Approved February 19, 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 Monday, Feburary 18, 1991 in room 531 N of the Capitol.

All members were present except:

Theo Cribbs - Excused
Darlene Cornfield - Excused
Tom Sawyer - Excused

Committee staff present:

Bill Edds - Revisor
Nikki Feuerborn, Secretary
Chris Courtwright - Research
Emalene Correll - Research
Gena Lott - Intern

Conferees appearing before the committee:

Representative Jim Garner
Mr. Bill Sneed
Mr. Harold Stones

Others Attending: See Attached List

Representative Helgerson moved for the approval of the minutes of February 13 and 14, 1991. Representative Campbell seconded the motion. Motion carried.

Representative Garner introduced proposed legislation (See Attachment 1) relating to Group-Funded Worker's Compensation Pool. This would be amend K.S.A. 44-581 so five or more "operating locations" may enter into pool agreements. The current language of the statute requires five or more "employers."

Representative Helgerson moved for the introduction of this legislation. Representative Welshimer seconded the motion. Motion carried.

Representative Welshimer introduced proposed legislation (See Attachment 2) regarding the payment of attorney's fees in PIP lien recovery matters. Currently the statute provides the insurer or self-insurer shall pay his proportionate share of attorneys fees fixed by the court in PIP recovery matters. However, this statute does not provide for the proportionate payment of legal expenses incurred by the insured and his attorney in the recovery process.

Representative Helgerson moved for the introduction of this legislation. Representative Campbell seconded the motion. Motion carried.

Representative Helgerson asked the committee to reintroduce legislation regarding title insurance. This bill was introduced last year but no hearings or action was taken on it.

Representative Welshimer moved for the introduction of this legislation. Representative Weiland seconded the motion. Motion carried.

Representative Turnquist asked the committee to amend HB 2610 by changing the present language from 25 to 50 employees.

Representative Helgerson moved for the introduction of this legislation. Representative Welshimer seconded the motion. Motion carried.

Chairman Turnquist announced the continuation of the Hearing for HB 2001. Mr. Bill Sneed, representing Health Insurance Association of America, testified as a proponent. (See Attachment 3). Mr. Sneed reiterated the committee's concern over the problem small employers have in obtaining and retaining reasonable health care benefits at an affordable price. Mr. Sneed reviewed the history of self-insurance plans and ERISA beginning in 1974, HMO's and PPO's, TPA's, and mandated coverages. He stated that although these activities stabilized health insurance in the short term as it related to price, it severely cut into the market share of commercial health insurers, and reduced the available "pool" of insurers to spread the various risks incurred by the companies. The commercial health insurance industry drew further away from the concept of community rating and moved more into an arena of risk classification methods to set premium rates commensurate with the level of risk an individual or group specifically represents.

Health insurance companies use risk classification methods to set premium rates commensurate with the level of risk an individual or group represents. This has maintained the affordability of health insurance for many employers as well as consumer options since premiums are set at levels that represent the relative risk of insuring a given group or individual. Without the ability to use risk classification, insurers may encounter adverse selection, which is the tendency of consumers to buy health insurers only after the onset of illness or whenever a likelihood of major illness has become apparent.

State mandated benefit laws do not apply equally to all health plans. ERISA exempts self-insurance plans from state mandated benefit laws. Mandated benefits have encouraged firms to self-insure and thereby escape state oversight from mandated benefits, reserve and financial solvency requirements, and premium tax. Employers too small to self-insure, however, do not have that flexibility. It is evident the burden of mandated benefits is placed on the backs of small employers.

Mr. Sneed reviewed the requested changes in language if this bill was to be adopted. (See Attachment 3). Mr. Sneed testified that community rating will increase the number of uninsureds in two different areas: those who are uninsured by choice will grow; and the increased loss of the young and healthy will by its absence place a further burden on the community rate thereby increasing the overall cost to the group.

As an alternative, Mr. Sneed proposed deleting HB 2001 in its entirety and substituting in its place Attachment 3, the NAIC Model Bill. The model bill would: 1) create a consistent pattern with other state regulations so insurers can implement the law efficiently and keep administrative expenses at a minimum; 2) provide for Insurance Department regulation; and 3) avoid problems for large employers in areas such as the need to modify benefit packages and rates as agreed to by the employers and insurer.

Mr. Sneed urged the Legislature to draft language in an effort to expand the program initially founded in HB 2610 of small employers with 25 or fewer employees. They cannot have offered health insurance to their employees in the past two years and must agree to make a minimum contribution to the health insurance premium on behalf of a participating employee. They may join together to create a small employer group or groups to be known as small employer health benefit plans for the purpose of offering a health benefit plan (health insurance) to their employees. Mr. Sneed said the Health Insurance Associations of America would like to allow insurers to create health insurance products that, subject to eligibility, would allow an employer to purchase a "no-frills" policy, exempted from state mandated benefit laws.

Mr. Harold Stones, representing Kansas Bankers Association, appeared before the committee as an opponent of HB 2001. His opposition included:

MINUTES OF THE HOUSE COMMITTEE ON INSURANCE,

room 531 N, Statehouse, at 3:30 ~~a.m./~~p.m. on Monday, February 18, 1991

1. HB 2001 would result in a significant increase in costs for small banks. A group health insurance plan is made available to 570 banks in the state of which 7,804 employees are covered, many from small banks. KBA retains less than 1/10 of one percent of the $23 million annual premium as administrative expenses. Claims and retention expenses are diligently negotiated and claims control is monitored closely. A very favorable premium rate compared to other plans is available to KBA insurees. HB 2001 would eliminate the 4,540 employees of the small banks with 25 or fewer employees from the KBA plan, thus removing them from the advantage of their own trade association's efforts.

