Approved February 18, 1991
Date

MINUTES OF THE HOUSE COMMITTEE ON INSURANCE.

The meeting was called to order by REPRESENTATIVE TURNQUIST at
Chairperson

3:30 ~~xxx~~./p.m. on Thursday February 14, 1991 in room 531 N of the Capitol.

All members were present except:

Theo Cribbs - Excused
Dale Sprague - Excused

Committee staff present:

Mr. Bill Edds, Revisor
Mr. Chris Courtwright, Research
Mrs. Nikki Feuerborn, Committee Secretary
Mrs. Emalene Correll, Research

Conferees appearing before the committee:

Mr. Dick Brock
Ms. Nancy Zogelman
Mr. Don Lynn
Mr. Rolland Smith
Ms. Cheryl Dillard
Mr. Chip Wheelan
Mr. Jim Schwartz
Mr. James R. Petrich

Others Attending: See Attached List

The Hearing on HB 2001 was held on Thursday, February 14, 1991. Mr. Bill Edds of the Revisor's Office appeared before the committee and presented a summation with balloons of HB 2001. See Attachment 1. Major changes include: a) prohibits exclusion of persons from eligibility or coverage under group health insurance; b) extraterritorial provision which applies to contracts issued in and outside of Kansas; c) authorizes a waiting period for pre-existing conditions upon initial coverage; d) portability provision which requires waiver of waiting period to extent it served while covered under a prior group sickness and accident policy with no gap in coverage; e) applies to group policies issued directly to employers, associations and trusts and other forms of group policy insurance; f) establishes a form of community rating for groups of 25 or fewer members and authorizes variations in rate by nor more than 40% above the community rate; and g) amended to make HB 2001 applicable to Blue Cross/Blue Shield.

Mr. Dick Brock, Insurance Commissioner's Office, appeared as a proponent for HB 2001. In his testimony he stated that the act would amend the statute which describes and defines the various kinds of groups in Kansas that are eligible for a group accident and sickness insurance. (See Attachment 2). The act will do three main things:

1. Prohibits insurance companies from excluding otherwise eligible group members from the group accident and sickness coverage.

2. To prevent circumvention of this prohibition by writing the coverage through an out-of-state group or trust, the new prohibition applies to all accident and sickness policies covering Kansas residents regardless of where the policy was issued.

3. Prohibition also extends for "condition riders" whereby the group insurer might otherwise insure an individual under the group contract but attach a rider or endorsement excluding coverage for a specific medical condition.

In his discussion of community ratings, Mr. Brock stated that it was in the best interest of every small group to support some means of achieving greater premium stability in a way that does not make a bad problem worse. HB 2001 attempts to do this by using 150% of the community rate as a benchmark. Small groups whose premium rate exceeds 150% of the community rate could not be subjected to a rate increase until their premium falls below the benchmark.

Mr. Brock reviewed suggested language changes in HB 2001 as described in Attachment 2.

Nancy Zogelman, Director of Legislative Relations for Blue Cross and Blue Shield of Kansas, Inc., appeared before the community as a proponent of HB 2001. In her testimony (See Attachment 3), Ms. Zogelman stated that the five main points of the bills are: 1) It prohibits excluding persons from eligibility; 2) prohibits limiting or excluding benefits for specific conditions; 3) establishes a waiting period for pre-existing conditions; 4) establishes portability which suggests that a policy waive a waiting period to the extent it had been served while covered under a prior group accident and sickness coverage with no gap in the coverage; 5) establishes equal rate regulation of all health insurers (at this time only BC/BS is the only insurance company doing group business in the State of Kansas which has its rates regulated.)

Mr. Don Lynn of Blue Cross/Blue Shield presented an example of a small group rating pool of ten groups. See Attachment 4. HB 2001 would establish a maximum various in rates of 50% above the average rate. Any group with rates above the maximum rate would have no rate adjustments made until five years or until their rates were below the maximum rate.

Mr. Rolland Smith, representing the Wichita Independent Business Association, spoke an a proponent of HB 2001. Eighty-nine percent of all businesses have 25 or fewer employees and 77.1% have fewer than 10 employees. These businesses have from 50 to 55% of all the employees in Kansas. Most of the new jobs are created by these small independent businesses. Health care costs and property taxes are the two largest problems for small independent businesses in Kansas. Mr. Smith reviewed the proposed language changes for HB 2001. See Attachment 5.

Ms. Cheryl Dillard of Kiaser Permanente, testified on behalf of HB 2001. Kiaser Permanente is a federally qualified HMO and supports any public policy which would return the industry to the equitable provision of health benefits. HB 2001 would spread the risks among a larger group of carriers. Two recommendations were made to the Committee: 1) the community rated group size be raised to 50; and 2) all carriers be required to have their rates reviewed by the Commissioner of Insurance. (See Attachment 6).

Mr. Chip Wheelan, representing the Kansas Medical Society, expressed support of HB 2001 and urged its passage. (See Attachment 7).

Mr. Jim Schwartz, representing Kansas Employer Coalition on Health, Inc., stated that risk pools differ from community rating in effect by charging higher than standard rates. The pros and cons of risk pools and community ratings were discussed. HB 2001 appears to be a good compromise of the differences by allowing up to a 50% rate differential. (Attachment 8)

Mr. James R. Petrich of Dorth Coombs Insurance, Inc., Wichita, supported the following portions of HB 2001: 1) addresses insurance contracts (extraterritorial); 2) does not allow replacing insurance carriers to decline or rider benefits to individuals currently covered under employer group health insurance plans, in that a replacing insurance carrier must insure all existing covered employees and their eligible dependents with no "gap in coverage," as well as insure new employees applying for coverage on a timely basis; 3) eliminates malicious premium rate tiering for employer groups with less than 25

covered employees yet allows the insurance carriers to differentiate rates based on the various risk elements of each group to the 50% cap. Opposition of language in HB 2001 is described in Attachment 9. The final recommendation of Mr. Petrich was to eliminate all state mandates and give some plan flexibility back to employers. (Attachment 9).

The meeting adjourned at 5:07 p.m.

GUEST LIST

COMMITTEE: House Insurance DATE: Thursday Feb. 14, 1991

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Nancy Zogleman	Topeka	BC/BS of Ks
Bill Sneed	Topeka	HIAA
Don Hymer	Topeka	BC/BS of Ks
Cheryl Dillard	Kansas City	Kaiser Permanente
ALAN COBB	WICHITA	WICHITA HOSPITALS
Hal Hans	Topeka	Kansas Bankers Assoc
Chuck Stones	"	"
Leland Smith	Wichita	WIBA
Dick Brock	Topeka	Ins Dept
Glenda Cafer	Topeka	AIA
Chip Wheelen	Topeka	KS Med Soc.
Larry MAGILL	"	IIAK
Len Lake	Topeka	Kaiser Permanente
Bill Curtis	Topeka	Ks. Assoc. of School Bds
Chris Wilson	Topeka	KS Grain & Feed Ass'n
Jim Petrich	Wichita	Dorth Counts Ins
Jim Schwartz	Topeka	KECU
David Hanzlick	Topeka	KDA

Session of 1991

HOUSE BILL No. 2001

By Special Committee on Insurance

Re Proposal No. 11

12-28

AN ACT relating to insurance; concerning accident and sickness insurance and the regulation of the rates thereof by the commissioner of insurance; concerning eligibility for coverage under group policies; amending K.S.A. 1990 Supp. 40-19c09, 40-2209 and 40-2215 and repealing the existing sections; also repealing K.S.A. 1990 Supp. 40-19c07.

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

Section 1. K.S.A. 1990 Supp. 40-2209 is hereby amended to read as follows: 40-2209. (A) Group sickness and accident insurance is declared to be that form of sickness and accident insurance covering groups of persons, with or without one or more members of their families or one or more dependents; ~~or one or more members of their families or one or more dependents, and~~. *Except at the option of the employee or member and except employees or members enrolling in a group policy after the close of an open enrollment opportunity, no individual employee or member of an insured group and no individual dependent or family member may be excluded from eligibility or coverage under a policy providing hospital, medical or surgical expense benefits both with respect to policies issued or renewed within this state and with respect to policies issued or renewed outside this state covering persons residing in this state. No group policy providing hospital, medical or surgical expense benefits issued or renewed within this state or issued or renewed outside this state covering residents within this state shall limit or exclude benefits for specific conditions existing at or prior to the effective date of coverage thereunder. Such policy may impose a waiting period, not to exceed one year for benefits for conditions, including related conditions, for which diagnosis, treatment or advice was sought or received in the 90 days prior to the effective date of coverage. Such policy shall waive such a waiting period to the extent the employee or member or individual dependent or family member was covered by a group sickness and accident policy prior to the effective date of coverage with no gap in coverage. Such policy may*

Prohibits exclusion of persons from eligibility or coverage under group health insurance.

The term "hospital, medical or surgical expense" makes clear that disability coverage (loss of time) not included. Disability is also considered group sickness and accident insurance.

Extraterritorial provision - law applies to both contracts issued in Kansas and those issued outside of Kansas - prohibits individual underwriting (ridering of specific conditions)

Authorizes a waiting period for pre-existing conditions upon initial coverage.

Portability provision - requires waiver of waiting period to extent it served while covered under a prior group sickness and accident policy with no gap in coverage.

House Insurance
Feb. 14, 1991
Attachment 1

be issued *to such group* upon the following basis:

(1) Under a policy issued to an employer or trustees of a fund established by an employer, who is the policyholder, insuring at least five employees of such employer, for the benefit of persons other than the employer. The term "employees" shall include the officers, managers, employees and retired employees of the employer, the partners, if the employer is a partnership, the proprietor, if the employer is an individual proprietorship, the officers, managers and employees and retired employees of subsidiary or affiliated corporations of a corporation employer, and the individual proprietors, partners, employees and retired employees of individuals and firms, the business of which and of the insured employer is under common control through stock ownership contract, or otherwise. The policy may provide that the term "employees" may include the trustees or their employees, or both, if their duties are principally connected with such trusteeship. A policy issued to insure the employees of a public body may provide that the term "employees" shall include elected or appointed officials. ~~No policy providing benefits for hospital, medical or surgical expense which replaces a policy issued under this section shall contain any provision which prevents any person insured under the replaced policy immediately prior to such replacement from being insured under the replacing policy. Except at the option of the employee, and except employees and individual dependent or family members enrolling in a group policy after the close of an open enrollment opportunity, no individual employee and no individual dependent or family member may be excluded from eligibility or coverage under a policy providing benefits for hospital, medical or surgical expense issued under this section. Notwithstanding the foregoing sentence, a waiting period, not to exceed one year, may be imposed upon coverage for conditions of health which existed prior to the date of enrollment of such employee, dependent or family member, hospitalization in progress on the date of enrollment need not be covered, and~~ The plan may impose participation requirements, define full-time employees and otherwise design the coverage for the group as a whole to be negotiated between the employer and insurer.

