Approved January 30, 1991
Date

MINUTES OF THE HOUSE COMMITTEE ON INSURANCE.

The meeting was called to order by Larry Turnquist at
Chairperson

3:35 ~~a.m.~~/p.m. on January 29, 1991 in room 531-N of the Capitol.

All members were present except:

Theo Cribbs - Illness
Tom Sawyer

Committee staff present:

Chris Courtwright - Research
Bill Edds - Revisor
Nikki Feuerborn - Committee Secretary

Conferees appearing before the committee:

NONE

Others Attending: See attached list

Representative Sprague moved for the approval of the minutes of January 2, 1991. Respresentative Hayzlett seconded the montion. Motion carried.

Chris Courtwright of the Research Department reviewed the activities and proposed legislation of the Special Committee on Insurance Attachment 1. The Special Committee had been directed to study the availability and affordability of group accident and health insurance, including the impact of mandates, eligibility for group coverage (S.B. 445), and proposed rate regulation (H.B. 3012); review the governance and structure of Blue Cross and Blue Shield and the policy issues surrounding a possible conversion to a mutual insurance company.

The above were explained in general terms by Mr. Courtwright and in the supporting document (Attachment 1).

The meeting was adjourned at 4:05 p.m.

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

GUEST LIST

COMMITTEE: Insurance (House) DATE: 1-29-91

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Nancy Zogleman	Topeka	BC/BS of Ks
Bill Sneed	Topeka	KHA
Bill Curtis	Topeka	Ks. Assoc. of School Bds.
Roland Smith	Wichita	WIBA
Joe FURJANIC	TOPEKA	KCA
Tom Bell	Topeka	KHA
Jim Oliver	Topeka	PIAK
Michelle Liester	Topeka	John Peterson & Associates
Dick Brock	"	Ins Dept
Terry Leatherman	Topeka	KCCI

COMMITTEE REPORT

TO: Legislative Coordinating Council

FROM: Special Committee on Insurance

RE: PROPOSAL NO. 11 – HEALTH INSURANCE*

Proposal No. 11 directed the Special Committee on Insurance to:

Study the availability and affordability of group accident and health insurance, including the impact of mandates, eligibility for group coverage (S.B. 445), and proposed rate regulation (H.B. 3012); review the governance and structure of Blue Cross and Blue Shield and the policy issues surrounding a possible conversion to a mutual insurance company.

Background

During the 1990 Session, the House Insurance Committee and the Senate Committee on Commercial and Financial Institutions and Insurance held extensive hearings on a number of health-insurance related topics. A variety of legislation directly or indirectly related to health insurance was enacted, and a number of other topics were recommended for interim study.

Mandates

One issue that was discussed extensively in the House Committee is mandated benefits and the extent to which the growing number of mandates has affected the availability and affordability of health insurance.

Mandates can come in a number of forms, including (1) participation of particular providers (podiatrists, psychologists, etc.); (2) specific benefits (drug and alcohol abuse treatment, mammography, etc.); (3) particular demographic groups (newborn children); and (4) coverage for specific diseases (Alzheimer's, diabetes, etc.).

The Health Insurance Association of America (HIAA) identified 14 mandates that existed in Kansas prior to the 1990 Session and 730 state government mandates nationwide. This figure is up substantially from 343 state mandates in 1978.

Impact of Mandates – HIAA Study

HIAA conferees said that one result of the increasing number of mandates has been an increase in the cost of health insurance and a corresponding increase in the number of uninsured persons. HIAA estimates,

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* H B. 2001, H B. 2002, S B. 15, S B. 16, and S B. 17 accompany this report.

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for example, that a mandated coverage for care by a psychologist tends to increase the average family coverage health insurance premium by 11.8 percent, all other factors held constant.

Because of the increasing cost of health insurance, many small firms have been unable to continue offering coverage to their employees. HIAA estimates that each new mandate enacted between 1982 and 1985 lowered the likelihood that a small firm would offer coverage by 1.5 percent.

HIAA said that many studies had also documented the fact that the increasing number of mandates had dramatically accelerated the tendency of large employers to self-insure. Under the provisions of the 1974 Employees Retirement Income and Security Act (ERISA), self-insurance plans are exempt from provisions of state law, including mandates and premiums taxes. So one argument often made is that mandates ultimately may drive a larger percentage of the insured population into coverages where the mandates do not, in fact, apply.

