Approved 1/31/91
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by CHAIRMAN RICHARD L. BOND at
Chairperson

9:00 a.m./~~p.m.~~ on TUESDAY, JANUARY 29, 1991 in room 529-S of the Capitol.

~~All~~ members ~~were~~ present ~~except~~

Senators Anderson, Francisco, Kerr, McClure, Moran, Reilly, Salisbury, and Strick.

Committee staff present:

Bill Wolff, Legislative Research
Fred Carman, Revisors Office
Louise Bobo, Secretary

Conferees appearing before the committee:
Ron Smith, Kansas Bar Association
Senator Paul Feleciano, Kansas Senate
Dick Brock, Adm Asst., Insurance Department
Cheryl Dillard, Kansas Permanente
Nancy Zogleman, Blue Cross Blue Shield

Chairman Bond called the meeting to order at 9:10 a.m.

Dr. Wolff, Legislative Research, passed out to each committee member a copy of the "Report and Recommendations on the Kansas Health Care System" prepared for Governor Mike Hayden by the Governor's Commission on Health Care.

Ron Smith, Kansas Bar Association, was recognized by the Chairman for the purpose of requesting the committee to introduce a bill. Mr. Smith explained that his proposal would allow the banking community to better collect and assign rents in large commercial shopping centers. (Attachment 1)

Senator Strick made the motion to allow introduction of this bill request. Senator Kerr seconded the motion and the motion carried.

SB 16 and 17 - concerning nonprofit medical corporations.

Chairman Bond reopened hearings on the above two bills which were first heard last Thursday, Jan. 24.

Senator Paul Feleciano, Kansas Senate, appeared in opposition to these two bills. Senator Feleciano informed the committee that his only reason for opposing SB 16 was because of the makeup of the Board. He said that he believed that the majority of the Board should be employees of the public sector. Senator Feleciano testified against SB 17 which would allow Blue Cross Blue Shield to become a private mutual company instead of a state regulated entity. He stated that he was against this proposal because, (1) current regulations protect consumers against premium increases and sudden changes in policies, (2) BCBS has 36% of the insurance market, therefore, is not in need of a "level playing field", (3) current regulations prohibit BCBS from excluding certain high risk individuals from coverage. Senator Feleciano concluded by stating that BCBS had been enormously successful despite regulations and that the needs of the people of Kansas would best be served by maintaining BCBS under state authority. (Attachment 2)

Discussion ensued with a committee member inquiring how many state employees covered under the state's contract with BCBS had been declared ineligible or had their claims refused. Dick Brock, Kansas Insurance Department, answered that if an employee met the qualifications for coverage under the State of Kansas group contract, the company has to accept the individual. Senator Feleciano observed that certain regulations were not always enforced even though the Department had the authority. Senator Feleciano suggested that the playing field should be evened by bringing all insurance companies under the Insurance Department and regulating their rates. He continued by saying that we had taken the risk out of the insurance business.

SB 51 - relating to health maintenance organizations.

Dick Brock, Kansas Insurance Department, explained that this bill proposes a slight change in the statute to more clearly specify the obligation of an HMO to provide enrollees and their dependents a reasonable notice of their conversion rights. Attachment 3)

Cheryl Dillard, Kansas Permanente, addressed the committee proposing a change in SB 51 which would place some responsibility on the employer to notify the insurance company that employees have lost HMO coverage. She also advised the committee of the difficulty of a 15 day notice period as currently specified in SB 51 and suggested a 30 day notice period. Ms. Dillard also pointed out a section of the statutes that had caused difficulty for her organization and requested legislative efforts to level the playing field in regard to pre-existing medical conditions. (Attachment 4)

Nancy Zogleman, Blue Cross Blue Shield, offered an amendment to SB 51 which would allow the insuror to put a clause in the contract to require the insured to notify the insuror in case of a change in the family unit. (Attachment 5) Ms. Dillard supported this change also and said that they are trying to put some of the responsibility on the subscriber. Ms. Zogleman also informed the committee that she was in agreement with Ms. Dillard's proposal of allowing 30 days for the right to convert after receiving notice from the employer of termination of coverage under the group contract.

