Approved February 28, 1991
Date

MINUTES OF THE House COMMITTEE ON Insurance.

The meeting was called to order by Representative Turnquist at
Chairperson

3:30 ~~x.m./~~p.m. on Wednesday, February 27, 1991 in room 531 N of the Capitol.

All members were present except:

Committee staff present:

Bill Edds, Revisor
Chris Courtwright, Research
Nikki Feuerborn, Committee Secretary
Emalene Correll, Research
Jena Lott, Intern

Conferees appearing before the committee:

Dick Brock, Insurance Commissioner's Office
Richard Mason, Kansas Trial Lawyer's Association
David Hanson
Bill Sneed , Health Insurance Agencies of America

Others attending: See attached list

Representative Sprague moved for the approval of the minutes of February 27, 1991, meeting. Representative Cribbs seconded the motion. Motion carried.

Dick Brock of the Insurance Commissioner's Officer, appeared as a proponent in the hearing on HCR 5011. (See Attachment 1). Mr. Brock summarized the history of the proposed resolution which is viewed as a vehicle to hopefully prompt discussion of a health insurance availability mechanism. This required the approval of the legislature prior to implementation. Copies of interim committee reports were attached to the testimony.

Mr. Brock stated that there is not a present method of financing the costs of health care for those people who are not eligible for public assistance or are not financially capable of self-insuring and have no insurance. The primary ways any state has addressed this problem so far is through a residual risk mechanism or through some employer mandate coupled with a state funded plan such as that envisioned by SB 205. Even with a health risk pool some people could not afford the coverage--the coverage would not sufficiently meet their needs. Other actions such as an expansion of medical eligibility, a strengthening of public health services and other initiatives would still be necessary.

Mr. Brock asked the committee to look at the plan attached as an example of what an availability mechanism for health insurance might look like and decide if it merits further consideration.

Tom Bell of the Kansas Hospital Association, appeared before the committee as a proponent of HCR 5011. (See Attachment 2). He stated that hospitals have taken on a large share of the financial burden of the medically indigent and medially underinsured. Third-party payers and paying patients are becoming more and more concerned about cost shifting. Payments hospitals receive from federal and state governments are less able to take care of the problem. In his view, HCR 5011 would bring some relief to the situation.

Chip Wheelen, appearing for the Kansas Medical Society, stated the Society was a proponent of a health risk pool for those who cannot be insured now. (See Attachment 3).

Bill Sneed, representing Health Insurance Association of America, appeared before the committee as an opponent of HCR 5011. (See Attachment 4). He stated that his organization felt it would be more appropriate that the Legislature not pass the Concurrent Resolution but review and debate the assigned risk proposal submitted by the Department. Included in this review should be funding mechanisms and as assigned risk plan.

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON INSURANCE,

room 531 N Statehouse, at 3:30 ~~a.m.~~/p.m. on Wednesday, February 27, 19 91

Discussion was continued on HB 2126. Representative Sawyer's motion from February 26, 1991, for adoption of the language as it appears in the proposed balloon by the Kansas Trial Lawyer's Association was still on the floor.

After a lengthy discussion regarding the proposed language, Representative Cornfield made a substitute motion that HB 2126 be tabled. Representative Neufeld seconded the motion. Motion failed due to a tie vote.

The committee expressed concern about increase insurance premiums which would purportedly be increased by approximately $1.50 every six months according to Mr. Lee Wright of Farmers Insurance. This was not factoring in those customers who could not pursue a claim before. This bill would set up different levels of coverage within some policies.

Representative Sawyer moved that the word "it" be struck from the proposed balloon on Page 2 of HB 2126 and the words "the other motor vehicles limit of liability" be added. Representative Welshimer seconded the motion. Motion carried.

The word "duplicative" as it appears in the bill was discussed by Richard Mason and David Hanson. Basically it meant in this situation that a person cannot be paid twice for the same benefits. Mr. Hanson said the second "duplicative" cuts off the right of subrogation.

Representative Sprague moved the word "duplicative" be struck from Lines 35 and 39 of Page 2 and removal of Section 2 of HB 2126. Motion seconded by Representative Neufeld. Motion failed by a vote of 7 to 6.

Representative Sawyer moved for the passage of HB 2126 as amended. Representative Welshimer seconded the motion. Motion carried.

Meeting adjourned at 5:00 p.m.

GUEST LIST

COMMITTEE: House Insurance DATE: 2/27/91

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Chip Wheelen	Topeka	Ks Medical Soc.
[illegible]	"	KTCA
[illegible] Wilson	McPher	Alliance Ins Co
LARRY MAGILL	TOPEKA	I.I.A.K.
HARRY SPRING	K.C.	HUMANA PREMIER HEALTH
David A. Ross	Topeka	KACU
[illegible]	[illegible]	[illegible]
Ken Bahr	Topeka	Ks. Hospital Assn
[illegible]	Topeka	KDHE
[illegible]	"	KBA
[illegible]	"	"
Tom Bell	Topeka	Ks. Hosp. Assn.
Bill Curtis	Topeka	Ks. Assoc. of School Bds.
ART BROWN	K.C.MO	KS. LBR. Dealers. Assn
Bill Pitsenberger	Topeka	Blue Cross Blue Shield
JIM OLIVER	TOPEKA	PIAK
Bill Sneed	Topeka	NIAA / State Farm
Nancy Zogleman	"	BC/BS of Ks
John Knack	TOPEKA	BC/BS
Lee Wright	Overland Park	Farmers Ins. Group
David Hanson	Topeka	Ks Insur Assocs

Testimony By
Dick Brock, Kansas Insurance Department
Before the House Insurance Committee
on House Concurrent Resolution No. 5011
February 27, 1991

When Commissioner Todd appeared before this committee earlier this year, the measure now identified as HCR 5011 was presented as one of two possible alternatives for consideration by the 1991 Kansas legislature each of which would authorize the creation of a mechanism that would make health insurance coverage available to some individuals who cannot obtain such coverage in the normal market. The other alternative is not under consideration today.

I understand your normal process is to consider specific legislative initiatives and, after due deliberation, dispose of them as public needs, desires and resources demand or suggest. While I will summarize for you the history and effect of House Concurrent Resolution 5011, the basic purpose of the Department's inclusion of suggestions for a health insurance availability mechanism in our 1991 legislative recommendations was to once again bring the issue to your attention. In other words, at this point in time, we do not view the content of House Concurrent Resolution 5011 to be of great significance.

We chose to use this approach as a vehicle to hopefully prompt discussion of a health insurance availability mechanism because the 1986 legislature authorized the Insurance Commissioner to create such a mechanism subject to certain prerequisites but also provided that the mechanism could not be implemented until approval of the legislature is obtained. All the requirements of that 1986 legislation were fulfilled except, rather than approving implementation of the plan recommended by the Insurance Department, the matter was referred to an interim legislative committee which expressed understandable and justifiable misgivings about such

House Insurance
Feb. 27, 1991
Attachment 1

mechanisms -- did not recommend approval -- and referred it to the then existing Commission on Access to Services for the Medically Indigent and the Homeless.

I have attached to my testimony a copy of two interim committee reports on this subject as well as a copy of the specific plan we recommended in 1988. The 1988 interim committee report is the one that deals with the plan attached to my testimony and HCR 5011. The 1979 report is an earlier study on the same subject.

In view of this previous legislative action, the reasons for again advancing these proposals is probably not clear. However, if the issue of the uninsured population is considered and of concern, the Department's purpose in bringing these proposals and this material to your attention makes more sense. There simply is no magic formula, any brilliant administrative action, or spontaneous outpouring of generosity from the medical community that is going to finance the costs of health care for those people who are not eligible for public assistance or are not financially capable of self-insuring and have no insurance. The primary ways any state has addressed this problem so far is through a residual risk mechanism of the nature proposed or through some employer mandate coupled with a state funded plan such as that envisioned by Senate Bill No. 205.

Needless to say, enactment of HCR 5011 or the other alternative we proposed would not totally solve the problem. Even with a health risk pool, some people could not afford the coverage -- the coverage would not sufficiently meet their needs -- or some other shortcoming would still exist. Therefore, other actions such as an expansion of medicaid eligibility, a strengthening of public health services and other initiatives would still be necessary. But these are all incremental

decisions and currently no action is being taken or proposed to make a health care financing mechanism available to individuals who cannot qualify for medicaid or obtain health insurance coverage.

Most of the initiatives now being explored, including House Bill No. 2001, relate to group coverage. While that bill addresses rates and underwriting and even though that bill will, if enacted, assist some who would otherwise be uninsured by making coverage available under a group program, it will not address the problem of individual uninsureds.

This problem continues to grow. It cannot be addressed without legislative or congressional action. Senate Bill No. 205 is, of course, another much more ambitious alternative. A health risk pool is a more modest approach but for now the concept of a mechanism to make insurance available to those persons who have some means of affording it but cannot obtain it in the voluntary market is what we want you to consider. If the concept has any merit, we can then pursue the details.

Therefore, I am not asking you to give your blessing to HCR 5011. What I am asking you to do is look at the plan attached to my testimony simply as an example of what an availability mechanism for health insurance might look like and determine whether or not -- conceptually -- such a mechanism merits further consideration.

FLETCHER BELL

COMMISSIONER OF INSURANCE

January 8, 1988

The Honorable Mike Hayden
Governor of Kansas
2nd Floor, State Capitol Bldg.
Topeka, KS 66612

The Honorable Robert V. Talkington
President of the Senate
State Capitol Bldg., Rm 359 East
Topeka, KS 66612

The Honorable James D. Braden
Speaker of the House
State Capitol Bldg., Rm 380 West
Topeka, KS 66612

The Honorable Michael L. Johnston
Minority Leader of the Senate
State Capitol Bldg., Rm 347-N
Topeka, KS 66612

The Honorable Marvin Wm. Barkis
Minority Leader of the House of Representatives
State Capitol Bldg., Rm 327 South
Topeka, KS 66612

Gentlemen:

The 1986 Kansas Legislature enacted Substitute for Senate Bill No. 121. This bill charged me with the responsibility of collecting data from accident and health insurers regarding the number of risks declined or coverage limitations imposed including the incidents of higher than standard rates being charged. The bill required the Insurance Department to report our findings to you and the legislature no later than the commencement of the 1988 regular session of the Kansas Legislature. Please find attached a copy of the formal "Accident and Health Risk Pool Report".

To meet the statutory directives of Substitute for Senate Bill No. 121, I issued Bulletin 1986-22 to all insurance companies authorized to transact accident and health insurance business in Kansas. This bulletin requested the companies' participation in reporting any adverse underwriting decisions made by the companies. The data has been compiled and incorporated into the attached report.

It should be noted that specific cost data is impossible to project for such a program inasmuch as accurate data is only obtainable after-the-fact. Not only is a pool mechanism for persons unable to obtain necessary coverage in the normal market

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a new idea for the state of Kansas, but it is also a relatively new idea for any state. Even among the few states which have had a "risk pool" in effect long enough to develop credible data, substantial differences exist within the programs that prevent a meaningful cost comparison. In spite of the above, we have been provided with some cost information by the Health Insurance Association of America. Although this information was received after the formal report had already gone to the printer, it provides some data which may be helpful to you.

In summary, I believe the report provides meaningful information and recommendations regarding the uninsurable population in Kansas. I support its recommendations and I am confident the report will be an important aid to you and the Kansas Legislature.

I do want to specifically note, however, that Substitute for Senate Bill No. 121 (1986) requires legislative approval before a plan can be implemented. In addition, implementation of the plan I have suggested would require some additional statutory provisions. Therefore, I hope the attached report and recommendations will be referred to an appropriate legislative body for consideration and possible action.

Very truly yours,

Fletcher Bell
Commissioner of Insurance

FB:lbah
5861fdp
Enclosures

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HIAA

Health Insurance Association of America

December 30, 1987

Mr. Richard G. Hunker
Accident and Health Supervisor
Kansas Department of Insurance
420 S.W. 9th Street
Topeka, Kansas 66612

Dear Dick:

This is in response to your inquiry as to whether HIAA has any data that would be useful in projecting an estimate of the costs to the State of Kansas involved with the enactment of an uninsurable pooling program.

There are 15 state "pools" at the present time, but only a smaller number have been operating for a period of time sufficient to develop any meaningful cost information. All of these pools, while based on rather common principles, are somewhat different in terms of premium limitations, scope of coverage, eligibility and the like. For these and other reasons, the actual cost of each pool is substantially different. Unfortunately, a comparative actuarial study has not been done to really identify and evaluate the factors among these pools to determine what might be causing the differences in cost. In the absence of such a study, we can only make rough assumptions about costs for other states in adopting pooling legislation.

The attached material consists of; 1) a list of 11 of the pools having been in existence for the longer time indicating such factors as deductibles, copayment limitations, maximum benefits and pre-existing periods; and 2) the operating cost data for 5 pools having been operational for some time (Florida is missing data since it is just becoming operational). The operational cost data include losses, assessments and several ratios indicating pool costs as per state population and to the insured segment of the population.