Several other policy questions exist surrounding the increasing number of firms opting to self-insure. (HIAA's model estimates that of the firms converting to self-insurance between 1981 and 1984, 51 percent would not have done so if mandates had not been enacted.) The state tends to lose premiums tax revenue as more and more firms self-insure. Also, the states lack the ability to regulate the solvency of such plans.

The crazy-quilt of mandate laws across all 50 states also tends to act as an economic development disincentive, according to HIAA. Not only do all employers lack flexibility in tailoring their own plans (provided they do not self-insure), large multistate employers face high administrative and compliance costs to keep up with the changes in all the states.

The Case for Mandates

Several conferees did explain the public policy reasons behind mandates. They suggested that certain types of coverages, including alcohol abuse, drug abuse, mammography, and PAP tests, tend to lower long-range social costs by providing immediate treatment and preventative medicine, even if the short-run costs of insurance are increased. Several conferees also said that certain coverages may not be available in the marketplace absent the mandates. Others said that although utilization of mandated services is increasing, so is utilization of all medical services.

Impact of Mandates – Other Studies

Wisconsin. The Insurance Commissioner in Wisconsin recently completed a study of six different mandates over a three-year (1987-1989) period: alcoholism, drug abuse, and mental health; equipment and supplies for treatment of diabetes; home care; skilled nursing care; treatment of kidney disease; and chiropractic services. The report's conclusions tend to contradict industry claims about the impact of mandates on premiums and even on their tendency to cause firms to self-insure.

The Wisconsin report concluded that:

1. only two of the mandates studied (the alcoholism, drug abuse, and mental health and chiropractic services mandates) accounted for more than 1 percent of medical benefits paid by insurers;

2. the six mandates studied accounted for less than 10 percent of the total benefits paid in each of the three years;

3. over the three-year period, claims paid for the six mandated benefits did not rise faster than claims paid for other medical benefits; and

4. data obtained from insurers who only administer self-insurance plans appear to indicate that such plans often include as many mandated benefits as insured plans, in spite of the ERISA exemption.

Maryland. A 1989 Maryland report by the Committee on Mandated Benefits, established as part of the Governor's Commission on Health Care Policy and Financing, recommended that the Maryland General Assembly enact legislation to:

1. establish a set of criteria by which current and proposed mandates be monitored;

2. establish an interdepartmental committee with its own staff responsible for empaneling expert review groups to study each mandate (studies on mandates would be routinely referred to the interdepartmental committee for interim study); and

3. provide for sunset dates for various mandates.

Maine. Maine also has devoted a substantial amount of resources to studying the impact of mandates. Legislation enacted in 1987 created the Mandated Benefits Advisory Commission, and additional legislation in 1989 and 1990 further expanded the responsibilities of the Commission. In February, the Commission completed a study on proposed screening mammography and PAP test mandates. In terms of data used to measure the social costs and benefits of the proposed screening mammography mandate, for example, that report noted the following:

1. Since one cancer is detected in approximately 550 screening mammograms, the cost of detecting one cancer is $33,000 (assuming a screening cost of $60).

2. Early (stage I) detection leads to a 90 percent recovery rate at an average cost of $8,500 per case, while the remaining 10 percent will require terminal illness care at an average cost of $60,000.

3. Later detection leads to substantially increased costs. Stage III detection, for example, has a mortality rate of approximately 30 percent (at an average cost of $60,000), while the treatment costs for the remaining 70 percent ranges between $8,500 and $60,000.

4. The American Cancer Society recommends that all women have one "baseline" screening mammogram sometime between the ages of 35 and 39. A mammogram is recommended every two years for ages 40 to 49, and annual screening is recommended for age 50 and above.

5. Population projections for females age 40 and above indicate a growth in this group in Maine from 270,000 in 1990 to about 405,000 by 1997.

6. A recent study by Blue Cross and Blue Shield of Massachusetts indicated that the mandate increased the premium for every policy in that state by $2.11 per month, or $25.32 per year.

