Approved March 4, 1991
Date

MINUTES OF THE HOUSE COMMITTEE ON INSURANCE.

The meeting was called to order by Representative Turnquist at
Chairperson

3:30 ~~a.m.~~/p.m. on Thursday, February 28, 1991 in room 531 N of the Capitol.

All members were present except:

Committee staff present:

Emalene Correll, Research
Chris Courtwright, Research
Bill Edds, Revisor
Nikki Feuerborn, Secretary

Conferees appearing before the committee:

Dick Brock, Insurance Commissioner's Office
Nancy Zogleman, Blue Cross/Blue Shield
Chip Wheelen, Kansas Medical Society
Lisa Getz, 4 Wichita hospitals
Harold Riehm, Kansas Association of Osteopathic Medicine
Larry Magill, Independent Insurance Agents

Others attending: See Attached List

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

The hearing on HB 2216 was begun with Representative Larry Turnquist testifying as a proponent on this bill which would authorize the development and use of a single universal form(s) for the filing of claims for accident and health insurance benefits. See Attachment 1. The Insurance Commissioner would be responsible for the development and implementation of this form. Improved efficiency, cost reduction in processing, shortening of process time, and the possible development of a multiple use data base would be some of the advantages of having such a universal form. The form would be adaptable for electronic filing. Insurance companies, health maintenance organizations, trade associations, and other interested parties would be involved in the development of such an instrument. This form could be required for usage by companies out of state also.

Dick Brock of the Insurance Commissioner's Office also spoke as a proponent of HB 2216. See Attachment 2. Mr. Brock indicated willingness for the Commissioner's Office to accept this responsibility and thought the system could be implemented within six months of development. There are two forms in existence which are widely accepted by insurers. They are HCFA 1500 for physician's services and UB 82 for hospital services. An amendment to apply its operative requirements to nonprofit optometric, nonprofit dental and nonprofit pharmacy service corporations should be added.

Nancy Zogleman, representing Blue Cross/Blue Shield, testified as a proponent of HB 2216. See Attachment 3. To require the use of a form other than the UB-82 for hospitals would costs millions for all parties to convert. Medicare and Medicaid currently use the UB-82. The other form is the HCFA 1500 which is currently used by physicians for Medicare, Medicaid, CHAMPUS, and other government programs.

Chip Wheelen, representing Kansas Medical Society, testified as a proponent of HB 2216. See Attachment 4. The provisions of HB 2216 would allow for sufficient input from the health insurance industry to develop a form that is acceptable to the industry as well as health care providers. A standard form could expedite the process of analyzing information by the use of computer scanners.

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

Lisa Getz, representing four Wichita hospitals, spoke as a proponent for HB 2216. See Attachment 5. The single greatest problem with claims processing is in meeting demands for attachments from insurance companies. Attachments are often requested for physician-ordered tests and procedures including procedures that were pre-authorized. The committee was urged to find ways to streamline claims processing by targeting the methodology that allows these delays.

Harold Riehm, Executive Director of the Kansas Association of Osteopathic Medicine, spoke as a proponent for HB 2216. See Attachment 6. In his testimony Mr. Riehm said that a standardized claims form would permit a set of like data for compiling statistical analyses of various health care services, would make it easier to learn the process of completing forms, facilitate the handling of claims processing by computer, and assist the Department of Health and Environment and other state agencies in gathering selected data required by law.

Larry Magill, representing the Independent Insurance Agents of Kansas, testified in support of HB 2216. In property and casualty claims, a form called ACORD is used universally.

There were no opponents. The Hearing on HB 2216 was concluded.

Discussion continued on HB 2001 with Dick Brock of the Insurance Commissioner's Office giving a complete explanation of each balloon on the proposed legislation. See Attachment 7.

Meeting adjourned at 5:00 p.m.

GUEST LIST

COMMITTEE: House DATE: 2/28/91

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
LISA Getz	WICHITA	WICHITA Hospitals
Bill Sneed	TOPEKA	HIAA
Nancy Zogleman	Topeka	BC/BS of Ks
Pam Scott	Topeka	Wheatland Group Holdings
Bill [illegible]senberger	Topeka	BCBS of KS
Charles [illegible]	Topeka	KFMC
Chip Wheelen	Topeka	KS Med. Soc.
David Hanzlick	Topeka	Ks Dental Ass'n
HARRY SPRING	K.C., MO.	HUMANA PRIME HEALTH
Wendell STROM	Topeka	AARP-CCTF
Ken Bahr	Topeka	Ks. Hospital Assn.
HAROLD RIEHM	TOPEKA	KS Assn OSTEOPATHIC MED
Dick Brock	Topeka	Ins Dept
Dave Hanson	Topeka	KS LIFE ASSOC
JIM OLIVER	TOPEKA	PIAK
Jim Maag	"	KBA
Jim Braden	CLAY CENTER	SS&G.

Testimony on HB 2216 - Universal Accident and Health Claim Form

By Representative Larry Turnquist

I have had a belief for sometime that we should be utilizing a single, universal form, or possibly forms, for the filing of claims in relationship to accident and health insurance claims in this state. Presently companies can have their own set of claim forms which ask for approximately the same kinds of information but are arranged and worded in a different fashion. This causes a great deal of inefficiency in the preparation of these claims by office personnel and duplication of effort if more than one insurance company is involved.

As was brought out during the joint hearings on the Canadian health care system, currently our system in the United States does expend a greater amount of premiums for administrative expenses than other health care systems. One reason is the use and processing of such a multitude of forms.

Besides alleviating administrative time in the completion of forms, one universal form would help eliminate the omission of required information which is oftentimes erroneously omitted in the preparation of such forms and causes delay in processing.