Some general observations might be appropriate. First, experience tends to indicate that pool premium rates are generally set too low. In most states, the pool premium is lower than premium rates applicable to conversion policies -- a result that is counter to the purpose of the pool. Also, where pool rates are too low, the assessments must be higher resulting in a higher impact on general revenue through premium tax offsets. Premium tax offsets are essential, however, to spread the cost of such social medical-economic

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programs throughout the population instead of merely through the insurance buying public. It is obvious that, in states where the impact on general revenue is considered too high, the pool rates need to be increased and eligibility tightened. There is growing thought also that pools should be required to administer cost containment programs and perhaps even managed care in order to curtail the inflationary spiral of health care costs themselves.

After you have had an opportunity to look over the attachments, you might want to call Peter Thexton in our Washington office for further information or explanation of the data. Perhaps an actuary might be able to draw some meaningful inferences as to projected costs better than we attorneys.

I hope this will be of assistance. Please let us know if we can provide anything further.

Yours truly,

Carroll Callaway
Senior Associate General Counsel

CC/dvp
Attachment

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STATE HIGH RISK POOLS
BENEFIT PLANS

State	Deductibles	Stop Loss Indiv.	Stop Loss Fam.	Maximum	Pre-existing Define	Pre-existing Wait	Pre-existing Wvr?	Med. Supp.
Conn.	400;1,000;1,500	2,000	4,000	$1 Mill.	6 mo.	12 mo.	No	No
Fla.	1,000 1,500 2,000	2,500(1) 3,000(1) 3,500(1)	4,000 4,500 5,000	500,000	6 mo.	6 mo.	No	Yes
Ill.	250;500;1,000	1,500(2)	3,000	500,000	6 mo.	6 mo.	10%(3) Conv.*	Yes
Ind.	200 500 1,000	1,000 1,500 2,000	2,000 3,000 4,000	Unlim.	6 mo.	6 mo.	25%	No
Iowa	500 1,000	1,500 2,000	3,000 4,000	250,000	6 mo.	6 mo.	Conv.*	Yes
Minn.	500;1,000	3,000	–	250,000	90 d.	6 mo.	Conv.*	Yes
Mont.	1,000	5,000	–	100,000	5 yrs.	12 mo.	Conv.*	Yes
Neb.	250 500 1,000	5,250 5,500 6,000	– – –	500,000	6 mo.	6 mo.		
N. Dak.	150;500;1,000	3,000	–	250,000	90 d.	180 d.	Conv.*	Yes
Tenn.	500 2,000	1,500 2,500	2,500 3,500	500,000	6 mo.	6 mo.		Yes
Wisc.	1,000	2,000	4,000	250,000	6 mo.	6 mo.	No	No

(1) Individual stop loss for medicare supplement plans is $1,500, $2,000, $2,500.
(2) $500 for medicare supplement.
(3) Change from 6 mo./6 mo. to 2 mo./2 mo. for 10% extra premium.
* Waiting period can be waived if previously covered and other defined requirements.

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STATE HIGH RISK POOLS
ACCRUED EXPERIENCE DATA ($1,000's) FOR CALENDAR YEAR 1986

State	Premium	Benefit	Bene. Ratio	Expense	Inv. Inco.	Expense-Inv. Inco. /Enr.	%Prem	% Bene
Conn.	$3,533	$ 4,228	120%	$ 222	$ 32	$ 60.00	5.4%	4.5%
Fla.								
Ind.	6,869	11,648	~~108~~ 170	436	55	127	5.5	3.3
Minn.	10,772	18,914	176	989	106	74	8.2	4.7
N. Dak.	1,322	2,864	217	109	17	72	7.0	3.2
Wisc.*	2,617	3,106	119	282	91	91	7.3	6.1

* Fiscal year ending June 30.

FINANCIAL DATA ($1,000's) FOR YEAR 1986

State	Loss(1)	Loss/Popul Total	Loss/Popul Insd.*	Loss/ Enrol	Assess Base Type	Assess Base Amt(Mil)	Assess Amount(1)	Assess Ratio
Conn.	$ 885	$ .28	$ .34	$ 385			1,490	
Fla.								
Ind.	5,161	.94	1.14	1,720			4,684	
Minn.	9,024	2.15	2.63	755	A&H Prem		9,024	
N. Dak.	1,633	2.38	2.91	1,276			1,510	
Wisc.	679	.14	.17	323			770	

(1) Losses are based on accrual amounts. Assessments are generally based on cash amounts.

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ACCIDENT AND HEALTH

RISK POOL REPORT

1986 SUBSTITUTE FOR SENATE BILL NO. 121

A REPORT FROM THE KANSAS INSURANCE DEPARTMENT ON THE FEASIBILITY OF IMPLEMENTING A HEALTH INSURANCE HIGH RISK POOL TO: MIKE HAYDEN, GOVERNOR, ROBERT V. TALKINGTON, PRESIDENT OF THE SENATE, MICHAEL L. JOHNSTON, MINORITY LEADER OF THE SENATE, JAMES D. BRADEN, SPEAKER OF THE HOUSE OF REPRESENTATIVES, AND MARVIN WM. BARKIS, MINORITY LEADER OF THE HOUSE OF REPRESENTATIVES.

JANUARY, 1988

Preamble

K.S.A. 40-2111 as amended by L. 1986, Chapter 178 requires the Commissioner of Insurance to accumulate data concerning declinations, terminations and offers to provide accident and sickness insurance at higher than standard rates and report such information to the governor and the legislature no later than commencement of the 1988 legislature.

This report is submitted in compliance with this statutory directive and is designed to address the issue identified in Section I.

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I. ISSUE

Is it necessary for the state of Kansas to implement a Pooled Risk Program for those who cannot obtain reasonably adequate accident and health insurance in the voluntary market?

II. BACKGROUND

Several times in recent years legislation has been considered or proposed which would address the concerns of uninsured Kansans. In 1976 a legislative recommendation was developed by the Insurance Department which would have established a comprehensive health insurance and health care cost containment mechanism. This recommendation was presented to interested state agencies, health care providers and others, but was subjected to considerable criticism and no support developed.

In 1977, the Insurance Department's Catastrophic Health Insurance and Health Care Cost Containment proposal was presented to the House Committee on Insurance -- the committee ultimately introduced the catastrophic health insurance portion of the proposal. Subsequently, the health care cost containment provisions of the proposal were introduced as an individual bill (House Bill No. 2453) but it was not enacted.

In 1978 a proposal to establish a residual market mechanism for catastrophic health insurance was recommended by the Insurance Department. The recommendation was introduced as House Bill No. 2270 but it was not enacted.

In 1986 House Bill No. 2167 was recommended by the Insurance Department and Senate Bill No. 121 was sponsored by Senator Francisco (D - Mulvane), each of which would have established a Pooled Risk program in the state of Kansas. A combination of these bills was enacted as Substitute for Senate Bill No. 121, which as noted in the Preamble to this report, charged the Insurance Commissioner with the responsibility of collecting data from accident and health insurers regarding the number of risks declined or coverage limitations imposed and reporting to the governor and legislature, no later than the commencement of the 1988 regular session of the Kansas legislature. Such report consists of data obtained from insurance companies along with a proposed plan including an analysis of the cost impact thereof. The Governor and the legislature will therefore have an opportunity to review the data and recommendations contained herein and comment on whether there is a need for implementation of the proposed plan and, if so, consider whether or not the proposed plan should be approved.

III. DATA

On June 27, 1986, the Insurance Department sent Bulletin 1986-22 to authorized Accident and Health companies requesting their participation in the reporting requirements of Substitute for Senate Bill No. 121. (Appendix A contains a copy of Bulletin 1986-22 and a copy of Substitute for Senate Bill No. 121) The prescribed reporting period was July 1, 1986 to June 30, 1987. The results of this survey have been tabulated and companies have reported processing 79,230 applications, of which 5.14% were declined. Of those not declined, 16.74% were issued with health restrictions (riders) and/or substandard rates. In addition, Blue Cross and Blue Shield of Kansas, Inc., the company which reported the largest number of applications, has reported that, during the reporting period, 1,635 or 43.16% of the applicants who were accepted with health restrictions terminated their policies within 60 days of issue. (See Appendices B and C)

The above statistics along with the grim predictions of the escalating AIDS crisis suggest that a new crop of uninsurable Kansans may be emerging over the next decade -- certainly a factor to be considered.

The data collected from companies is not without its weaknesses. We know how many applications were denied during the time period of the study, but that figure may be misleading in that many of those applicants rejected by one company may have been accepted by another, or may have later secured group coverage. Of those rejected, we will not know how many could afford to participate in a risk pool. On the other hand, we will not know how many of the uninsured were not counted in the study, such as those whose applications were never processed because the agent in the field informed the applicant that he/she was uninsurable, those whose applications were processed before or after the reporting period, or those who did not apply because they already knew they were not an insurable risk. In other words, the data which we have compiled only tells us the frequency of adverse underwriting. An approximate number of uninsureds or uninsurables is not something which can be concluded from our study, and even if it could, we would not know how many of those could afford to be candidates for the risk pool. We simply do not know how many Kansans will benefit from such a program but, we do know with absolute certainty that a number of Kansans cannot obtain adequate health insurance and we also know it does not require huge numbers to determine that a significant public policy consideration exists.

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IV. OPTIONS

Alternative I. Establish a pooled risk program to be administered either through a risk assignment mechanism or through a single plan administered by a selected insurer or administrator. Similar plans in other states typically include a minimum level of benefits and premium rates which are capped at a level ranging from 125 to 400 percent of the average charged for an individual policy. Despite the substandard rates, plans in other states tend to operate at a loss, which is typically assessed to insurers, distributed in proportion to the insurer's share of the state's total premium income. In some states, these costs are then transferred to the state by permitting insurers to deduct the amount they are assessed from the premium taxes otherwise payable in subsequent years.

Alternative II. Under this alternative, catastrophic medical expenses are financed directly by state appropriations and administered by a state agency. Basically, under this type of program, residents become eligible for assistance if their medical bills exceed a certain portion of their income. This program is intended to be the "payer of last resort" -- that is, state financial support begins only after all other forms of private insurance have been exhausted. This arrangement is designed, as is Alternative I, to protect people who are in poor health and who need insurance protection. Generally, in the states that administer their own risk pools, participants do not include those eligible for Medicaid assistance.

Over the years, practically all of the programs of this nature that states have adopted have experienced excessively high costs and utilization. As a result, some states have tightened their eligibility requirements whereas other states have curtailed funding altogether. This alternative is administratively feasible but is impractical without adequate state funding to provide the needed protection for those desiring coverage.

V. RECOMMENDATION

The Insurance Department recommends proceeding with Alternative I. In addition to those health insurance applications which are declined, there are a number of situations where policies are issued with broad health restrictions which render the insured effectively uninsured due to chronic health problems which are not covered by the policy. Further, as the AIDS epidemic worsens in Kansas, private insurance will become harder to obtain, more and more victims will be financially dependent on the state unless the medical costs of this disease can be alleviated by catastrophic health insurance coverage.

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Although a pooled risk program of this nature would provide availability of coverage, it is important to recognize that affordability would not be assured. Obviously, the uninsured are generally not entitled to group coverage through their place of employment. Many are unemployed, self-employed, farmers, part-time or temporary workers, those employed by firms which do not provide health insurance to workers, or those who cannot afford the employee health plan despite employer contribution. Coverage under the risk pool will no doubt be expensive, and will be out-of-reach to many uninsured Kansans even though limitations on the maximum extent premiums can exceed those charged in the standard market will result in some subsidization. Consequently, this plan should not be viewed as a panacea -- it would not insure all of the uninsured, it would not compensate for all uncompensated care, and it probably would not significantly impact a savings on Medicaid reimbursements. Nevertheless, the plan can be very effective in providing insurance to a subset of the Kansas population - people in poor health who are able to afford the cost of the premiums. Even a catastrophic health insurance plan with high deductibles and co-payments places an upper limit on an individual's or family's health care expenditures. This gives them a target to budget for whereas now they are faced with the possibility of a limitless drain on their resources and ultimately dependency on public programs.

The establishment of a plan of this nature will also permit the acquisition of better data through which to measure more precisely the cost of such a program. From such data it is possible that at some point in the future, public funding might be effectively used to subsidize the premium for the medically indigent at a lower cost than would be the case if the Medicaid program or other public assistance alternatives are required to absorb the entire burden.

Although Alternative I will have some degree of fiscal and administrative effect upon the operations of the Kansas Insurance Department, we believe our current staff can handle such tasks.

VI. PROPOSED PLAN

Pursuant to Substitute for Senate Bill No. 121, the Kansas Insurance Department has prepared a proposed plan. (See Appendix D). This health insurance pooling mechanism is patterned after the National Association of Insurance Commissioners model law and includes, in part, provisions relating to operation of the pool, eligibility, assessments, minimum benefits and complaint and grievance procedures.

VII. LEGISLATIVE CONSIDERATIONS

The following subsections of this Section VII, are topics relating to the risk pool mechanism which may require additional

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legislative resolutions for effective implementation of the pool mechanism.