A brief discussion followed with a committee member inquiring if he failed to notify of a change in his family structure would his claim still be paid. Ms. Zogleman responded that under the policy he would have the reponsibility so he might have to end up paying his own claim. Bill Pitzenberger, Attorney for BCBS, informed the committee that the insuror of group contracts had no direct contact with the insured, however, the insuror needs to notify the insured of his conversion right. It was agreed that the language needed to be reworked and the Chairman requested Mr. Brock, Ms. Zogleman, and Ms. Dillard to get together and return to the committee with clarified language.

Minutes of Thursday, January 24, 1991 were approved as written on a motion by Senator Reilly with Senator McClure seconding the motion. The motion carried.

The meeting adjourned at 9:53.

GUEST LIST

COMMITTEE: FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE DATE: Tues Jan 29, 1991

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Nancy Zogleman	Topeka	BC/BS of Ks.
GARY Robbins	Topeka	Ks Optom Assn
Bill Curtis	Topeka	KASP
Roland Smith	Wichita	WIBA
Sophie Graham	Topeka	Sen Hensley
Bill Sneed	TOPEKA	NIAA
Don Hoyt	Topeka, Kan	Delta
Ed Roling	WICHITA	DELTA
Joe FURJANIC	TOPEKA	KCA
Dick Brock	"	Ins Dept
Steve Dickson	Topeka	KCA
Ron Smith	"	KSA
Bill Pitzenberger	Topeka	BCBS
David Hanzlicek	Topeka	KDA
Cheryl Dillard	Kansas City	Kaiser Permanente

House Bill ____

AN ACT concerning financial institutions; assignment of rents and profits as security for loans.

Be it enacted ...

Section 1. (a) As used in this section,

(1) "Assignment instrument" means any mortgage, deed of trust, real property security instrument, or other instrument or agreement by which a borrower assigns, transfers, pledges, or otherwise grants a lien upon or encumbers its rights to rents or real property therein described to or for the benefit of a lender as security for the repayment of any indebtedness or the performance of any obligations.

(2) "Borrower" means any mortgagor, deed of trust grantor, assignor, or debtor of any lender.

(3) "Lender" means any mortgagee, deed of trust beneficiary, assignee, or creditor, or its assigns, holding an assignment instrument.

(4) "Rents" includes the rents, income, proceeds, profits and other sums which (A) are derived under present and future leases, licenses, contracts and other agreements for the use or possession of real property and (B) are either in the possession or control of the borrower or are due and unpaid or are to become due and payable.

(b) The lien of an assignment instrument shall be a good, valid and enforceable lien on the rents from the real property therein described. Such lien shall be valid and binding against, unavoidable by and fully perfected as to the borrower and all subsequent purchasers, mortgagees, lien creditors, other lienholders and other persons for all purposes from the time of filing the assignment instrument for record in accordance with K.S.A. 58-2221, with a priority dating from the time of such filing, without any necessity for the lender to take possession or control of such rents or the property from which such rents are derived, to take any action tantamount to the taking of such possession or control, or to take other action whatsoever.

(c) Upon default by a borrower under the terms of an assignment instrument, the lender shall be entitled to apply to the district court of the county in which the real property is located for the appointment of a receiver for the rents or other appropriate relief to gain possession and control of the rents in enforcement of the assignment instrument. Upon such application, the court shall enter such orders and take such actions as appear necessary to collect, protect and preserve the rents and protect and preserve the lender's interest therein pending final disposition of an action upon the obligations secured by the assignment instrument.

Section 2. This act shall have force and effect upon publication in the statute books.

FI + I
1/29/91
Attachment 1

BEFORE THE SENATE COMMITTEE ON
FINANCIAL INSTITUTIONS AND INSURANCE
TESTIMONY OF SENATOR PAUL FELECIANO
IN OPPOSITION TO S.B. 16 AND 17
January 29, 1991

THE FACT THAT I AM HERE TODAY TO GIVE YOU MY VIEWS AGAINST THE PROPOSAL TO REMOVE BC/BS FROM A STATE REGULATED ENTITY TO A PRIVATE, MUTUAL COMPANY SHOULD SPEAK FOR ITSELF. RARELY IN ALL MY YEARS OF LEGISLATIVE SERVICE HAVE I ASKED FOR THE OPPORTUNITY TO GIVE TESTIMONY BEFORE A SENATE COMMITTEE. I DO SO TODAY TO PREVENT A GRAVE INJUSTICE FROM BEING DONE TO THE PEOPLE OF THE STATE OF KANSAS, AN INJUSTICE WHICH I FEAR WILL BE ALMOST IMPOSSIBLE TO CORRECT ONCE THE DAMAGE IS DONE.