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Attachment 1

Along with improving efficiency, there should also be a cost reduction in form planning and printing. Such a universal claim form would allow the state or any other interested organization to set up a health and/or medical information data base. This data base would allow for the development of statistical data which would be of benefit to various health organizations, insurance companies, and the state in the planning of health care programs.

Possible benefits from having access to such current data are limitless. The only way to have such data made available to the public and organizations is the use of a universal claim form. It would be very difficult to garner this information from the various claim forms that are now in use.

The actual planning and development of this form would become the responsibility of the Kansas Insurance Commissioner's Office. They have the expertise and the knowledge to develop such a form. Quite possibly this form could be patterned after other forms such as Medicare's form, which is already accepted by some insurance companies. Insurance companies, health maintenance organizations, trade associations, and other interested parties would be involved in the development of such an instrument.

Thank you for the opportunity to speak before the committee. I appreciate your support and would urge you to vote for the favorable passage of this bill as I am convinced it would be of benefit to both the insurance industry and the consumers.

Testimony By

Dick Brock, Kansas Insurance Department

Before the House Insurance Committee

on House Bill No. 2216

February 28, 1991

House Bill No. 2216 requires the Commissioner to devise a uniform claim form for accident and sickness insurance claims. In addition, the bill requires all accident and sickness insurers, health maintenance organizations and Blue Cross and Blue Shield plans to begin using the form not later than six months following notification to those entities effected that such form has been developed and providing them a copy with appropriate instructions.

The Insurance Department has no problem with this assignment -- it would seem to be "doable" -- and there are few, if any, situations where administrative uniformity does not result in a more efficient, cost-effective and a better understood process.

In checking with our Consumer Assistance Division, I was informed that two forms already exist which are widely accepted by insurers. I have attached a copy of these forms to my testimony and, as you will note, one of them is designed for physician services and one is for hospital services. Because these are widely accepted and because there are two different forms, my only question about House Bill No. 2216 is whether or not it should provide some latitude to the Commissioner to also make a distinction between the two types of providers i.e. institutional as opposed to physicians or other providers.

Our Consumer Assistance Division also reported that they don't encounter many complaints from consumers regarding the submission of claims for "general" medical and/or hospital services but there are some misunderstandings and problems regarding the submission of claims for

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Attachment 2

various "specialty" type services or policies. Vision care, cancer policies, drugs, disability income are some of the conditions and products in this category.

Having advised you of the experience of our Consumer Assistance Division, I also must tell you that I doubt that our Department is in a position to accurately evaluate the situation. This is because most provider offices and most, probably all, hospitals submit claims for or on behalf of their patients. Therefore, the acceptance, non-acceptance and other administrative problems caused by claim forms are handled at that level.

To confirm this, I called my wife who is a medical secretary but whose duties include the processing of insurance claims in an ophthalmologist's office. She asked me to tell you that anything that could be done to acquire some uniformity in health insurance claim forms would be very helpful from their perspective. She indicated that most companies will accept the HCFA 1500 form but many do not. She also said that in the past, there was a universal claim form that virtually all insurers she dealt with would accept but about 10 years or so ago many companies started requiring their own form. She did not know and I have been unable to discover the reason.

Finally, I note House Bill No. 2216 has been amended to apply its operative requirement to nonprofit medical and hospital service corporations. I will simply point out that the nonprofit optometric, nonprofit dental and nonprofit pharmacy service corporations acts will need a similar amendment if the requirement is to apply to them.

KANSAS BLUE SHIELD
1133 TOPEKA BLVD
239
EKA, KS
66629

HCFA-1500 – Physicians Services

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

[ ] MEDICARE (MEDICARE NO.) [ ] MEDICAID (MEDICAID NO.) [ ] CHAMPUS (SPONSOR'S SSN) [ ] CHAMPVA (VA FILE NO.) [ ] FECA BLACK LUNG (SSN) [XX] OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
2. PATIENT'S DATE OF BIRTH
3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NO.
5. PATIENT'S SEX: MALE [ ] FEMALE [XX]
6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS)
7. PATIENT'S RELATIONSHIP TO INSURED: SELF [XX] SPOUSE [ ] CHILD [ ] OTHER [ ]
8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)
[ ] INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN
9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)
10. WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT: YES [ ] NO [ ]
B. ACCIDENT: AUTO [ ] OTHER [ ]
11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
6774
TELEPHONE NO.
11.a. CHAMPUS SPONSOR'S: STATUS [ ] ACTIVE DUTY [ ] DECEASED [ ] RETIRED — BRANCH OF SERVICE
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING)
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.
SIGNED DATE
13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.
SIGNATURE ON FILE
SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF: ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION
16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES
16.a. IF EMERGENCY CHECK HERE [ ]
17. DATE PATIENT ABLE TO RETURN TO WORK
18. DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES: ADMITTED DISCHARGED
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES [ ] NO [XX] CHARGES:
23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE
1. 989.5 INSECT STING HYPERSE
2.
3.
4.
B. EPSDT YES [ ] NO [ ] — FAMILY PLANNING YES [ ] NO [ ]
PRIOR AUTHORIZATION NO.

24. A. DATE OF SERVICE FROM TO	B.* PLACE OF SERVICE	C. PROCEDURE CODE (IDENTIFY)	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G.* T.O.S.	H. LEAVE BLANK
112990	0	99080	MEDICAL REPORT	989.5	1300	01		
112990	0	95145	PROVIDE ANTIGENS,HOM	989.5	14600	01		

Page 3 of 2

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)
THOMAS M GOLBERT, MD
DATE: 11/30/90
26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES [ ] NO [ ]
27. TOTAL CHARGE 15900
28. AMOUNT PAID 000
29. BALANCE DUE 1590
30. YOUR SOCIAL SECURITY NO.
31. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.
DENVER ALLERGY
ASSOCIATES, LTD
255 UNION BLVD #120
LAKEWOOD 80228
(303) 988-49
32. YOUR PATIENT'S ACCOUNT NO. 87000097
33. YOUR EMPLOYER I.D. NO. 84-0612659

* PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK
REMARKS:
PREPARED BY CLINIC SERVICE CORP.