2. HB 2001 would result in a financial confiscation for small banks. KBA has built up nearly $2 million in a premium stabilization reserve fund and the bill does not allow the small banks to utilize this fund although their premiums paid for a large share of it.

3. HB 2001 would result in significant discrimination. Why is the requirement for 25 or fewer employees only? If a community pool needs a larger base, why not require all health insurance policyholders to be subject to a community rated pool. 418 banks in Kansas would be affected. The plan would continue to be offered but the pool would be seriously weakened and additional costs added.

Mr. Stones asked that the bill be amended to make such community ratings voluntary rather than mandatory. (attachment 4),

Discussion between committee members and conferees included open enrollment, experience rating, waiting periods, methods for establishing premiums (age groups), possibility of lumping all banks under one contract with different benefit packages, premium costs as compared to other plans, and underwriting.

The meeting adjourned at 4:45 p.m.

GUEST LIST

COMMITTEE: House Insurance DATE: 2/18/91

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Bill Sneed	Topeka	NIAA
Larry Magill	"	IIAK
Nancy Zogleman	Topeka	BC/BS of Ks
Don Lynn	Topeka	FC/ES of Ks
W P Ben Berger	"	"
~~Lori~~ Lori Rowe	Topeka	Intern Rep Welshimer
~~Bob Helsheimer~~	Augusta	Rep Welshimer
Ed Watson	Topeka	KTLA
TOM TUNNELL	TOPEKA	KANSAS GRAIN & FEED ASSOCIATION
Kristy Parker	Manhattan	Intern - Rep. Whiteman
BILL KING	C.A. ROSE CITY	TAX PAYER
Helen Hazlett	Lakin	legis. wife
Dick Brock	Topeka	Ins Dept
Lee WRIGHT	O.P. Ks	Farmers Ins. Group
Chuck Stones	Topeka	Ks Bankers Assn
Jawld Stones	Topeka	Ks. Banks Assn
Herb Toms	Topeka	Ks. Bankers. Assn.
Chris Wilson	Topeka	KS Grain & Feed Assn
Jim Maag	"	KS Bankers Assoc.

JIM D. GARNER
REPRESENTATIVE, 11TH DISTRICT
P.O. BOX 538
COFFEYVILLE, KS 67337
STATE CAPITOL
TOPEKA, KS 66612

STATE OF KANSAS

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
MEMBER AGRICULTURE AND SMALL BUSINESS
JUDICIARY
TRANSPORTATION
LEGISLATIVE, JUDICIAL &
CONGRESSIONAL APPORTIONMENT

February 18, 1991

TO: House Insurance Committee

FROM: Representative Jim D. Garner

RE: Request for Introduction of Bill

I appear before the Committee today to request that the Committee introduce a bill relating to Group-Funded Worker's Compensation Pool. This request is made on behalf of one of my constituents.

I request that a bill be introduced to amend K.S.A. 44-581 so five or more "operating locations" may enter into pool agreements. The current language of the statute requires five or more "employers."

I appreciate your consideration of this issue.

House Insurance
Feb. 16, 1991
Attachment 1

Health Care Facilities

MEDICALODGES, INC.

316-251-6700 • 512 WEST 11th STREET • P.O. BOX 509 • COFFEYVILLE, KANSAS 67337

January 29, 1991

The Honorable Jim Garner
Kansas House of Representatives
Room 281 West
State Capital Building
Topeka, KS 66612

Dear Representative Garner:

In accordance to past conversations relating to group Workers' Compensation pools, I am submitting the following request in anticipation that you may appear before the Insurance Committee to request that they introduce this item as a committee bill. My specific request relates to K.S.A. 44-581, Group--Funded Workers' Compensation Pool; Requirements. Five or More Employers, Regardless of Domicile. I am asking that the language be modified to read five or more operating locations within the State, regardless of domicile.

As you can see, the above item for modification is minor in nature and, in my opinion, does not add a significant problem to the intent of the statutes. The significant portion of the group funding is in Section 44-582 that establishes a combined net worth of one million dollars under Section F and a minimum gross premium amount of $250,000.00 as established in Section H.

I feel that modification to our recommendation would simplify the process overall for multiple location entities meeting compliance without merely gaming the program by establishing multiple corporations to accomplish the overall objective of Workers' Compensation pools.

I have discussed this issue with Mr. John Spain of the Department of Insurance, and he did not see any reason the Department would take exception to this type of modification at this time. Although, he said the Department would not take a position on the issue until it was proposed in bill form.

Should you require any additional information to complete this request, I will be happy to discuss it at your convenience.

Respectfully submitted,

MEDICALODGES, INC.

Larry Fischer, C.P.A.
Vice President

LF/bc

Page 271

other claims for compensation against such fund shall be paid in accordance with the workmen's compensation act pursuant to awards or orders of the director of workers' compensation or a court.

History: L. 1974, ch. 204, § 3; L. 1977, ch. 180, § 2; July 1.

44-578. Same; administrative rules and regulations. The secretary of administration may adopt rules and regulations necessary for the administration of the state workmen's compensation self-insurance fund, including the processing and settling of claims for compensation made against such fund. Such rules and regulations shall be subject to the provisions of K.S.A. 75-3706 and shall be adopted in accordance therewith.