A. Subsidizing Pool Losses:

According to the September 1987, second edition of a report entitled, Comprehensive Health Insurance for High Risk Individuals, which was developed by Aaron K. Trippler of Communicating for Agriculture, Inc., fifteen states have enacted legislation creating risk pools of which nine are currently active. The other six are expected to begin enrolling people and become operational sometime during 1988. Approximately 67% of these states share or offset the losses assessed against the pool participants. Generally the states have chosen to subsidize pool losses through some form of tax credit. Twenty (20) percent of the states require the pool participants to bear the entire burden of pool losses, while one state or approximately 6.5% will recoup any losses through appropriations made by the General Assembly. The remaining state has a unique manner to offset the losses in that an assessment on hospital revenues will be used to pay for losses sustained by the pool.

In light of the above statistics it appears that some form of premium tax offset for adverse loss experience would make the pooling mechanism an equitable and viable program in the state of Kansas. Enabling legislation will be necessary if the legislature chooses to allow for state subsidies in conjunction with the Kansas Health Insurance Risk Pool.

Under a premium tax offset approach, the pooled risk mechanism would be implemented by the member insurers with start-up and administrative costs born by said members. Annually, or at such other times as the legislature may direct, the premium revenue and investment income thereon would be compared to the losses incurred during the same period of time. Member insurers would then be assessed for the amount the losses exceeded revenues. Each member insurer would then be permitted to deduct the amount of such assessment from premium taxes due the state of Kansas under such formula as the legislature may direct.

B. Collective Action

In order to protect the participants of the pool from legal action as a result of actions required by the pool, it would also appear necessary to provide for such protection via a separate law which may read as follows:

> "Neither the participation in the pool as members, the establishment of rates, forms or procedures nor any other joint or collective action required by the pool mechanism

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shall be the basis of any legal action, criminal or civil liability or penalty against the pool or any of its members."

C. Effective Date

We suggest that the provisions of the pooling mechanism contained in Appendix D become effective January 1, 1989.

VIII. CONCLUSION

From the information presented above, we believe it is apparent that a need for a risk pool arrangement, however small it may be, has been identified. It is always important to remember the original purpose of a high risk pool. That is, to develop a mechanism which provides a comprehensive health insurance product for individuals who are high risks even though it does not address the major issue of affordability.

Naturally, these types of programs are expensive and decisions must be made regarding the entities which will pick up the costs. A major problem to be addressed at the federal level is the effect of ERISA in precluding states from developing a broad base for subsidization. Specifically, federal law now prevents states from including self-insurers as members of any risk pool which, in turn, permits self-insurers to avoid participation.

In this regard, recent federal legislation, which would assist in this area, has been introduced by Representative Kennelly and Senator Heinz (HR 1770 and S1372) and by Representative Stark and Senator Kennedy (HR 3210 and S1346). The enforcement mechanism proposed in these bills is a tax on employers, whether insured or self-funded, whose employee's health benefits plan do not participate. The federal tax mechanism is obviously a way of circumventing ERISA's prohibition against states requiring self-funded employee benefit plans to participate in pools.

Legislative attention should also be drawn to another Federal proposal known as the Access to Health Care Act of 1986 which was introduced in congress by Senators Edward Kennedy, John Heinz, Donald W. Riegle and David F. Dureuberger. This Senate Bill, would, in part, require states to set up insurance pools for people not insured through their jobs, regardless of health history, with premiums no more than 50% higher than the prevailing rate for individual health policies. If the premium is more than 50% higher, employers and insurers would have to subsidize the difference.

On July 1, 1987, the House Ways and Means Health Subcommittee of Congress voted to include a voluntary risk pool provision as part of its reconciliation package. The provision essentially requires all employers with 20 or more employees, whether they provide

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insurance or not or whether they are self-funded, to participate in the pool. Qualified employers who do not participate are subject to a tax penalty equal to 5% of gross wages.

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Appendix A - Kansas Insurance Department Bulletin 1986-22 - Including a copy of Substitute for Senate Bill No. 121 and a copy of reporting form for adverse underwriting decisions.

Appendix B - Kansas Insurance Department Adverse Underwriting Report

Appendix C - Letter dated October 14, 1987 from Blue Cross and Blue Shield of Kansas regarding the company's adverse underwriting data.

Appendix D - Kansas Health Insurance Pooling Mechanism.

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APPENDIX A

STATE OF KANSAS

KANSAS
INSURANCE DEPARTMENT

420 S.W. 9th
Topeka 66612-1678 913-296-3071

1-800-432-2484
Consumer Assistance
Division calls only

FLETCHER BELL
Commissioner

BULLETIN 1986-22

TO: All Companies Authorized to Transact Accident & Health Business in the State of Kansas

FROM: Fletcher Bell, Commissioner of Insurance
Kansas Insurance Department

SUBJECT: Substitute for Senate Bill No. 121

DATE: June 27, 1986

Enclosed for your reference is a copy of Substitute for Senate Bill No. 121 which was enacted by the 1986 session of the Kansas Legislature and becomes effective July 1, 1986.

Substitute for Senate Bill No. 121 charges the Kansas Insurance Department with gathering data from Accident & Health insurers regarding those Kansas residents receiving declinations of coverage, termination of coverage or offers to insure at higher than standard rates. The information is being gathered as part of a study to determine the feasibility and impact of a residual market mechanism for health insurance.

The type of coverage which is involved is hospital, medical and surgical expense coverage. We do not wish, at this time, to gather data on underwriting review of disability income, overhead expense, other income replacement contracts, specified disease, accident only or Medicare Supplement contracts. We do however, need data reported on both individual and group medical contracts which receive underwriting review of the applicant's or insured person's insurability. Please report only on Kansas residents.

K.S.A. 40-2,112, which has been in effect since July 1, 1981, requires that data concerning adverse underwriting decisions be maintained for at least 60 days following notification to the applicant or insured. This includes all underwriting decisions which have the potential of declination, termination or increasing rates above standard. Therefore, we must assume you are already recording the necessary information.

Enclosed is a copy of the form developed for reporting the various kinds of adverse underwriting decisions specified. The report must be filed with this department, at least monthly, no later than the 15th of the month following the reported month. The period on which the data is to be reported begins July 1, 1986 and ends June 30, 1987. The first report is due August 15, 1986 and the last report is due July 15, 1987.

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Instructions for completing the form are numbered to correspond with the line numbers on the form.

1. Company name and address.

2. Date report compiled.

3. Indicate the total number of applicants for medical coverage on which underwriting review was completed. This number should include the person applying, the spouse and any children as long as each person was reviewed for insurability prior to contract issuance. Please do not report applicants on which underwriting review is pending or not yet finalized.

4. Indicate the total number of applicants (See 3 above) who are declined medical coverage as uninsurable.

5. Indicate the total number of applicants who have specific conditions excluded from coverage, as a requirement of contract issuance.

6. Indicate the number of applicants requiring rates higher than standard in order to obtain the medical coverage involved. This total should reflect the number of people rated up, not the number of applications.

7. Indicate the number of applicants requiring exclusion of specific health conditions combined with rates higher than standard as a condition for policy issuance.

8. Indicate the number of existing insureds whose coverage is terminated in the month reported because of benefit utilization reflected by claims experience. This total should reflect the number of people terminated, not the number of contracts.

9. Indicate the number of existing insureds whose rates are increased above standard because of benefit utilization reflected by claims experience, as a condition of continued coverage.

If, after reviewing the form and these instructions you have questions, please let us know.

If your company currently does not perform underwriting review on medical, hospital and surgical contracts, or if you do not currently have these kinds of contracts issued in Kansas, please provide written verification to us immediately. In these instances you are not required

to report on a monthly basis. If, in the future, the requirements of this bill become applicable, it is your responsibility to file this form for the duration of the study. All other companies must file the initial report no later than August 15, 1986 and by the 15th of each subsequent month for the duration of the study.

Very truly yours,

Fletcher Bell
Commissioner of Insurance

FB:dbah
Attachments
3098mt

Substitute for SENATE BILL No. 121

AN ACT concerning insurance; relating to apportionment or assignment of risk for accident and sickness insurance policies; amending K.S.A. 40-2111 and K.S.A. 1985 Supp. 40-19c09 and repealing the existing sections.

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

Section 1. K.S.A. 40-2111 is hereby amended to read as follows: 40-2111. *(a)* Every insurer *authorized to issue a policy of accident and sickness insurance as defined in K.S.A. 40-2201 and amendments thereto or* undertaking to transact in the state of Kansas the kinds of insurance specified in subsection (a), (b) or (c) of K.S.A. 40-901 *and amendments thereto* or subsection (b) or (c) of K.S.A. 40-1102 *and amendments thereto*, and every rating organization which makes rates for such insurance, shall at the discretion of the commissioner of insurance, cooperate in the preparation of and submission to the commissioner *and participate in* a plan or plans for the equitable apportionment among insurers of applicants for insurance who are, in good faith, entitled to such kinds of insurance, or subdivisions or combinations thereof, but who are unable to procure the same through ordinary methods: ~~*Provided, That.*~~ This section shall not apply to the kinds of insurance specified in K.S.A. 40-2102 and 40-2108 *and amendments thereto.*

(b) Such plan or plans shall provide:

~~(a)~~ *(1)* Reasonable rules governing the equitable distribution of risks, by direct insurance, reinsurance or otherwise, and their assignment to insurers;

~~(b)~~ *(2)* rates and rate modifications applicable to such risks which shall be reasonable, adequate and not unfairly discriminatory;

~~(c)~~ *(3)* the extent of liability which each insurer shall be required to assume; *and*

~~(d)~~ *(4)* a method whereby applicants for insurance, insureds, agents and insurers may have a hearing on grievances and the right of appeal of the commissioner.

For every such plan or plans, there shall be a governing board, to be appointed by the commissioner of insurance, which shall meet at least annually to review and prescribe operating rules, and which shall consist of the following members:

~~(1)~~ *(A)* Seven ~~(7)~~ members who shall be appointed as follows: Three ~~(3)~~ ~~of such~~ members shall be representatives of foreign insurance companies, two ~~(2)~~ members shall be representatives of domestic insurance companies and two ~~(2)~~ members shall be licensed independent insurance agents. ~~Said~~ *Such* members shall be appointed for a term of three ~~(3)~~ years, except that the initial appointment shall include two ~~(2)~~ members appointed for a ~~two (2) year~~ *two-year* term and two ~~(2)~~ members appointed for a ~~one (1) year~~ *one-year* term, as designated by the commissioner; and

~~(2)~~ *(B)* Two ~~(2)~~ members representative of the general public interest, with ~~said~~ *such* members to be appointed for a term of two ~~(2)~~ years.

(c) With regard to accident and sickness insurance, prior to the implementation of a plan under this section: (1) Every insurer shall report to the commissioner at such time as the commissioner may require, on a form prescribed by the commissioner, information concerning each instance of declination of insurance coverage, termination of insurance coverage and offering to insure at higher than standard rates, with respect to the type of insurance proposed to be provided under this section; (2) the commissioner shall report to the governor and to the legislature, no later than the commencement of the 1988 regular session of the Kansas legislature, data obtained under the provisions of this section along with a proposed plan, including an analysis of the cost impact thereof, developed in accordance with this section; (3) the legislature shall have an opportunity to review the data and comment on whether there is a need for implementation of the plan; and (4) approval by the legislature must be obtained.

Sec. 2. K.S.A. 1985 Supp. 40-19c09 is hereby amended to read as follows: 40-19c09. Corporations organized under the

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nonprofit medical and hospital service corporation act shall be subject to the provisions of the Kansas general corporation code, articles 60 to 74, inclusive, of chapter 17 of the Kansas Statutes Annotated, applicable to nonprofit corporations, to the provisions of K.S.A. ~~1984~~ *1985* Supp. 40-2,116 and 40-2,117 and to the provisions of K.S.A. 40-214, 40-215, 40-216, 40-218, 40-219, 40-222, 40-223, 40-224, 40-225, 40-226, 40-229, 40-230, 40-231, 40-235, 40-236, 40-237, 40-247, 40-248, 40-249, 40-250, 40-251, 40-252, 40-254, 40-2,100, 40-2,101, 40-2,102, 40-2,103, 40-2,104, 40-2,105, 40-2a01 to 40-2a19, inclusive, *40-2111 to 40-2116, inclusive,* 40-2216 to 40-2220, inclusive, 40-2401 to 40-2421, inclusive, and 40-3301 to 40-3313, inclusive, and amendments thereto, except as the context otherwise requires, and shall not be subject to any other provisions of the insurance code except as expressly provided in this act.

Sec. 3. K.S.A. 40-2111 and K.S.A. 1985 Supp. 40-19c09 are hereby repealed.

Sec. 4. This act shall take effect and be in force from and after its publication in the statute book.