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

Form HCFA-1500 (1-84) Form OWCP-1500
Form CHAMPUS-501 Form RRB-1500

UB 82 Hospital Services

OSAWATOMIE STATE HOSPIT(

(ATOMIE KANSAS 66(

48421

5 BC/BS PROV NO | 6 FEDERAL TAX NO. 48-602992: | MEDICARE NO. | 8 MEDICAID NO.

10 PATIENT'S LAST NAME	FIRST NAME	INITIAL	11 PATIENT'S ADDRESS	CITY	STATE	ZIP
[redacted]			[redacted]		[redacted]	

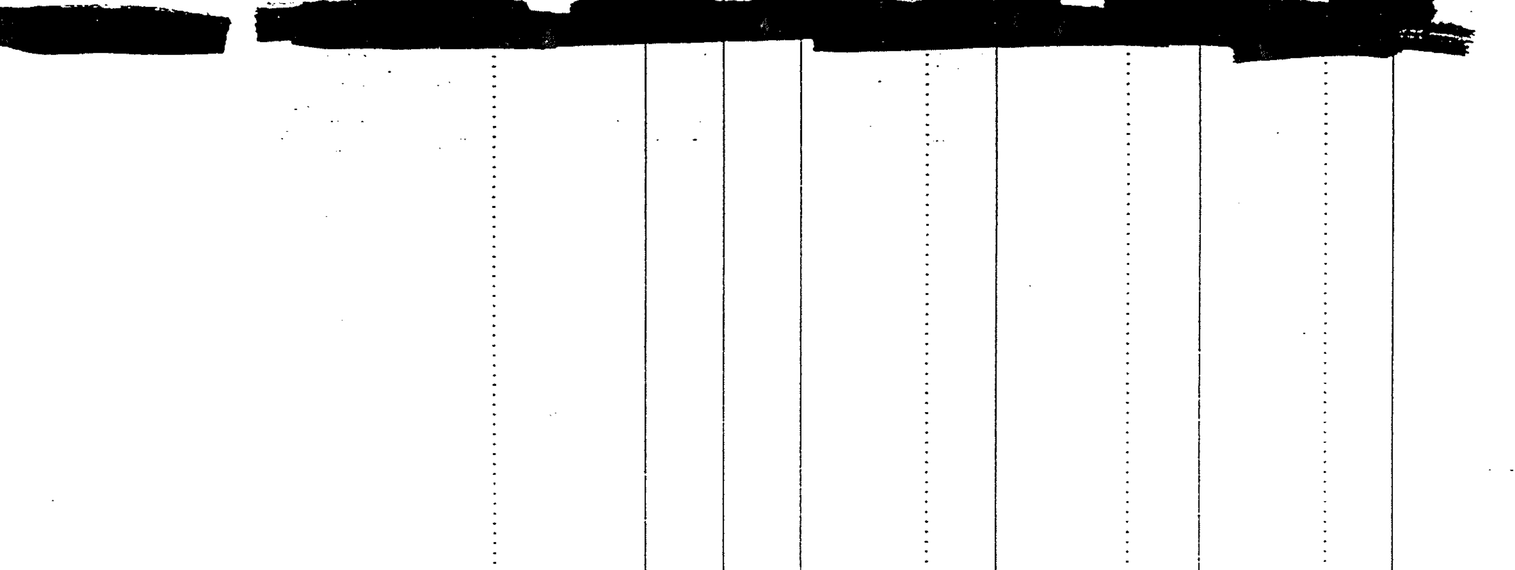
12 BIRTH DATE	13 SEX	14 MS	15 ADMISSION DATE	16 HR	17 TYPE	18 SRC	19 A.H.	20 D.H.	21 STAT	22 STATEMENT COVERS PERIOD FROM	THROUGH	23 COV D	24 N-C D.	25 C-I D.	26 L-R D	27
06-22-77	M	S	03-15-90						01	06-21-90	06-21-90					

28 OCCURRENCE CD DATE | 29 OCCURRENCE CD DATE | 30 OCCURRENCE CD DATE | 31 OCCURRENCE CD DATE | 32 OCCURRENCE CD DATE | 33 OCCURRENCE SPAN CD FROM THROUGH

34 | CONDITION CODES 35 36 37 38 39 | BLOOD RECORD (PINTS) 40 FURN 41 REPL 42 NOT RP. 43 DED. | 44 SP PROG. | 45

46 VALUE CD AMT | 47 VALUE CD AMT | 48 VALUE CD AMT | 49 VALUE CD AMT

a
b



50 DESCRIPTION	51 R. CODE	52 S UNITS	53 TOTAL CHARGES	54	55	56
PHARMACY	250		13 : 80			
TOTAL	001		13 : 80			
[redacted]						

57 PAYER	58 REL INFO	59 ASG BEN	60 DEDUCTIBLE	61 CO-INSURANCE	62 EST RESPONSIBILITY	63 PRIOR PAYMENTS	64 EST AMOUNT DUE
A [redacted]							
B							
C							

DUE FROM PATIENT

65 INSURED'S NAME	66 SEX	67 REL	68 CERT.-SSN-HIC.-ID NO.	69 GROUP NAME	70 INSURANCE GROUP NO
A [redacted]					
B					
C					

71 EIO | 72 ESC | 73 EMPLOYER NAME | 74 EMPLOYEE ID. | 75 EMPLOYER LOCATION

76 PRINCIPAL AND OTHER DIAGNOSES DESCRIPTIONS	77 PRIN. CODE	78 OTHER DIAGNOSES CODES	79	80	81
[redacted]	314.01				

82 P.C. | 83 PRINCIPAL AND OTHER PROCEDURES DESCRIPTIONS | 84 PRINCIPAL PROCEDURE CD DATE | 85 OTHER PROCEDURE CD DATE | 86 OTHER PROCEDURE CD DATE

PSRO UR DATA 87 CD | 88 APP. FROM | 89 APP. THROUGH | 90 GRC. | 91 TREATMENT AUTH | 92 ATTENDING PHYSICIAN ID. | 93 OTHER PHYSICIAN ID.