History: L. 1974, ch. 204, § 4; April 8.

44-579. Same; copies of accident reports to secretary of administration. From and after July 1, 1974, whenever any report is required to be made to the workmen's compensation director by any state agency as an employer pursuant to the provisions of K.S.A. 44-557, or any amendments thereto, such state agency shall make such report to the workmen's compensation director and shall send a copy thereof to the secretary of administration.

History: L. 1974, ch. 204, § 5; April 8.

44-580. Same; construction of 44-575 to 44-580. The provisions of K.S.A. 44-575 to 44-580, inclusive, shall be construed as supplemental to and as a part of the workmen's compensation act.

History: L. 1974, ch. 204, § 6; April 8.

44-581. Group-funded workers' compensation pools; requirements. Five or more employers, regardless of domicile, who are members of the same bona fide trade or professional association, regardless of domicile, which has been in existence for not less than five years and who are engaged in the same or similar type of business may enter into agreements to pool their liabilities for Kansas workers' compensation benefits and employers' liability. Such arrangements shall be known as group-funded workers' compensation pools, which shall not be deemed to be insurance or insurance companies and shall not be subject to the provisions of chapter 40 of the Kansas Statutes Annotated, except as otherwise provided herein.

History: L. 1983, ch. 166, § 1; July 1.

44-582. Same; certificate of authority; application. Application for a certificate of authority to operate a pool shall be made to the commissioner of insurance not less than 60 days prior to the proposed inception date of the pool. The application shall include the following:

(a) A copy of the bylaws of the proposed pool, a copy of the articles of incorporation, if any, and a copy of all agreements and rules of the proposed pool. If any of the bylaws, articles of incorporation, agreements or rules are changed, the pool shall notify the commissioner within 30 days after such change.

(b) A copy of the trust agreement securing the payment of workers' compensation benefits. If the trust agreement is changed, the pool shall notify the commissioner within 30 days after such change.

(c) Designation of the initial board of trustees and administrator. When there is a change in the membership of the board of trustees or change of administrator, the pool shall notify the commissioner within 30 days after such change.

(d) The address where the books and records of the pool will be maintained at all times. If this address is changed, the pool shall notify the commissioner within 30 days after such change.

(e) An individual application for each initial member of the pool. Each individual application shall include a current certified financial statement on a form approved by the commissioner.

(f) A current certified financial statement on a form approved by the commissioner showing that the combined net worth of all members applying for coverage on the inception date of the pool is in an amount not less than $1,000,000.

(g) A current certified financial statement on a form approved by the commissioner showing the financial ability of the pool to meet its obligations under the workmen's compensation act.

(h) Evidence that the annual Kansas gross premium of the pool will be not less than $250,000. The annual Kansas gross premium shall be based upon the autho

Page 347

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Attachment 2

Mr. Chairman,

I propose this Committee consider sponsorship of an amendment to KSA 40-3113(a)(e) concerning the payment of attorney fees in PIP lien recovery matters. Currently the statute provides the insurer or self-insurer shall pay its proportionate share of attorney fees fixed by the court in PIP recovery matters. However, this statute does not provide for the proportionate payment of legal expenses incurred by the insured and her attorney in the recovery process.

It has been brought to my attention that insurers are not willing to share in these expenses because they are not statutorily mandated to do so. Because this litigation benefits the insurer as well as the insured, it is not unreasonable to expect the insurer to share in the cost of reasonably incurred ~~litigation~~ expenses. This is part of the rationale behind requiring the insurer to share in attorney fees. Just as the Court currently fixes the attorney fees in these cases it could likewise determine what are reasonably incurred expenses and have

House Insurance Feb. 18, 1991 Attachment 2

the insurer pay its proportionate share accordingly.

I have received a copy of correspondence which explains the attorneys position on this matter. This is also accompanied by a proposed amendment allowing for the ~~attorney~~ payment of expenses as well as fees by the insurer. I will have copies of this information available to the Committee as soon as possible.

Now, I am requesting this Committee's permission to submit the letter and the proposed amendment to ~~the~~ Bill Eads in the Revisor's Office on behalf of the House Insurance Committee.

Gwen Welshimer

MEMORANDUM

TO: Larry Turnquist
Chairman, House Insurance Committee

FROM: Bill Sneed
Health Insurance Association of America

DATE: February 14, 1991

RE: H.B. 2001

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I am Legislative Counsel for the Health Insurance Association of America (HIAA). The HIAA is a health insurance trade association consisting of over 325 insurance companies that write over 85% of the health insurance in the United States today. Please accept this memorandum as our testimony in regard to H.B. 2001 and its potential effect in the health insurance marketplace in the state of Kansas.

The HIAA shares the concerns of the Kansas Legislature, employers and consumers concerning the high cost of health care in the United States. Also, we share concern over the problem the small employers have in obtaining and retaining reasonable health care benefits at an affordable price. As you are aware, insurance company premiums reflect the charges made by hospitals, health care practitioners, claims administration costs, premium tax, and, of course, hopefully a profit. However, we must point out that this is just the beginning of everyone's work in regard to addressing this problem. I am sure you are all familiar with the Interim Committee report on Proposal No. 11 -- Health Insurance, and the report prepared by the Governor's Commission on Health Care issued November 28, 1990. In order to fully explain my client's position, I believe it

Attachment 3
Page 1 of 1
House Insurance
Feb. 15, 1991

is important to look at this situation on several fronts: first, a review of historically how we got to this point today; secondly, a review of H.B. 2001 and why, in our belief, it does not truly address the concerns enumerated by the Legislature; and finally, our recommendation for a substitution for H.B. 2001 by utilizing the attached amendment.