I hereby certify that the above BILL originated in the SENATE, and passed that body

_____

SENATE concurred in HOUSE amendments _____

_____
President of the Senate.

_____
Secretary of the Senate.

Passed the HOUSE as amended _____

_____
Speaker of the House.

_____
Chief Clerk of the House.

APPROVED _____

_____
Governor.

2691

1. _____ 1a. _____
Company Name Date

_____
Address

_____
City, State, Zip Code

2. _____
Month, year reported

3. Number of applicants reviewed _____

4. Number of applicants declined _____

5. Number of applicants requiring exclusion of specific health condition(s) as a requirement of issuance _____

6. Number of applicants requiring rates higher than standard as a requirement of issuance _____

7. Number of applicants regarding exclusion of specific health condition(s) and rates higher than standard as a requirement of issuance _____

8. Number of insureds covered by existing contracts terminated due to claims experience _____

9. Number of persons covered by existing contracts requiring rate increases above standard as a condition of renewal due to claims experience _____

MT:lbah
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APPENDIX B

KANSAS INSURANCE DEPARTMENT
ACCIDENT & HEALTH DIVISION
BULLETIN 1986-22 REPORTING FORM
ADVERSE UNDERWRITING STUDY REPORT
7/86 TO 6/87

NUMBER OF REPORTS TABULATED	1,615
NUMBER OF APPLICANTS REVIEWED	79,230
NUMBER OF APPLICANTS DECLINED	4,069
NUMBER OF APPLICANTS REQUIRING EXCLUSION OF SPECIFIC HEALTH CONDITIONS AS A REQUIREMENT OF ISSUANCE	9,061
NUMBER OF APPLICANTS REQUIRING RATES HIGHER THAN STANDARD AS A REQUIREMENT OF ISSUANCE	1,957
NUMBER OF APPLICANTS REQUIRING EXCLUSION OF SPECIFIC HEALTH CONDITIONS AND RATES HIGHER THAN STANDARD AS A REQUIREMENT OF ISSUANCE	495
NUMBER OF INSUREDS COVERED BY EXISTING CONTRACTS TERMINATED DUE TO CLAIMS EXPERIENCE	297
NUMBER OF PERSONS COVERED BY EXISTING CONTRACTS REQUIRING RATE INCREASES ABOVE STANDARD AS A CONDITION OF RENEWAL DUE TO CLAIMS EXPERIENCE	1,072

APPENDIX C

e Cross
Blue Shield
of Kansas

1133 Topeka Avenue
P.O. Box 239
Topeka, Kansas 66629

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

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

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

BOEING EMPLOYEES
1-800-223-0529

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

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

MEDICARE BENEFICIARIES
In Topeka
913 232-3773
In-State
1-800-432-3531

October 14, 1987

Richard G. Huncker
Accident and Health Supervisor
Kansas Insurance Department
420 Southwest Ninth Street
Topeka, KS 66614

RE: ADVERSE UNDERWRITING DATA

In response to our conversation of September 28, 1987, we are forwarding the following data in regard to individual underwriting. We hope that this information is helpful.

For the period January 1, 1987 through June 30, 1987, we recorded a total of 9622 applicants in our Non-Group and Farm Bureau categories of business. Of those, a total of 1,897 memberships were ridered for at least one condition.

Of the 1,897 memberships which were ridered, a total of 849 were terminated within sixty-one days of the effective date. A breakdown of the reasons for which those memberships were terminated appears below:

	Reason	Total Number
1)	By request, no reason given	265
2)	Transferred to another membership number	27
3)	Transferred to another group number	21
4)	Changed to another category of business	27
5)	Cancelled due to returned check	2
6)	Cancelled for non-payment of dues	471
7)	Cancelled to commercial coverage	3
8)	Transferred to HMO Kansas	1

3191

In addition to the reasons listed above, we find that 32 memberships which had been cancelled were undergoing reinstatement or other maintenance transactions at the time this data was compiled.

As you will remember, on May 15, 1987, we reported figures for the period July 1, 1986 through December 31, 1986. Of a total of 10,099 applicants, we reported a total of 1,892 memberships which were ridered. Of those ridered memberships, 786 were cancelled within sixty-one days of the effective date.

Compiling that data with data extracted for the period January 1, 1987 to June 30, 1987 results in the following totals for the period July 1, 1986 through June 30, 1987:

Total applicants	-	19,721
Ridered memberships	-	3,789
Cancelled	-	1,635

We hope that this information is helpful. If you have any further questions, please feel free to contact us.

Barbara Casto

BARBARA CASTO, Manager
Special Services
Customer Service Center

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cp50/01o

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APPENDIX D

KANSAS HEALTH INSURANCE POOLING MECHANISM

Section 1. Definitions.

1. "Pool" means the Kansas Health Insurance Pool.

2. "Board" means the Board of Directors of the pool.

3. "Insured" means any individual resident of this state who is eligible to receive benefits from any insurer as defined in this section.

4. "Insurer" means any insurance company, health maintenance organization, and non-profit hospital and medical service company authorized to transact business in this state.

5. "Insurance arrangement" means any plan, program, contract or any other arrangement under which one or more employers, unions or other organizations provide to their employees or members, either directly or indirectly through a trust or third party administrator, health care services or benefits other than through an insurer.

6. "Health insurance" means any hospital and medical expense incurred policy, and nonprofit health care service plan contract. The term does not include insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

7. "Medicare" means coverage under both part A and B of Title XVIII of the Social Security Act, 42 USC 1395, et seq as amended.

8. "Physician" may be defined by including the words "duly qualified physician" or "duly licensed physician". An insurer using these terms shall recognize and accept, to the extent of its obligation under the contract, all providers of medical care and treatment when these services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

9. The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

   a. be an institution operated pursuant to law; and

   b. be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and

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c. provide twenty-four (24) hour nursing service by or under the supervision of registered graduate professional nurses (R.N.'s).

The definition of the term "hospital" may state that such term shall not be inclusive of:

a. convalescent homes, convalescent, rest, or nursing facilities; or

b. facilities primarily affording custodial, educational or rehabilitory care; or

c. facilities for the aged, drug addicts or alcoholics; or

d. any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.

10. "Plan of operation" means the plan of operation of the pool, including articles, bylaws and operating rules, adopted by the board pursuant to §2 of this pooling mechanism.

11. "Benefits plan" means the coverages to be offered by the pool to eligible persons pursuant to §6 of this pooling mechanism.

12. "Department" means the Kansas Insurance Department.

13. "Commissioner" means the Kansas Insurance Commissioner.

14. "Member" means all insurers participating in the pool.

Section 2. Operation of the Pool.

1. A non-profit entity to be known as the Kansas Health Insurance Pool, will be established for the purposes of implementing this pooling mechanism. All insurers providing health plan benefits in this state on and after the effective date of this pooling mechanism shall be members of the pool.

2. The Commissioner shall appoint members of the governing board as specified in K.S.A. 40-2111. The Commissioner shall give notice to all insurers of the time and place for the initial organizational meeting.

3. If, within sixty (60) days of the organizational meeting, the administering insurer has not been appointed by the Board, the Commissioner shall appoint an administering insurer.

4. The Board shall submit to the Commissioner a plan of operation for the pool and any amendments thereto necessary or suitable to assure the

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fair, reasonable and equitable administration of the pool. The Commissioner shall, after notice and hearing, approve the plan of operation provided such is determined to be suitable to assure the fair, reasonable and equitable administration of the pool, and provides for the sharing of pool gains or losses on an equitable proportionate basis. The plan of operation shall become effective upon approval in writing by the Commissioner consistent with the date on which the coverage under this pool mechanism must be made available. If the pool fails to submit a suitable plan of operation within 180 days after the appointment of the board of directors, or at any time thereafter fails to submit suitable amendments to the plan, the Commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this section. Such rules shall continue in force until modified by the Commissioner or superseded by a plan submitted by the pool and approved by the Commissioner.

5. In its plan the Board shall,

   a. Establish procedures for the handling and accounting of assets and monies of the pool.

   b. Select an administering insurer in accordance with §4 of this pooling mechanism.

   c. Establish procedures for the collection of assessments from all members to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made. The level of payments shall be established by the board, pursuant to §5 of this pooling mechanism. Assessment shall occur at the end of each calendar year. Assessments are due and payable within 30 days of receipt of the assessment notice.

   d. Develop and implement a program to publicize the existence of the plan, the eligibility requirements, and procedures for enrollment, and to maintain public awareness of the plan.

6. Powers and Authority of the pool. The pool shall have the specific authority to:

   a. Enter into contracts as are necessary or proper to carry out the provisions and purposes of this pooling mechanism, including the authority, with the approval of the Insurance Commissioner, to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

   b. Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against pool members;

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c. Take such legal action as necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

d. Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas and any other actuarial function appropriate to the operation of the pool. Rates shall not be unreasonable in relation to the coverage provided, the risk experience and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claims costs and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices.

e. Assess members of the pool in accordance with the provisions of this section, and to make advance interim assessments as may be reasonable and necessary for the organizational and interim operating expenses. Any such interim assessments to be credited as offsets against any regular assessments due following the close of the fiscal year.

f. Issue policies of insurance in accordance with the requirements of this pooling mechanism.

g. Appoint from among members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design, and any other function within the authority of the pool.

h. Establish rules, conditions and procedures for reinsuring risks of pool members desiring to issue pool plan coverages in their own name. Such reinsurance facility shall not subject the pool to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers.

Section 3. Eligibility.

1. Any individual person, who is a resident of this state shall be eligible for pool coverage, except the following:

a. persons who have on the date of issue of coverage by the pool, coverage under health insurance or an insurance arrangement.

b. any person who is at the time of pool application eligible for health care benefits under any state Medicaid law.

c. any person having terminated coverage in the pool unless twelve months have lapsed since such termination.

d. any person on whose behalf the pool has paid out $1,000,000 in benefits.

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e. inmates of public institutions and persons eligible for public programs.

2. Any person who ceases to meet the eligibility requirements of this section may be terminated at the end of the policy period.

3. Any person whose health insurance coverage is involuntarily terminated for any reason other than nonpayment of premium and who is not eligible for conversion, may apply for coverage under the plan. If such coverage is applied for within 60 days after the involuntary termination and if premiums are paid for the entire coverage period, the effective date of the coverage shall be the date of termination of the previous coverage.

Section 4. Administering Insurer.

1. The board shall select an insurer or insurers through a competitive bidding process to administer the pool. The board shall evaluate bids submitted based on criteria established by the board which shall include:

   a. The insurer's proven ability to handle individual accident and health insurance.

   b. The efficiency of the insurer's claim paying procedures.

   c. An estimate of total charges for administering the plan.

   d. The insurer's ability to administer the pool in a cost efficient manner.

2. a. The administering insurer shall serve for a period of three (3) years subject to removal for cause.

   b. At least 1 year prior to the expiration of each 3 year period of service by an administering insurer, the board shall invite all insurers, including the current administering insurer, to submit bids to serve as the administering insurer for the succeeding 3 year period. Selection of the administering insurer for the succeeding period shall be made at least 6 months prior to the end of the current 3 year period.

3. a. The administering insurer shall perform all eligibility and administrative claims payment functions relating to the pool.

   b. The administering insurer shall establish a premium billing procedure for collection of premium from insured persons. Billings shall be made on a periodic basis as determined by the board.

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c. The administering insurer shall perform all necessary functions to assure timely payment of benefits to covered persons under the pool including:

1. Making available information relating to the proper manner of submitting a claim for benefits to the pool and distributing forms upon which submission shall be made.

2. Evaluating the eligibility of each claim for payment by the pool.

d. The administering insurer shall submit regular reports to the board regarding the operation of the pool. The frequency, content, and form of the report shall be as determined by the board.

e. Following the close of each calendar year, the administering insurer shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the board and the department on a form as prescribed by the Commissioner.

f. The administering insurer shall be paid as provided in the plan of operation for its expenses incurred in the performance of its services.

Section 5. Assessments.

1. Following the close of each fiscal year, the pool administrator shall determine the net premiums (premiums less administrative expense allowances), the pool expenses of administration and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. Health insurance premiums that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments.

a. Each insurer's assessment shall be determined by multiplying the total cost of operation by a fraction the numerator of which equals that insurer's premium and subscriber contract charges for health insurance written in the state during the preceding calendar year and the denominator of which equals the total of all premiums, subscriber contract charges written in the state during the preceding calendar year.

2. If assessments exceed actual losses and administrative expenses of the pool, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" include reserves for incurred but not reported claims.

3. a. Each member's proportion of participation in the pool shall be determined annually by the board based on annual financial

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statements and other reports deemed necessary by the board and filed by the member with it.

b. Any deficit incurred by the pool shall be recouped by assessments apportioned under subsection (1) of this section by the board among members.

4. The board may abate or defer, in whole or in part, the assessment of a member if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. In the event an assessment against a member is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in subsection (1) of this section. The member receiving such abatement shall remain liable to the pool for the deficiency for 4 years.

Section 6. Minimum Benefits - Availability.

1. The pool shall offer major medical expense coverage to every eligible person who is not eligible for Medicare. Major medical expense coverage offered by the pool shall pay an eligible person's covered expenses, subject to limits on the deductible and coinsurance payments authorized under paragraph (4)(d) of this section, up to a lifetime limit of $1,000,000 per covered individual. The maximum limit under this paragraph shall not be altered by the Board, and no actuarial equivalent benefit may be substituted by the Board.