Page 4 of 2

94 REMARKS
P.O. Box ~~2546~~ 9300
Sherman, TX 75091-2546

VERIFIED N-C STAY DATES FROM THROUGH | FOR INTERMEDIARY USE ONLY | PR. PSC. D
AMT. REIMBURSED | N-PYM. CD | APPROV. BY | DATE APPR

95 I CERTIFY THAT THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

PROVIDER REPRESENTATIVE X | 96 DATE

Blue Cross
Blue Shield
of Kansas, Inc.

Legislative Relations

Nancy G. Zogleman
Director

TESTIMONY ON HOUSE BILL 2216
BLUE CROSS AND BLUE SHIELD OF KANSAS, INC.
FEBRUARY 28, 1991

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

HB 2216 would require the commissioner of insurance to devise a universal accident and sickness claim form. Currently, there are two claim forms, one for hospitals and one for physicians, which I believe would serve this purpose. (see attached)

Hospitals have a common billing form, the UB-82, that's used for Medicare Part A intermediary, Medicaid, Blue Cross, HMO Kansas, and many commercial carriers. In fact, Medicare and Medicade mandate its use and Blue Cross and Blue Shield Association as much has done the same.

All of our processing systems, both using paper claims and electronic claims are programmed on UB-82 for hospitals, freestanding substance abuse facilities, dialysis centers, home health agencies, and skilled nursing facilities. To require the use of a form other than the UB-82 for hospitals would cost millions for all parties to convert. Medicare and Medicaid would continue on UB-82 and all other parties would be on another form.

The other form is the HCFA 1500 which is currently being used by physicians for Medicare, Medicaid, Champus (military) and other government programs. As mentioned with the UB-82, our paper and paperless claims are programmed on the HCFA 1500 and any change to another form would cause many of the same problems mentioned previously.

House Insurance
Feb. 28, 1991
Attachment 3

1133 S.W. Topeka Boulevard • Topeka, KS 66629-0001 • 913-291-8695

Since many insurers are currently using these forms perhaps the bill should require all insurers to use them. Some suggested language for HB 2216 could say, "All insurers authorized to write health insurance in this state must accept from providers of health care services claims submitted on forms UB-82 or HCFA 1500 or other forms established by HCFA.

MCP® MOORE BUSINESS FORMS, INC.

UB82-B

APPROVED OMB NO. 0938-0279

1

2

3 PATIENT CONTROL NUMBER

4 TYPE OF BILL

5 BC/BS PROV. NO.

6 FEDERAL TAX NO.

7 MEDICARE NO.

8 MEDICAID NO.

9

10 PATIENT'S LAST NAME | FIRST NAME | INITIAL

11 PATIENT'S ADDRESS | CITY | STATE | ZIP

12 BIRTH DATE | 13 SEX | 14 MS

ADMISSION: 15 DATE | 16 HR. | 17 TYPE | 18 SRC

19 A.H. | 20 D.H. | 21 STAT

22 STATEMENT COVERS PERIOD: FROM | THROUGH

23 COV.D. | 24 N-C.D. | 25 C-I.D. | 26 L-R.D. | 27

28 OCCURRENCE: CD | DATE

29 OCCURRENCE: CD | DATE

30 OCCURRENCE: CD | DATE

31 OCCURRENCE: CD | DATE

32 OCCURRENCE: CD | DATE

33 OCCURRENCE SPAN: CD | FROM | THROUGH

34

CONDITION CODES: 35 | 36 | 37 | 38 | 39

BLOOD RECORD (PINTS): 40 FURN | 41 REPL | 42 NOT RP. | 43 DED.

44 SP. PROG.

45

46 VALUE: CD | AMT

47 VALUE: CD | AMT

48 VALUE: CD | AMT

49 VALUE: CD | AMT

a

b

50 DESCRIPTION	51 R. CODE	52 S. UNITS	53 TOTAL CHARGES	54	55	56

	57 PAYER	58 REL INFO	59 ASG BEN	60 DEDUCTIBLE	61 CO-INSURANCE	62 EST. RESPONSIBILITY	63 PRIOR PAYMENTS	64 EST. AMOUNT DUE
A								
B								
C								

DUE FROM PATIENT ▶

	65 INSURED'S NAME	66 SEX	67 P.REL.	68 CERT.-SSN-HIC.-ID. NO.	69 GROUP NAME	70 INSURANCE GROUP NO.
A						
B						
C						

71 EID | 72 ESC | 73 EMPLOYER NAME | 74 EMPLOYEE ID. | 75 EMPLOYER LOCATION

76 PRINCIPAL AND OTHER DIAGNOSES DESCRIPTIONS

77 PRIN. CODE

OTHER DIAGNOSES CODES: 78 | 79 | 80 | 81

82 P.C.

83 PRINCIPAL AND OTHER PROCEDURES DESCRIPTIONS

84 PRINCIPAL PROCEDURE: CD | DATE

85 OTHER PROCEDURE: CD | DATE

86 OTHER PROCEDURE: CD | DATE

PSRO UR DATA: 87 CD | 88 APP. FROM | 89 APP. THROUGH | 90 GRC.

91 TREATMENT AUTH.

92 ATTENDING PHYSICIAN ID.

93 OTHER PHYSICIAN ID.

94 REMARKS

FOR INTERMEDIARY USE ONLY

VERIFIED N-C. STAY DATES: FROM | THROUGH

PR. PSC. D.