(2) Under a policy issued to a labor union which shall have a constitution and bylaws insuring at least 25 members of such union.

(3) Under a policy issued to the trustees of a fund established by two or more employers or business associations or by one or more labor unions or by one or more employers and one or more labor unions, which trustees shall be the policyholder, to insure

Applies to group policies issued directly to employers, associations and trusts and other forms of group policy issuance.

Deleted lines 18-34 eliminate provisions similar enacted in 1988 covering single employer groups

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employees of the employers or members of the union or members of the association for the benefit of persons other than the employers or the unions or the associations. The term "employees" shall include the officers, managers, employees and retired employees of the employer and the individual proprietor or partners if the employer is an individual proprietor or partnership. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship.

(4) A policy issued to a creditor, who shall be deemed the policyholder, to insure debtors of the creditor, subject to the following requirements: (a) The debtors eligible for insurance under the policy shall be all of the debtors of the creditor whose indebtedness is repayable in installments, or all of any class or classes determined by conditions pertaining to the indebtedness or to the purchase giving rise to the indebtedness. (b) The premium for the policy shall be paid by the policyholder, either from the creditor's funds or from charges collected from the insured debtors, or from both.

(5) A policy issued to an association which has been organized and is maintained for the purposes other than that of obtaining insurance, insuring at least 25 members, employees, or employees of members of the association for the benefit of persons other than the association or its officers. The term "employees" shall include retired employees. The premiums for the policies shall be paid by the policyholder, either wholly from association funds, or funds contributed by the members of such association or by employees of such members or any combination thereof.

(6) Under a policy issued to any other type of group which the commissioner of insurance may find is properly subject to the issuance of a group sickness and accident policy or contract.

(B) Each such policy shall contain in substance: (1) A provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties, and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or the insured's beneficiary.

(2) A provision setting forth the conditions under which an individual's coverage terminates under the policy, including the age, if any, to which an individual's coverage under the policy shall be limited, or, the age, if any, at which any additional limitations or restrictions are placed upon an individual's coverage under the

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policy.

(3) Provisions setting forth the notice of claim, proofs of loss and claim forms, physical examination and autopsy, time of payment of claims, to whom benefits are payable, payment of claims, change of beneficiary, and legal action requirements. Such provisions shall not be less favorable to the individual insured or the insured's beneficiary than those corresponding policy provisions required to be contained in individual accident and sickness policies.

(4) A provision that the insurer will furnish to the policyholder, for the delivery to each employee or member of the insured group, an individual certificate approved by the commissioner of insurance setting forth in summary form a statement of the essential features of the insurance coverage of such employee or member, the procedure to be followed in making claim under the policy and to whom benefits are payable. Such certificate shall also contain a summary of those provisions required under paragraphs (2) and (3) of this subsection in addition to the other essential features of the insurance coverage. If dependents are included in the coverage, only one certificate need be issued for each family unit.

(C) No group disability income policy which integrates benefits with social security benefits, shall provide that the amount of any disability benefit actually being paid to the disabled person shall be reduced by changes in the level of social security benefits resulting either from changes in the social security law or due to cost of living adjustments which become effective after the first day for which disability benefits become payable.

(D) A group policy of insurance delivered or issued for delivery or renewed which provides hospital, surgical or major medical expense insurance, or any combination of these coverages, on an expense incurred basis, shall provide that an employee or member or such employee's or member's covered dependents whose insurance under the group policy has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy or under any group policy providing similar benefits which it replaces for at least three months immediately prior to termination, shall be entitled to have such coverage nonetheless continued under the group policy for a period of six months and have issued to the employee or member or such employee's or member's covered dependents by the insurer, at the end of such six-month period of continuation, a policy of health insurance which conforms to the applicable requirements specified in this subsection. This requirement shall not apply to a group policy which provides

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benefits for specific diseases or for accidental injuries only or a group policy issued to an employer subject to the continuation and conversion obligations set forth at title I, subtitle B, part 6 of the employee retirement income security act of 1974 or at title XXII of the public health service act, as each act was in effect on January 1, 1987. An employee or member or such employee's or member's covered dependents shall not be entitled to have such coverage continued or a converted policy issued to the employee or member or such employee's or member's covered dependents if termination of the insurance under the group policy occurred because: (a) The employee or member or such employee's or member's covered dependents failed to pay any required contribution after receiving reasonable notice of such required contribution from the insurer in accordance with rules and regulations adopted by the commissioner of insurance; (b) any discontinued group coverage was replaced by similar group coverage within 31 days; (c) the employee or member is or could be covered by medicare (title XVIII of the United States social security act as added by the social security amendments of 1965 or as later amended or superseded); or (d) the employee or member is or could be covered by any other insured or noninsured arrangement which provides expense incurred hospital, surgical or medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination. In the event the group policy is terminated and not replaced the employee or member, at the option of the employee or member or at the option of the insurer, may be issued a conversion policy or certificate which otherwise meets these provisions in lieu of the right to continue group coverage required herein. The continued coverage and the issuance of a converted policy shall be subject to the following conditions:

(1) Written application for the converted policy shall be made and the first premium paid to the insurer not later than 31 days after termination of coverage under the group policy.

(2) The converted policy shall be issued without evidence of insurability.

(3) The terminated employee or member shall pay to the insurer the premium for the six-month continuation of coverage and such premium shall be the same as that applicable to members or employees remaining in the group. Failure to pay such premium shall terminate coverage under the group policy at the end of the period for which the premium has been paid. The premium rate charged for converted policies issued subsequent to the period of continued coverage shall be such that can be expected to produce an anticipated

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loss ratio of not less than 80% based upon conversion, morbidity and reasonable assumptions for expected trends in medical care costs. In the event the group policy is terminated and is not replaced, converted policies may be issued at self-sustaining rates that are not unreasonable in relation to the coverage provided based on conversion, morbidity and reasonable assumptions for expected trends in medical care costs. The frequency of premium payment shall be the frequency customarily required by the insurer for the policy form and plan selected, provided that the insurer shall not require premium payments less frequently than quarterly.

(4) The effective date of the converted policy shall be the day following the termination of insurance under the group policy.

(5) The converted policy shall cover the employee or member and the employee's or member's dependents who were covered by the group policy on the date of termination of insurance. At the option of the insurer, a separate converted policy may be issued to cover any dependent.

(6) The insurer shall not be required to issue a converted policy covering any person if such person is or could be covered by medicare (title XVIII of the United States social security act as added by the social security amendments of 1965 or as later amended or superseded). Furthermore, the insurer shall not be required to issue a converted policy covering any person if:

(a) (i) such person is covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program, or

(ii) such person is eligible for similar benefits (whether or not covered therefor) under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis, or

(iii) similar benefits are provided for or available to such person, pursuant to or in accordance with the requirements of any state or federal law, and

(b) the benefits provided under the sources referred to in paragraph (i) above for such person or benefits provided or available under the sources referred to in paragraphs (ii) and (iii) above for such person, together with the benefits provided by the converted policy, would result in over-insurance according to the insurer's standards. The insurer's standards must bear some reasonable relationship to actual health care costs in the area in which the insured lives at the time of conversion and must be filed with the commissioner of insurance prior to their use in denying coverage.

(7) A converted policy may include a provision whereby the in-

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surer may request information in advance of any premium due date of such policy of any person covered as to whether:

(a) Such person is covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program;

(b) such person is covered for similar benefits under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or

(c) similar benefits are provided for or available to such person, pursuant to or in accordance with the requirements of any state or federal law.

The converted policy may provide that the insurer may refuse to renew the policy and the coverage of any person insured for the following reasons only:

(a) Either the benefits provided under the sources referred to in paragraphs (i) and (ii) above for such person or benefits provided or available under the sources referred to in paragraph (iii) above for such person, together with the benefits provided by the converted policy, would result in over-insurance according to the insurer's standards on file with the commissioner of insurance, or the converted policyholder fails to provide the requested information;

(b) fraud or material misrepresentation in applying for any benefits under the converted policy;

(c) eligibility of the insured person for coverage under medicare (title XVIII of the United States social security act as added by the social security amendments of 1965 or as later amended or superseded) or under any other state or federal law providing for benefits similar to those provided by the converted policy; or

(d) other reasons approved by the commissioner of insurance.

(8) An insurer shall not be required to issue a converted policy which provides coverage and benefits in excess of those provided under the group policy from which conversion is made.

(9) The converted policy shall not exclude a preexisting condition not excluded by the group policy. The converted policy may provide that any hospital, surgical or medical benefits payable may be reduced by the amount of any such benefits payable under the group policy after the termination of the individual's insurance. The converted policy may also include provisions so that during the first policy year the benefits payable under the converted policy, together with the benefits payable under the group policy, shall not exceed those that would have been payable had the individual's insurance under the group policy remained in force and effect.

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(10) Subject to the provisions and conditions of this act, if the group insurance policy from which conversion is made insures the employee or member for basic hospital or surgical expense insurance, the employee or member shall be entitled to obtain a converted policy providing, at the insured's option, coverage on an expense incurred basis under any one of the plans meeting the following requirements:

Plan A

(a) hospital room and board daily expense benefits in a maximum dollar amount approximating the average semi-private rate charged in metropolitan areas of this state, for a maximum duration of 70 days,

(b) miscellaneous hospital expense benefits of a maximum amount of 10 times the hospital room and board daily expense benefits, and

(c) surgical operation expense benefits according to a surgical schedule consistent with those customarily offered by the insurer under group or individual health insurance policies and providing a maximum benefit of $800, or

Plan B

(a) hospital room and board daily expense benefits in a maximum dollar amount equal to 75% of the maximum dollar amount determined for plan A, for a maximum duration of 70 days,

(b) miscellaneous hospital expense benefits of a maximum amount of 10 times the hospital room and board daily expense benefits, and

(c) surgical operation expense benefits according to a surgical schedule consistent with those customarily offered by the insurer under group or individual health insurance policies and providing a maximum benefit of $600, or

Plan C

(a) hospital room and board daily expense benefits in a maximum dollar amount equal to 50% of the maximum dollar amount determined for plan A, for a maximum duration of 70 days,

(b) miscellaneous hospital benefits of a maximum amount of 10 times the hospital room and board daily expense benefits, and

(c) surgical operation expense benefits according to a surgical schedule consistent with those customarily offered by the insurer under group or individual health insurance policies and providing a maximum benefit of $400.