7. Although enactment of the mandate in Maine would increase utilization of screening mammography, it is difficult to gauge by how much. A survey of Maine physicians listed the following reasons for their not ordering screening mammograms:

   a. patient embarrassment, reluctance, or refusal -- 74 percent;

   b. patient under episodic rather than regular care -- 65 percent;

   c. inadequate insurance coverage -- 41 percent; and

   d. cost of mammograms -- 38 percent.

8. Most basic individual and group policies cover only diagnostic mammograms (ordered if a patient has disease symptoms or is considered "high risk" because of personal or family history). Coverage for screening mammograms is sometimes available as an add-on, but the extent of the availability is unknown.

9. Studies completed in 1987 indicated that 51 percent of Maine women aged 45-54, 55 percent of Maine women aged 55-64, and 65 percent of Maine women over age 65 had never had a mammogram. Nationwide, the estimates were that only 16 percent of women aged 50-75 had a mammogram during the previous year and 62 percent had never had a mammogram.

10. Since the offsetting savings in cancer detection and treatment (to the premium increases for the mandate) would be realized in the future, the "cost savings might not be realized by the insurance carrier who covered the screening, since the person might be uninsured or covered by Medicare or Medicaid before any savings are realized."

The Maine Legislature also passed a new law in 1990 requiring the Commission to review all existing mandates and submit another report by June 1, 1991. The Commission is authorized to seek a consultant through competitive bidding to undertake the comprehensive study.

Kansas 1990 Mandate Legislation

Several additional mandates were added by the 1990 Legislature, but a new law was adopted which could make it more difficult to enact additional mandates in the future.

S.B. 431, the Kansas Adoption and Relinquishment Act, extended the mandated coverages for ill newborn children in K.S.A. 40-2,102 to children for whom a petition for adoption is filed within 31 days of birth. Covered expenses include treatment of medically diagnosed congenital defects and birth abnormalities. All other adopted children become eligible for coverage under a family-member policy on the date the petition for adoption is filed. The bill also mandates the offering of coverage to include the delivery expenses of the birth mother when a child is adopted within 90 days of birth.

H.B. 2888 requires that most policies delivered, renewed, or issued for delivery within or outside the state reimburse for the services of an advanced registered nurse practitioner (ARNP) if such services would be paid for when provided by a duly licensed physician. An exception to this mandate is made for ARNP services performed in Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, and Wyandotte counties unless the county has been designated as "critically medically underserved" pursuant to K.S.A. 76-375 or as "medically underserved in

primary care" pursuant to K.S.A. 76-374. Information obtained by the Insurance Department indicates that for this year's certification, Leavenworth County has, in fact, been designated as critically underserved (and will maintain this status for at least two more years for purposes of the scholarship program). The mandate therefore apparently will apply to services performed in Leavenworth County.

H.B. 2888 also requires that, prior to the Legislature's consideration of any bill mandating health insurance coverage or mandating the offering of a type of coverage, proponents will be required to submit impact reports to the appropriate committees concerning social and financial effects. The reports must contain a variety of "social impact" information on utilization of the services, demand for the services, and the extent to which the coverage may or may not be available absent the mandate. The "financial impact" data required must include the extent to which the mandate would increase or decrease the costs of the service, the utilization of the service, and the costs of health insurance. The Insurance Commissioner is directed to assist persons making the impact reports.

Bills Seeking to Change or Eliminate Mandates

The Legislature failed to pass two other measures which would have changed the mandates to "mandated offerings" or would have eliminated the mandates altogether.

H.B. 2889 would have required that all policies simply offer the current mandated coverages to insureds. H.B. 3015, on the other hand, while mandating "availability" of the current mandated coverages for group policies (a slight distinction from a "mandated offering"), would have completely repealed the application of the mandates to individual policies.

H.B. 3012 – Rate Regulation

H.B. 3012 would provide a mechanism under which the Insurance Commissioner would be required, starting in 1991, to regulate group and blanket health insurance rates. With the exception of disability income, hospital confinement indemnity, specified disease, or accident only coverage, all risk classifications and premium rates for health insurance would have to be filed with the Commissioner before the policies are issued or delivered.

The Commissioner would be required to approve or disapprove the rate filings unless they are unreasonable, excessive, unfairly discriminatory, discriminatory against any individuals eligible for participation in a group, attempting to subclassify within a group, or not otherwise in compliance with the provisions of the law. If the Commissioner has not acted within 30 days, the filings will be deemed to have been approved. If the filings are disapproved, the Commissioner will be required to notify the insurer in writing of the reasons and schedule a hearing within 20 days.