I AM HERE TODAY SPEAKING AS A FORMER INSURANCE AGENT AND CURRENT MEMBER OF THE KANSAS STATE SENATE. I HAVE DEDICATED MUCH OF MY PUBLIC LIFE TO THE ISSUE OF HOW TO PROVIDE AFFORDABLE HEALTH INSURANCE TO ALL KANSANS. IT IS MY OPINION THAT BY REMOVING BC/BS FROM STATE CONTROL, REGULATION AND OVERSIGHT, I FEAR THAT THE AFFORDABLE INSURANCE SOUGHT AND NEEDED BY MANY KANSANS WILL ONLY BE A DREAM. THE RESULTING REALITY WILL BE A NIGHTMARE.

CURRENTLY, BC/BS IS UNDER THE AUSPICES OF STATE REGULATIONS. THESE REGULATIONS PROVIDE INSURANCE CONSUMERS MUCH NEEDED PROTECTION AGAINST PREMIUM INCREASES AND SUDDEN CHANGES IN POLICIES. THESE REGULATIONS PROVIDE KANSANS WITH A GREAT DEAL OF PROTECTION WHICH IS NOT FOUND IN PRIVATE, UNREGULATED HEALTH INSURANCE POLICIES. THESE REGULATIONS WERE DESIGNED TO PROVIDE A STABLE ENVIRONMENT TO A MOST UNSTABLE INSURANCE INDUSTRY. AT A TIME WHEN THE S & L CRISIS IS RAGING IN CONGRESS AND AFFECTING

FI + I
1/29/91
Attachment 2

EVERY CITIZEN, WHEN MANY OF OUR BANKS ARE ON THE VERGE OF ECONOMIC COLLAPSE, MOSTLY DUE TO DEREGULATION BY THE GOVERNMENT, HOW CAN WE SERIOUSLY PROPOSE TO DEREGULATE THE LARGEST HEALTH INSURANCE PROVIDER IN KANSAS AND SAY TO OUR FELLOW KANSANS THAT THIS IS IN THEIR BEST INTEREST.

YOU ARE ALL AWARE OF MY CAMPAIGN FOR THE OFFICE OF INSURANCE COMMISSIONER. AS POLITICIANS YOURSELVES YOU KNOW HOW MUCH INFORMATION WE ARE EXPOSED TO DURING A LEGISLATIVE CAMPAIGN. DURING MY STATEWIDE CAMPAIGN FOR THE INSURANCE COMMISSIONERS OFFICE I WAS BLESSED WITH A HUGE AMOUNT OF INFORMATION ON THIS ISSUE. AFTER CAREFUL STUDY OF THIS MATERIAL I HAVE COME TO THE DEFINITE CONCLUSION THAT THE WORST ABROGATION OF OUR DUTIES WE COULD COMMIT WOULD BE TO UNLEASH THE AWESOME POWER OF BLUE CROSS AND BLUE SHIELD ON THE GENERAL PUBLIC.

I AM NOT ADVOCATING THAT GOVERNMENT EXCLUSIVELY CONTROL THE INSURANCE INDUSTRY. WE ALL KNOW THE DANGERS OF TOO MUCH GOVERNMENT. BUT, WE HAVE ALL BECOME PAINFULLY AWARE OF THE CONSEQUENCES OF TOO LITTLE GOVERNMENT RESPONSIBILITY AND CONTROL. WITH AN ECONOMIC CRISIS NOW FACING MUCH OF THE INSURANCE INDUSTRY, IT BEHOOVES US TO CAREFULLY CONSIDER SUCH A DRAMATIC REVERSAL OF LONG ESTABLISHED AND EFFECTIVE STATE REGULATION OF BC/BS.