A | B | C | D | E

AMT. REIMBURSED | N-PYM. CD | APPROV. BY | DATE APPROV.

F | G | H | I

PLEASE DO NOT STAPLE IN THIS AREA

FORM APPROVED OMB NO.

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

☐ MEDICARE (MEDICARE NO.) ☐ MEDICAID (MEDICAID NO.) ☐ CHAMPUS (SPONSOR'S SSN) ☐ CHAMPVA (VA FILE NO.) ☐ FECA BLACK LUNG (SSN) ☐ OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
2. PATIENT'S DATE OF BIRTH
3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
5. PATIENT'S SEX — MALE ☐ FEMALE ☐
6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS)
7. PATIENT'S RELATIONSHIP TO INSURED — SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐
8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)
   ☐ INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN

TELEPHONE NO.

9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)
10. WAS CONDITION RELATED TO:
   A. PATIENT'S EMPLOYMENT — YES ☐ NO ☐
   B. ACCIDENT — AUTO ☐ OTHER ☐
11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
   TELEPHONE NO.

11.a. CHAMPUS SPONSOR'S: STATUS ☐ ACTIVE DUTY ☐ DECEASED ☐ RETIRED — BRANCH OF SERVICE

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.

SIGNED DATE

13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.

SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF: ◀ ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION
16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES
16.a. IF EMERGENCY CHECK HERE ☐
17. DATE PATIENT ABLE TO RETURN TO WORK
18. DATES OF TOTAL DISABILITY — FROM — THROUGH
   DATES OF PARTIAL DISABILITY — FROM — THROUGH
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES — ADMITTED — DISCHARGED
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ ☐ NO CHARGES:
23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE
   1.
   2.
   3.
   4.

   B. EPSDT YES ☐ ☐ NO
   FAMILY PLANNING YES ☐ ☐ NO
   PRIOR AUTHORIZATION NO.

24. A. DATE OF SERVICE FROM TO	B.* PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN — PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G.* T.O.S.	H. LEAVE BLANK

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)
   DATE:
26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES ☐ NO ☐
27. TOTAL CHARGE
28. AMOUNT PAID
29. BALANCE DUE
30. YOUR SOCIAL SECURITY NO.
31. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.

Page 4 of 3

I.D. NO.

32. YOUR PATIENT'S ACCOUNT NO.
33. YOUR EMPLOYER I.D. NO.

* PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK
REMARKS:

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

Form HCFA-1500 (1-84) Form OWCP-1500
Form CHAMPUS-501 Form RRB-1500

1589062

HCFA 1500 - Preset 7600

PRINTED BY THE STANDARD REGISTER COMPANY, U.S.A.

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

February 28, 1991

TO: House Insurance Committee

FROM: Kansas Medical Society *Chip Wheelen*

SUBJECT: House Bill 2216; Uniform Health Insurance Claim Form

Thank you for this opportunity to support the provisions of HB 2216. Seldom do we actually hear complaints from physicians about the myriad of different, confusing forms employed by the various health insurance companies for purposes of obtaining reimbursement. We do, however, frequently hear from those individuals who serve as medical group managers or in other administrative capacities employed by medical practices. It is sometimes alleged that the reason health insurance companies use different claim forms requiring questionable information, is to simply delay reimbursement for extended periods. While this is probably not the reason for employing the different claim forms, it is the practical effect, because if the form is not completed correctly, it will be returned for revision prior to reimbursement being paid.

The provisions of HB 2216 would allow for sufficient input from the health insurance industry to develop a form that is acceptable to the industry as well as health care providers. We believe that this could standardize administration of reimbursement for health care, and thereby streamline the process to the extent possible. Hopefully, the ultimate result would be cost avoidance by reducing the total number of man hours devoted to administration of health insurance. There could also be an additional benefit derived from a universal health insurance claim form. Because today's state of the art technology requires the use of automated computer systems for collecting and analyzing data, a standard form could expedite the process of analyzing such information by the use of computer scanners. Such equipment can be utilized if the information is contained on a standard form. In the long term, this aspect might be even more beneficial than simplicity of administration.

Thank you for considering our comments. We respectfully request that you recommend HB 2216 for passage.

CW/cb

House Insurance
Feb. 28, 1991
Attachment 4

TESTIMONY BEFORE HOUSE INSURANCE COMMITTEE

February 28, 1991

Chairman Turnquist, members of the committee, I am Lisa Getz, representing the four Wichita hospitals, in support of HB 2216.

From the perspective of our hospital CFOs, the standardized federal UB 82 claim form that is presently used adequately transmits claim data. Problems arise when insurance carriers require specific handling such as directives on how they want the form processed. That might include particular formatting of data in computer fields that differs from the way another company processes the same form. Obviously, more time and effort must go into processing such claims.

Our hospital budget department experts tell us the single greatest problem with claims processing is in meeting demands for attachments from insurance companies. Attachments are often requested for physician-ordered tests and procedures including procedures that were pre-authorized.

Before I limit my focus to the scope of HB 2216, please allow me to give you the "big picture" involving claims processing. To simplify, I'll use one hospital as an example, HCA Wesley, and make conservative projections from there, on behalf of all four Wichita hospitals.

HCA Wesley processes the following:

* 40,000 inpatient claims per year
* 100,000 outpatient claims per year - including emergency room
* 60,000 claims in a category including professional emergency room charges, Lifewatch - air ambulance service, and cardiology professional fees
* 40,000 claims for Wesley Clinic - the teaching clinic delivering primary care

House Insurance
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Attachment 5

Governmental Relations and Public Affairs Consulting

532 North Broadway • Wichita, KS 67214 • Tel 316 267-9992 • Fax 316 267-1448

This breaks down to approx. 550 claims per day. Medicare, Medicaid and Champus make up a major part of this processing requiring much time following up on special requests for handling.