The maximum dollar amounts of plan A shall be determined by the commissioner of insurance and may be redetermined by such official from time to time as to converted policies issued as new policies subsequent to such redetermination. At the request of the insured, such redetermined amounts shall, subject to the provisions

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of condition (17) and submission of reasonable evidence of insurability, be made available to the holders of converted policies which have been in effect at least three years on the date the redetermined amounts become effective. At the option of the insurer, any such requested increase or decrease in coverage on outstanding policies or any renewal thereof need not be made effective until the first policy anniversary date following the insured's request. Such redetermination shall not be made more often than once in three years. The maximum dollar amounts in plans A, B and C shall be rounded to the nearest multiple of $10.

(11) Subject to the provisions and conditions of this act, if the group insurance policy from which conversion is made insures the employee or member for major medical expense insurance, the employee or member shall be entitled to obtain a converted policy providing catastrophic or major medical coverage under a plan meeting the following requirements:

(a) A maximum benefit at least equal to either, at the option of the insurer, paragraphs (i) or (ii) below:

(i) The smaller of the following amounts:

1. The maximum benefit provided under the group policy.

2. A maximum payment of $250,000 per covered person for all covered medical expenses incurred during the covered person's lifetime.

(ii) The smaller of the following amounts:

1. The maximum benefit provided under the group policy.

2. A maximum payment of $250,000 for each unrelated injury or sickness.

(b) Payment of benefits at the rate of 80% of covered medical expenses which are in excess of the deductible, until 20% of such expenses in a benefit period reaches $1,000, after which benefits will be paid at the rate of 100% during the remainder of such benefit period. Payment of benefits for outpatient treatment of mental illness, if provided in the converted policy, may be at a lesser rate but not less than 50%.

(c) A deductible for each benefit period which, at the option of the insurer, shall be (a) the sum of the benefits deductible and $100, or (b) the corresponding deductible in the group policy. The term "benefits deductible," as used herein, means the value of any benefits provided on an expense incurred basis which are provided with respect to covered medical expenses by any other hospital, surgical, medical insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan, or any other plan or program whether on an insured or uninsured basis, or in

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accordance with the requirements of any state or federal law and, if pursuant to condition (12), the converted policy provides both basic hospital or surgical coverage and major medical coverage, the value of such basic benefits.

If the maximum benefit is determined by paragraph (a)(ii) above, the insurer may require that the deductible be satisfied during a period of not less than three months if the deductible is $100 or less, and not less than six months if the deductible exceeds $100.

(d) The benefit period shall be each calendar year when the maximum benefit is determined by paragraph (a)(i) above or 24 months when the maximum benefit is determined by paragraph (a)(ii) above.

(e) The term "covered medical expenses," as used above, shall include at least, in the case of hospital room and board charges 80% of the average semi-private room and board rate for the hospital in which the individual is confined and twice such amount for charges in an intensive care unit. Any surgical schedule shall be consistent with those customarily offered by the insurer under group or individual health insurance policies and must provide at least a $1,200 maximum benefit.

(12) The conversion privilege required by this act shall, if the group insurance policy insures the employee or member for basic hospital or surgical expense insurance as well as major medical expense insurance, make available the plans of benefits set forth in conditions (10) and (11). At the option of the insurer, such plans of benefits may be provided under one policy.

The insurer may also, in lieu of the plans of benefits set forth in conditions (10) and (11), provide a policy of comprehensive medical expense benefits without first dollar coverage. The policy shall conform to the requirements of condition (11). An insurer electing to provide such a policy shall make available a low deductible option, not to exceed $100, a high deductible option between $500 and $1,000, and a third deductible option midway between the high and low deductible options.

(13) The insurer may, at its option, also offer alternative plans for group health conversion in addition to those required by this act.

(14) In the event coverage would be continued under the group policy on an employee following the employee's retirement prior to the time the employee is or could be covered by medicare, the employee may elect, in lieu of such continuation of group insurance, to have the same conversion rights as would apply had such person's insurance terminated at retirement by reason of termination of em-

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ployment or membership.

(15) The converted policy may provide for reduction of coverage on any person upon such person's eligibility for coverage under medicare (title XVIII of the United States social security act as added by the social security amendments of 1965 or as later amended or superseded) or under any other state or federal law providing for benefits similar to those provided by the converted policy.

(16) Subject to the conditions set forth above, the continuation and conversion privileges shall also be available:

(a) To the surviving spouse, if any, at the death of the employee or member, with respect to the spouse and such children whose coverage under the group policy terminates by reason of such death, otherwise to each surviving child whose coverage under the group policy terminates by reason of such death, or, if the group policy provides for continuation of dependents' coverage following the employee's or member's death, at the end of such continuation;

(b) to the spouse of the employee or member upon termination of coverage of the spouse, while the employee or member remains insured under the group policy, by reason of ceasing to be a qualified family member under the group policy, with respect to the spouse and such children whose coverage under the group policy terminates at the same time; or

(c) to a child solely with respect to such child upon termination of such coverage by reason of ceasing to be a qualified family member under the group policy, if a conversion privilege is not otherwise provided above with respect to such termination.

(17) If the benefit levels required in condition (10) exceed the benefit levels provided under the group policy, the conversion policy may offer benefits which are substantially similar to those provided under the group policy either at the time the group policy was discontinued in its entirety and not replaced or as the group policy is in effect at the time the benefits under the converted policies are determined or redetermined in lieu of those required in condition (10).

(18) The insurer may elect to provide group insurance coverage which complies with this act in lieu of the issuance of a converted individual policy.

(19) A notification of the conversion privilege shall be included in each certificate of coverage.

(20) A converted policy which is delivered outside this state must be on a form which could be delivered in such other jurisdiction as a converted policy had the group policy been issued in that jurisdiction.

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(21) The insurer shall give the employee or member and such employee's or member's covered dependents reasonable notice of the right to convert at least once during the six-month continuation period in accordance with rules and regulations adopted by the commissioner of insurance.

Sec. 2. K.S.A. 1990 Supp. 40-2215 is hereby amended to read as follows: 40-2215. (a) No individual policy of accident and sickness insurance as defined in K.S.A. 40-2201 and amendments thereto shall be issued or delivered to any person in this state nor shall any application, rider or endorsement be used in connection therewith, until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto, have been filed with the commissioner of insurance.

(b) No group or blanket policy of accident and sickness insurance shall be issued or delivered to any person in this state, nor shall any application, rider or endorsement be used in connection therewith, until a copy of the form thereof has been filed with the commissioner of insurance.

~~(b)~~ *(c)* No such policy shall be issued, nor shall any application, rider or endorsement be used in connection therewith, until the expiration of 30 days after it has been filed unless the commissioner gives written approval thereof.

~~(c)~~ *(d)* The commissioner may, within 30 days after the filing of any ~~such~~ form *required to be filed pursuant to subsection (a)*, disapprove such form: (1) If the benefits provided therein are unreasonable in relation to the premium charged; or (2) if it contains a provision or provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of such policy. If the commissioner notifies the insurer which has filed any such form that it does not comply with the provisions of this section or K.S.A. 40-2202 and 40-2203, and amendments thereto, it shall be unlawful thereafter for such insurer to issue such form or use it in connection with any policy. In such notice the commissioner shall specify the reasons for disapproval and state that a hearing will be granted within 20 days after request in writing by the insurer.

(e) (1) Any risk classifications, premium rates, rating formulae, and all modifications of either applicable to Kansas residents shall not establish an unreasonable, excessive or unfairly discriminatory rate or, with respect to group or blanket policies issued pursuant to K.S.A. 40-2209 or 40-2210, and amendments thereto, discriminate against any individuals eligible for participation in a group, or establish rating classifications within a group except those based on criteria solely and directly relevant to recognition of rating differ-

Requires filing of copies of group and blanket accident and sickness policies with commissioner prior to use in state.

Should be amended to add "providing hospital, medical and surgical expense benefits" so that disability insurance is not affected.

Rating applicable to Kansas residents not to be unreasonable, excessive or unfairly discriminatory or discriminate against individuals eligible for participation in a group.

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ences attributable to the marital status of a group's members and persons eligible for dependents' benefits.

(2) All rates for accident and sickness insurance covering Kansas residents shall be made in accordance with the following provisions: (A) Due consideration shall be given to: (i) Past and prospective loss experience; (ii) past and prospective expenses; (iii) adequate contingency reserves; and (iv) all other relevant factors within and without the state;

(B) risks may be grouped by classifications for the establishment of rates for individual, group or blanket policies;

(C) rates shall be reasonable, not excessive and not unfairly discriminatory; and

(D) rates charged to an employer of 25 or fewer employees under group and blanket policies, including such employers covered under a policy issued to an association or trust located within or outside this state covering an employer which is a resident of this state, shall be based on the aggregate loss and expense experience of all such employers insured by the insurer, contingency reserves and other factors required to be considered in making rates to which this act applies. Such rates shall apply to all such employers insured in this state by the insurance company using the rates on a per person basis but may vary with the number of persons in a family, and may vary from employer to employer from a community rate by no more than 50% above the community rate. As used herein, "community rate" means the rate which would be derived by dividing all of the claims expense or anticipated claims expense for the rating period for which such rates will be in effect and all of the administrative expense and other retentions for all such employers covered by the same or similar coverage which is equivalent in value by all of the persons covered by such coverage. For the purposes of this definition, employee, family, spouse and dependent expense and numbers of such persons covered may be separately aggregated and divided. With respect to policies issued prior to the effective date of this act, in any case where the premium rate exceeds the community rate by more than 50%, no increase in such rates may be made until the later of the beginning of a rating period in which such premium rates would be lower than 50% more than the community rate or five years following the effective date of this act. Thereafter, the rates for such policies shall comply with the requirements of this subsection.