THE ARGUMENT HEARD BY THE LEARNED MEMBERS OF THIS COMMITTEE IS THAT BY DEREGULATING BC/BS, WE WILL BE "LEVELING THE PLAYING FIELD." IT WILL ALLOW BC/BS TO BECOME MORE COMPETITIVE WITH THE NONREGULATED PRIVATE INSURANCE PROVIDERS. MY CONCERN IS HOW MUCH MORE COMPETITIVE DOES A PROVIDER WHO HAS 36% OF THE INSURANCE

MARKET NEED TO BE. I SUBMIT TO YOU THAT ANY ONE OF THE OTHER HEALTH CARE INSURERS WOULD BE DELIGHTED IF WE ASSISTED THEM IN "LEVELING THE PLAYING FIELD" BY BUILDING THEM TO THE LARGEST HEALTH INSURANCE CARRIER IN THE STATE BY GIVING THEM THE TREMENDOUS ADVANTAGES AND PROTECTION WE HAVE GIVEN BC/BS AND THEN ELIMINATING ALL REGULATION.

SINCE THE COMMITTEE HEARING LAST WEEK WHEN WE RAN OUT OF TIME BEFORE I HAD A CHANCE TO SPEAK, I HAVE HAD THE OPPORTUNITY TO DISCUSS THIS MATTER WITH MY COLLEAGUES. IT APPEARS THAT SOME OF THEM WERE UNAWARE OF THE SERIOUS RAMIFICATIONS OF THE CHANGES BEING PROPOSED. FOR EXAMPLE, MANY THOUGHT THAT IF THESE BILLS WERE ADOPTED AS LAW, THE FORM OF BC/BS WOULD CONTINUE AS BEFORE WITH ONLY THE ORGANIZATIONAL STRUCTURE UNDERGOING MINOR CHANGES. THIS IS INCORRECT.

CURRENTLY BC/BS IS REQUIRED TO CARRY CERTAIN POLICIES BECAUSE THEY ARE REGULATED. THAT WOULD NOT BE TRUE IF WE ADOPT THIS BILL AS LAW. CURRENTLY BC/BS IS PROHIBITED FROM EXCLUDING CERTAIN HIGH RISK INDIVIDUALS, FOR EXAMPLE, SOMEONE WITH A KNOWN HEART CONDITION FROM A GROUP POLICY,BECAUSE THEY ARE REGULATED. YOU CAN EXPECT THAT TO CHANGE IF YOU ADOPT THIS PROPOSAL. RIGHT NOW BC/BS, UNLIKE OTHER HEALTH INSURERS IN THE STATE, IS REQUIRED TO SUBMIT IT'S PREMIUM INCREASES AND NEW PROGRAMS FOR REVIEW TO THE INSURANCE COMMISSIONER FOR APPROVAL PRIOR TO IMPLEMENTATION. IF THIS MEASURE IS ADOPTED, WE WILL NO LONGER HAVE THAT PROTECTION.

DESPITE ALL OF THESE PROTECTIONS AND MORE BC/BS HAS THRIVED AND GROWN TO BE THE LARGEST IN THE STATE. THEY DON'T NEED A PLAYING FIELD ANY MORE LEVEL THAN IT IS ALREADY. IN FACT BC/BS, DESPITE

THESE REGULATIONS WHICH PROTECT US AND OUR CONSTITUENTS, IS LARGE ENOUGH THAT IT HAS RUN OFF ALL OF IT'S UNREGULATED COMPETITION IN THE LAST SEVERAL YEARS ON ONE OF THE MOST COVETED GROUP CONTRACTS IN KANSAS. I AM SPEAKING, OF COURSE, OF THE GROUP HEALTH INSURANCE CONTRACT FOR STATE EMPLOYEES. EVERY YEAR WE OPEN THIS CONTRACT UP FOR BID, BC/BS BLOWS AWAY THE UNREGULATED COMPETITION. I AM TOLD THEY HAVE BEEN ABLE TO DO THE SAME THING WITH OTHER LARGE GROUP CONTRACTS INCLUDING THE GROUP CONTRACT FOR THE CITY OF TOPEKA AND OTHER CITIES, COUNTIES, SCHOOL DISTRICTS AND MORE. IF THEY CAN DO THAT IN THE PRESENT REGULATED STATUS, HOW MUCH MORE COMPETITIVE DO THEY NEED TO BE?

YET, WITH THIS REGULATION WHAT KIND OF SERVICE IS BEING PROVIDED? THERE ARE STATE EMPLOYEES WHO ARE NOT ABLE TO GET THE SERVICES THEY NEED BECAUSE THEY ARE NOT ALLOWED TO GO TO A PHYSICIAN OF THEIR CHOICE. I KNOW OF LEGISLATORS WHO HAVE VOICED THE SAME COMPLAINTS. JUST HOW ONEROUS IS THIS REGULATORY BURDEN?