2. Covered Expenses -- Covered expenses shall be the prevailing charge in the locality for the following services and articles when prescribed by a physician and determined by the pool to be medically necessary.

a. Hospital services.

b. Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than mental or dental, which are rendered by a physician, or by other licensed professionals at his direction.

c. Drugs requiring a physician's prescription.

d. Services of a licensed skilled nursing facility for not more than 120 days during a policy year.

e. Services of a home health agency up to a maximum of 270 visits per year.

f. Use of radium or other radioactive materials.

g. Oxygen.

h. Anesthetics.

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i. Prostheses other than dental.

j. Rental of durable medical equipment, other than eyeglasses and hearing aids, for which there is no personal use in the absence of the condition for which is prescribed.

k. Diagnostic X-rays and laboratory tests.

l. Oral surgery for excision of partially or completely unerupted, impacted teeth or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

m. Services of a physical therapist.

n. Transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition.

o. Services for diagnosis and treatment of alcoholism, drug abuse or nervous or mental conditions shall be covered in the manner prescribed in K.S.A. 40-2,105.

3. Exclusions -- Covered expenses shall not include the following:

a. Any charge for treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or a congenital bodily defect to restore normal bodily functions.

b. Care which is primarily for custodial or domiciliary purposes.

c. Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician.

d. That part of any charge for services rendered or articles prescribed by a physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality or for any charge not medically necessary.

e. Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual providing the services or articles.

f. Any expense incurred prior to the effective date of coverage by the pool for the person on whose behalf the expense is incurred.

g. Dental care except as provided in subsection (3)(l) of this section.

h. Eyeglasses and hearing aids.

i. Illness or injury due to acts of war.

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j. Services of blood donors and any fee for failure to replace the first 3 pints of blood provided to an eligible person each policy year.

k. Personal supplies or services provided by a hospital or nursing home, or any other nonmedical or nonprescribed supply or service.

4. Premiums, Deductibles, and Coinsurance.

a. Premiums charged for coverages issued by the pool may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage.

b. Separate schedules of premium rates based on age, sex, and geographical location may apply for individual risks.

c. The pool shall determine the standard risk rate by calculating the average individual standard rate charged by the five largest insurers offering coverages in the state comparable to the pool coverage. In the event five insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Initial rates for pool coverage shall not be less than 150% of rates established as applicable for individual standard risks. Subsequent rates shall be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein. In no event shall pool rates exceed 200% of rates applicable to individual standard risks. All rates and rate schedules shall be submitted to the Commissioner for approval.

d. The pool coverage defined in Section 6 shall provide optional deductibles of $1,500 or $3,500 per annum per individual, and coinsurance of 20%, such coinsurance and deductibles in the aggregate not to exceed $5,000 per individual nor $7,500 per family per annum. The deductibles and coinsurance factors may be adjusted annually according to the Medical Component of the Consumer Price Index.

5. Pre-Existing Conditions.

Pool coverage shall exclude charges or expenses incurred during the first twelve months following the effective date of coverage as to any condition, which during the six month period immediately preceding the effective date of coverage, (i) had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment or (ii) for which medical advice, care or treatment was recommended or received. Such pre-existing condition exclusions shall be waived to the extent to which similar exclusions, if any, have been

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satisfied under any prior health insurance coverage which was involuntarily terminated; provided, that application for pool coverage is made not later than thirty-one (31) days following such involuntary termination and, in such case, coverage in the pool shall be effective from the date on which such prior coverage was terminated.

6. Nonduplication of Benefits.

Benefits otherwise payable under pool coverage shall be reduced by amounts paid or payable through any other health insurance, or insurance arrangement, and by all hospital and medical expense benefits paid or payable under any worker's compensation coverage, automobile medical payment and by any hospital or medical benefits paid or payable under or provided pursuant to any state or Federal law or program except Medicaid.

Section 7. Complaint and Grievance Procedure.

1. Purpose. The Pool recognizes that from time to time participants may encounter situations where the performance of the Pool does not meet their expectations. When this occurs, the participant may wish to call the matter to the attention of the Board of Directors of the Pool. It is the policy of the Pool to promptly and fairly consider all complaints and grievances of its participates. The procedure outlined in this Section is established to define and assure this policy.

2. Definitions. For the proposes of this Complaint and Grievance Section, the following terms and their definitions apply:

a. Complaint means a relatively minor verbal or written expression of concern about a condition in the Pool's operation which may be resolved on an informal basis.

b. Grievance means a more serious written expression of concern about the Pool's operation or a complaint which has not been resolved to the participant's satisfaction. Both situations require a formal response by the Pool, including a thorough investigation and appropriate answer to the participant.

c. Participant means applicants for insurance, insureds, agents and insurers.

3. Procedure for Filing a Complaint or Grievance.

a. A complaint may be directed to the Pool by the Participant by telephone, in person, or in writing expressing the details of the participant's concern. Complaints will be handled by the Pool complaint/grievance coordinator who may involve other staff members of the Pool or providers of care in making the determination. The objective is to handle the complaint as quickly and as courteously as possible. If the participant does not receive prompt resolution, or wishes to express his

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concern to a higher level of authority, he may file a written grievance with the Pool.

b. A grievance is to be submitted to the Pool by completing the Grievance Form available from the Pool's office. This form should be filed within 90 days after the incident occurred. The participant must sign the form acknowledging that all incidents are accurately described.

Upon receipt of the Grievance Form, the Pool will conduct a thorough review of the situation. A response to the participant's grievance will be prepared and the participate will be notified of the Pool's decision in writing. If the solution is satisfactory, the matter ends.

If the solution is not satisfactory to the participant, he may within 30 days submit a written request for review by the Grievance Committee of the Board of Directors of the Pool. The request for review must state the participant's reason for appeal, including his reason for dissatisfaction with the first grievance response. The Committee will be convened within 30 days after receipt of the appeal. The participant who submitted the appeal will be invited to appear before the Committee to explain his position. The Committee will review all previous findings of the Pool. The participant will be notified of the Committee's decision within 15 days after the date of the Committee review.

c. If any party involved is not satisfied with the decision of the Board of the Pool or its committee, he may pursue normal remedies of law including a right of appeal to the Commissioner of Insurance. Prior to the institution of any legal proceeding or suit against the Pool the foregoing "Complaint" and "Grievance" procedure shall be utilized by any party alleging a claim against the Pool. In all events, such suit or proceeding must be commenced not later than five (5) years after the date the notice of final determination under the grievance procedure is transmitted to such party.

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KANSAS HEALTH INSURANCE POOLING MECHANISM

Section 1. Definitions.

1. "Pool" means the Kansas Health Insurance Pool.

2. "Board" means the Board of Directors of the pool.

3. "Insured" means any individual resident of this state who is eligible to receive benefits from any insurer as defined in this section.

4. "Insurer" means any insurance company, health maintenance organization, and non-profit hospital and medical service company authorized to transact business in this state.

5. "Insurance arrangement" means any plan, program, contract or any other arrangement under which one or more employers, unions or other organizations provide to their employees or members, either directly or indirectly through a trust or third party administrator, health care services or benefits other than through an insurer.

6. "Health insurance" means any hospital and medical expense incurred policy, and nonprofit health care service plan contract. The term does not include insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

7. "Medicare" means coverage under both part A and B of Title XVIII of the Social Security Act, 42 USC 1395, et seq as amended.

8. "Physician" may be defined by including the words "duly qualified physician" or "duly licensed physician". An insurer using these terms shall recognize and accept, to the extent of its obligation under the contract, all providers of medical care and treatment when these services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

9. The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

a. be an institution operated pursuant to law; and

b. be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and

c. provide twe four (24) hour nursing servic or under the supervision of registered graduate professional nurses (R.N.'s).

The definition of the term "hospital" may state that such term shall not be inclusive of:

a. convalescent homes, convalescent, rest, or nursing facilities; or

b. facilities primarily affording custodial, educational or rehabilitory care; or

c. facilities for the aged, drug addicts or alcoholics; or

d. any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.

10. "Plan of operation" means the plan of operation of the pool, including articles, bylaws and operating rules, adopted by the board pursuant to §2 of this pooling mechanism.

11. "Benefits plan" means the coverages to be offered by the pool to eligible persons pursuant to §6 of this pooling mechanism.

12. "Department" means the Kansas Insurance Department.

13. "Commissioner" means the Kansas Insurance Commissioner.

14. "Member" means all insurers participating in the pool.

Section 2. Operation of the Pool.

1. A non-profit entity to be known as the Kansas Health Insurance Pool, will be established for the purposes of implementing this pooling mechanism. All insurers providing health plan benefits in this state on and after the effective date of this pooling mechanism shall be members of the pool.

2. The Commissioner shall appoint members of the governing board as specified in K.S.A. 40-2111. The Commissioner shall give notice to all insurers of the time and place for the initial organizational meeting.

3. If, within sixty (60) days of the organizational meeting, the administering insurer has not been appointed by the Board, the Commissioner shall appoint an administering insurer.

4. The Board shall submit to the Commissioner a plan of operation for the pool and any amendments thereto necessary or suitable to assure the

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fair, reasonable and equitable administration of the pool. The Commissioner shall, after notice and hearing, approve the plan of operation provided such is determined to be suitable to assure the fair, reasonable and equitable administration of the pool, and provides for the sharing of pool gains or losses on an equitable proportionate basis. The plan of operation shall become effective upon approval in writing by the Commissioner consistent with the date on which the coverage under this pool mechanism must be made available. If the pool fails to submit a suitable plan of operation within 180 days after the appointment of the board of directors, or at any time thereafter fails to submit suitable amendments to the plan, the Commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this section. Such rules shall continue in force until modified by the Commissioner or superseded by a plan submitted by the pool and approved by the Commissioner.

5. In its plan the Board shall,

a. Establish procedures for the handling and accounting of assets and monies of the pool.

b. Select an administering insurer in accordance with §4 of this pooling mechanism.

c. Establish procedures for the collection of assessments from all members to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made. The level of payments shall be established by the board, pursuant to §5 of this pooling mechanism. Assessment shall occur at the end of each calendar year. Assessments are due and payable within 30 days of receipt of the assessment notice.

d. Develop and implement a program to publicize the existence of the plan, the eligibility requirements, and procedures for enrollment, and to maintain public awareness of the plan.

6. Powers and Authority of the pool. The pool shall have the specific authority to:

a. Enter into contracts as are necessary or proper to carry out the provisions and purposes of this pooling mechanism, including the authority, with the approval of the Insurance Commissioner, to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

b. Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against pool members;

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c. Take such legal action as necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

d. Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas and any other actuarial function appropriate to the operation of the pool. Rates shall not be unreasonable in relation to the coverage provided, the risk experience and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claims costs and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices.

e. Assess members of the pool in accordance with the provisions of this section, and to make advance interim assessments as may be reasonable and necessary for the organizational and interim operating expenses. Any such interim assessments to be credited as offsets against any regular assessments due following the close of the fiscal year.

f. Issue policies of insurance in accordance with the requirements of this pooling mechanism.

g. Appoint from among members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design, and any other function within the authority of the pool.

h. Establish rules, conditions and procedures for reinsuring risks of pool members desiring to issue pool plan coverages in their own name. Such reinsurance facility shall not subject the pool to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers.

Section 3. Eligibility.

1. Any individual person, who is a resident of this state shall be eligible for pool coverage, except the following:

a. persons who have on the date of issue of coverage by the pool, coverage under health insurance or an insurance arrangement.

b. any person who is at the time of pool application eligible for health care benefits under any state Medicaid law.

c. any person having terminated coverage in the pool unless twelve months have lapsed since such termination.

d. any person on whose behalf the pool has paid out $1,000,000 in benefits.

e. inmates of public institutions and persons eligible for public programs.

2. Any person who ceases to meet the eligibility requirements of this section may be terminated at the end of the policy period.

3. Any person whose health insurance coverage is involuntarily terminated for any reason other than nonpayment of premium and who is not eligible for conversion, may apply for coverage under the plan. If such coverage is applied for within 60 days after the involuntary termination and if premiums are paid for the entire coverage period, the effective date of the coverage shall be the date of termination of the previous coverage.

Section 4. Administering Insurer.

1. The board shall select an insurer or insurers through a competitive bidding process to administer the pool. The board shall evaluate bids submitted based on criteria established by the board which shall include:

   a. The insurer's proven ability to handle individual accident and health insurance.

   b. The efficiency of the insurer's claim paying procedures.

   c. An estimate of total charges for administering the plan.

   d. The insurer's ability to administer the pool in a cost efficient manner.

2. a. The administering insurer shall serve for a period of three (3) years subject to removal for cause.

   b. At least 1 year prior to the expiration of each 3 year period of service by an administering insurer, the board shall invite all insurers, including the current administering insurer, to submit bids to serve as the administering insurer for the succeeding 3 year period. Selection of the administering insurer for the succeeding period shall be made at least 6 months prior to the end of the current 3 year period.