History

As most of you know, the insurance industry is one of a cyclical nature. There are periods of time of high usage, and consequently, high increases in premiums, historically followed by lulls and relatively modest increases in premiums and payments. During the mid- to late 1970's, the health insurance industry was experiencing a period of substantial utilization of the products, and consequently, dramatic increases in premiums. Because of the atmosphere, several things occurred, and although they could arguably have occurred independent of each other, when all put together they played a role in the problems we are faced with today. First, the federal government, under the provisions of the 1974 Employees Retirement Income and Security Act (ERISA), provided that self-insurance plans could be created and be exempt from provisions of state law, including mandates and premium taxes. With the implementation of ERISA, and since many mandates had not yet been enacted by the Legislature, there was very little initial growth by self-insurance plans.

Then, by the end of the 1970's and beginning in the early 1980's, employers became sophisticated with the utilization of self-insurance plans, and fueled by the

enactment of mandated benefits, which ERISA plans would not have to provide, growth began in the ERISA self-insurance plans.

During this same time period, the industry itself changed with the emergence of HMO's and PPO's. Along with this came the ability of third party administrators and the ability for entities to administer self-insurance plans.

Thus, you have now in the mixing bowl new types of delivery services (HMO's, PPO's, ASO's), new types of facilities to provide coverages (ERISA, MET, group-funded pools and self-insurance plans), and the increase in mandated coverages in traditional health insurance plans. Thus, while all these activities in the short term stabilized the health insurance marketplace as it relates to price, it severely cut into the market share of commercial health insurers, and thus reduced the available "pool" of insurers to spread the various risks incurred by the companies.

Thus, with the diminishing market share upon it, the commercial health insurance industry drew further away from the concept of community rating and moved more into an arena of risk classification methods to set premium rates commensurate with the level of risk an individual or group specifically represents. I will discuss risk classification later in my remarks.

Therefore, the most important point to bring out of this historical analysis is that it is my client's contention that it is an array of reasons which have caused the current status of health insurance, and to appropriately address these concerns, it would be inappropriate to look only at the commercial health insurers for answers. Attached to

my remarks is a chart which demonstrates that the commercial insurers compared to the total overall insurance picture play only a small part in this analysis.

Risk Classification

Much has been said about community rating, or the lack thereof, in discussion of the problem of health insurance. Generally speaking, health insurance companies use risk classification methods to set premium rates commensurate with the level of risk an individual or group represents. The use of such techniques by insurers has maintained the affordability of health insurance for many employers, as well as consumer options, since premiums are set at levels that represent the relative risk of insuring a given group or individual.

Risk classification also helps to form a direct link between health care expenditures and the cost of coverage. Since employers who self insure avoid subsidizing other higher cost employer groups, insurers must be able to classify risk in order to offer reasonable prices to clients preferring traditional insurance. Moreover, if insurers were prevented from charging a client the true cost of coverage, a major incentive for employers to hold costs down would be diminished. Employers would have less reason to provide safe work environments, establish wellness programs, or seek efficient providers of care. Without risk classification, every group would pay the same in premiums regardless of their true health care costs. The process of risk classification depends on fairness. Without the ability to use risk classification, insurers may encounter adverse selection, which is the tendency of consumers to buy health insurers only after the onset of illness, or whenever

a likelihood of major illness has become apparent. Adverse selection can seriously threaten insurers' financial stability. In order to insure the financial soundness of the industry, health insurers must be permitted to classify their policy holders according to expected risk of loss. This necessarily includes the use of readily available data about applicants' age, sex, occupation and health status. To ignore data that ties the cost of claims to a fair premium cost is to invite financial failure.

Mandated Benefits

As was pointed out in the summer hearings, the list of state mandated benefits and providers has grown dramatically. While the merits of any particular benefit or provider group can be vigorously defended by its proponents, the cumulative effect is a hodgepodge of state laws that increase the cost of health insurance, particularly to the small employers who are most in need of relief from the high cost of health care.

State mandated benefit laws do not apply equally to all health plans. ERISA exempts self-insurance plans from state mandated benefit laws. Thus, mandated benefits have encouraged firms to self-insure, and thereby escape state oversight from mandated benefits, reserve and financial solvency requirements, and premium tax. Again, this adds fuel to the fire of insureds leaving the traditional market, thus reducing the "pool" of insureds available to spread the risk within the group.

Those employers, large and small, who decide to go through a self-insured program, are allowed the ability to pick and choose the benefits that are most desirable and cost effective for their employees. Employers too small to self insure, however, do not

have that flexibility, thus making it less likely that they will offer health insurance at all. Putting all of this together, then, it becomes obvious that the burden of mandated benefits is placed squarely on the backs of small employers.

House Bill 2001

With the above rationale as our basis, we will attempt to go item by item through my client's objections to various provisions of H.B. 2001. I will not reiterate those reasons given above with each particular provision inasmuch as we believe the information provided to you in the initial part of our comments gives you the overall rationale for the basis of our objections.