The bill also provides that the rate regulation requirements and prohibitions would apply to all policies covering Kansas residents or employees, regardless of where the policies are issued.

Most of the language in the bill would make the regulation of group health insurance rates similar to the rate regulation provisions currently applicable to Blue Cross and Blue Shield.

The House Committee amended the bill to clarify its application to "blanket" as well as group policies; to add language prohibiting tier-rating and rate filing discrimination against certain individuals eligible for group participation; to require community rating for all groups of fewer than 25; to extend the requirements in an extraterritorial fashion to certain policies issued outside of Kansas; to apply the new rating classification

restrictions and community-rating requirements to Blue Cross and Blue Shield; and to change the effective date to January 1, 1991.

The bill passed the House 118-1, but died in the Senate Committee on Commercial and Financial Institutions and Insurance.

S.B. 445 – Group Eligibility

S.B. 445 was introduced by Senators Ehrlich and Anderson on behalf of the Commission on Access to Services for the Medically Indigent and Homeless. In health and accident policies for an individual employee or member of an insured group consisting of 25 or more persons, the bill would provide that no individual or member may be excluded from eligibility or coverage under a group policy.

In 1988, an identical measure was introduced at the request of the Insurance Commissioner; however, the bill encountered significant resistance on the basis that passage of the bill would increase premiums to such an extent (to cover persons who would have been underwritten out of the group) that the group could no longer afford any health insurance coverage. That 1988 legislation (S.B. 539) was substantially amended to apply only to single-employer groups and by the incorporation of provisions relating to waiting periods for preexisting conditions; exclusion of coverage for hospitalization in progress on the date of enrollment; and the definition of "full-time" employee eligible for coverage. S.B. 539 was enacted in its amended form.

In its report to the Governor and the Legislature, the Commission on Access to Services to the Medically Indigent and Homeless made the following observations:

> Of the Kansans who do not have health insurance, perhaps as many as 80 percent are employed either full or part time or are the dependents of persons who are employed. Since it is estimated that as many as 90 percent of Kansas businesses employ 25 or fewer employees, thus qualifying as small businesses, it can be assumed that many Kansans who are employed do not have access to group health insurance through their place of employment because it is not offered. Others have access to health insurance through their worksite, but are unable to participate in the group because they are not eligible due to underwriting by the carrier based on preexisting conditions or previous illness. Others can participate in a group only by accepting restrictions on coverage or premium rating.
>
> The Commission is aware that underwriting within groups has been used as a tool to keep group premiums competitive and affordable. However, the exclusion of some members of a group because of a previous illness or health condition appears to be increasing as carriers struggle to keep rate escalations at a minimum. Additionally, there appears to be a trend toward excluding preexisting conditions from coverage, either for a period of time or for the policy period. While these practices may be defended on the basis of keeping affordable insurance available to the group as a whole, they represent a departure from the concept of group coverage and result in thrusting some individuals into the ranks of the uninsured. The Commission believes the issues of rating and underwriting within groups should be examined by the Legislature. In order to initiate discussion, the Commission has drafted S.B. 445, which would prohibit carriers from excluding any eligible individual member of a group of 25 or more members insured through certain types of group coverage. A full exploration of the pros and cons of such practices should result in a better understanding of the issues involved.

S.B. 445 was referred to the Senate Committee on Financial Institutions and Insurance. A hearing was held on the measure on February 6, 1990. Representatives of the Commission and the Insurance Commissioner supported the bill and persons representing the Independent Insurance Agents of Kansas, the Kansas Farm Bureau Life Insurance Company, Inc., and the Kansas Life Association opposed the bill. Following the hearings, the Committee recommended that the bill be included in an interim study. No further action was taken on the bill and it died upon *sine die* adjournment of the 1990 Legislature.

Blue Cross and Blue Shield Governance

Another part of the charge concerns a legislative proposal to allow Blue Cross and Blue Shield to convert to a mutual insurance company. Several states have enacted such legislation based on the rationale that maintaining separate statutory regulation of Blue Cross and Blue Shield plans may no longer be necessary. A policy decision on this matter could depend in part on the policy decisions made with respect to H.B. 3012, which would "level the playing field" in terms of rate regulation.