3. a. The administering insurer shall perform all eligibility and administrative claims payment functions relating to the pool.

   b. The administering insurer shall establish a premium billing procedure for collection of premium from insured persons. Billings shall be made on a periodic basis as determined by the board.

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c. The administering insurer shall perform all necessary functions to assure timely payment of benefits to covered persons under the pool including:

1. Making available information relating to the proper manner of submitting a claim for benefits to the pool and distributing forms upon which submission shall be made.

2. Evaluating the eligibility of each claim for payment by the pool.

d. The administering insurer shall submit regular reports to the board regarding the operation of the pool. The frequency, content, and form of the report shall be as determined by the board.

e. Following the close of each calendar year, the administering insurer shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the board and the department on a form as prescribed by the Commissioner.

f. The administering insurer shall be paid as provided in the plan of operation for its expenses incurred in the performance of its services.

Section 5. Assessments.

1. Following the close of each fiscal year, the pool administrator shall determine the net premiums (premiums less administrative expense allowances), the pool expenses of administration and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. Health insurance premiums that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments.

a. Each insurer's assessment shall be determined by multiplying the total cost of operation by a fraction the numerator of which equals that insurer's premium and subscriber contract charges for health insurance written in the state during the preceding calendar year and the denominator of which equals the total of all premiums, subscriber contract charges written in the state during the preceding calendar year.

2. If assessments exceed actual losses and administrative expenses of the pool, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" include reserves for incurred but not reported claims.

3. a. Each member's proportion of participation in the pool shall be determined annually by the board based on annual financial

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statements and other reports deemed necessary by the board and filed by the member with it.

b. Any deficit incurred by the pool shall be recouped by assessments apportioned under subsection (1) of this section by the board among members.

4. The board may abate or defer, in whole or in part, the assessment of a member if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. In the event an assessment against a member is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in subsection (1) of this section. The member receiving such abatement shall remain liable to the pool for the deficiency for 4 years.

Section 6. Minimum Benefits - Availability.

1. The pool shall offer major medical expense coverage to every eligible person who is not eligible for Medicare. Major medical expense coverage offered by the pool shall pay an eligible person's covered expenses, subject to limits on the deductible and coinsurance payments authorized under paragraph (4)(d) of this section, up to a lifetime limit of $1,000,000 per covered individual. The maximum limit under this paragraph shall not be altered by the Board, and no actuarial equivalent benefit may be substituted by the Board.

2. Covered Expenses -- Covered expenses shall be the prevailing charge in the locality for the following services and articles when prescribed by a physician and determined by the pool to be medically necessary.

a. Hospital services.

b. Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than mental or dental, which are rendered by a physician, or by other licensed professionals at his direction.

c. Drugs requiring a physician's prescription.

d. Services of a licensed skilled nursing facility for not more than 120 days during a policy year.

e. Services of a home health agency up to a maximum of 270 visits per year.

f. Use of radium or other radioactive materials.

g. Oxygen.

h. Anesthetics.

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i. Prostheses other than dental.

j. Rental of durable medical equipment, other than eyeglasses and hearing aids, for which there is no personal use in the absence of the condition for which is prescribed.

k. Diagnostic X-rays and laboratory tests.

l. Oral surgery for excision of partially or completely unerupted, impacted teeth or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

m. Services of a physical therapist.

n. Transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition.

o. Services for diagnosis and treatment of alcoholism, drug abuse or nervous or mental conditions shall be covered in the manner prescribed in K.S.A. 40-2,105.

3. Exclusions -- Covered expenses shall not include the following:

a. Any charge for treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or a congenital bodily defect to restore normal bodily functions.

b. Care which is primarily for custodial or domiciliary purposes.

c. Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician.

d. That part of any charge for services rendered or articles prescribed by a physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality or for any charge not medically necessary.

e. Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual providing the services or articles.

f. Any expense incurred prior to the effective date of coverage by the pool for the person on whose behalf the expense is incurred.

g. Dental care except as provided in subsection (3)(l) of this section.

h. Eyeglasses and hearing aids.

i. Illness or injury due to acts of war.

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j. Services of blood donors and any fee for failure to replace the first 3 pints of blood provided to an eligible person each policy year.

k. Personal supplies or services provided by a hospital or nursing home, or any other nonmedical or nonprescribed supply or service.

4. Premiums, Deductibles, and Coinsurance.

a. Premiums charged for coverages issued by the pool may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage.

b. Separate schedules of premium rates based on age, sex, and geographical location may apply for individual risks.

c. The pool shall determine the standard risk rate by calculating the average individual standard rate charged by the five largest insurers offering coverages in the state comparable to the pool coverage. In the event five insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Initial rates for pool coverage shall not be less than 150% of rates established as applicable for individual standard risks. Subsequent rates shall be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein. In no event shall pool rates exceed 200% of rates applicable to individual standard risks. All rates and rate schedules shall be submitted to the Commissioner for approval.

d. The pool coverage defined in Section 6 shall provide optional deductibles of $1,500 or $3,500 per annum per individual, and coinsurance of 20%, such coinsurance and deductibles in the aggregate not to exceed $5,000 per individual nor $7,500 per family per annum. The deductibles and coinsurance factors may be adjusted annually according to the Medical Component of the Consumer Price Index.

5. Pre-Existing Conditions.

Pool coverage shall exclude charges or expenses incurred during the first twelve months following the effective date of coverage as to any condition, which during the six month period immediately preceding the effective date of coverage, (i) had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment or (ii) for which medical advice, care or treatment was recommended or received. Such pre-existing condition exclusions shall be waived to the extent to which similar exclusions, if any, have been

satisfied under any prior health insurance coverage which was involuntarily terminated; provided, that application for pool coverage is made not later than thirty-one (31) days following such involuntary termination and, in such case, coverage in the pool shall be effective from the date on which such prior coverage was terminated.

6. Nonduplication of Benefits.

Benefits otherwise payable under pool coverage shall be reduced by amounts paid or payable through any other health insurance, or insurance arrangement, and by all hospital and medical expense benefits paid or payable under any worker's compensation coverage, automobile medical payment and by any hospital or medical benefits paid or payable under or provided pursuant to any state or Federal law or program except Medicaid.

Section 7. Complaint and Grievance Procedure.

1. Purpose. The Pool recognizes that from time to time participants may encounter situations where the performance of the Pool does not meet their expectations. When this occurs, the participant may wish to call the matter to the attention of the Board of Directors of the Pool. It is the policy of the Pool to promptly and fairly consider all complaints and grievances of its participates. The procedure outlined in this Section is established to define and assure this policy.

2. Definitions. For the proposes of this Complaint and Grievance Section, the following terms and their definitions apply:

a. Complaint means a relatively minor verbal or written expression of concern about a condition in the Pool's operation which may be resolved on an informal basis.

b. Grievance means a more serious written expression of concern about the Pool's operation or a complaint which has not been resolved to the participant's satisfaction. Both situations require a formal response by the Pool, including a thorough investigation and appropriate answer to the participant.

c. Participant means applicants for insurance, insureds, agents and insurers.

3. Procedure for Filing a Complaint or Grievance.

a. A complaint may be directed to the Pool by the Participant by telephone, in person, or in writing expressing the details of the participant's concern. Complaints will be handled by the Pool complaint/grievance coordinator who may involve other staff members of the Pool or providers of care in making the determination. The objective is to handle the complaint as quickly and as courteously as possible. If the participant does not receive prompt resolution, or wishes to express his

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concern to a higher level of authority, he may file a written grievance with the Pool.

b. A grievance is to be submitted to the Pool by completing the Grievance Form available from the Pool's office. This form should be filed within 90 days after the incident occurred. The participant must sign the form acknowledging that all incidents are accurately described.

Upon receipt of the Grievance Form, the Pool will conduct a thorough review of the situation. A response to the participant's grievance will be prepared and the participate will be notified of the Pool's decision in writing. If the solution is satisfactory, the matter ends.

If the solution is not satisfactory to the participant, he may within 30 days submit a written request for review by the Grievance Committee of the Board of Directors of the Pool. The request for review must state the participant's reason for appeal, including his reason for dissatisfaction with the first grievance response. The Committee will be convened within 30 days after receipt of the appeal. The participant who submitted the appeal will be invited to appear before the Committee to explain his position. The Committee will review all previous findings of the Pool. The participant will be notified of the Committee's decision within 15 days after the date of the Committee review.

c. If any party involved is not satisfied with the decision of the Board of the Pool or its committee, he may pursue normal remedies of law including a right of appeal to the Commissioner of Insurance. Prior to the institution of any legal proceeding or suit against the Pool the foregoing "Complaint" and "Grievance" procedure shall be utilized by any party alleging a claim against the Pool. In all events, such suit or proceeding must be commenced not later than five (5) years after the date the notice of final determination under the grievance procedure is transmitted to such party.

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RE: PROPOSAL NO. 23 - CATASTROPHIC
HEALTH INSURANCE

Proposal No. 23 directed the Special Committee on Health Care Costs to determine whether the Legislature should enact a program of major medical insurance coverage for residents of Kansas.

Background

The 1979 Legislature was presented with at least three bills which concerned catastrophic health insurance, S.B. 277, H.B. 2529 and H.B. 2270. The latter measures are identical and would, if enacted, create a pooling mechanism or association comprised of all carriers and health maintenance organizations (HMOs) providing health insurance or health care services in Kansas. The association would make available to any person who could not obtain insurance in the private market and who could afford the premiums, catastrophic health insurance coverage for medical expenditures in excess of $5,000 per individual or $7,500 per family.

While it, too, related to catastrophic health insurance, S.B. 277 would apply to persons whose medical expenses were of such magnitude so as to constitute a financial catastrophe for themselves or for those responsible for their medical expenses. Generally, those eligible under S.B. 277 would be persons whose income was just above the eligibility level for state or federal assistance programs, but insufficient to afford the purchase of health insurance.

The issues presented in these bills are not new to the Kansas Legislature. For example, the provisions of H.B. 2270 are quite similar to those contained in catastrophic health insurance proposals presented by the Commissioner of Insurance since 1975. Nor are these issues unique to the Kansas situation. The National Association of Insurance Commissioners (NAIC), as early as June, 1976, adopted model comprehensive health insurance legislation, including health care cost containment provisions.

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Because catastrophic illness and the financial impact of such illness are not solely Kansas phenomena, catastrophic coverage has been included in some national health insurance plans. Two national health insurance plans to include catastrophic coverage are the Carter Administration's proposal and the health insurance industry's plan. The catastrophic portion of the President's plan would, among other things, mandate that all employers provide full-time employees and their families both a standard benefits package and catastrophic protection. Employers would be required to pay at least 75 percent of the premiums and offer a benefits program available after $2,500 had been spent out-of-pocket. On the other hand, the health insurance industry plan proposes a partnership between the private health sector and the federal government -- private health insurers would administer and be financially responsible for providing catastrophic protection to cover all Americans who can afford to pay, while the government would continue to administer and be financially responsible for the Medicare and Medicaid programs.

Committee Activity

Prior to inviting conferees for a hearing on the Proposal, staff was informed that the Commissioner of Insurance intended to withdraw support for his bill on catastrophic insurance. Due to this withdrawal of support, only the Commissioner was invited to testify. Testimony was then received stating that this withdrawal of support is due to the continued apparent lack of support for the bill among legislators and representatives of the insurance industry. Nonetheless, the Commissioner believes that some program of catastrophic insurance may be needed.

Committee Recommendation

The Committee recommends that no bill on catastrophic insurance be passed at this time. This recommendation is based on several factors: state action in this area may be premature and unnecessary because

catastrophic coverage has been included in several national health insurance proposals; no reliable estimates as to the need for such a program in Kansas have been made; and proposals for catastrophic coverage could increase health care costs either by encouraging use of only the most expensive types of health care or by raising insurance premiums for all insureds if a pooling mechanism is mandated.

Respectfully submitted,

November 2, 1979

Rep. Rex Hoy,
Chairperson
Special Committee on Health
Care Costs

Sen. Bill Morris,
Vice-Chairperson
Sen. Ron Hein
Sen. Mike Johnston
Sen. Frank Smith
Rep. Roy Ehrlich

Rep. Roy Garrett
Rep. Belva Ott
Rep. John Reimer
Rep. Kent Roth
Rep. Larry Turnquist

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RE: PROPOSAL NO. 11 -- FUNDING AN ACCIDENT AND HEALTH ASSIGNED RISK POOL

Proposal No. 11 directed the Special Committee on Commercial and Financial Institutions to study the implications of implementing the plan proposed by the Insurance Commissioner for the apportionment among accident and sickness insurers of applicants who are unable to procure insurance through ordinary methods and to review alternative funding mechanisms for such a plan.