WE MUST REMEMBER THE ORIGINAL PURPOSES FOR THE CREATION OF BC/BS. IT WAS CREATED IN THE 1930'S AND DEVELOPED IN THE 1940'S FOR THE PURPOSE OF COMMUNITY SERVICE. IT WAS DESIGNED AT A TIME WHEN MANY OF OUR CITIZENS HAD NO HEALTH INSURANCE AND A GREAT NUMBER HAD NO ACCESS TO HEALTH CARE. BC/BS WAS DESIGNED TO TAKE CARE OF THOSE PEOPLE. PERHAPS IN THE MID TO LATE 1970'S IT COULD HAVE BEEN SUCCESSFULLY ARGUED THAT THE NEED WAS NO LONGER THERE AS A GREAT NUMBER OF OUR CITIZENS HAD HEALTH INSURANCE COVERAGE EITHER INDIVIDUALLY OR THROUGH GROUP EMPLOYMENT PLANS.

NOW, HOWEVER, WE HAVE COME FULL CIRCLE. ALMOST 500,000

CITIZENS OF OUR STATE HAVE NO HEALTH INSURANCE NOR ANY MEANS OF OBTAINING ACCESS TO AFFORDABLE HEALTH CARE. I SUBMIT TO YOU THAT DEREGULATING BCBS WOULD ONLY ADD TO THEIR NUMBERS, THEIR FRUSTRATION, AND THE GROWING HEALTH CARE CRISIS WE FACE IN KANSAS.

THEY ARE THE LARGEST HEALTH INSURANCE CARRIER IN THE STATE BECAUSE THEY HAVE HAD THE PROTECTION,SUPPORT, BACKING, ENCOURAGEMENT AND ASSISTANCE OF THE RESOURCES OF THE STATE OF KANSAS. WE MADE THEM NUMBER ONE. NOW THEY WANT TO TAKE THE BENEFITS OF THE LARGESS OF ALL THE CITIZENS OF THE STATE OF KANSAS AND PRIVATIZE THOSE RESOURCES TO THE BENEFIT OF A FEW. IF ALLOWING THIS PROPOSAL IS "LEVELING THE PLAYING FIELD" FOR BC/BS, THAT FIELD WILL BE SO FAR ABOVE THE FIELDS OF OTHER CARRIERS AS TO BE LAUGHABLE. IT IS NOT THE LARGEST HEALTH INSURANCE CARRIER IN THE STATE WE SHOULD BE LEVELING THE PLAYING FIELD FOR. IF ANYONE IT SHOULD BE FOR THE SMALLER COMPANIES WHO ARE STRUGGLING TO PROVIDE AFFORDABLE HEALTH INSURANCE IN A COMPETITIVE MARKET. THIS BILL WOULD NOT LEVEL THE PLAYING FIELD FOR THEM. INSTEAD IT WOULD CREATE A CRATER IN THAT FIELD LARGER THAN ONE OF SADDAM HUSSEIN'S SCUD MISSILES.

IT WOULD APPEAR THAT MORE REGULATIONS MAY BE NECESSARY, NOT TO "LEVEL THE PLAYING FIELD," BUT TO OFFER INSURANCE CONSUMERS IN KANSAS MUCH NEEDED RELIEF AND PROTECTION FROM SUDDEN PREMIUM INCREASES AND POLICY CANCELLATIONS. AT A TIME WHEN BC/BS IS CANCELLING THE POLICIES OF TEACHERS AND LOCAL GOVERNMENT WORKERS, IT IS UNCONSCIONABLE TO DEREGULATE A COMPANY THAT HAS 36% OF THE MARKET AND RISK CREATING A CRISIS SUCH AS THAT SEEN IN THE S & L

MESS.

WHILE ON THE CAMPAIGN TRAIL THIS PAST YEAR I SPOKE TO AN ESTIMATED 50,000 PEOPLE, I HEARD FROM THOUSANDS AND I PERSONALLY SPOKE TO HUNDREDS ABOUT THE ISSUES YOU NOW CONSIDER. I HAVE FOUND NO POPULAR SUPPORT FOR THIS TYPE OF ACTION.