Other 1990 Health Insurance Legislation

Municipal Group-Funded Pools. S.B. 587 amends several sections of the Kansas Municipal Group-Funded Pool Act. The bill adds to the list of liabilities that five or more municipalities may enter into agreements to pool group sickness and accident and life insurance. An applicant for a certificate of authority to operate such a pool would have to show evidence that the annual gross premium for group sickness and accident insurance coverage would be not less than $1 million, and that group life coverage would insure at least 60 percent of the eligible participants or the total number of persons covered would exceed 600.

Further, the bill changes existing law regarding reinsurance of the pool's risk to confine such reinsurance to an insurance company holding a certificate of authority to do business in this state.

Finally, S.B. 587 requires that premiums charged by any pool for life insurance or group sickness and accident insurance be based upon sound actuarial principles.

Small Employer Health Benefit Plans. H.B. 2610 creates a new act under which eligible small employers, defined as employers with 25 or fewer employees who have not offered health insurance to their employees in the past two years and who agree to make a minimum contribution to the health insurance premium on behalf of a participating employee, may join together to create a small employer group or groups to be known as small employer health benefit plans for the purpose of offering a health benefit plan (health insurance) to their employees. As an incentive for such employers to offer health benefits to their employees, insurance offered through a small employer group created pursuant to H.B. 2610 is exempted from the premium tax, is exempted from required coverage created by state mandated benefits laws, could be offered at a cost that is affordable for the small business and its employees, and, if the employer qualifies, allows such employer to claim a limited, decreasing tax credit over a five-year period.

A small employer group created under the provisions of H.B. 2610 would be required to have a board that is responsible for developing a health benefits plan (group insurance plan) or plans that would be offered through the group, for negotiating with and contracting with carriers or health care providers on behalf of the group, and for the operation of the plan. The group could contract with third parties and delegate duties to such contracting entities. A small employer health benefit plan is required to provide Part I coverage, defined as coverage up to a statutory maximum for necessary care and treatment of sickness or injury in excess of $5,000 for an individual insured employee or $7,500 in the case of an insured family and subject to a prohibition on copayments and certain exclusions. A plan could also offer Part II coverage as an option. Pursuant to H.B. 2610,

Part II coverage, if offered, must contain at least an option that would reduce the deductible under Part I coverage, and all other options offered under Part II coverage must contain incentives to encourage an insured to utilize services in a cost effective manner. All covered eligible employees would be required to participate in Part I coverage, but Part II coverage would be optional. H.B. 2610 specifies the maximum premium amount an employer must pay on Part I coverage for each eligible covered employee and authorizes the employer to require a minimum employee premium contribution.

Health Insurance Data. H.B. 3027 requires the Insurance Commissioner, starting in 1991, to develop or approve statistical plans for the filing of loss and expense experience by health insurance companies, HMOs, and Blue Cross and Blue Shield. The data must be available at least annually to aid the Commissioner and others in determining whether the rates being charged are, in fact, reasonable. The statistical plans could be required to contain reporting of expense experience for items specific to Kansas, *i.e.*, certain mandates.

The Commissioner is given authority through rules and regulations to develop the plans, but is required to consider the rating systems and various insurance classifications that are already filed, as well as the rating systems in other states.

The Commissioner is authorized to designate recognized trade associations or other agencies to assist in gathering the experience data.

Committee Activity

The Committee received extensive briefings from staff and from the Insurance Department on the history of the health insurance mandate issue in Kansas and other states. The Department also presented information on the extent to which extraterritorialization is applicable to the current mandates through K.S.A. 40-2,103.

At the August meeting, the Committee held public hearings on mandates and tried to gather as much hard data as possible from conferees on both sides of the issue. Mandate proponents, mostly health care providers, argued that mandates generally help lower long-run social costs by encouraging greater utilization of services. Mandate opponents, mostly the insurance industry and small business conferees, argued that the mandates limited flexibility in tailoring group health insurance plans, caused premium increases, and were a contributing factor to the increasing number of uninsured persons.

Also at the August meeting, staff outlined some of the important questions involved in making public policy decisions on mandates. Staff also made comments regarding the difficulty of data availability in terms of answering those questions. Staff explained that several states had hired consultants and actuaries to complete comprehensive studies on mandates.