(3) Nothing in this act is intended to prohibit or discourage reasonable competition or discourage or prohibit uniformity of rates except to the extent necessary to accomplish the aforementioned pur-

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Rates to take into consideration items enumerated on lines 5-8.

Establishes a form of community rating for groups of 25 or fewer members. Authorizes variations in rate by no more than 50% above the community rate. Defines community rate.

Lines 33-40 have a grandfather clause for existing policies and provide that no increase in rates may be made where the rate exceeds the community rate by more than 50% until the commencement of a rating period in which the rates would be lower than such 50% on January 1, 1997.

pose. The commissioner is hereby authorized to issue such rules and regulations as are necessary and not inconsistent with this act.

~~(d)~~ *(f)* The commissioner may at any time, after a hearing of which not less than 20 days' written notice shall be given to the insurer, withdraw approval of any such form ~~on any of the grounds stated in this section~~ *or rate in the event the commissioner finds such filing no longer meets the requirements of this section or of article 22 of chapter 40 of the Kansas Statutes Annotated, and amendments thereto.* It shall be unlawful for the insurer to issue such form or use it in connection with any policy after the effective date of such withdrawal of approval.

(g) Violations of subsection (e) shall be treated as violations of the unfair trade practices act and subject to the penalties prescribed by K.S.A. 40-2407 and 40-2411 and amendments thereto.

~~(e)~~ *(h)* Hearings under this section shall be conducted in accordance with the provisions of the Kansas administrative procedure act.

Sec. 3. K.S.A. 1990 Supp. 40-19c09 is hereby amended to read as follows: 40-19c09. Corporations organized under the nonprofit medical and hospital service corporation act shall be subject to the provisions of the Kansas general corporation code, articles 60 to 74, inclusive, of chapter 17 of the Kansas Statutes Annotated, applicable to nonprofit corporations, to the provisions of K.S.A. 1990 Supp. 40-2250 and 40-2251 and to the provisions of K.S.A. 40-214, 40-215, 40-216, 40-218, 40-219, 40-222, 40-223, 40-224, 40-225, 40-226, 40-229, 40-230, 40-231, 40-235, 40-236, 40-237, 40-247, 40-248, 40-249, 40-250, 40-251, 40-252, 40-254, 40-2,100, 40-2,101, 40-2,102, 40-2,103, 40-2,104, 40-2,105, 40-2,116, 40-2,117, 40-2a01 *et seq.*, 40-2111 to 40-2116, inclusive, ~~40-2216~~ *40-2215* to 40-2220, inclusive, 40-2401 to 40-2421, inclusive, and 40-3301 to 40-3313, inclusive, and amendments thereto, and to the provisions of K.S.A. 1989 Supp. 40-2221a, 40-2221b, 40-2229 and 40-2230, and amendments thereto, except as the context otherwise requires, and shall not be subject to any other provisions of the insurance code except as expressly provided in this act.

Sec. 4. K.S.A. 1990 Supp. 40-19c07, 40-19c09, 40-2209 and 40-2215 are hereby repealed.

Sec. 5. This act shall take effect and be in force from and after January 1, 1992, and its publication in the statute book.

Rule and regulation authority of commissioner

Clerical error - line 6

Rate violations subject to penalties under unfair trade practices act.

40-19c09 is amended to make the foregoing applicable to Blue Cross/Blue Shield rather than doing so in a separate statute.

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Testimony By
Dick Brock, Kansas Insurance Department
Before the House Insurance Committee
on House Bill No. 2001
February 14, 1991

Much of my testimony on House Bill No. 2001 is old news to many members of this committee. You heard it at the January 30, 1990 joint meeting of this committee and your Senate counterpart. You heard it again when I testified last year on House Bill No. 3012 when, among other things, I suggested and you ultimately adopted amendments dealing with the problems associated with tier rating (i.e. establishing different rate classifications within a group) and the need to return to a community rating methodology for small groups. Those of you on the interim committee heard it again last summer during the information gathering phase of your work. And some of you have heard some of what I am going to say more times than that because the Insurance Department has been an advocate of some of the issues addressed by House Bill No. 2001 as far back as 1972 with respect to Blue Cross and Blue Shield and 1979 for other health insurers. So, I apologize in advance for the repetition but I just don't know how to otherwise address the changes contained in House Bill No. 2001.

I will begin with the new language which appears on page 1. This amends the statute which describes and defines the various kinds of groups in Kansas that are eligible for a group accident and sickness insurance contract in Kansas. In effect, the new language does three things. First, it will prohibit insurance companies from excluding otherwise eligible group members from the group accident and sickness coverage. Second, to prevent circumvention of this prohibition by writing the coverage through an out-of-state group or trust, the new prohibition applies on an extraterritorial basis which means it applies to all accident and sickness policies covering Kansas residents regardless of

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where the policy was issued. And, third, the prohibition also extends to "condition riders" whereby the group insurer might otherwise insure an individual under the group contract but attach a rider or endorsement excluding coverage for a specific medical condition.

These are important new restrictions because one of the most obvious problems that has evolved from the health care cost dilemma is the erosion of the group insurance concept. Too many insurers that continue to write group health insurance are really doing little more than insuring a number of individuals under one policy. Rather than evaluating the underwriting characteristics of a group as a whole, some insurers 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 sometimes be attractive to the group policyholder and those fortunate enough to be insured under the policy. Also 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 without coverage or forced into a conversion contract. 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 alternatives are not a panacea or even an acceptable alternative because the cost of either of these possibilities is usually very high and often unaffordable. Therefore, despite the availability of continuation and conversion options, many people who are individually rejected for coverage under a group plan in which they are otherwise eligible to participate will ultimately be added to the ranks of the uninsured. Beyond that, however,

it just isn't fair and isn't right that two people can be employed at the same place or belong to the same association and one of them can fully participate in group coverage and the other can't.

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 the issue of arbitrarily excluding individuals from group coverage but during the course of the legislative process, the legislation was amended to apply only to replacement policies for groups formed under the auspices of a single employer. The language which is struck on page 2 of House Bill 2001 is the 1988 provision. This left multiple employer trusts, associations and others free to sponsor groups which can and do leave individual members and/or dependents outside the group coverage. Section 1 of House Bill 2001 will finish what was started in 1988 by placing necessary restrictions on this practice and prevent a further erosion of the group concept that can be attributed to the individual underwriting of a group's members.

Section 2 of House Bill No. 2001 deals with ratemaking on group accident and sickness insurance products by establishing certain standards rates must meet with respect to group policies and certificates covering Kansas residents. The general standards included in this section are that rates shall not be unreasonable, excessive or unfairly discriminatory. These are the same standards as now apply to Blue Cross and Blue Shield rates and the kinds of property and casualty insurance that are subject to rate regulation. However, section 2 goes beyond the customary standards by prohibiting rate discrimination against individuals eligible for participation in a group; the establishment of rating classifications

within a group except as may be necessary to recognize pricing differences for a spouse and dependents; and, provisions intended to address the rate volatility many small groups are experiencing.

The prohibition against individual rate discrimination is contained in lines 40 and 41, page 12 of the bill and is necessary to complement the prohibition introduced on page 1 regarding a limitation or exclusion of benefits for specific conditions. Unless we address the rating aspect of this prohibition, it can be effectively circumvented by including coverage for a specific condition but applying a premium surcharge for the condition that produces the same result.

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 age, health condition, or other characteristics and attempting to measure the consequent loss potential by pricing differences for the resulting divisions within the group. 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, this 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. Common sense and familiarity with the way insurers operate tells us that the different categories only mean one category is populated with persons who are presumed to be older or more or less healthy than those in another category. It doesn't necessarily or even probably mean the people in any category are people we would normally consider to be in bad health.

House Bill No. 2001 addresses the practice I have just described in lines 41 through 43, page 12 and lines 1 and 2, page 13 of the bill where the establishment of rating classifications within a group is prohibited except with respect to those necessary to accommodate the distinction between single and family or dependents coverage.

Another version of tier rating works a little differently but produces quite similar results. Traditionally, insurers combined the experience of smaller groups -- for example groups of 25 or fewer members -- and 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 or largely on the basis of their own loss experience. Thus, because of the small size of the group, one moderately serious illness to one group member can produce a very dramatic premium increase. 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. Nevertheless, the fragmentation of the rates applied to small groups obviously amplifies the adverse effect of a serious illness or accident among the members of the group effected. It is no secret that 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 dramatically and this is the source of many of the horror stories we have all heard about tremendous premium increase some groups experience from one year to the next.

Subsection (e)(2)(D) of House Bill No. 2001 reintroduces by statutory requirements a return to what is referred to as community rating. Under

these provisions, each insurer would be required to develop a single rate based on the aggregate experience of all small groups covering Kansas residents that are insured by that company or prepaid service plan. Through this means, the rates for small groups should be stabilized because the claims are spread among a larger population. As a result, a small group is not nearly as susceptible to the massive premium fluctuations we know occur.

We have a problem, however, because in the real world today small groups are rated as small groups and, as horrendous as some of the stories are, it is a relatively few groups in relation to the total that have been subjected to mind-boggling increases. Therefore, if our effort to return to a community rating structure stopped at this point, we would create many more problems than we would solve because the vast majority of risks would receive a significant premium increase and only a few risks would receive a decrease. Many, probably most, of that vast majority are simply borrowing time because sooner or later one or more of their members are going to incur significant medical expenses and when that happens one of you as well as the Insurance Commissioner will have another constituent complaint. Therefore, it is in the best interest of every small group to support some means of achieving greater premium stability but we need to do so in a way that does not make a bad problem worse. House Bill No. 2001 attempts to do this by using 150% of the community rate as a benchmark. Small groups whose premium rate exceeds 150% of the community rate could not be subjected to a rate increase until their premium falls below the benchmark. I realize the bill includes a 5 year time period relating to this maximum premium rate but I want to discuss that in the context of some amendments we believe are necessary to clarify certain provisions or avoid some unintended effects. (Amendments and explanations)

(21) The insurer shall give the employee or member and such employee's or member's covered dependents reasonable notice of the right to convert at least once during the six-month continuation period in accordance with rules and regulations adopted by the commissioner of insurance.

