Approved 3/18/91
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE

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

9:00 a.m./~~p.m.~~ on THURSDAY, MARCH 7, 1991 in room 529-S of the Capitol.

All members were present ~~except~~

Committee staff present:
Bill Wolff, Research Department
Fred Carman, Revisors Office
Louise Bobo, Secretary

Conferees appearing before the committee:
Senator Paul Feleciano
Chip Wheelen, Kansas Medical Society
Bill Sneed, Health Insurance Association of America

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

SB 229 - Health insurance: community rates; eligibility for coverage.

Chairman Bond recognized Senator Paul Feleciano for the purpose of explaining his bill to the members of the committee. Senator Feleciano advised the committee that he realized a number of other bills were floating around which were very similar to SB 229. He stated that he had no "pride of authorship" but just wanted to create an awareness of the magnitude of the problem. Senator Feleciano stressed to the committee that we could not afford to spend another summer studying health issues in interim committees while the number of Kansans without access to affordable health care increased yearly. He continued by stating that SB 229 basically does two things: (1) raises the group number to 50 instead of 25, and (2) provides a phase-in period on community ratings. Senator Feleciano added that he thought that commercial insurance carriers needed to be brought under the jurisdiction of the Insurance Department and that the laws governing Blue Cross Blue Shield needed to be restructured to make BCBS a mutual company. He concluded his remarks by offering to work with the committee in attempting to draft a workable bill.

SB 228 - Uniform policy provisions in sickness and accident insurance policies.

Senator Feleciano began his testimony on this bill by stating that the uniqueness of the problem is a system that has evolved slowly into a million dollar industry. He said that the crux of the problem is that there is no regulatory review by physicians. Chairman Bond advised that he had trouble with the language on page 5 of the bill and asked Senator Feleciano if he was saying that a lot of claims are not being paid because of some arbitrary decision by insurance companies because there is not a proper review board. Senator Feleciano agreed and added that about five states had addressed the problem by creating their own oversight committees. Staff added that summaries of the actions of these five states could be found in the Interim Committee report. Senator Feleciano concluded his remarks by stating that he prepared this bill in answer to complaints from physicians who are having trouble collecting claims.

Chip Wheelen, Kansas Medical Society, stated in his testimony that some insurers are responsible in their utilization review determinations but that others do not respond to patients or health care providers and do not employ health care professionals on their utilization review boards. Some providers have objected to utilization review boards because they consider it an invasion of their privacy as well as the privacy of their patients. Also, they object to the amount of paperwork involved and question the qualifications of individuals who conduct the utilization review procedures. Mr. Wheelen concluded by stating that his organization did not think SB 228 addressed the problem of irresponsible utilization review practices. He further stated his

organization recommended no legislation at this time and that the Kansas Medical Society and the Kansas Foundation for Medical Care have plans to get together and work out a proposal that will comprehend the problem and will be ready to introduce to the 1992 Legislature. (Attachment 1)

Bill Sneed, Health Insurance Association of America, informed the committee that his organization opposed the passage of SB 228. He stated that they felt this bill was an attempt to diminish the ability of a health insurance provider to review the necessity and validity of claims. He further stated that his organization considered it inappropriate for the Legislature to consider a bill that would eliminate one of our cost saving mechanisms at a time when it is considering how to curb health care costs. (Attachment 2)

During a brief discussion, Mr. Sneed was asked by a committee member what avenues the public currently could follow if they had a complaint. Mr. Sneed replied that there are internal processes throughout a company which one might follow or a complaint could be filed with the State Insurance Department.

Written testimony provided by Roland Smith, Wichita Independent Business Association, and enumerating the concerns of his organization with regard to group health care insurance, was passed out to the members of the committee. (Attachment 3)

There being no additional conferees, the hearing was closed. The Chairman determined the consensus of the committee concerning SB 229 was to hold it in committee and consider it, at a later date, with other bills of similar content.

Minutes of Tuesday, March 5, were approved on a motion by Senator Salisbury. Senator Reilly seconded the motion. The motion carried.

The meeting adjourned at 9:50 a.m.