Background

Consideration of issues relating to the creation of an accident and health insurance risk pool is not a new topic for the Kansas Legislature and its committees. In 1975 the Insurance Commissioner recommended a variety of health insurance proposals to the Legislature, including the creation of a joint underwriting mechanism to make health insurance available to persons unable to secure coverage by ordinary means. The 1975 proposals, which were considered by the Commissioner to be cost containment proposals, were neither drafted into bill form nor introduced. In 1979, the Commissioner proposed the creation of a catastrophic health insurance pooling mechanism or association composed of all carriers and health maintenance organizations providing health insurance or health care services in Kansas. The 1979 proposal was introduced as H.B. 2270 and was studied by the Special Committee on Health Care Costs as a part of 1979 Proposal No. 23 -- Catastrophic Health Insurance. The 1979 interim committee recommended that the 1979 bill not be enacted and noted in its report that the cost of required participation in such a pooling mechanism would be passed on to all insureds in the form of higher premiums.

In 1980, Governor Carlin proposed several bills based on model legislation prepared by the National Association of Insurance Commissioners, including a joint insurance underwriting mechanism that would have been implemented by 1980 S.B. 689. The bill died at the end of the 1980 Session. The issue of creating a pooled risk mechanism was again studied by the Special Committee on Commercial and Financial Institutions as a part of 1980 Proposal No. 3 -- Comprehensive Health Care Benefits. The 1980 study concluded that, although individual Kansans could not in some cases secure health insurance because of preexisting conditions or the cost, a pool would not ensure an improvement in the availability of insurance for these individuals since preexisting conditions would continue to be excluded for a period of time and the

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cost would be even higher than comparable insurance secured in the market. In 1985, the Commissioner of Insurance again recommended a bill that would have authorized the Commissioner to establish a health insurance pooling mechanism, H.B. 2167.

Another interim study conducted as 1985 Proposal No. 14 -- Health Insurance for Uninsurables -- originated out of interest generated by bills introduced in 1985. The 1985 study noted that an individual can be considered uninsurable by virtue of having inadequate resources available to pay for health insurance or by virtue of having a chronic illness or condition needing frequent medical care, which leads to difficulty in obtaining insurance or to the exclusion of a preexisting condition or the rating of the applicant for health insurance purposes. The former are often referred to as the medically indigent and a number of states have addressed this group in the context of indigent care programs. A subset of the latter have been addressed by some states through the creation of risk pools. The 1985 interim study recommended that a substitute for S.B. 121 and S.C.R. 1621 be enacted by the 1986 Legislature. 1986 Substitute for S.B. 121, which amended K.S.A. 40-2111, required the Commissioner of Insurance to accumulate data concerning declinations, terminations, and offers to provide accident and sickness insurance at higher than standard rates and to report such information to the Governor and the Legislature no later than commencement of the 1988 Legislature.

The Commissioner submitted a report entitled, Accident and Health Risk Pool Report, in January of 1988 as required by 1986 Substitute for S.B. 121. Data compiled in the report were collected from carriers authorized to transact accident and health insurance business in Kansas for the period July 1, 1986, to June 30, 1987, and from Blue Cross and Blue Shield of Kansas. Companies reported processing 79,230 applications for insurance, of which 5.14 percent were declined and 16.74 percent were issued with health restrictions, i.e., riders or higher rates after an underwriting review. The report noted that the data simply reported how many applications were denied during the time period of the study but did not report how many of the applicants denied by one company were accepted by another or later secured group coverage. Nor from the raw data submitted by carriers was it possible to determine how many of the applicants who were denied would have been able to afford to participate in a risk pool which, by definition, is more expensive than the same coverage secured in the market. Additionally, the data did not include persons who did not apply for insurance during the period because they knew they were not an insurable risk or that a preexisting condition would subject them to restrictions on any policy issued.

In the 1988 report, the Insurance Commissioner noted two options for providing coverage to those who are uninsured against catastrophic medical expense. One option is the creation of a pooled risk mechanism administered either through a risk assignment mechanism or through a single plan administered by a selected insurer or administrator to provide insurance coverage to those persons who can afford the cost of the insurance. The second option submitted involves the financing of catastrophic medical expenses directly by state appropriations administered by a state agency. Under the latter option, residents would become eligible for assistance if their medical bills exceed a specified portion of their income. Both options, according to the report, are designed to protect people who are in poor health and who need insurance protection. States have experimented with both options. The Insurance Department recommended the first option, noting that although a pooled risk program would provide the availability of coverage, it is important to recognize that affordability would not be assured, and that the uninsured in Kansas include the unemployed, self-employed, part-time and temporary workers, and those who cannot afford the employee health plans offered by their employers despite an employer contribution. Thus, the creation of a risk pooling mechanism would provide insurance to only a small subset of those without health insurance even if some subsidization by participating carriers or the state through a premium tax credit were included in the plan.

Two bills were introduced in 1988 -- S.B. 674, which was the plan proposed by the Insurance Department patterned on the model law prepared by the National Association of Insurance Commissioners, and S.B. 670, which would have amended K.S.A. 40-2111 to allow any insurer required to participate in an assigned risk plan to offset the amount assessed pursuant to such plan against its premium tax liability. Neither bill was enacted. Rather, a Senate Resolution requesting the Legislative Coordinating Council to assign an interim study was adopted.

The Special Committee on Commercial and Financial Institutions initiated study on Proposal No. 11 by reviewing the previous interim studies on the issue of creating an accident and health risk pool and the conclusions and recommendations reached by previous committees that had considered this subject. The Committee found that one additional avenue of study was available to the members in 1988, i.e., the experience of about half the 15 states that have enacted legislation authorizing the creation of a pooled risk mechanism. Additionally, a great deal of information is available about the uninsured and underinsured who are not covered by governmental or other third-party

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reimbursement and who may be at risk for access to basic health care, i.e., the population referred to as the medically indigent. The characteristics of the latter population give some guidance in determining the potential role of a pooled risk mechanism in serving the needs of those who have difficulty in accessing health care because of the cost of such care.

Experience in Other States

Comprehensive Health Care Associations. One of the strategies states have adopted to combat the problem of access to health care for those persons who are not covered by public or private third-party payors is the establishment of comprehensive health associations, usually referred to as risk pools. The first legislation enacted was that of Minnesota in 1975. Six legislatures had acted by 1984 to create accident and health pooling mechanisms, another two acted in 1985, two acted in 1986, and five acted in 1987. Even though many states without legislation requiring the creation of a risk pool considered legislation in 1988, none had enacted legislation by the time of the Committee study. Although the issue has been before the legislatures of the surrounding states frequently in recent years, only the neighboring state of Nebraska has acted affirmatively on such legislation.

The first legislation implemented was that of Connecticut and Minnesota, with both plans implemented in 1976. The next plan to be implemented was that of Wisconsin in 1981, and the Indiana and North Dakota plans were implemented the following year. In 1983, the Florida Comprehensive Health Association was implemented. Following a hiatus of several years, the Nebraska plan was implemented in 1986 and the Iowa, Montana, Tennessee, and Washington plans in 1987. The Illinois, Maine, New Mexico, and Oregon plans were all scheduled for implementation in 1988. For all practical purposes, only six of the 15 states that have created comprehensive health associations pursuant to legislative enactment have been in operation long enough to provide any data about cost and insureds and the extent to which the plans have accomplished the legislative intent in mandating their creation. All 15 states that have acted to create associations, unlike several of the Kansas proposals, have detailed the administration and the parameters governing the operation of the associations by statute rather than by authorizing a state official to create a plan and to implement it.

Organization and Administration. While the operation of risk pools varies from state to state, there are some basic patterns that can be

identified. The legislation requires the formation of an association of all health insurance carriers doing business in the state, and one organization is selected to administer the plan under the guidelines relating, among other things, to benefits, premiums, and deductibles set out in the state law. In all existing associations, Blue Cross and Blue Shield plans are also included in the association, and, in 12 of the 15 associations, health maintenance organizations are also required to be members. Although legislation mandating the creation of an association in six of the states includes self-insured organizations among those mandated to participate in the association, U.S. district courts have held that under the provisions of the Employee Retirement Income Security Act (ERISA), employers with self-insurance plans are exempt from state insurance regulation and cannot be required to participate in a plan. The association manages the pool program through its governing body which is constituted pursuant to state law. The association then contracts with an insurance company or another entity to carry out the day-to-day administration of the plan, i.e., issue policies, collect premiums, process claims, and maintain records.

Eligibility. All but two of the risk pools have general eligibility requirements for coverage in the risk pool. Three require the refusal of coverage by two insurers, and the other ten require refusal by one insurer. Some allow applications from persons who are offered only limited coverage by other insurers, and some allow applications from persons who have been offered coverage at high premiums by other insurers. Seven of the pools accept applications from individuals suffering from specified diseases. In some instances the eligibility provisions are set out in state law.

Coverage. Usually, the coverage provided through the association includes a fairly comprehensive package of benefits described as a minimum benefit package. Generally, a range of deductibles and coinsurance is offered by the plan, with resulting differences in premiums. The deductibles set by the pools are generally higher than deductibles under medium size and large group plans offered by employers. Deductibles ranged from a low of $150 to a high of $1,000 in Florida and Wisconsin under a low deductible plan and from a low of $1,000 in 11 plans to a high of $2,000 in two plans under the high deductible plans offered at the time of the Committee study by 14 of the associations. Risk pool coinsurance requirements were more comparable with the group plans offered by large and medium sized employer-sponsored plans, i.e., 13 of the pools required an insured to pay 20 percent of covered medical expenses after meeting the deductible requirements, and Nebraska required a 10 percent coinsurance payment.

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State laws may set a maximum out-of-pocket loss which may be experienced by an insured. In 1987 the limits on cost sharing ranged from a low of $1,000 for an individual in one plan to a high of $5,000 for an individual insured in another. Cost sharing was also limited for a covered family. All but two of the 15 risk pools also had a maximum lifetime benefit ranging from a low of $250,000 for four of the pools to a high of $1,000,000 for two of the pools.

All the risk pools in operation or about to become operational in 1988 issue policies that exclude preexisting medical conditions from coverage for a period of time. Preexisting conditions are those that were diagnosed or treated during a specified period of time before the effective date of the policy. Costs of treating preexisting conditions are not covered for a specified period after the effective date of the policy. Traditionally, insurers use waiting periods for preexisting conditions to prevent persons in poor health from purchasing insurance only when they plan to seek treatment. The risk pools that were in operation set the period for determining a preexisting condition from a low of 60 days to a high of six months. The lowest exclusion of a preexisting condition and the most common was six months. The highest was 12 months. Several of the pools allowed a waiver of the preexisting condition exclusion if insurance had been in force prior to enrollment in the risk pool, and several allowed a waiver if the applicant paid a premium surcharge. In one instance a waiver could be granted if insurance had been in force and if a premium surcharge were paid. Most of the plans excluded applicants who were eligible for Medicaid from coverage and some excluded applicants who were eligible for Medicare.

Premiums. The legislation mandating the creation of a risk pool usually sets out the basis for setting the insurance premiums that may be charged by the comprehensive insurance association. Premiums are usually established on the basis of rates charged for private health insurance in the state and vary by age and, in some cases by sex and geographic area. Although the rates are generally set by the legislation on the basis of premiums that are believed to be adequate to cover anticipated claims, experience has shown that the legislatively set "caps" are inadequate to cover the losses experienced by the comprehensive associations. State laws usually limit premium rates to a multiple of the rates charged by private insurers. Legislation in 12 of the 15 states provides for premiums based on multiples that range between 125 and 150 percent. Three states provide for higher multiples, including the Montana legislation which provides for a 400 percent limit. Of the six states surveyed by the General Accounting Office, the annual premium rates for a 55-year old female with a $1,000 deductible policy with 20

percent coinsurance provisions ranged from a low of $999 to a high of $3,153 in 1987. The state pool having the low premium was in Minnesota where the legislation limits premiums to 125 percent of the rates charged for private health insurance in the state; and the high premium was in Florida where premiums are limited to 200 percent of the rates charged for private health insurance.

Funding. Authorizing legislation usually prescribes how program operating deficits are to be financed. In 12 of the 15 states, deficits are shared by association members through assessments on the members. It is usual to distribute assessments in proportion to each member's share of total premium income in the state, i.e., the revenue an insurer earns from the sale of insurance. Under the Connecticut law, assessments are apportioned according to the share of total claims paid by individual members of the association, and in Washington assessments are based on the total share of health insurance subscribers of each member of the association. Maine plans to finance deficits through a tax on hospital revenues, and Illinois will subsidize its risk pool through state general revenues. The Tennessee law provides for up to $2 million a year from general revenues to cover deficits with any remaining deficits to be made up from assessments against association members. Oregon assessed association members for start-up costs, but the legislation does not address how operating deficits are to be financed. In all but three of the states that allow an assessment against participants in the pool, the members are allowed to offset any deficits assessed as a credit against premiums tax or other taxes. In eight of the states the tax credit equals 100 percent of the assessment. The New Mexico law will allow a partial offset against taxes after a specified loss through assessment has been met, and beginning January 1, 1988, Wisconsin will allow tax relief in a specified amount from general revenues for pool members. Only Connecticut and Minnesota do not provide for some form of subsidy for the losses experienced by the pool members, although Minnesota law provided for a tax credit until it was repealed in 1987. In the latter two states, losses may be taken into account when carriers apply for rate increases allowing losses to be passed on to other persons in the state who purchase health insurance.