INSTEAD, I FOUND INCREDIBLE STORIES ABOUT BC/BS AND THEIR DENIAL OF BENEFITS, THEIR ELIMINATION OF SERVICES AND THEIR OUTRAGEOUS INCREASES IN PREMIUMS, IN SOME CASES AS MUCH AS 400% FROM $200 PER MONTH TO OVER $800 PER MONTH. AND THESE ARE THINGS THEY ARE DOING WHILE THEY ARE REGULATED. IF THESE CRUEL PRACTICES ARE TAKEN WHILE WE ARE LOOKING OVER THEIR SHOULDER WHAT WILL HAPPEN IF WE DEREGULATE THIS COMPANY? WILL THE PREMIUM INCREASES BE 600%? 700%? 2000%?

THE STATE OF KANSAS LEGISLATIVELY CREATED BC/BS. BC/BS HAS UTILIZED THE REGULATIONS OFFERED BY THE STATE TO PROVIDE MUCH NEEDED AND AFFORDABLE HEALTH INSURANCE TO MANY KANSANS, MANY TIMES AT A COMPETITIVE OR LOWER RATE THAN NONREGULATED, PRIVATE INSURANCE PROVIDERS. I AM REMINDED OF THE OLD PROVERB, "IF IT AIN'T BROKE, DON'T FIX IT."

BC/BS IS NOT BROKE NOR DOES IT NEED TO BE FIXED. INSTEAD OF DEBATING WHETHER BC/BS SHOULD BECOME A MUTUAL COMPANY, WE SHOULD FOCUS OUR WISDOM AND THOUGHTS ON HOW TO PROVIDE MORE AFFORDABLE HEALTH CARE TO MORE KANSANS. WE SHOULD FOCUS OUR WISDOM AND THOUGHTS ON HOW TO REDUCE THE COST OF HEALTH INSURANCE POLICIES AND STILL PROVIDE QUALITY CARE AND COVERAGE TO INSURANCE CONSUMERS.

THE EXCESSES OF THE 1980's ARE BECOMING PAINFUL REALITIES IN THE 1990's. WE MUST KEEP IN MIND THAT WE ARE HERE TO DO THE BUSINESS OF THE PEOPLE IN THESE GREAT HALLS. BY MAINTAINING BC/BS UNDER STATE AUTHORITY AND REGULATIONS, THE BUSINESS OF THE PEOPLE OF KANSAS WILL HAVE BEEN WELL SERVED.

WIBA

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

ROLAND E. SMITH, *Executive Director*

January 24, 1991

STATEMENT TO: Kansas Senate Committee on Insurance
FROM: Roland E. Smith, Executive Director of the Wichita Independent Business Association
SUBJECT: Senate Bill No. 17 that would allow Blue Cross/Blue Shield of Kansas to become a Mutual Insurance Co.

Chairman Bond and members of the committee; I am sorry I was unable to return to Topeka for your hearing on this bill this morning because of previous commitments. Unfortunately, it was not published so those interested could plan accordingly to attend.

Most of this committee is familiar with WIBA, but for those who may not know WIBA, it is an association of around 1400 locally owned businesses in the Wichita trade area. Of the businesses in Kansas 89% have 25 or less employees. The same is true of the WIBA membership.

Please review the statute that created Blue Cross/Blue Shield of Kansas and you will see there was a definite reason for doing so in order to provide group health insurance to the people of Kansas at reasonable rates. I was told BC/BS controls approximately 35% of the health insurance in Kansas, more than any other insurance carrier. It is my opinion that they have strayed considerably from the original intent of the legislation that created them and have attempted to be a for-profit organization as an insurance company. They shouldn't operate at a loss as a non-profit, but with marginal profits for reserves. I have observed over the past ten years, since my involvement with them through the WIBA sponsored BC/BS Health Care Plan for WIBA members, that their management and marketing policies were not geared to its original purposes and would be doomed to increased losses in my opinion. I knew something was in the wind as each move they made seemed to prostitute themselves in making affordable health insurance for the small independent business. We were told by the insurance department that the only way we could define the term reasonable rates as stated in the statutes would be in a court of law. BC/BS moved all our members in the

WIBA sponsored BC/BS plan to their Multiple Employers Trust, October 1, 1990. They have progressively moved in the position of other insurance companies with the excuse they needed a more even playing field with them. As a result rates for many of our 350 WIBA members still in BC/BS will run from $500 to $1480 per month for man and wife. That is not affordable rates for anyone unless you are rich.