Sec. 2. K.S.A. 1990 Supp. 40-2215 is hereby amended to read as follows: 40-2215. (a) No individual policy of accident and sickness insurance as defined in K.S.A. 40-2201 and amendments thereto shall be issued or delivered to any person in this state nor shall any application, rider or endorsement be used in connection therewith, until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto, have been filed with the commissioner of insurance.

(b) No group or blanket policy of accident and sickness insurance shall be issued or delivered to any person in this state, nor shall any application, rider or endorsement be used in connection therewith, until a copy of the form thereof has been filed with the commissioner of insurance.

~~(b)~~ *(c)* No such policy shall be issued, nor shall any application, rider or endorsement be used in connection therewith, until the expiration of 30 days after it has been filed unless the commissioner gives written approval thereof.

~~(c)~~ *(d)* The commissioner may, within 30 days after the filing of any ~~such~~ form *required to be filed pursuant to subsection (a)*, disapprove such form: (1) If the benefits provided therein are unreasonable in relation to the premium charged; or (2) if it contains a provision or provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of such policy. If the commissioner notifies the insurer which has filed any such form that it does not comply with the provisions of this section or K.S.A. 40-2202 and 40-2203, and amendments thereto, it shall be unlawful thereafter for such insurer to issue such form or use it in connection with any policy. In such notice the commissioner shall specify the reasons for disapproval and state that a hearing will be granted within 20 days after request in writing by the insurer.

(e) (1) Any risk classifications, premium rates, rating formulae, and all modifications of either applicable to Kansas residents shall not establish an unreasonable, excessive or unfairly discriminatory rate or, with respect to group or blanket policies issued pursuant to K.S.A. 40-2209 or 40-2210, and amendments thereto, discriminate against any individuals eligible for participation in a group, or establish rating classifications within a group except those based on criteria solely and directly relevant to recognition of rating differ-

or certificate

EXPLANATION: With respect to group accident and sickness policies, insured members receive a certificate issued off a master policy which contains the coverage provisions. As a result, certificates are also subject to the filing requirement.

accident and sickness

providing hospital or medical-surgical expense benefits

EXPLANATION: These amendments are intended to clarify the types of policies to which these provisions apply.

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ences attributable to the marital status of a group's members and persons eligible for dependents' benefits.

(2) All rates for accident and sickness insurance covering Kansas residents shall be made in accordance with the following provisions: (A) Due consideration shall be given to: (i) Past and prospective loss experience; (ii) past and prospective expenses; (iii) adequate contingency reserves; and (iv) all other relevant factors within and without the state;

~~*(B) risks may be grouped by classifications for the establishment of rates for individual, group or blanket policies;*~~

~~*(C) rates shall be reasonable, not excessive and not unfairly discriminatory;*~~ *and*

~~*(D)*~~ *rates charged to* ~~*an employer*~~ *of 25 or fewer employees, under group and blanket policies, including such* ~~*employers*~~ *covered under a policy issued to an association or trust located within or outside this state covering an* ~~*employer*~~ *which is a resident of this state, shall be based on the aggregate loss and expense experience of all such* ~~*employers*~~ *insured by the insurer, contingency reserves and other factors required to be considered in making rates to which this act applies. Such rates shall apply to all such* ~~*employers*~~ ~~*insured*~~ *in this state by the insurance company using the rates on a per person basis but may vary with the number of persons in a family, and may vary from* ~~*employer to employer*~~ *from a community rate by no more than 50% above the community rate. As used herein, "community rate" means the rate which would be derived by dividing all of the claims expense or anticipated claims expense for the rating period for which such rates will be in effect and all of the administrative expense and other retentions for all such* ~~*employers*~~ *covered by the same or similar coverage which is equivalent in value by all of the persons covered by such coverage. For the purposes of this definition, employee, family, spouse and dependent expense and numbers of such persons covered may be separately aggregated and divided. With respect to policies issued prior to the effective date of this act, in any case where the premium rate exceeds the community rate by more than 50%, no increase in such rates may be made until the* ~~*later of*~~ *the beginning of a rating period in which such premium rates would be lower than 50% more than the community rate* ~~*or five years following the effective date of this act. Thereafter, the rates for such policies shall comply with the requirements of this subsection.*~~

(3) Nothing in this act is intended to prohibit or discourage reasonable competition or discourage or prohibit uniformity of rates except to the extent necessary to accomplish the aforementioned pur-

Delete

Delete

(B)

a group

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providing hospital or medical-surgical expense benefits

employees, members or member units

employer,

employee or member

persons

insureds

group to group

groups

Delete

equal to or

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EXPLANATION: These provisions are deleted because they are duplicative of the provisions in subparagraph (1).

EXPLANATION: The above amendments are necessary to clarify that the new provisions apply to all group and blanket policies providing hospital or medical-surgical expense benefits as opposed to applying only to employer/employee groups.

EXPLANATION: These amendments are intended to clarify the application of the 150% limitation. Without these amendments, it appears a group whose premium is lower than 150% prior to 5 years from the effective date of the act would still not be subject to a rate increase. On the other hand, if, after 5 years a group's rate still exceeds 150% of the community rate, the rate would "automatically" be reduced to 150%. Perhaps these amendments do not reflect the intent but, in any event, some clarification would seem to be necessary.

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pose. The commissioner is hereby authorized to issue such rules and regulations as are necessary and not inconsistent with this act.

~~(d)~~ ~~(f)~~ The commissioner may at any time, after a hearing of which not less than 20 days' written notice shall be given to the insurer, withdraw approval of any such form ~~on any of the grounds stated in this section~~ or rate *in the event the commissioner finds such filing no longer meets the requirements of this section or of article 22 of chapter 40 of the Kansas Statutes Annotated, and amendments thereto.* It shall be unlawful for the insurer to issue such form or use it in connection with any policy after the effective date of such withdrawal of approval.

~~(g)~~ *Violations of subsection (e) shall be treated as violations of the unfair trade practices act and subject to the penalties prescribed by K.S.A. 40-2407 and 40-2411 and amendments thereto.*

~~(e)~~ ~~(h)~~ Hearings under this section shall be conducted in accordance with the provisions of the Kansas administrative procedure act.

Sec. 3. K.S.A. 1990 Supp. 40-19c09 is hereby amended to read as follows: 40-19c09. Corporations organized under the nonprofit medical and hospital service corporation act shall be subject to the provisions of the Kansas general corporation code, articles 60 to 74, inclusive, of chapter 17 of the Kansas Statutes Annotated, applicable to nonprofit corporations, to the provisions of K.S.A. 1990 Supp. 40-2250 and 40-2251 and to the provisions of K.S.A. 40-214, 40-215, 40-216, 40-218, 40-219, 40-222, 40-223, 40-224, 40-225, 40-226, 40-229, 40-230, 40-231, 40-235, 40-236, 40-237, 40-247, 40-248, 40-249, 40-250, 40-251, 40-252, 40-254, 40-2,100, 40-2,101, 40-2,102, 40-2,103, 40-2,104, 40-2,105, 40-2,116, 40-2,117, 40-2a01 *et seq.*, 40-2111 to 40-2116, inclusive, ~~40-2216~~ ~~40-2215~~ to 40-2220, inclusive, 40-2401 to 40-2421, inclusive, and 40-3301 to 40-3313, inclusive, and amendments thereto, and to the provisions of K.S.A. 1989 Supp. 40-2221a, 40-2221b, 40-2229 and 40-2230, and amendments thereto, except as the context otherwise requires, and shall not be subject to any other provisions of the insurance code except as expressly provided in this act.

Sec. 4. K.S.A. 1990 Supp. 40-19c07, 40-19c09, 40-2209 and 40-2215 are hereby repealed.

Sec. 5. This act shall take effect and be in force from and after January 1, 1992, and its publication in the statute book.

(f) The provisions of subsection (e) shall not apply to any medicare supplement policy as defined by the commissioner pursuant to rule and regulation, any policy of long-term care insurance as defined by K.S.A. 1990 Supp. 40-2227 and amendments thereto, any specified disease, specified accident or accident only coverage, credit insurance, or any disability income protection policy.

EXPLANATION: This is a new concept developed to address problems associated with the cost of accident and sickness policies utilized by groups as the primary means of financing health care costs. Therefore, this amendment is intended to specifically identify those specialty type products that are exempt from its provisions.

(g)

disapprove any

filed in accordance with K.S.A. 40-2215(a)

EXPLANATION: These amendments have nothing to do with the purpose of House Bill No. 2001 but will correct a long-standing administrative difficulty by permitting the commissioner to directly disapprove a rate applicable to an individual accident and sickness policy. Historically and currently any regulatory control could be applied only to the form with which the rate is used.

(h)

(i)

Section 2, subsection (e) of this act

EXPLANATION: Without this amendment, Blue Cross and Blue Shield will no longer be subject to prior approval rate regulation. Since the "post-use" system of rate regulation enforcement contained in this bill is new and unproven, it is suggested that we not replace the existing mechanism at the present time.

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Blue Cross
Blue Shield
of Kansas

1133 S. W. Topeka Boulevard
Topeka, Kansas 66629-0001

Local Corporate Phone #-
(913) 291-7000
Corporate 800 Number -
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TESTIMONY ON HOUSE BILL 2001
BLUE CROSS AND BLUE SHIELD OF KANSAS, INC.
FEBRUARY 14, 1991

Mr. Chairman, members of the committee, my name is Nancy Zogleman and I serve as Director of Legislative Relations for Blue Cross and Blue Shield of Kansas, Inc.

Before I address specific provisions of HB 2001, I would like to remind the committee of this bills evolution. HB 2001 was recommended by the Special Committee on Insurance after the committee heard considerable testimony, explored possible amendments, listened to staff briefings and reviewed provisions by many groups.

Certain components of this bill are not new. Several provisions in this bill have been before the Insurance Committee in previous sessions. However, in several aspects HB 2001 is very different. This bill combines recommendations from the Insurance Department, the insurance industry, National Association of Insurance Commissioners, and many other groups in order to provide REAL reform. And what I found to be really interesting, is that another group, The Governor's Commission on Health Care, came up with many of the same recommendations which are provided for in this bill.

Some may criticize this bill for going too far and some may criticize this bill for not going far enough, but until we have at least moved off dead center, we will not know how far we need to go.