With respect to the question relating to why firms self-insure, staff indicated that other states had noted that the desire to escape premiums taxes and the administrative costs and profits associated with the insurance industry were often as important as the desire to escape mandates. In an attempt to answer the question, the Committee solicited testimony on membership surveys from the Kansas Employers Coalition on Health (KECH) and the Kansas Chamber of Commerce and Industry (KCCI). The Insurance Department also completed a survey of third-party administrators on the extent to which a number of the mandates are components of ERISA plans.

The Committee also held public hearings on 1990 H.B. 3012 as amended by the House Insurance Committee. House Speaker Jim Braden and the Insurance Department appeared as proponents. Opponents included HIAA and the Independent Insurance Agents of Kansas (IIAK). Blue Cross and Blue Shield suggested several amendments, including "phase-ins" for the community-rating requirement and the tier-rating prohibition.

Blue Cross and Blue Shield opposed 1990 S.B. 445 in its original form, suggesting a number of amendments designed to clarify its application. The Insurance Department testified in support of S.B. 445.

With respect to the part of the charge relating to Blue Cross and Blue Shield governance, conferees from Blue Cross and Blue Shield encouraged the Committee to recommend legislation allowing mutualization.

Committee Conclusions and Recommendations

With respect to the current mandated coverage for mammography, the Committee agrees with conferees who indicated that "no mammography is better than bad mammography." To encourage the development of effective mammography in Kansas, the Committee believes that the mandate should be narrowed to apply only to those mammograms performed under a certain set of standards which would be promulgated by the Secretary of Health and Environment. S B. 15 would accomplish this recommendation.

The Committee also notes that there has been a great deal of controversy about the mental health, alcoholism, and drug abuse mandates, as well as the application of managed care and utilization review procedures. The Committee concludes that because of emergencies, insureds should be entitled to a minimum of three covered days of inpatient care prior to any determination that the care is medically unnecessary. Enactment of H B. 2002 would amend K.S.A. 40-2,105 to implement this policy.

The Committee considered legislation which would have required insurers to provide coverage for mental health, alcoholism, and drug abuse to the same extent as coverage is provided for other health conditions. Although the Committee is not recommending such a change at this time, further study of such a proposal may be warranted.

The Committee finds that in the health insurance marketplace of the 1990s, nonprofit health-care related service corporations should be able to compete with other entities on a more "level playing field" by converting their charters to mutual insurance companies. S B. 17 authorizes nonprofit dental service corporations, nonprofit optometric service corporations, nonprofit medical and hospital service corporations, and nonprofit pharmacy service corporations, at their option and without reincorporation, to adopt and become subject to statutory provisions governing mutual life insurance companies and nonlife mutual insurance companies.

Should nonprofit health-care related service corporations choose not to mutualize, S B. 16 would remove from the statutes governing such corporations language which specifies the composition of the membership of the boards of directors. Under the Committee's proposal, the number, qualifications, terms of office, and appointment of directors would be provided in the by-laws of the corporations.

The concept of prior-approval rate regulation of group health insurance was analyzed by the Committee, which recommends instead the language in H B. 2001, which clarifies that the Insurance Commissioner may utilize the Unfair Trade Practices Act to enforce provisions prohibiting rates which are unreasonable, excessive, or unfairly discriminatory.

That bill also provides for a phased-in community rating requirement as well as a prohibition against certain individuals' being excluded from group coverage. The Committee believes that such changes are necessary to help alleviate many of the dramatic premium increases and coverage cancellations which have characterized the group health insurance market in recent years.

Respectfully submitted,

Dale M. Sprague

Dec. 1, 1990

Rep. Dale Sprague, Chairperson
Special Committee on Insurance

Sen. Richard Bond,
Vice-Chairperson
Sen. Roy Ehrlich
Sen. Paul Feleciano, Jr.*
Sen. Janice McClure
Sen. Nancy Parrish
Sen. Alicia Salisbury
Sen. Don Sallee

Rep. Joann Flower
Rep. Henry Helgerson
Rep. Marvin Littlejohn
Rep. Artie Lucas
Rep. John McClure
Rep. Michael Sawyer
Rep. Hank Turnbaugh
Rep. Larry Turnquist
Rep. Elaine Wells

* Ranking minority member.