Pages 1-2, lines 23-43 and 1. This amendment is an attempt to provide access to group coverages by all employees in a given group. While this sounds like a noble concept, it is fraught with problems. As it relates to new policies, the law would require that an insurer must write 100% of all employees and dependents, i.e., all or none. If that is the case, insurers will be required to assign a rate to that group commensurate with the healthiness of the group. It is our position that this will discourage employers from initially offering health insurance if the high cost of a particular employee or dependent with a pre-existing condition is going to be added into the group. Also, the provision providing for a one-year exclusion does not answer this problem, but simply delays when the cost would be incurred. Further, it appears to require dependent coverage even if coverage is not being provided to the employee.

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In an attempt to cover contracts issued outside of the state of Kansas, there is a provision for extra-territorial coverages. However, we would submit that large employers who provide health insurance on a nation-wide basis will simply change the format of their coverages (self-insurance), and again reduce the available market share.

Page 12, lines 14-18. This amendment would require all group policies to be filed and approved by the Commissioner of Insurance. Again, we point out the chilling effect this will have on large employers who issue group policies on a nation-wide basis. These plans are substantially negotiated as it relates to benefits and premiums, and as such, employers, having once agreed upon a plan, will not be interested in availing themselves of Department review and approval. Further, although we recognize that the language insert in these lines was taken from H.B. 3012, we are still concerned as to whether this language creates a "file and use" statute or is a "prior approval" statute.

Page 12, lines 36-43; page 13, lines 1-12. We earlier discussed our concerns relative to risk classification and the reasons we believe this amendment is unnecessary.

Community rating advances an artificial and counter-productive "one size fits all" notion. Thus, it is fundamentally flawed, as it operates to thwart the objective of any rating scheme which is to produce a rate that is adequate, competitive and equitable.

Community rating can inspire churning, rate instability and inequity. A simple example helps to illustrate this point:

> Carrier A community rates. It insures 50 computer programmers and 50 coal miners. The costs incurred by computer programmers average $100 per month and the costs incurred by coal miners average $200 per month, so Carrier A can cover its costs with a community rate of $150.

7 of 3

> Carrier B's costs also run at $100 for computer programmers and $200 for coal miners, but it insures 75 computer programmers and 25 coal miners so it needs a community rate of $125 to cover its costs.
>
> All of Carrier A's customers see the better deal offered by Carrier B except 10 coal miners who like Company A's claim service. Carrier A is left with 10 coal miners generating cost of $200 per month while paying premiums of only $150 per month. Carrier A is left with two options--go out of the business or raise its rates to $200. Carrier B is faced with problems as well. It now insures 125 computer programmers with an average cost of $100 per month and 65 coal miners with an average cost of $200 per month. therefore, Carrier B now has overall average costs of $134 per month compared to its community rate of $125. It too will be forced (artificially) to raise rates.
>
> Community rating clearly leads to unfair cross-subsidization (e.g., coal miners subsidized by computer programmers). It ignores appropriate risk elements and encourages artificially high claim payments (at a time when the opposite should be encouraged).

Finally, my client contends that community rating will increase the number of uninsureds in two different areas. First, those who are uninsured by choice will grow. This group tends to be composed of younger, healthier individuals who choose not to spend wages on health insurance until they are approaching a definitive need. If rates are averaged (as under community rating), the rates for this particular group (young and healthier) will increase, thus putting further strain on this group's willingness to obtain coverage.

Secondly, the increased loss of the young and healthy will by its absence place a further burden on the community rate, thus increasing the overall cost to the group. This places the employer in a position of dropping its group coverage because of

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cost, or leaving the traditional marketplace. Therefore, the vicious circle begins, and only ends with higher premiums and a growing number of uninsureds.

Page 12, lines 13-40. This is an attempt by the Legislature to answer concerns relative to the small group employer. It is our contention that the NAIC "small group rating and renewability" proposal is a more appropriate answer to the problems faced by the small group employer. It is important to note that this model bill has been worked on by regulators and industries over the last eighteen months to address this problem. Further, it was prepared on a more global front so that there would be a commonality between the various states as this issue was addressed. Finally, although the bill does not specifically address availability, it does address large, dramatic increases in premiums that would appear to us to be the major concern of the small group employer.

Recommendations

The HIAA would respectfully request that this Committee consider deleting H.B. 2001 in its entirety and substituting in its place the attached proposal. This proposal, the NAIC Model Bill, would, in our opinion, provide a more accurate and fair answer to what we believe is the main pricing issue.

Attached as Exhibit 2 is a bulletin by my client which highlights the NAIC Model bill. As stated earlier, the model bill would create a consistent pattern with other state regulations so insurers can implement the law efficiently, and thus keep administrative expenses at a minimum. The Model Bill also provides for Insurance Department regulation. Finally, the Model Bill avoids many of the problems H.B. 2001 will cause to

9g-3

large employers in areas like the need to modify benefit packages and rates as agreed to by the employer and insurer. The remainder of the exhibit is the NAIC Model Bill, which we request to be substituted for H.B. 2001.

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

What we would suggest is to allow insurers to create health insurance products that, subject to eligibility requirements, allow an employer to purchase a "no-frills" policy. The main feature would be, like those encompassed in H.B. 2610, a policy exempted from state mandated benefit laws.

Conclusion

On behalf of my client, again let me thank you for allowing us the opportunity to appear before this Committee. It is our hope that these remarks and attachments will provide the Legislature a positive approach to the health insurance concerns that are being reviewed by the Legislature. We stand ready to provide any additional assistance, technical or otherwise, in reaching this goal.