Permitting Blue Cross/Blue Shield of Kansas to become a mutual insurance company, we believe is not in the best interest of the citizens of Kansas. It will destroy what little control the Kansas Insurance Department has over them now. Also it will further help them put the squeeze on the small independent businesses with an employee with health problems. They have deliberatly reduced the risk pools for small businesses and are eliminating many by over excessive premiums, a practice major insurance companies have done for years.

I would ask that this bill be tabled until House Bills 2001 & 2002 are worked. If the concepts in those bills pass where all insurance companies have to have community group rates and all the rates of all insurance companies marketing health insurance in Kansas are regulated, there is no reasonable reason for this bill. Until then, we will continue to oppose Senate Bill No. 17.

I will be in Topeka almost every week for one to three days and will be glad to appear in person with reasonable notice and share with you more input on this subject. It would be very disappointing to see this bill go out of committee this quickly without letting more people know it is being worked.

Thank You!

2-9

Testimony By

Dick Brock, Kansas Insurance Department

Before the Senate Financial Institutions & Insurance Committee

on Senate Bill No. 51

January 29, 1991

In 1988, the legislature enacted a proposal presented by the Insurance Department which requires health maintenance organizations (HMOs) to provide conversion coverage to enrollees or their dependents if their HMO coverage is terminated for any reason and the HMO continues to transact business in the service area. One of the fundamental differences between an HMO and more traditional insurance is that HMOs provide or arrange for the provision of health care services directly to their enrollees rather than in some way paying for or indemnifying insureds for such services. Consequently, when a conversion responsibility was imposed on HMOs it was not believed to be appropriate to attempt to place HMOs under the same kind of continuation and conversion requirements applicable to Blue Cross and Blue Shield and commercial insurers. However, there were a number of similarities so a number of the provisions relevant to conversions generally were made applicable to HMOs by reference. These appear on lines 31 and 22 of page 2.

Senate Bill No. 51 proposes a slight change in this law to more clearly specify the obligation of an HMO to provide enrollees and their dependents a reasonable notice of their conversion rights. Originally an attempt to accommodate this need was by reference to the notice requirement applicable to Blue Cross and Blue Shield and other insurers. This was paragraph (21) on line 32, page 2. However, because this provision also refers to a continuation right not present with respect to HMOs -- although it perhaps should be -- one HMO doing business in Kansas has resisted application of this statute. Therefore, Senate Bill No. 51 proposes the addition of a specific notice requirement to the conversion law applicable to HMOs which should eliminate this problem.

FI & I
1/29/91
Attachment 3

KAISER PERMANENTE

Testimony before
Kansas Senate Committee
on Financial Institutions and Insurance

Senate Bill No. 51
January 29, 1991

Cheryl Dillard
Government and Community Relations Manager
Kaiser Permanente

Mr. Chairman, thank you for the opportunity to present Kaiser Permanente's views on Senate Bill No. 51.

Kaiser Permanente is the country's largest and most experienced health maintenance organization, providing and financing health care for over 6 million members in 16 states and the District of Columbia. In the Kansas City area, we have 44,000 members.

Kaiser Permanente has in the past and will continue to operate in a manner which, we believe, is consistent with the intentions of the Insurance Department and the joint Special Committee on Insurance to offer health insurance coverage to as many Kansans as possible. We reluctantly gave up community rating only two years ago and would welcome a return to that rating method. We are the only HMO in the Kansas City area to offer individual (non-group) coverage and we provide group coverage to small employers with as few as 10 employees.

Senate Bill No. 51, as we understand it, specifies that we give employees who have lost coverage notice within 15 days that they have conversion rights. While we currently have a process in place that notifies our members about their conversion rights, I would propose a change in (7) (C) which would correctly place some responsibility on the employer to notify us in a timely fashion that employees have lost HMO coverage and would also recognize the operational difficulties of a 15 day notice period.