This committee like many others this session may also be discussing some type of universal health care. However, before we throw the baby out with the bath water, I believe we must first look to what will fix our current system. US Congressman and House Majority Leader Richard Gephardt, D-Mo., told a Senate committee last month that the best way to reform the nation's health care system is to build on the current framework, not start over with a

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new one. Gephardt said that the current system is in need of major reforms, but, "I personally believe that it would be best to build on what we have, rather then starting anew with an entirely different system."

This bill addresses many of the reforms which can be made on a state level with our present framework.

Prohibits excluding persons from eligibility

HB 2001 addresses a practice of insurers which creates a substantial barrier to access to health insurance for Kansans, particularly for employees of small employers, and for their dependents.

The practice is that of a health insurer insuring only healthy persons within a group, and refusing to insure persons with current health conditions.

In late December of 1989, Blue Cross and Blue Shield started documenting some cases in which another insurer would replace Blue Cross and Blue Shield coverage and would refuse to accept all persons within the group because of past health conditions. Under most circumstances, where this occurs, Blue Cross and Blue Shield continues coverage for such persons for six months and then offers a conversion privilege at the end of that time, but the conversion coverage is very expensive and frequently not as broad as the group coverage.

Since December of 1989, over 138 cases have been brought to our attention where persons have asked for continued coverage because a carrier replacing our coverage refused to insure persons currently in the group. Some of the reasons cited by those seeking coverage were:

- "The subscriber's wife is overweight and they are a very conservative company."

- "Because of pre-existing, I will not be covered for one to two years."

- "Wife not eligible due to high blood pressure."

• "At first they said I was eligible then three days later said I wasn't eligible due to colon surgery in November, 1989."

• "Hysterectomy and found cancer, doctor stated everything was taken care of, but new insurance won't take her."

• "Considered a health risk -- will not accept group is she is enrolled. Brain tumor. Recovered."

The insurers in these situations engage in the group insurance business, but do not insure anyone who is not healthy -- they only insure those who need the insurance least, not those who have a clear need for the insurance.

This provision found in HB 2001 is to prohibit an insurer from excluding a person from coverage under a group policy under these situations. Blue Cross and Blue Shield of Kansas strongly supports this concept. This same concept has been endorsed by the National Association of Insurance Commissioner (NAIC) and the Governor's Commission on Health Care.

This provision is also extraterritorial which means it applies to both contracts issued in Kansas and those issued outside of Kansas.

Prohibit limiting or excluding benefits for specific conditions

This provision, in addition to not being able to refuse coverage, an insurer also could not place a rider on coverage, saying, for example, "No coverage is available for John Doe for heart conditions." This goes hand-in-glove with the first provision, since as insurer accepting people in a group for coverage but then stripping all that coverage by specific riders would be creating the same practical effect as excluding them. This same concept has been endorsed by the NAIC and the Governor's Commission.

This provision is also extraterritorial.

Waiting period for pre-existing conditions

This provision suggests allowing insurers to impose a waiting period for pre-existing conditions for up to one year. That is, it permits the insurer to have some safeguard against persons who previously were eligible but wait to enroll during a later open enrollment period when they know they are going to have claims, or against persons who obtain employment merely to obtain health coverage. This has been endorsed by the NAIC and the Governor's Commission.

Portability

The concept of portability suggest that a policy waive a waiting period to the extent it had been served while covered under a prior group accident and sickness coverage with no gap in the coverage. That is, an insured could go from one employer to another, or an employer, could replace current group coverage with another group coverage, without the employees having to re-serve a new one year waiting period for conditions that may have been covered under the prior insurance. This same concept has been endorsed by the NAIC and the Governor's Commission.

Equal Rate Regulation of All Health Insurers

Blue Cross and Blue Shield of Kansas supports the concept that all insurers should be regulated equally. Currently, because of the unique way in which Blue Cross and Blue Shield of Kansas is set up, it is the only insurance company doing group business in the State of Kansas which has its rates regulated. Some may suggest because we are the largest insurer in the state (35% of the population) that our rates should be regulated. However, my question to the committee is why should 65% of the Kansas population have insurance with those who are not regulated? I would simply request that when the committee makes its final decision on whether to rate regulate or in what form, that you treat all insurers doing business in the state of Kansas equally.

If the rate regulation provisions are retained, they should be modified so that they do not include groups disability or "loss of time" insurance. Both disability and health insurance are "policies of accident and sickness insurance," but currently only non-group disability insurance rates are regulated, and there is no apparent reason to include group disability insurance rates or rating methods in this legislation.

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EXAMPLE OF SMALL GROUP RATING POOL OF TEN GROUPS

I. Current Rate Distribution: (5 Family Contracts Per Group)

1 Group at $200 per month per family contract
2 Groups at $300 per month per family contract
3 Groups at $400 per month per family contract
2 Groups at $700 per month per family contract
1 Group at $900 per month per family contract
1 Group at $1,200 per month per family contract
10 Groups at an average rate of $550 per month per contract

(Above rates would produce Total Premiums of $27,500 per month)

II. H.B. 2001 would establish a maximum variation in rates of 50% above the average rate. Any group with rates above the maximum rate would have no rate adjustments made until five years or until their rates were below the maximum rate.

A. First year adjustments with an annual 10% increase to the pool

($550 Average Rate X 110% = $605) ($605 Average Rate X 150% = $908 (Maximum rate)

	Current Rates		1st Yr. Rates	Increase $ Amount	Increase Percentage
1 Group at	$ 200 per month per contract	would go to	$ 230	$ 30	16%
2 Groups at	$ 300 per month per contract	would go to	$ 348	$ 48	16%
3 Groups at	$ 400 per month per contract	would go to	$ 464	$ 64	16%
2 Groups at	$ 700 per month per contract	would go to	$ 812	$ 112	16%
1 Group at	$ 900 per month per contract	would go to	$ 908	$ 8	1%
1 Group at	$ 1,200 per month per contract	would go to	$ 1,200	$ 0	0%
Total Premium	$27,500 per month		$30,250		

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B. Second year adjustments with an annual 10% increase to the pool

($605 Average Rate X 110% = $666) ($666 Average Rate X 150% = $999 (Maximum rate)

		1st Yr. Rates		2nd Yr. Rates	Increase $ Amount	Increase Percentage
1	Group at	$ 230	per month per contract would go to	$ 261	$ 31	13%
2	Groups at	$ 348	per month per contract would go to	$ 393	$ 45	13%
3	Groups at	$ 464	per month per contract would go to	$ 524	$ 60	13%
2	Groups at	$ 812	per month per contract would go to	$ 918	$ 106	13%
1	Group at	$ 908	per month per contract would go to	$ 999	$ 91	10%
1	Group at	$ 1,200	per month per contract would go to	$ 1,200	$ 0	0%
Total Premium		$30,250 per month		$33,270		

C. Third year adjustments with an annual 10% increase to the pool

($666 Average Rate X 110% = $733) ($733 Average Rate X 150% = $1,100 (Maximum rate)

		2nd Yr. Rates		3rd Yr. Rates	Increase $ Amount	Increase Percentage
1	Group at	$ 261	per month per contract would go to	$ 296	$ 35	13%
2	Groups at	$ 393	per month per contract would go to	$ 443	$ 50	13%
3	Groups at	$ 524	per month per contract would go to	$ 590	$ 66	13%
2	Groups at	$ 918	per month per contract would go to	$ 1,034	$ 116	13%
1	Group at	$ 999	per month per contract would go to	$ 1,100	$ 101	10%
1	Group at	$ 1,200	per month per contract would go to	$ 1,200	$ 0	0%
Total Premium		$33,270 per month		$36,600		

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D. Fourth year adjustments with an annual 10% increase to the pool

($733 Average Rate X 110% = $806) ($806 Average Rate X 150% = $1,209 (Maximum rate)

		3rd Yr. Rates		4th Yr. Rates	Increase $ Amount	Increase Percentage
1	Group at	$ 296	per month per contract would go to	$ 332	$ 36	12%
2	Groups at	$ 443	per month per contract would go to	$ 498	$ 55	12%
3	Groups at	$ 590	per month per contract would go to	$ 662	$ 72	12%
2	Groups at	$ 1,034	per month per contract would go to	$ 1,160	$ 126	12%
1	Group at	$ 1,100	per month per contract would go to	$ 1,209	$ 109	10%
1	Group at	$ 1,200	per month per contract would go to	$ 1,209	$ 9	1%
Total Premium		$36,600 per month		$40,260		

E. Fifth year adjustments with an annual 10% increase to the pool

($806 Average Rate X 110% = $887) ($887 Average Rate X 150% = $1,330 (Maximum rate)

		4th Yr. Rates		5th Yr. Rates	Increase $ Amount	Increase Percentage
1	Group at	$ 332	per month per contract would go to	$ 366	$ 34	10%
2	Groups at	$ 498	per month per contract would go to	$ 548	$ 50	10%
3	Groups at	$ 662	per month per contract would go to	$ 728	$ 66	10%
2	Groups at	$ 1,160	per month per contract would go to	$ 1,276	$ 116	10%
1	Group at	$ 1,209	per month per contract would go to	$ 1,330	$ 121	10%
1	Group at	$ 1,209	per month per contract would go to	$ 1,330	$ 121	10%
Total Premium		$40,260 per month		$44,290		

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WICHITA INDEPENDENT BUSINESS ASSOCIATION
Riverview Plaza • 2604 W. 9th St. at McLean Blvd. • Wichita, Kansas 67203
(316) 943-2565

ROLAND E. SMITH, *Executive Director*

February 14, 1991

STATEMENT TO: Kansas House Insurance Committee
FROM: Roland Smith, Executive Director
Wichita Independent Business Association
SUBJECT: House Bill No. 2001

Chairman Turnquist, members of the Committee and staff, I thank you for the opportunity to appear before you today with comments on HB 2001.

WIBA, in general, supports this bill with certain modifications and more clearly defined language. Before I discuss this bill in detail, I would like to make some general statements to help you understand our concern in making available affordable health insurance coverage for small businesses in Kansas.