Respectfully submitted,

William W. Sneed
Legislative Counsel
Health Insurance Association of America

1143

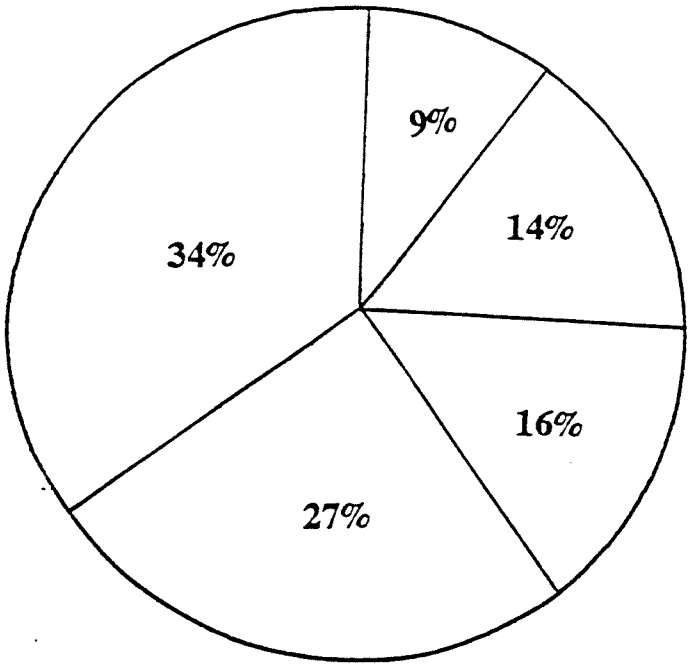

Figure 1

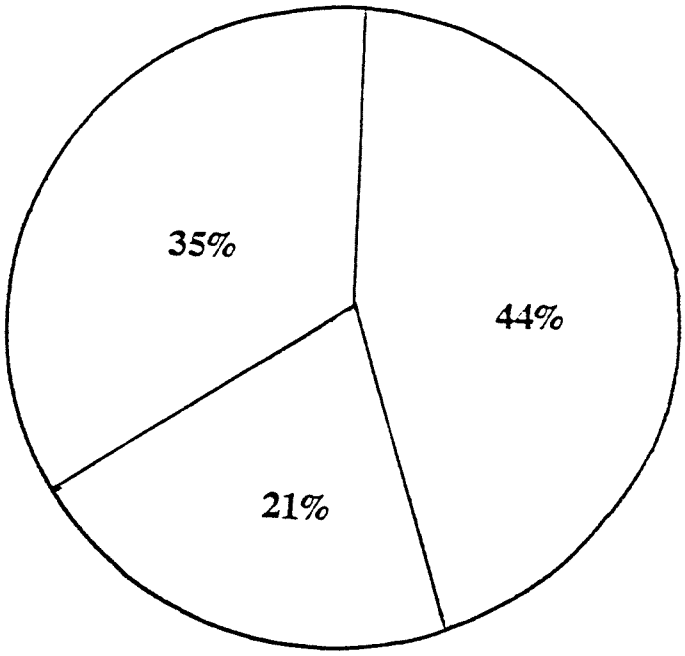

Figure 2

PERCENTAGES OF INSURANCE MARKETPLACE IN KANSAS				
TYPE OF PROGRAM	# OF INDIVIDUALS WITHIN PROGRAM	% AS OPPOSED TO TOTAL POPULATION (Figure 1)	TOTAL NUMBER OF INDIVIDUALS	% AS COMPARED TO "INSURANCE" MARKETPLACE (Figure 2)
Self Insurance	840,027	34%	1,907,733	44%
BC/BS	667,706	27%		35%
Traditional Insurance	400,000	16%		21%
Public Assistance	222,981	9%		
Uninsured	346,860	14%		
Total	2,477,574	100%		100%

Health Insurance Association of America

The NAIC adopted a model for Small Group Rating and Renewal Requirements which:

- Effectively limits the relationship between the highest and lowest rates a carrier can charge groups of 25 lives or less. Within a class the maximum difference is 25% (plus or minus) of the average.

- Effectively limits rate increases on existing in-force small group plans to 15 percent over the increase in the lowest rate the carrier is currently offering within the class. (Assumes no change in demographics).

- Eliminates selective cancellation of a group because of bad experience by requiring a carrier to renew all business or cease to renew all business in a class. Also provides notification procedures.

- Requires disclosure of rating practices to small employers before issue of the extent premium rates in the future will reflect duration and/or health experience or status.

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SUBSTITUTE FOR HOUSE BILL 2001

AN ACT relating to health insurance; concerning the availability of health insurance coverage to small employers, to prevent abuse rating practices, to require disclosure of rating practices to purchasers, to establish rules for continuity of coverage for employers and covered individuals, and to improve the efficiency and fairness of the small group health insurance marketplace.

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

Section 1. Sections 1 through 9 shall be known and may be cited as the Premium Rates and Renewability of Coverage for Health Insurance Sold to Small Groups Act.

Section 2. As used in sections 1 through 9:

(A) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of Section 4 of this Act, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the carrier in establishing premium rates for applicable health benefit plans.