GUEST LIST

COMMITTEE: FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE DATE: Thurs. March 7, 91

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
CARRI HAJEK	RR1 BOX 216 MARION KS	MARION HIGH SCHOOL
Brian Crofoot	203 Meadow Ln Marion 66861	Marion High School
George Goebel	Topeka	AARP SLC - CCTF
BRENDAN SWEEGAS	1919 MACVICAR	WASHBURN UNIVERSITY
Stephen Burgess	Topeka	Sr. Judiciary Staff
Roland Smith	Winfield	WIBA
TOM PALACE	TOPEKA	SLSI
CHARLES WALKER	TOPEKA	SRS/DMS
GARY Robbins	Topeka	Ks Opt Assn
Chip Wheelen	Topeka	Ks Med. Society
Daniel Zajicmann	606 S. Freedom Marion Ks	Marion High School
Mayor L. Goodman	Kansas City	Humana Prime Health
Ann McWinden	208 S. Roosevelt	Marion High School
Julie Sellers	RR1 Box 60, Florence KS	Marion High
Laurie Tajchman	606 S. FREEBORN Marion KS	Marion High
Sheldon Bina	404 S Roosevelt Marion KS 66861	Marion High
William Rafel	1007 Marion Florence KS 66851	Marion High
JOE FURJANIC	TOPEKA	KCA
Nancy Zogleman	Topeka	BC/BS of Ks
BILL SNEED	TOPEKA	NIAA
Lynn GRANT	TOPEKA	KCCI
JIM OLIVER	"	PEAK
Wendell STROIN	"	AARP-CCTF
Dick Brock	"	Ins Dept

KMS

KANSAS MEDICAL SOCIETY

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Kansas WATS 800-332-0156 FAX 913-235-5114

March 7, 1991

TO: - Senate Financial Institutions and Insurance Committee

FROM: Kansas Medical Society Chip Wheelen

SUBJECT: Senate Bill 228, Accountability of Utilization Review

Thank you for this opportunity to comment regarding the proposed amendment to current law contained in SB 228 and the subject of utilization review in general. Some insurers are indeed responsible in their utilization review determinations, but others fail or refuse to respond to patients or their health care providers as to the criteria for denying coverage. Accessibility to utilization review decisionmakers is sometimes difficult, particularly when insurers do not employ health care professionals in the process. The current situation was described extremely well in the report on 1990 interim studies (proposal no. 28).

In the recent past, utilization review -- the method used by purchasers of health care to promote quality in health care, cost effective health care, and to hold down the costs of health care -- has undergone a rapid growth. A decade ago, utilization review was virtually unknown in the private sector, although governmental programs were utilizing health care procedure review in managing programs such as Medicare and Medicaid. During the 1980s, both utilization review and utilization management services came into wider use. A wide range of payers now use some form of utilization review to try to identify inappropriate or unnecessary health care procedures performed by a range of providers, with particular emphasis on the practice of physicians and on hospital services. Utilization review is generally carried out by a third-party agency on behalf of insurers, HMOs, preferred provider organizations, and many large employers who are self-insurers or who are concerned about keeping health benefit costs from escalating at an increasingly rapid rate.

Utilization review has come under fire from some providers who see utilization review procedures as an intrusion into their practice and as a threat to their autonomy in prescribing the care they believe best for their patients. Providers, particularly physicians, are faced with an increasing number of requests to supply information, patient records, and backup data to support the decisions they have made as to the appropriate and necessary treatment for their patients. A source of particular irritation is the lack of standardization among utilization review procedures resulting in physician

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offices and hospitals being asked to supply data in different formats to entities that reimburse for their services. Complaints about the amount of paperwork involved in reviews, concerns over patient privacy, and questions about the qualifications of persons who conduct utilization review procedures also have been voiced by providers. Questions have been raised as to the value of utilization review procedures as they become increasingly intrusive, particularly in the practice of medicine and surgery. Other issues raised by providers of health care are the lack of standardization of review procedures, failure of review agencies to disclose the criteria they use in making decisions about the appropriateness and necessity of procedures performed, and the lack of clear and uniform procedures for appealing decisions made by reviewers. Several provider groups, but primarily state medical societies, have lobbied in the past two years for state regulation of utilization review, of the agencies carrying out reviews, and of personnel employed to conduct reviews.