All of that aside, we are left with 200 third-party insurance claims per day, of which approx. 75 require attachments. Many insurance carriers have the capability to allow computer transfer of claims from the hospital to the carrier through electronic downloading mainframe computer to mainframe, without paperwork, postage and additional clerical support time. HCA Wesley subscribes to the service called NEIC, National Electronic Insurance Corporation, a clearinghouse for claims processing to simplify transfer if a company does not provide this service.

However, going back to the 75 claims per day that require attachments, electronic transfer, the desired method of processing, is not an option. Instead, the hospital must utilize clerical support to find the attachments and to check that the claim is in order accordingly. Moreover, the hospital incurs mailing costs that were otherwise avoidable. A conservative projection by this hospital on addition costs to their system associated with processing these claims needing attachments, is $50,000 per year.

Since I ask you to consider four hospitals in this projection, even allowing conservatively that one of the four does not process as many claims as the other three, which are comparable, multiplying that $50,000 by three, its reasonable to say that at least $150,000 a year is spent in our view, wastefully.

Mr. Chairman, members of the committee, we urge you, in your quest to reduce wasteful spending in the health care delivery system, to streamline claims processing by targeting the methodology that allows these delays. The Wichita Hospitals come before you in support of a measure that is "system smart".

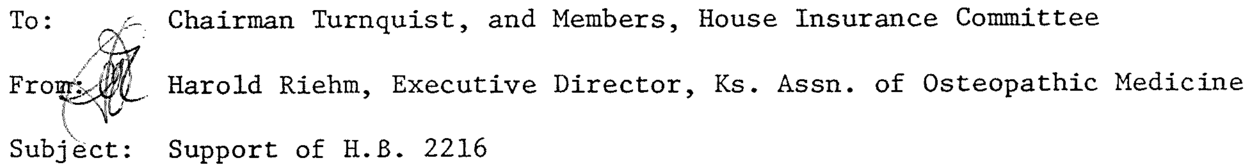
Thank you.

Kansas Association of Osteopathic Medicine

Harold E. Riehm, Executive Director

1260 S.W. Topeka
Topeka, Kansas 66612
(913) 234-5563

February 28, 1991



To: Chairman Turnquist, and Members, House Insurance Committee

From: Harold Riehm, Executive Director, Ks. Assn. of Osteopathic Medicine

Subject: Support of H.B. 2216

I appear today in support of H.B. 2216. Most assuredly the development of such a form will not be easy; neither should it be impossible. Its advantages, we think, outweigh the somewhat sizable task of coordinating required and desirable bits ofinformation.

We think the development of such a form would have several advantages, both internal and external, to the physician community. Among these are:

(1) To permit a set of like data for compiling statistical analyses of various health care services.

(2) Making it easier to learn the process of completing forms, now a major time consuming task of physician office personnel.

(3) Facilitating handling claims processing by computer, with a standardized form permitting more reasonable cost for forms processing software.

(4) To assist The Department of Health and Environment, and other State Agencies, in gathering selected data required by law, e.g., being able to refer to such data in part by its location on the standardized form.

In lines 21, and 22, we assume that included in the "other interested parties" to be confered with by the Insurance Commissioner, would be provider groups, more particularly, physician groups. We also would urge that the forms, if and where possible, also seek some conformity to those forms required of providers for medicare and medicaid patients. Though the one single uniform form may not be practical at this time, it remains an admirable objective.

Should H.B. 2216 be enacted into law, we look forward to working with the Insurance Commissioner in the development of such form(s).

Thank you for this opportunity to offer our views on H.B. 2216.

House Insurance
Feb. 28, 1991
Attachment 6

Session of 1991

HOUSE BILL No. 2001

By Special Committee on Insurance

Re Proposal No. 11

12-28

10 AN ACT relating to insurance; concerning accident and sickness
11 insurance and the regulation of the rates thereof by the commis-
12 sioner of insurance; concerning eligibility for coverage under group
13 policies; amending K.S.A. 1990 Supp. 40-19c09, 40-2209 and 40-
14 2215 and repealing the existing sections; also repealing K.S.A.
15 1990 Supp. 40-19c07.
16
17 *Be it enacted by the Legislature of the State of Kansas:*
18 Section 1. K.S.A. 1990 Supp. 40-2209 is hereby amended to read
19 as follows: 40-2209. (A) Group sickness and accident insurance is
20 declared to be that form of sickness and accident insurance covering
21 groups of persons, with or without one or more members of their
22 families or one or more dependents, ~~or one or more members of~~
23 ~~their families or one or more dependents, and~~. *Except at the*
24 *option of the employee or member* ~~and~~ *except employees or members*
25 *enrolling in a group policy after the close of an open enrollment*
26 *opportunity, no individual employee or member of an insured group*
27 *and no individual dependent or family member may be excluded*
28 *from eligibility or coverage under a policy providing hospital, med-*
29 *ical or surgical expense benefits both with respect to policies issued*
30 *or renewed within this state and with respect to policies issued or*
31 *renewed outside this state covering persons residing in this state.*
32 *No group policy providing hospital, medical or surgical expense*
33 *benefits issued or renewed within this state or issued or renewed*
34 *outside this state covering residents within this state shall limit or*
35 *exclude benefits for specific conditions existing at or prior to the*
36 *effective date of coverage thereunder. Such policy may impose a*
37 *waiting period, not to exceed one year for benefits for conditions,*
38 *including related conditions, for which diagnosis, treatment or advice*
39 *was sought or received in the* ~~90 days~~ *prior to the effective date of*
40 *coverage. Such policy shall waive such a waiting period to the extent*
41 *the employee or member or individual dependent or family member*
42 *was covered by a group sickness and accident policy prior to the*
43 *effective date of coverage with no gap in coverage. Such policy may*

,

Delete

no less favorable than 31 days from the employee or member's date of initial eligibility and ending no later than 31 days following the employee or member's initial eligibility date and except employees or members covered under a group plan that covers less than 75% of eligible employees or members on any annual anniversary date of the group policy with respect to new employees or members applying for coverage during the succeeding 12 month period.