In Kansas 89% of all businesses have 25 or fewer employees and 77.1% have fewer than 10 employees. It is estimated that these businesses have from 50 to 55 percent of all the employees in Kansas. The most recent economic development studies show that most of the new jobs are created by these small independent businesses. Even with these known facts, we believe very little is being done on the state or federal level to assist these businesses to grow or even survive. There are some exceptions in the high-tech, some in manufacturing and minority business areas, but not in the main stream of small independent businesses. Health care costs and property taxes are the two largest problems for small independent businesses in Kansas. In many cases, health insurance costs are more devastating than their property taxes, especially when the business is renting space and the owner can not pass on all his increased property tax load to the renter when there is an abundance of available space in that area.

WIBA is an association of approximately 1400 independent (at least 51% locally owned) businesses in the Wichita trade area. WIBA was started 60 years ago in 1931 to support the interests of independent business in the Wichita area. Over 1100 of our members have fewer than 10 employees. Until October 1990, when BC/BS transferred our members with BC/BS into their Multiple Employers Trust, WIBA had 365 businesses in a WIBA sponsored Blue Cross/Blue Shield Plan. Because of BC/BS going to a tier rat-

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ing system two or three years ago, the premiums for a couple or a family has ranged all the way from $400 to $1480 per month. Many of these people had been in BC/BS for over 20 years before they had much usage and when they did have a major problem, their premium jumped 60 to 80 percent in one year. Even without many claims their premiums increased as they moved up in age brackets. All major insurance companies have had tier rating for years and are only insuring the well employes in small business. BC/BS is now following the same path and leaving the federal qualified HMO's where they are willing to cover the others or they go uninsured. When the insurance agents in Wichita learned that WIBA's Equicor Plan would take employees with pre-existing conditions three years ago, a large influx of their rejects enrolled in Equicor through WIBA membership. This caused adverse selection in our group and Equicor had to close open enrollment for new WIBA members starting in January 1990 and have an open enrollment for only two weeks, once a year. We now have 667 businesses in the WIBA sponsored Equicor Plan.

Our office receives several calls a day from small independent businesses looking for affordable health care insurance. All the insurance companies are eliminating small groups by not spreading the risk over a larger pool of insured and causing those small companies with large claims or older employees to drop out as they can no longer afford the high premiums.

We believe that the concept of HB2001 is only one step in helping to correct the situation. It will not solve the entire problem, but it can, if amended, bring some relief to small independent businesses now struggling with the problem.

On Page 1 of HB2001, line 25, "Open Enrollment" needs to be defined. There are numerous definitions possible, but one suggestion might be... once a year for not more than 30 days. We agree with the rest of the page, however a question has been raised to clarify the wording as it relates to a change of carriers and change of employers. It is clear that a carrier cannot exclude employees upon renewal, but unclear in the other situations. I do not have suggested wording at this time to make this clear. It would be our position that a change in carriers would not exclude any employee and I think this was the intent of the current wording. The problem of changing employers raises some serious questions. From the employee's point of view, changing employers should not force a waiting period with the new employer's plan. This has not, however, been a problem that has been brought to my attention with WIBA members. Our problem is more basic in just being able to get the coverage at reasonable costs. There is, I am told, a problem with the large manufacturers in Wichita of employees changing jobs to

increase the availability of health insurance coverage when they have reached their maximum with their current employer.

I don't know where all the specifications came from for the conversion options on pages 5 through 11, but it appears to be watered down coverage and does not allow the employee to keep the same level of coverage he had even if he is willing to pay for it. Lower coverage at conversion, unfortunately, is a common practice with most insurance companies today. This could be corrected if the employee was also offered the option to keep the same coverage. If it is in the bill language, I did not find it.

On Page 13, Line 9(B), I assume classifications refers to the definition on Page 12, Lines 40 through 43 and on Page 13, Lines 1 and 2. If not, it should be spelled out so classifications in the tier rating system of today are not used.

Page 13, Line 11(C), says... rates shall be reasonable, not excessive and not unfairly discriminatory. "C" language is in the statutes that formed BC/BS and the Insurance Department tells me that "reasonable rates" in the statutes would have to be defined in a court of law. Therefore, this wording, in my opinion, has no meaning unless a definition is spelled out. According to BC/BS and the insurance carriers, their current system is not unreasonable, excessive or discriminatory in nature. I could argue that they are all three today and this wording would change very little if not defined in this bill. WIBA believes in free enterprise, but some regulations are necessary to avoid abuses. Auto insurance rates are regulated and we believe that health insurance rates should be regulated and not just filed with the Kansas Insurance Department. All insurance companies marketing health inurance plans in Kansas should be subject to rate regulations and so stated in this bill.

Page 13, Line 13(D), we feel needs to include employers with 100 or less employees. The reason for this is that these businesses are getting hit hard when they have one major claim and therefore should be included in a larger risk pool.

Page 13, Lines 21 through 40, dealing with community rates, needs to define community rates clearly. There are numerous definitions and variations depending on who is defining it. It is the WIBA position that community rating should be within all businesses of 100 or fewer employees in Kansas doing business with one carrier. We strongly oppose the provision that allows the rate to go 50 percent above the community group rate. That almost destroys the community group rating concept and would not help very much those that are now paying excessive premium rates. Again, the definition in lines 31 through 33 appear to be another form of tier rating. The five-year provision for

phasing-in the rates is unclear and unacceptable from our point of view. Some form of phasing-in is necessary for the entire concept, but not this way. We realize there are down sides to community rating because it penalizes those businesses with wellness problems that result in healthier employees and those employers with young employees. Also that it opens the door for healthy and/or younger employees to drop group coverage in favor to private policies at much lower premiums. I don't know what provisions could be added to this bill that would help solve those problems, unless private health policy premiums were also regulated.

It is our opinion this bill needs more work and should not be slanted toward the BC/BS suggestions, but to the consumer. I would be glad to work with the committee in any way possible to achieve this. This legislation is WIBA's highest priority this session. If Kansas does not meet the challenge in the accessability and affordability of health insurance for small employers, national health insurance is inevitable.

Thank You! and I'll be glad to answer any questions that I can.

KAISER PERMANENTE

Testimony before the
Kansas House Insurance Committee
House Bill 2001
February 14, 1991

Cheryl Dillard
Government and Community Relations Manager
Kaiser Permanente

Mr. Chairman, I am Cheryl Dillard, Government and Community Relations Manager for Kaiser Permanente in Kansas City. I appreciate the opportunity to appear before you today in support of House Bill No. 2001.

Kaiser Permanente is the oldest and largest HMO in the country, with over 6 million members in 16 states and the District of Columbia. In the Kansas City area, we have 44,000 members who receive care from our physicians practicing in our six medical offices.

Kaiser Permanente has operated for over 45 years in a manner which we believe is consistent with the goal of the legislature and the Insurance Department, that of making health insurance coverage available and affordable for as many Kansans as possible. We believe the provisions of House Bill 2001 move the insurance industry towards that goal.

Regarding preexisting condition clauses, Kaiser Permanente does not and cannot, according to federal law, screen out members of an employers' group based on health status. Federal qualified HMOs, of which Kaiser Permanente is one, must take all persons in a group no matter what their health conditions. Most HMOs operating in Kansas are federally qualified. Kaiser Permanente supports any public policy efforts which return our industry to the basic principals that underlie the equitable provision of health benefits coverage. We welcome the opportunity to spread the risks among a larger group of carriers. House Bill 2001 will do that.

Since our beginnings in the 1940's, Kaiser Permanente has established premium rates based on community rating methods, believing that was the fairest way to charge all our subscribers for care. As our competitors moved away from community rating over the years, it continued to be our corporate philosophy to use that rating method and we opposed changes in the provisions of the federal HMO law which required community rating. It was only two years ago that we reluctantly moved to an adjusted community rating method with groups larger than 100 enrollees. This change was prompted by competitive pressures which we could no longer resist and by repeated requests from national employers who demanded a premium rate based on the actual health services used by their employees. With smaller groups--those with fewer than 100 enrollees in our

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

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plan--we continue to establish rates using community rating methods. Groups with under 100 employees represent over half our business. Listed below by size are the employer groups offering Kaiser Permanente:

Group Size (number of employees)	Number of Groups	% of Total Groups
under 25	179	39.3%
26 to 50	74	16.3%
51 to 100	55	12.1%
over 100	147	32.3%
	455	100%

We believe that community rating is the fairest approach to offering health insurance coverage to small employers who operate under the dual disadvantage of narrow operating margins and minimal buying power.

We would make two recommendations to the Committee--that the community rated group size be raised to 50 and that all carriers be required to have their rates reviewed by the Commissioner. We believe both of these changes will increase even further the worthy purposes of this legislation.

KANSAS MEDICAL SOCIETY
1300 Topeka Avenue • Topeka, Kansas 66612 • (913) 235-2383
Kansas WATS 800-332-0156 FAX 913-235-5114

February 14, 1991

TO: House Insurance Committee

FROM: Kansas Medical Society

SUBJECT: House Bill 2001; Phase-In Community Rating of Health Insurance Premiums

Thank you for this opportunity to express the support of the Kansas Medical Society for the provisions of HB 2001. We believe that community rating of insurance risks restores the fundamental premise upon which the concept of insurance should be based. This in turn should make health insurance more affordable for many groups, thereby generally increasing access to health care for the people of Kansas. This bill also includes a very important feature that would prohibit the exclusion of individual employees of any group seeking health insurance coverage. We support this provision as well.

Because there was an extensive study of this topic during the 1990 interim, it is not necessary to elaborate on all of the considerations involved. We do, however, wish to express the support of the KMS for HB 2001 and urge you to recommend it for passage. Thank you very much.

/cb

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

Testimony to House Insurance Committee on HB 2001 (prohibiting individual exclusions and requiring community rating for small groups)

by James P. Schwartz Jr.
Consulting Director
February 14, 1991

I am Jim Schwartz, consulting director for the Kansas Employer Coalition on Health. The coalition is 100 employers across Kansas who share concerns about the cost-effectiveness of healthcare we buy for our 350,000 Kansas employees and dependents.

Although members of this coalition are not unanimous in their reaction to HB 2001, our board voted in December to support the general principles contained in the bill. We should acknowledge, though, that the coalition tends to comprise larger healthcare purchasers who would not be so affected by the bill as would smaller companies.

You're probably aware that we've authored a paper describing a possible restructuring of the healthcare system. Part of that paper, and perhaps the only part amenable to early implementation, involves insurance reform consistent with the provisions of HB 2001. A stated principle in our paper is, "The insurance system should spread the risks for medical expenses across the widest practical base, thus assuring that no individual or group bears a disproportionate exposure." That principle was also adopted by Governor Hayden's Commission on Health Care.

