for listening to the concerns of our 25,000 members.

K-NEA informal health insurance survey results
(Selected responses)

USD	Premium (family/per month)	% increase '88-89 to '89-90
243 (Lebo-Waverly)	$ 364.00	32%
246 (Northeast)	348.39	
333 (North Cloud)	330.47	33%
329 (Mill Creek Valley)	285.78	22%
372 (Silver Lake)	378.88	40%
287 (W. Franklin)	291.67	31%
251 (N. Lyon Co.)	327.92	68%
457 (Garden City)	401.86	
421 (Lyndon)	349.00	47%
202 (Turner)		46.3%
450 (Shawnee Heights)	461.61	54%
467 (Wichita Co.)	414.32	59%
294 (Oberlin)		55%
445 (Coffeyville)	424.03	50%
409 (Atchison)	411.00	42%
442 (Nemaha Valley)		37%
451 (Nemaha Co.)		34%
405 (Lyons)	300.00	22%
304 (Bazine)	402.30	25%
350 (St. John-Hudson)	396.70	25%
403 (Otis-Bison)	363.72	31%
351 (Macksville)	378.00	32%
228 (Hodgeman Co.)	400.82	31%
496 (Pawnee Heights)	389.36	46%
495 (Ft. Larned)	379.65	40%
367 (Osawatomie)	475.62	43%
365 (Garnett)	315.73	69%
400 (Smoky Valley)	**395.59**	**78%**
435 (Abilene)	258.23	47%
223 (Barnes, Hanover, Linn)	**453.00**	**155%**
455 (Hillcrest, Cuba)	324.89	34%
305 (Salina)	446.71	46%
254 (Barber Co. N)	369.27	63%
422 (Greensburg)	310.00	54%
438 (Skyline)	**365.04**	**80%**
474 (Haviland)	**427.11**	**80%**
267 (Andale)	**853.00**	

The Honorable Dale Sprague
Kansas House of Representatives
State Capitol
Topeka, Kansas 66612

January 29, 1990

Dear Representative Sprague:

Thank you for the opportunity to present testimony to the Joint House-Senate Insurance Committee.

I am a social worker with the disabled and have eight years of direct experience with the State of Kansas Medicaid (and MediKan) systems and the Kansas Automobile Injury Reparations Act (40-3101 to 40-3103). I am on federal jury duty today and apologize for my inability to present this in person.

Over half of the severely injured young (18 to 25 years of age) motorists that I see (I am employed at a Wichita regional medical center which operates three air ambulance stations) become eligible for Medicaid within the first month of hospitalization. The above-mentioned law mandates a $4,500 medical payment (40-3103 k), and in a climate where fewer Kansans can afford health insurance, Medicaid becomes the "insuror of last resort." The medical bills for the severely injured often range beyond $50,000. Further, "Rehabilitation Benefits" (40-3103 r) are narrowly defined and are NEVER available for wheelchairs,ramps, or automobile hand controls for amputees, quadriplegics, or paraplegics. Section "r" stresses occupational training and makes NO provision for children who face rehabilitation needs, despite the absence of a work history.

> PROPOSED: Delete "prosthetic devices" in (40-3103 k) Exhibit 1. Add "physical medicine services, physical therapy, speech therapy, prosthetic devices, wheelchairs, walkers, ramps, and bathroom modifications" as covered rehabilitation benefits to (40-3103 r) Note that people who are head injured in auto accidents have speech and cognitive impediments and have balance and mobility problems which effect safety in bathing and toileting.

The current $4,500 minimums are far too low and Kansas Medicaid covers what Colorado Medicaid doesn't need to. Colorado Statute (Exhibit 2) 10-4-706 (Regulation of Minimin Coverage) requires $50,000 medical, $50,000 for rehabilitation (for the first five years after the injury), $400 per week wage loss, $1,000 death benifit, and a $2,500 lawsuit threshold. Kansas Social and Rehabilitation Services has not been able to tell us how many severely injured Kansan motorists are in long term nursing homes, totally dependent on state-funded services. (Estimates range from 200 to 300.) Whatever the numbers, Colorado has private insurance pay for up to $100,000 in each of their cases--Kansas had $4,500 in each.

PROPOSED: Raise the figure $4,500 in 40-3103 k and r to $50,000.

What will the costs be to Kansas motorists? Previous testimony suggests zero to minimal changes! (See exhibit 3 from previous Kansas Automobile Injury Reparations Act hearings). At least two carriers, State Farm and Kansas Farm Bureau have raised Personal Injury Protection to $7,500 and $7,000, respectively, ON THEIR OWN. Perhaps their reason was to avoid litigation in a larger number of cases.

It should be stated that Welfare, Vocational Rehabilitation, Special Health Services (formerly Crippled Children's Services), and other State salaried bureaucracies are currently providing wheelchairs, equipment, vocational rehabilitation, and other services which could be axed from the State budget if the private sector was allowed to do what is routine in Colorado.

I have discussed the above proposals with Ron Todd of the State Insurance Commissioners Office and he states that there is much to recommend these proposals. With 32,000 Kansans injured each year in motor vehicle accidents (Kansas Highway Patrol figures) the potential saving to the taxpayer could be significant.

I have not touched on the lack of a motorcycle helmet law (1-1-89 Nebraska reinstated their law); the right of cyclists to WAIVE Personal Injury Protection coverage when their exposure to danger and thus Kansas Medicaid liability is greatest; the rarity of "breathalyzer-ignition interlock" systems in Kansas despite their incredible effectiveness in eliminating multiple DWI convictions may be that local governments miss the fine revenue. (see Exhibit 4)

Thank you for the opportunity to raise these issues.

Sincerely

Roger D. Harms LMSW
(316) 688-2464

Exhibit 1 Kansas Statute 40-3103
Exhibit 2 Colorado Statute 10-4-706
Exhibit 3 various items from previous Auto Injury Reparations Act Hearings
Exhibit 4 Judge Fisher's (Eighteenth Judicial Destrict) letter to the Governor's Special Assistant on Drug Abuse
Exhibit 5 Roger Harms letter sent 1-17-1990 to various Kansas legislators

ATTachments are available in the Speaker pro Tems office