EXPLANATION: This amendment incorporates 2 changes. First, it in effect defines the term open enrollment opportunity so the legislative intent will be clear and consistent for all groups. Second, it adds an exception to the individual underwriting restrictions that would encourage insurers to continue coverage on groups who fall below the standard 75% participation requirement by permitting individual underwriting on new members applying for coverage during the following year.

Delete

six months

EXPLANATION: This amendment reduces the ability of insureds to conceal pre-existing medical conditions for the purpose of avoiding the prescribed waiting period.

impose participation requirements, define full-time employees or members and otherwise be designed for the group as a whole through negotiations between the group sponsor and the insurer to the extent such design is not contrary to or inconsistent with this act and may

EXPLANATION: Essentially this same language is contained in current law with respect to single employer groups as evidenced by the provision appearing in lines 35 through 37 on page 2 of the bill. This amendment simply relocates this provision so it will apply to all groups.

House Ins.
Feb. 28, 1991
Attachment 7

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

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

Delete

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

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

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1 (21) The insurer shall give the employee or member and such
2 employee's or member's covered dependents reasonable notice of
3 the right to convert at least once during the six-month continuation
4 period in accordance with rules and regulations adopted by the
5 commissioner of insurance.
6 Sec. 2. K.S.A. 1990 Supp. 40-2215 is hereby amended to read
7 as follows: 40-2215. (a) No individual policy of accident and sickness
8 insurance as defined in K.S.A. 40-2201 and amendments thereto
9 shall be issued or delivered to any person in this state nor shall any
10 application, rider or endorsement be used in connection therewith,
11 until a copy of the form thereof and of the classification of risks and
12 the premium rates pertaining thereto, have been filed with the
13 commissioner of insurance.
14 *(b) No group or blanket policy of accident and sickness insurance*
15 *shall be issued or delivered to any person in this state, nor shall*
16 *any application, rider or endorsement be used in connection there-*
17 *with, until a copy of the form thereof has been filed with the com-*
18 *missioner of insurance.*
19 ~~(b)~~ *(c)* No such policy shall be issued, nor shall any application,
20 rider or endorsement be used in connection therewith, until the
21 expiration of 30 days after it has been filed unless the commissioner
22 gives written approval thereof.
23 ~~(c)~~ *(d)* The commissioner may, within 30 days after the filing of
24 any ~~such~~ form *required to be filed pursuant to subsection (a)*, dis-
25 approve such form: (1) If the benefits provided therein are unrea-
26 sonable in relation to the premium charged; or (2) if it contains a
27 provision or provisions which are unjust, unfair, inequitable, mis-
28 leading, deceptive or encourage misrepresentation of such policy. If
29 the commissioner notifies the insurer which has filed any such form
30 that it does not comply with the provisions of this section or K.S.A.
31 40-2202 and 40-2203, and amendments thereto, it shall be unlawful
32 thereafter for such insurer to issue such form or use it in connection
33 with any policy. In such notice the commissioner shall specify the
34 reasons for disapproval and state that a hearing will be granted within
35 20 days after request in writing by the insurer.
36 *(e) (1) Any risk classifications, premium rates, rating formulae,*
37 *and all modifications of either applicable to Kansas residents shall*
38 *not establish an unreasonable, excessive or unfairly discriminatory*
39 *rate or, with respect to group or blanket policies issued pursuant*
40 *to K.S.A. 40-2209 or 40-2210, and amendments thereto, discriminate*
41 *against any individuals eligible for participation in a group, or es-*
42 *tablish rating classifications within a group* ~~*except those based on*~~
43 ~~*criteria solely and directly relevant to recognition of rating differ-*~~

or certificate

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

accident and sickness
providing hospital or medical-surgical benefits
EXPLANATION: These amendments are intended to clarify the types of policies to which these provisions apply.
that are based on medical conditions
Delete
EXPLANATION: This is a significant change which allows much greater latitude with respect to the establishment of rating classifications within a group. With this amendment, the only restriction is that rating classifications based on medical condition cannot be established. Any other relevant risk characteristics such as age, occupation, smoking/non-smoking, wellness participation etc. would be permitted.

Page 3-8

1 ~~ences attributable to the marital status of a group's members and~~
2 ~~persons eligible for dependents' benefits.~~
3 *(2) All rates for accident and sickness insurance covering Kansas*
4 *residents shall be made in accordance with the following provisions:*
5 *(A) Due consideration shall be given to: (i) Past and prospective loss*
6 *experience; (ii) past and prospective expenses; (iii) adequate contin-*
7 *gency reserves; and (iv) all other relevant factors within and without*
8 *the state;*
9 ~~(B) risks may be grouped by classifications for the establishment~~
10 ~~of rates for individual, group or blanket policies;~~
11 ~~(C) rates shall be reasonable, not excessive and not unfairly dis-~~
12 ~~criminatory; and~~
13 ~~(D)~~ *rates charged to an employer of 25 or fewer employees under*
14 *group and blanket policies, including such employers covered under*
15 *a policy issued to an association or trust located within or outside*
16 *this state covering an employer which is a resident of this state,*
17 *shall be based on the aggregate loss and expense experience of all*
18 *such employers insured by the insurer, contingency reserves and*
19 *other factors required to be considered in making rates to which*
20 *this act applies. ~~Such~~ rates shall apply to all such employers insured*
21 *in this state by the insurance company using the rates on a per*
22 *person basis but may vary with the number of persons in a family,*
23 *and may vary from employer to employer from a community rate*
24 *by no more than 50% above the community rate. As used herein,*
25 *"community rate" means the rate which would be derived by dividing*
26 *all of the claims expense or anticipated claims expense for the rating*
27 *period for which such rates will be in effect and all of the admin-*
28 *istrative expense and other retentions for all such employers covered*
29 *by the same or similar coverage which is equivalent in value by all*
30 *of the persons covered by such coverage. For the purposes of this*
31 *definition, employee, family, spouse and dependent expense and num-*
32 *bers of such persons covered may be separately aggregated and*
33 *divided. With respect to policies issued prior to the effective date*
34 *of this act, in any case where the premium rate exceeds the com-*
35 *munity rate by more than 50%, no increase in such rates may be*
36 *made until ~~the later of~~ the beginning of a rating period in which*
37 *such premium rates would be lower than 50% more than the com-*
38 *munity rate ~~or five years following the effective date of this act.~~*
39 ~~*Thereafter, the*~~ *rates for such policies shall ~~comply with the re-~~*
40 ~~*quirements of this subsection.*~~
41 *(3) Nothing in this act is intended to prohibit or discourage*
42 *reasonable competition or discourage or prohibit uniformity of rates*
43 *except to the extent necessary to accomplish the aforementioned pur-*