Arguable is whether the community rating provision of HB 2001 is the best way to achieve that principle. Risk pools could conceivably provide a mechanism for insuring individuals considered otherwise uninsurable. To decide between risk pools and community rating, one needs to answer this question: "Should people who are sick or at risk of becoming sick, pay more for insurance than well or low-risk people?" Risk pools differ from community rating in effect by charging higher than standard rates. If you believe that high-risk people should pay more, then risk pools may be a better solution. If you believe that insurance rates should not reflect health status or risk, then community rating looks better. Actually, the community rating provision of HB 2001 compromises the differences between approaches by allowing up to a 50% rate differential.

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Neither community rating nor risk pools deal adequately with a related element of the health insurance crisis. That problem is the polarizing of high and low-risk groups into desirables and undesirables because of insurers' competition for low-risk groups. Under risk pools, even though the worst risks are segmented out, there is still competition for preferred risks within the remaining segment. Under community rating, high-risk groups will still be shunned, perhaps even more so than today, unless there is a provision in the law, as there is in the KECH and Governor's Commission proposals, to require insurers to accept any applying employer group.

The benefit of reducing or eliminating risk competition is that insurers must then compete solely on the basis of service, efficiency and price — the very things customers are looking for — instead of by the fortune or misfortune of groups.

Fortunate groups, who stand to lose by community rating, need to understand that they are tomorrow's older and perhaps unluckier groups. Community rating, by involving fortunate groups as more nearly equal partners in the health cost problem, will add a new constituency to the clamor for healthcare reform. That alone would be a service.

HB 2001 will not decrease overall healthcare costs. It just tends to homogenize the cost problem. Still, by leveling costs and closing some cracks, the bill prepares the way for later reforms that could deal more comprehensively with the profound problems of soaring costs and high numbers of uninsureds.

DORTH COOMBS INSURANCE, INC.
A CORROON & BLACK COMPANY

DORTH COOMBS INSURANCE, INC.
Actuarial Consulting • Employee Benefits • Property & Casualty

February 13, 1991

The Honorable Larry Turnquist, Chairman
Special Committee on Insurance
State Capital Building
Room 115 South
Topeka, KS 66612

RE: House Bill #2001

Dear Sirs:

It is our opinion that proposed House Bill #2001 is unworkable in its present form, however, is a starting point for discussion. The position of Corroon & Black/Dorth Coombs Insurance, Inc. is as follows:

A. We are in favor of the following parts of the proposed House Bill:

1. It addresses insured contracts (covering Kansas residents) issued outside the State of Kansas, as well as inside the State of Kansas.

2. It does not allow replacing insurance carriers to decline or rider (limit coverage on specific conditions) benefits to individuals currently covered under employer group health insurance plans. A replacing insurance carrier must insure all existing covered employees and their eligible dependents with no "gap in coverage", as well as insure new employees applying for coverage on a timely basis (subject to any pre-existing conditions limitations, where applicable).

3. It eliminates malicious premium rate tiering for employer groups with less than 25 covered employees (by creating a premium rate cap at a level which is 50% higher than the insurance carrier community rates), and yet allows the insurance carriers to differentiate rates based on the various risk elements of each group up to the 50% cap. The 50% above community rates provision should not significantly raise premium rates for the majority of small employer groups and eliminates the devastating affects of true community rating under the prior proposed House Bill #3012.

B. We are opposed to the following parts of the proposed House Bill:

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1. Page 12, Lines 14 through 18, along with "enforcement wording" on page 13, Lines 5 and 6, seem to indicate all group premium rates must be filed with the Insurance Department before use. Prior rate filing would add to administrative costs and have the possibility of discouraging competition. Only a very small fraction of the group health insurance premium written by national commercial group insurance carriers is actually attributable to Kansas Groups. The actual profits (group insurance target profit margins are figured at anywhere from 1-5%, depending on the size of group) from these Kansas Groups are so miniscule that many quality commercial group insurance carriers may bail out of Kansas under the proposed House Bill requirements, as it would not be worth all the time and expense associated with doing business in Kansas under the proposed House Bill (we are not talking about Blue Cross and Blue Shield of Kansas where virtually all of their group premium comes from Kansas Groups).

2. Page 12, Lines 39 through 43, seem to indicate that relevant factors having a very big impact on premium rates (i.e., age, area, industry, employer contribution, etc.) may no longer be used to determine premium rates. That would be absurd. It does go on to say, however, on page 13, Lines 7 and 8, that "all other relevant factors within and without the State" can be given due consideration when establishing premium rates and on page 13, Lines 9 and 10, that "risks may be grouped by classifications for the establishment of rates". Does this mean insurance carriers can establish their premium rates based on normal risk factors such as age, area, industry, employer contribution, etc. (which we would support)?

3. Page 13, Lines 17 & 18 and Lines 28 & 29 seem to indicate insurance carriers "nationwide" experience should be used to establish "Kansas" community rates (regardless of age, area, industry, employer contribution, etc.). Again, this would be absurd. All insurance carriers develop premium rates that are area sensitive which could be used to establish Kansas community rates.

4. There appears to be a mistake on Page 13, Line 36. The word "later" should be replaced by the word earlier, so that insurance carriers could make adjustments to premium rates before a five (5) year period expires (where applicable).

C. Areas that need clarification:

1. Page 1, Line 25: "Open enrollment" should be more clearly defined.

2. Page 1, Lines 40 through 43: Is it the intent of the House Bill to require an employee changing jobs to be subject to the pre-existing conditions limitation of the new Employer plan (which we favor), or must the pre-existing conditions limitation of the new Employer Plan be waived because the employee was covered under the prior Employer's plan?

3. Page 2, Line 35 through 37, indicate plans may impose participation requirements (most insurance carriers require at least a 75% participation level). What participation requirements are acceptable under the House Bill? It is important to note that many Kansas residents are insured based on satisfactory Evidence of Insurability (EVI) required by the insurance carrier because of poor employee participation in the plan (i.e., EVI would not have been required by the insurance company if 75% or more of the Employer's eligible employees were participating in the Plan). Question: Can an insurance company continue to require EVI on employees in groups with poor participation (which we favor), or must the insurance carrier terminate coverage on currently covered individuals due to the new House Bill (i.e., the insurance carriers would terminate coverage on existing Kansas residents whose coverage was originally based on Satisfactory EVI due to poor employee participation, rather than be forced to provide coverage on all eligible employees where there is a known employee participation problem - generally because of little or no Employer contribution toward the cost of the Plan). This could affect thousands of Kansas residents.

4. Page 13, Line 25: "community rate" should be more clearly defined.

In summary, the proposed House Bill in its present form is unworkable, however, with some revisions could greatly benefit Kansas residents without discouraging competition. I would be remiss without stating that if the legislature <u>really</u> wanted to do something to positively affect health care costs for Kansas Employers, it would pass legislation to eliminate all the costly State mandates and give some plan flexibility back to Employers.

Sincerely,

DORTH COOMBS INSURANCE, INC.

James R. Petrich, FLMI
Vice President of Group Operations

Table I

IOWA GROUPS, EMPLOYEES AND INSUREDS
DISTRIBUTED BY SUBJECT TO AND EXEMPT FROM MANDATES

	Subject to Mandate			Exempt From Mandate			
Employee Group Size	No. of Group Contracts	No. of Covered Employees	No. of Insureds	No. of Group Contracts	No. of Covered Employees	No. of Insureds	Exempt Insureds as % of All Insureds
1,000 or more	18	66,461	150,814	34	78,586	189,045	55.67
500-999	22	15,550	31,079	35	24,284	56,895	64.70
250-499	44	15,414	36,079	44	16,298	42,196	53.90
100-249	155	22,265	51,336	115	17,312	41,818	44.90
10- 99	2,194	56,636	131,323	587	17,930	42,989	24.70
Less than 10	7,662	26,935	60,705	413	1,610	3,727	5.80
Totals	10,095	203,261	461,336	1,228	156,020	376,670	44.90%

Source: Ralston, A., M.L. Power and S. McGinnis "State Legislatively Mandated Life and Health Insurance Coverages," The Legislative Extended Assistance Group of the Iowa General Assembly, January 1988, p. 37.

(55.1%) of the group insureds, are not exempt and, therefore, are subject to both state compliance with mandates and the provisions of ERISA. A key aspect demonstrated by the data is that the regulatory inequality is of substantial proportions. That is, the data show that it is not merely a small percentage of the group insured population that is in plans subject concurrently to state and federal regulation. Instead, there are substantial numbers of insureds on each side. The situation in Iowa probably is replicated in all other states.

The second important point regarding discrimination and regulatory inequality drawn from the data in Table I involves the question of the small versus the large employer. Clearly, the data show that it is the relatively small employer instead of the relatively large employer that will be subject to both state and federal regulation. The totals for the number of group contracts provide the initial evidence. The term *contracts* includes both insured and self-funded plans. Even if self-funded, a contractual relationship exists between the employer and employees in a plan. As shown in Table I, although the numbers of insureds in the *subject to* and *exempt* categories are divided approximately 55/45, 10,095 group contracts fall within the *subject to* category, while only 1,228 contracts fall within the *exempt* category. Those in the *exempt* category are, in effect, self-funded plans and, therefore, subject only to ERISA regulation. Most likely, the considerable number of *exempt* smaller employers in the table reflect participation in self-funded multiple employer trusts.

The basis of the disparity is the large number of small employers that have insured group plans. For example, in Table I, employers with 99 or fewer employees account for 9,856 or 87.0% of all contracts (10,095 plus 1,228) or 97.6% of the insured contracts (10,095). Thus, the data in Table I show that the larger the firm, the less likely the welfare benefits plan will be subject to state MHBL. This puts a significant potential cost burden on small employers relative to large employers. Small employers are more likely to provide health insurance through a contract of insurance and, therefore, be required to meet the MHBL requirement.

The Nebraska Law

The state of Nebraska, after identifying and analyzing the inequality described above, chose to enact legislation that specifically ties state and ERISA regulation. In 1986, Nebraska's governor signed a law that provides:

> No legislative proposal to mandate or require the offering of health care coverages or services shall apply to any insurer unless the proposal applies equally to employee welfare benefit plans described in ERISA.[12]