Experience. According to a General Accounting Office study of the six plans that had been in operation long enough to have an experience history, all have consistently operated at a loss. According to estimates prepared by the Health Care Financing Administration, private insurers paid about $.87 in claims for each dollar of premium income collected in 1986. During the same period, the six pools paid an average of $1.60 on claims for each dollar of premium income collected. The six pools

had an aggregate net operating loss of about $18.1 million in 1986, with Minnesota experiencing the largest loss at $9,024,288.

Enrollment in risk pools has increased since 1983, the first year the six pools with experience were offering policies, from 13,842 to 20,545 at the end of 1986. However, about half the insured at the end of 1986 were in Minnesota. The number of insured over the period would be greater than the 1986 total because of turnover in enrollees. Wisconsin, the only state with data on why former enrollees had cancelled their policies, found that about one-fourth of those who responded to a survey indicated they had cancelled because they could not afford the premiums. Other cancellations were due to enrollees becoming eligible for group coverage, moving, or becoming eligible for Medicare. A large majority of the policies issued by the pools represented individual rather than family coverage.

Conferees

Conferees who met with the Special Committee included representatives of the Kansas Division of the American Cancer Association; the American Diabetes Association-Kansas Affiliate,Inc.; Kaiser Permanente, Blue Cross-Blue Shield; the Health Insurance Association of America; a Kansas commercial carrier who also represented the Kansas Life Association and the National Life and Health Insurance Association; and an insurance salesman and two registered nurses. Additionally, the Committee received written testimony from the Topeka Cystic Fibrosis Action/Support Group, the Sunflower Branch of the Cystic Fibrosis Foundation, United Cerebral Palsy of Kansas, and the Sedgwick County Medical Society. Testimony centered on (1) the difficulty of survivors of childhood cancer in securing life and health insurance as opposed to a control group of siblings, i.e., 24 of 100 patients reported difficulty in obtaining health insurance while none of the control group experienced difficulty, and 15 patients did not have health insurance as opposed to seven persons in the control group; (2) the difficulty persons with diabetes mellitus experience in securing health insurance without exclusion of the preexisting condition and the lack of coverage for diabetic supplies, equipment, and education in standard health insurance coverage even though a publication presented to the Committee by a conferee indicates that an estimated 92 percent of all persons with diabetes have at least some health insurance; (3) the difficulty persons with cystic fibrosis have in securing insurance; (4) the difficulty persons with cerebral palsy have in obtaining insurance without a preexisting condition clause that will be in effect for a period of time and the fact

that insurance frequently does not cover certain therapies; (5) proposals to decrease the "cap" on premiums and the copayments and deductibles as well as the period of time that preexisting conditions could be excluded from a risk pool as set out in the legislation proposed in 1988; (6) the need to expand the funding base for any risk pool to include employers who do not offer group health insurance coverage to employees as well as to those who self-insure; and (7) questions about the extent to which a risk pool would, in fact, increase access to health care for Kansans who are a part of the estimated 37,000,000 persons in the United States who do not have health insurance or other third-party coverage. While no conferee expressed complete opposition to the creation of an accident and health insurance pooling mechanism, questions were raised about the purpose of such a mechanism, the funding, and the need for a pool in Kansas.

Actuarial Study

The Kansas Insurance Department retained Tillinghast, Nelson and Warren to perform an actuarial review to determine the fiscal impact of a proposed accident and health risk pool in Kansas. The report entitled "Report on Accident and Health Risk Pool Study - State of Kansas" was made available to the Special Committee in August. The study contains two major actuarial items -- a determination of premium rates and financial projections -- based on data provided by the Insurance Department and various insurance carriers. The study was constructed on the basis of the Insurance Commissioner's proposed legislation, i.e., initial rates of not less than 150 percent of the five largest carriers offering comparable coverage in Kansas and benefits as set out in the proposed legislation. The report presents five different financial projections, with one identified as the baseline or best estimate projection, and all using the assumption that rates would begin at 150 percent of the projected industry rates initially and rise to 200 percent over the life of the projection. The baseline projections of Tillinghast indicate a first-year enrollment of 582 and a tenth-year enrollment of 2,950 individuals. The projected accrued loss in the first year is $325,000 or $558 per enrollee and $.13 per Kansas resident. In the tenth year, the accrued loss is projected at $4,865,000 or $1,649 per enrollee and $1.69 per Kansas resident. None of the projections make any explicit provision for increased adverse claims experienced due to AIDS. The projected initial premium rates, which vary by attained age, sex, and geographical location of the applicant as well as by the amount of the deductible at $1,500 or $3,500, would range from a high of $3,552 for a male at an attained age of 60-64 with a $1,500 deductible to a low

of $446 for a child under family coverage. Rates assume a "cap" of 150 percent of the standard rate for the first two years, an increase to 175 percent in years three through five, and 200 percent after the fifth year. The actuarial study also included the following suggestions: consideration of setting the initial premiums higher than 150 percent of standard; adding eligibility requirements such as having been declined at least once for health insurance; adding authority for an initial assessment to provide for working capital; consideration of the inclusion of routine maternity benefits as appropriate for coverage under a risk plan; and whether Medicare eligible persons should be included.

The actuarial study did not include consideration of the expansions in coverage and the reductions in out-of-pocket costs to insureds covered by policies issued by a risk pool that were recommended to the Special Committee by conferees. It would appear that any such expansions would result in increased premiums and increased revenue losses through state subsidy of the pool.

Conclusions

During the Committee study, the members were reminded by conferees of the creation of the Commission on Access to Services for the Medically Indigent and Homeless pursuant to legislation enacted in 1987. It was noted that the Commission is charged with making recommendations to the Governor and the Legislature on ways to provide access to health care for those Kansans who are uninsured, underinsured, not eligible for governmental programs, and not able to pay all or part of the costs of necessary health care. A subset of the group that is the subject of Commission study is comprised of those persons who find it difficult to secure insurance at a price they can afford or who face high out-of-pocket costs because of incomplete coverage or the exclusion of preexisting conditions. In light of the potential cost to the state of a health and accident risk pooling mechanism as proposed by the Insurance Commissioner (over $4 million in the tenth year of a plan) and the relatively small number of persons projected to be assisted (about 3,000 individuals), the Special Committee concluded that a potential drain on state revenues of this magnitude should not be recommended at this time. In reaching this conclusion, the members were mindful of two things -- the demonstrated difficulty faced by persons suffering from certain conditions and diseases in securing adequate health insurance coverage in the market and the probability that consideration will be given to recommendations that would improve the access of a greater number of persons to basic health care at a yet

unknown cost to the state in the near future. While the members are sympathetic with the problems faced by conferees, they are also mindful that a health and accident risk pool would assist only a small number of Kansans in improving their access to health care and that conferees indicated that changes in the proposal presented by the Insurance Commissioner are desirable that would undoubtedly increase state revenue losses if a risk pool is to meet their needs. Thus, the members believe that a pool should be considered only in conjunction with other proposals to meet the needs of Kansans whose access to health care is restricted. The preface to the Model Health Insurance Pooling Mechanism Act developed by the National Association of Insurance Commissioners contains the following statement, "Each state is urged to determine, through independent study, whether a pooling mechanism is needed and whether enactment of the model would be cost effective." Some members of the Committee concluded the criteria of cost effectiveness may not be met by proposals that have been studied by the Legislature.

Recommendations

The Special Committee on Commercial and Financial Institutions recommends that no legislation be enacted that would direct or authorize the creation of a health and accident insurance pooling mechanism in Kansas at this time. If legislation of this type is to be considered in the future, it should be considered only within the context of the broader goal of improving the access to health care for persons who would not benefit from a risk pooling mechanism.

Respectfully submitted,

November 11, 1988

Rep. Dale Sprague, Chairman
Special Committee on Commercial and Financial Institutions

Sen. Neil Arasmith, Vice-Chairman
Sen. Eugene Anderson
Sen. Roy Ehrlich
Sen. Phil Martin
Sen. John Strick*
Sen. Merrill Werts

Rep. Kenneth Francisco
Rep. Clyde Graeber
Rep. Richard Harper
Rep. J. C. Long
Rep. Kerry Patrick
Rep. L. V. Roper
Rep. Don Sallee
Rep. Tim Shallenburger
Rep. Larry Turnquist
Rep. Bill Wisdom

* Ranking Minority Member

KAN[illegible]SPITAL ASSOCIATION

Memorandum

Donald A. Wilson
President

February 27, 1991

TO: House Insurance Committee

FROM: Kansas Hospital Association

RE: **HCR 5011**

The Kansas Hospital Association supports House Concurrent Resolution 5011 establishing a Kansas Health Insurance Pooling Mechanism. Financing care for the medically indigent and the medically underinsured has become one of the toughest problems in health care, threatening the financial viability of hospitals in Kansas and throughout the nation.

Hospitals have taken on a large share of the financial burden medically indigent and medically underinsured patients pose. With the health care marketplace turning more and more competitive, third-party payers and paying patients are becoming more and more concerned about cost shifting. In addition, the payments hospitals receive from federal and state governments are less able to take care of the problem. The emphasis on deficit reduction on the federal level and budget constraints on the state level have forced governments to be very cost conscious with medical programs.

Most importantly, our current system is denying some individuals coverage for medical care that is necessary. We are supportive of HCR 5011 because it would help to bring some relief to that situation.

Thank you for your consideration of our comments.

/cdc

House Insurance
Feb. 27, 1991
Attachment 2

1263 Topeka Avenue • P.O. Box 2308 • Topeka, Kansas 66601 • (913) 233-7436 • FAX (913) 233-6955

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

February 27, 1991

TO: House Insurance Committee

FROM: Kansas Medical Society Chip A. Wheelen

SUBJECT: HCR 5011; Health Risk Pooling

Thank you for this opportunity to express the general support of the Kansas Medical Society for the concept of health risk pooling. Our membership agrees that the State should take the initiative to assure adequate and affordable health insurance coverage for those Kansans who otherwise cannot purchase such coverage in the commercial insurance market. We do, however, hesitate to recommend that the Insurance Commissioner should be immediately directed to implement the pooling mechanism described in the Insurance Department report that was submitted to the 1988 Legislature. The only reason for our reluctance at this time, is because we have recently urged the Senate Public Health and Welfare Committee to request a comprehensive study of the delivery and financing of health care by the Joint Committee on Health Care Decisions for the 1990s. This recommendation was made in the context of our testimony on a number of bills being considered by the Senate Public Health and Welfare Committee. The recommendations that result from that study could very likely include implementation of a health risk pool identical or similar to the plan proposed by the Insurance Department in 1988.

Thank you for considering our comments on this subject.

CW:ns

House Insurance
Feb. 27, 1991
Attachment 3

MEMORANDUM

TO: Representative Larry Turnquist
Chairman, House Insurance Committee

FROM: William W. Sneed
Legislative Counsel
Health Insurance Association of America

DATE: February 27, 1991

RE: House Concurrent Resolution 5011

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.C.R. 5011.

We have previously testified in regard to House Bill 2001, and are aware of other health insurance related bills, either in this Committee or in the Senate Insurance Committee. Because of our involvement, we are aware of the Legislature's concern relative to access to health insurance for those people who desire health insurance but are unable to procure such insurance.

H.C.R. 5011 would direct the Commissioner of Insurance to implement a health risk pool that was incorporated in the 1988 report by the Insurance Department to the Kansas Legislature under the title of "Accident and Health Risk Pool Report."

House Insurance
Feb. 27, 1991
Attachment 4

State risk pools are designed to guarantee the availability of private health insurance to all Americans under age 65 who want to purchase protection, who are willing to pay for it, but who are not considered medically insurable. The commercial health insurance industry has actively supported such initiatives since the late 1960's. However, the Association's chief concern about state pools is that they be equitably funded.

As you are aware, the Insurance Department requested the introduction of this House Concurrent Resolution along with the alternative introduction of a specific bill detailing an assigned risk pool for health insurance. Because of my client's concerns on several aspects, we believe it would be more appropriate that the Legislature not pass the Concurrent Resolution, but debate the assigned risk proposal submitted by the Department. Although there may be certain parts of that bill that my client may object to, we believe it would be more prudent to debate the issue through looking at the bill itself and reviewing it in total.

As stated earlier, it is our belief that such pools be equitably funded. Funding mechanisms can vary, and do from state to state. Thus, this, along with other points, should be brought before the Legislature and actively debated when attempting to decide whether the State of Kansas should establish an assigned risk plan for health insurance.

I have a great deal more information on these types of pools, but I believe it would be more expedient to provide that information when the Committee debates the specific plan itself. Thus, we respectfully request that the Committee not act upon H.C.R. 5011, but if there is a desire to look into some type of assigned risk plan, to do so utilizing the Insurance Department's proposal as the potential vehicle for such a discussion.

Again, as we have stated, we stand willing to assist the Committee in attempting to review these possibilities, and if there are any additional questions, we will be happy to attempt to answer them.

Respectfully submitted,

William W. Sneed
Legislative Counsel
Health Insurance Association of America