Delete

Delete

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

(B)

providing hospital or medical-surgical expense benefits

For purposes of this subsection (B) members of an association shall be construed as employees whether or not an employer and employee relationship exists. With the exception of groups created pursuant to K.S.A. 1990 Supp. 40-2209(A)(5) which were in existence on January 1, 1991 and whose rates were established solely on the basis of their own experience as of that date

EXPLANATION: This change encompasses 2 amendments. First, it recognizes the fact that some association groups exist whose membership does not involve employer/employee arrangements. Second, it exempts existing association groups whose rates are based solely on their own experience from the community rating requirements.

such

In no event shall the rates charged to any employer to which this subsection applies increase by more than 80% during any annual period unless the insurer can clearly document a material and significant change in the risk characteristics of the group.

EXPLANATION: This provision adds additional stability to a small group's rates by limiting the effect of any rate increase to not more than 80% in any one year.

Nothing in this act shall be construed as prohibiting the application of rates to a particular employer that are less than the community rate established pursuant to this subsection.

EXPLANATION: This added provision simply clarifies the original intent that on the basis of individual risk characteristics some groups could vary downward from the community rate. This amendment does not, however, affect the manner in which the community rate is established.

Delete

. (F)

Delete

Delete

no

exceed the community rate by more than 50%.

EXPLANATION: These amendments are intended to clarify the application of the community rating provisions. Specifically, it provides that no community rated group may receive a rate increase as long as its rates are more than 50% above the group rate. At the end of 5 years following the effective date of the act, any group's rates that are still more than 50% of the community rate must be reduced to the 150% level.

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

3 ~~(d)~~ ~~*(f)*~~ The commissioner may at any time, after a hearing of
4 which not less than 20 days' written notice shall be given to the
5 insurer, withdraw approval of any such form ~~on any of the grounds~~
6 ~~stated in this section~~ *or rate in the event the commissioner finds*
7 *such filing no longer meets the requirements of this section or of*
8 *article 22 of chapter 40 of the Kansas Statutes Annotated, and*
9 *amendments thereto.* It shall be unlawful for the insurer to issue
10 such form or use it in connection with any policy after the effective
11 date of such withdrawal of approval.
12 ~~*(g)*~~ *Violations of subsection (e) shall be treated as violations of*
13 *the unfair trade practices act and subject to the penalties prescribed*
14 *by K.S.A. 40-2407 and 40-2411 and amendments thereto.*
15 ~~(e)~~ ~~*(h)*~~ Hearings under this section shall be conducted in ac-
16 cordance with the provisions of the Kansas administrative procedure
17 act.
18 Sec. 3. K.S.A. 1990 Supp. 40-19c09 is hereby amended to read
19 as follows: 40-19c09. Corporations organized under the nonprofit
20 medical and hospital service corporation act shall be subject to the
21 provisions of the Kansas general corporation code, articles 60 to 74,
22 inclusive, of chapter 17 of the Kansas Statutes Annotated, applicable
23 to nonprofit corporations, to the provisions of K.S.A. 1990 Supp.
24 40-2250 and 40-2251 and to the provisions of K.S.A. 40-214, 40-215,
25 40-216, 40-218, 40-219, 40-222, 40-223, 40-224, 40-225, 40-226, 40-
26 229, 40-230, 40-231, 40-235, 40-236, 40-237, 40-247, 40-248, 40-249,
27 40-250, 40-251, 40-252, 40-254, 40-2,100, 40-2,101, 40-2,102, 40-
28 2,103, 40-2,104, 40-2,105, 40-2,116, 40-2,117, 40-2a01 *et seq.*, 40-
29 2111 to 40-2116, inclusive, ~~40-2216~~ ~~*40-2215*~~ to 40-2220, inclusive,
30 40-2401 to 40-2421, inclusive, and 40-3301 to 40-3313, inclusive, and
31 amendments thereto, and to the provisions of K.S.A. 1989 Supp.
32 40-2221a, 40-2221b, 40-2229 and 40-2230, and amendments thereto,
33 except as the context otherwise requires, and shall not be subject
34 to any other provisions of the insurance code except as expressly
35 provided in this act.
36 Sec. 4. K.S.A. 1990 Supp. ~~40-19c07~~, 40-19c09, 40-2209 and 40-
37 2215 are hereby repealed.
38 Sec. 5. This act shall take effect and be in force from and after
39 January 1, 1992, and its publication in the statute book.

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

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

(g)

disapprove any

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

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

(h)

(i)

Section 2, subsection (e) of this act

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

Delete