I would also call your attention to a section of K.S.A. 1989 Supp. 40-3209 which has created some difficulties for HMOs. Under Section (7) (B), HMOs are not required to offer conversion rights if "similar group coverage" is offered by the employer within 31 days. In our original support of this legislation two years ago, Kaiser Permanente understood "similar" to mean another group plan offering similar coverage. We did not understand that "similar" was going to be interpreted to mean "identical". We are concerned that this interpretation may make HMOs the "dumping ground" for persons with health conditions which make them unacceptable to a replacement insurer whose policies contain pre-existing condition clauses. As Kaiser Permanente provides coverage for all members of a group regardless of their health status, we strongly support any legislative efforts to level the playing field in regard to pre-existing conditions.

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

FI + I
1/29/91
Attachment 4

KAISER PERMANENTE

Proposed Change in
Senate Bill No. 51

(C) the employee or member is or could be covered by any other insured or noninsured arrangement which provides expense incurred hospital, surgical or medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination. Written application for the converted contract shall be made and the first premium paid not later than 31 days after termination of the group coverage or receipt of notice of conversion rights from the health maintenance organization, whichever is later, and shall become effective the day following the termination of coverage under the group contract. The health maintenance organization shall give the employee or member and such employee's or member's covered dependents reasonable notice of the right to convert at least once within 30 days after the health maintenance organization has received written notice from the employer of termination of coverage under the group contract. In addition, the converted contract shall be subject to the provisions contained in paragraphs (2), (4), (5), (6), (7), (8), (9), (13), (14), (15), (16), (18), (19), and (20) of subsection (D) of K.S.A. 40-2209, and amendments thereto.

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

4-2

Nancy Y- BCBS

frequency of premium payment shall be the frequency customarily required by the health maintenance organization, mutual nonprofit hospital and medical service corporation or insurer for the policy form and plan selected, except that the insurer, mutual nonprofit hospital and medical service corporation or health maintenance organization shall require premium payments at least quarterly. The coverage shall be available to all enrollees of any group without medical underwriting. The requirement imposed by this subsection shall not apply to a contract which provides benefits for specific diseases or for accidental injuries only, nor shall it apply to any employee or member or such employee's or member's covered dependents when:

(A) Such person was terminated for cause as permitted by the group contract approved by the commissioner;

(B) any discontinued group coverage was replaced by similar group coverage within 31 days; or

(C) the employee or member is or could be covered by any other insured or noninsured arrangement which provides expense incurred hospital, surgical or medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination. Written application for the converted contract shall be made and the first premium paid not later than 31 days after termination of the group coverage *or receipt of notice of conversion rights from the health maintenance organization, whichever is later,* and shall become effective the day following the termination of coverage under the group contract. *The health maintenance organization shall give the employee or member and such employee's or member's covered dependents reasonable notice of the right to convert at least once within 15 days of termination of coverage under the group contract.* In addition, the converted contract shall be subject to the provisions contained in paragraphs (2), (4), (5), (6), (7), (8), (9), (13), (14), (15), (16), (18), (19)~~,~~ *and* (20) ~~and~~ ~~(21)~~ of subsection (D) of K.S.A. 40-2209, and amendments thereto.

(b) No health maintenance organization authorized under this act shall contract with any provider under provisions which require enrollees to guarantee payment, other than copayments and deductibles, to such provider in the event of nonpayment by the health maintenance organization for any services which have been performed under contracts between such enrollees and the health maintenance organization. Further, any contract between a health maintenance organization and a provider shall provide that if the health maintenance organization fails to pay for covered health care services as set forth in the contract between the health maintenance

organization and its enrollee, the enrollee or covered dependents shall not be liable to any provider for any amounts owed by the health maintenance organization. If there is no written contract between the health maintenance organization and the provider or if the written contract fails to include the above provision, the enrollee and dependents are not liable to any provider for any amounts owed by the health maintenance organization.

(c) No contract form or amendment to an approved contract form shall be issued unless it is filed with the commissioner. Such contract form or amendment shall become effective within 30 days of such filing unless the commissioner finds that such contract form or amendment does not comply with the requirements of this section.

(d) Every contract shall include a clear and understandable description of the health maintenance organization's method for resolving enrollee grievances.

Sec. 2. K.S.A. 1990 Supp. 40-3209 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

Insurers may include provisions in their group policies, subscription agreements and certificates of coverage that are necessary to identify or obtain identification of persons and events that would activate the continuation and conversion rights created by this Section.

DIA-1
1/29/91
Attachment 5