(B) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or which could have been charged under a rating

system for that class of business, by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

(C) "Carrier" means any person who provides health insurance in this state. For the purposes of this Act, carrier includes a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, a multiple employer welfare arrangement or any other person providing a plan of health insurance subject to state insurance regulation.

(D) "Case characteristics" mean demographic or other relevant characteristics of a small employer, as determined by a small employer carrier, which are considered by the carrier in the determination of premium rates for the small employer. Claim experience, health status and duration of coverage since issue are not case characteristics for the purposes of this Act.

(E) "Class of business" means all or a distinct grouping of small employers as shown on the records of the small employer carrier.

(1) A distinct grouping may only be established by the small employer carrier on the basis that the applicable health benefits plans:

(a) Are marketed and sold through individuals and organizations which are not participating in the marketing or sale of other distinct groupings of small employers for such small employer carrier;

(b) Have been acquired from another small employer carrier as a distinct grouping of plans;

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(c) Are provided through an association with membership of not less than four small employers which has been formed for purposes other than obtaining insurance; or

(d) Are in a class of business that meets the requirements for exception to the restrictions related to premium rates provided in Subsection A(1)(a) of Section 4.

(2) A small employer carrier may establish no more than two (2) additional groupings under each of the subparagraphs in Paragraph (1) on the basis of underwriting criteria which are expected to produce substantial variation in the health care costs.

(3) The commissioner may approve the establishment of additional distinct groupings upon application to the commissioner and a finding by the commissioner that such action would enhance the efficiency and fairness of the small employer insurance marketplace.

(F) "Commissioner" means the Commissioner of Insurance.

(G) "Department" means the Department of Insurance.

(H) "Health benefit plan" or "plan" means any hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract. Health benefit plan does not include accident-only, credit, dental or disability income insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical-payment insurance.

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(I) "Index rate" means for each class of business for small employers with similar case characteristics the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(J) "New business premium rate" means, for each class of business as to a rating period, the premium rate charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(K) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier.

(L) "Small employer" means any person, firm, corporation, partnership or association actively engaged in business who, on at least fifty percent (50%) of its working days during the preceding year, employed no more than twenty-five (25) eligible employees. In determining the number of eligible employees, companies which are affiliated companies or which are eligible to file a combined tax return for purposes of state taxation shall be considered one employer.

(M) "Small employer carrier" means any carrier which offers health benefit plans covering the employees of a small employer.

Section 3.

(A) Except as provided in Subsection (b) of this section, the provisions of this Act apply to any health benefit plan which provides coverage to one or more employees of a small employer.

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(B) The provisions of this Act shall not apply to individual health insurance policies which are subject to policy form and premium rate approval as provided in K.S.A. 40-2215.

Section 4.

(A) Premium rates for health benefit plans subject to this Act shall be subject to the following provisions:

(1) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent (20%). Paragraph (1) shall not apply to a class of business if all of the following apply:

(a) The class of business is one for which the carrier does not reject, and never has rejected, small employers included within the definition of employers eligible for the class of business or otherwise eligible employees and dependents who enroll on a timely basis, based upon their claim experience or health status;

(b) The carrier does not involuntarily transfer, and never has involuntarily transferred, a health benefit plan into or out of the class of business; and

(c) The class of business is currently available for purchase.

(2) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates which could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than twenty-five percent (25%) of the index rate.

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(3) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day for the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate;

(b) An adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the carrier's rate manual for the class of business; and

(c) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.

(4) In the case of health benefit plans issued prior to the effective date of this Act, a premium rate for a rating period may exceed the ranges described in Subsection a(1) or (2) of this section for a period of five (5) years following the effective date of this Act. In that case, the percentage increase in the premium rate charged to a small employer in such a class of business for a new rating period may not exceed the sum of the following:

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In

the case of a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate; and

(b) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.

(B) Nothing in this section is intended to affect the use by a small employer carrier of legitimate rating factors other than claim experience, health status or duration of coverage in the determination of premium rates. Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business.

(C) A small employer carrier shall not involuntarily transfer a small employer into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration since issue.

Section 5.

(A) Except as provided in Subsection b of this section, a health benefit plan subject to this Act shall be renewable to all eligible employees and dependents at the option of the small employer, except for the following reasons:

(1) Nonpayment of required premiums;

(2) Fraud or misrepresentation of the small employer, or with respect to coverage of an insured individual, fraud or misrepresentation by the insured individual or such individual's representative;

(3) Noncompliance with plan provisions;

(4) The number of individuals covered under the plan is less than the number or percentage of eligible individuals required by percentage requirements under the plan; or

(5) The small employer is no longer actively engaged in the business in which it was engaged on the effective date of the plan.

(B) A small employer carrier may cease to renew all plans under a class of business. The carrier shall provide notice to all affected health benefit plans and to the commissioner in each state in which an affected insured individual is known to reside at least ninety (90) days prior to termination of coverage. A carrier which exercises its right to cease to renew all plans in a class of business shall not:

(1) Establish a new class of business for a period of five (5) years after the nonrenewal of the plans without prior approval of the commissioner; or

(2) Transfer or otherwise provide coverage to any of the employers from the nonrenewed class of business unless the carrier offers to transfer or provide coverage to all affected employers and eligible employees and dependents without regard to case characteristics, claim experience, health status or duration of coverage.

Section 6. Each small employer carrier shall make reasonable disclosure in solicitation and sales materials provided to small employers of the following:

(A) The extent to which premium rates for a specific small employer are established or adjusted due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer;

(B) The provisions concerning the carrier's right to change premium rates and the factors, including case characteristics, which affect changes in premium rates;

(C) A description of the class of business in which the small employer is or will be included, including the applicable grouping of plans; and

(D) The provisions relating to renewability of coverage.

Section 7.

(A) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation which demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(B) Each small employer carrier shall file each March 1 with the commissioner an actuarial certification that the carrier is in compliance with this section and that the rating methods of the carrier are actuarially sound. A copy of such certification shall be retained by the carrier at its principal place of business.

(C) A small employer carrier shall make the information and documentation described in Subsection A of this section available to the commissioner upon request. The information shall be considered proprietary and trade secret information and shall not

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be subject to disclosure by the commissioner to persons outside of the department except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

Section 8. The commissioner may suspend all or part of Section 4 as to the premium rates applicable to one or more small employers for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner that either the suspension is reasonable in light of the financial condition of the carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

Section 9. The provisions of this Act shall apply to each health benefit plan for a small employer that is delivered, issued for delivery, renewed or continued in this state after the effective date of this Act. For purposes of this section, the date a plan is continued is the first rating period which commences after the effective date of this act.

Section 10. This Act shall take effect and be in force from and after its publication in the statute book.

KANSAS BANKERS ASSOCIATION

TESTIMONY ON HOUSE BILL 2001
FEBRUARY 18, 1991

Mr. Chairman, Members of the House Committee on Insurance:

My name is Harold Stones. I am on the staff of the Kansas Bankers Association. We have reviewed H.B. 2001 to determine if it would affect the members in our KBA Group Health Insurance plan, and could not arrive at a decision. But after the first day's hearings, we learned from the testimony of the Kansas Insurance Department, that the intent of Section 2 (e) (2) (D) commencing on Page 13, Line 13 of the bill is to require groups of 25 or fewer employees to withdraw from their present coverage, and be rated by a "community rate". This would negatively impact the 4,540 employees in the 418 Kansas banks with 25 or fewer employees. In their behalf, the Kansas Bankers Association strongly opposes this measure. We would respectfully ask the Committee and the Kansas Insurance Department to carefully consider the following:

1. HB 2001 would result in a significant increase in costs for small banks. For many, many years, KBA has administered a group health insurance plan, through Blue Cross-Blue Shield available to all 570 member banks. The vast majority of banks, especially small banks, utilize our plan. Today, we insure 7,804 Kansas bank employees. 3,070 have single coverage, and 4,734 also insure their families through our plan. We take this responsibility very seriously. We have retained Dorth Coombs, Inc. of Wichita as our consultants, and we negotiate our claims expense and other retention expense very diligently. The KBA retains less than 1/10 of one percent of the $23 million annual premium as administrative expenses. We also work constantly on claims control. As a result, we have been able to secure a very favorable premium rate, compared to other plans. H.B. 2001 would eliminate the 4,540 employees of our small banks with 25 and fewer employees from our KBA plan, thus removing them from the advantage of their own trade association's efforts.

2. HB 2001 would result in a financial confiscation for small banks. Through the years, KBA has built up nearly $2 million in a premium stabilization reserve fund. We see no language in the bill that would allow our small banks to utilize this fund for premium stabilization **even though a large portion is their money, paid by their premiums.** This would result in a confiscation of property of significant proportion to our small banks.

3. HB 2001 would result in significant discrimination. KBA questions why such requirements would apply ONLY to employee groups of 25 or fewer. Why not 50, or 150? In fact, if community pools need a larger base, why not require ALL health insurance policyholders to be subject to a community rated pool? At least the discrimination applied to small employee groups by HB 2001 would be removed, and the bill infinitely more fair. If its good for employees of small companies, why not let everyone share?

In summary, Mr. Chairman, our small banks already suffer from a federal regulatory attitude that would like to eliminate them. Regulation after regulation is applied with the implied purpose of decreasing the number of banks. However, in my 24 years, with the KBA, my experience with the Kansas Legislature is that no such "anti-small" bias exists--in fact, it is usually eliminated, if identified.

Feb 18, 1991 House Insurance
Attachment 4
1 of 4

(OVER, PLEASE)

The final result of HB 2001 will be that it will cost more for some small banks, others will pass on a greater share of the expense to their employees and still others will drop coverage entirely, because of the additional costs. Therefore, the employees of the 418 affected banks in Kansas (73% of all banks) will be hurt. The KBA would, no doubt attempt to continue to offer our plan to the remaining bank employees. But since our pool would be seriously weakened, we do not know the result. All the rest of the banks might be set adrift to secure new coverages.

We strongly urge that H.B. 2001 be amended to make such community ratings voluntary, rather than mandatory; or to otherwise remove discriminatory requirements. When the day comes that community ratings are lower in price than our KBA plan, we would urge our member banks to consider changing. But until then, we fail to see the fairness of pulling only the little out of our plan.

Thank you for your time and consideration.

Harold A. Stones
Executive Vice President

ADDITIONAL INFORMATION
[effective 6/30/89]

Employee Range	No. Banks	No. Employees	Total Assets
1 through 25	418	4,540	$8.9 billion
26 through 50	91	3,307	$5.8 billion
51 through 100	38	2,434	$4.1 billion
101 through 150	10	1,207	$3.3 billion
Over 150	13	3,329	$6.4 billion
TOTALS	**570**	**14,817**	**$28.5 billion**