The statutory amendment found on page 5 of SB 228 could possibly improve accountability of insurance coverage decisions, but only if it is amended to require that denial of a claim shall be made only if such review is performed by a physician licensed to practice in Kansas. This would mean that if a patient or the patient's physician disagrees with the reviewer's decision to not provide insurance coverage, a complaint could be filed with the State Board of Healing Arts. Unfortunately, the Board of Healing Arts has expressed reluctance to become involved in what might arguably be considered regulation of insurance contracts. Furthermore, SB 228 (amended or not) would not address the problem of irresponsible utilization review practices by administrators of self-insured employee health benefits programs.

Lastly, we should mention that the 1990 Special Committee on Public Health and Welfare recommended in regard to proposal no. 28 "that no legislation be introduced at this time, but that the standing Public Health and Welfare committees, instead, monitor the progress made by the Utilization Review Accreditation Commission in developing standards to accredit utilization review firms." In the meantime, the staff of the Kansas Medical Society has initiated dialogue with staff of the Kansas Foundation for Medical Care to develop options for consideration by our House of Delegates which will convene in May. The outcome of that process will likely be a proposal for legislation to be requested in the 1992 Session.

Thank you for considering our comments.

/cb

MEMORANDUM

TO: The Honorable Dick Bond
Chairman, Senate Financial Institutions and Insurance Committee

FROM: William W. Sneed
Health Insurance Association of America

DATE: March 7, 1991

RE: Senate Bill 228

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 Senate Bill 228.

Although we are not completely certain, we believe that S.B. 228 is an amendment to the uniform policy provisions of K.S.A. 40-2203, which is an attempt to diminish the ability of a health insurance provider to review the necessity and validity of health claims.

The high cost of health care is a major problem in the United States. Although cost escalation has many causes, research shows that one key problem is that patients receive much care that is not appropriate for their condition. Eliminating such deficiencies, which may account for 25% or more of medical expenditures, is clearly a critical objective, both as a way of reducing costs and improving quality of care.

Increasingly, managed care is recognized as the best mechanism for carrying out such improvements. The key objective of managed care is to assure that patients

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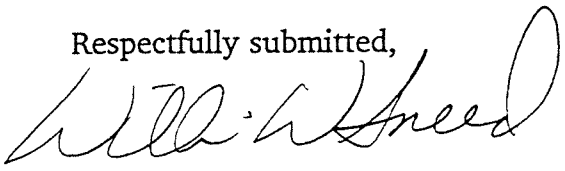
receive appropriate care and that it is high quality care efficiently provided in the least costly setting.

I am sure most of the members of the Committee are familiar with managed care types of programs such as Health Maintenance Organizations or Preferred Provider Organizations. Another type of managed care is programs for ongoing quality assurance and utilization review. It would appear that the amendment found in S.B. 228 is an attempt to limit the ability of insurers to provide quality assurance and utilization review.

We believe it is inappropriate for the Legislature, when it is looking at various alternatives to limit or curb the escalating health care costs, to consider a bill which would eliminate one of the mechanisms currently in place that does indeed lead to a reduction in costs.

Based upon the foregoing, the HIAA respectfully requests your disfavorable action on S.B. 228. We appreciate the opportunity to appear before the Committee, and if there are any additional questions, please feel free to contact me.

Respectfully submitted,



William W. Sneed
Legislative Counsel
Health Insurance Association of America

WICHITA INDEPENDENT BUSINESS ASSOCIATION
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(316) 943-2565

ROLAND E. SMITH, *Executive Director*

March 7, 1991

STATEMENT TO: Senate Committee on Financial Institutions and Insurance
FROM: Roland Smith, Executive Director - Wichita Independent Business Association
SUBJECT: SB 229 and related legislation

Chairman Bond and members of the Committee, I would like to relate to you some concerns WIBA members have without relating the many horror stories that exist with small independent businesses when it comes to group health insurance availability and affordability.

It is my understanding you will be combining several bills including SB 229 into a single bill that will deal with group health insurance. There are several points that are very important to us that I would like to relate to you. They are:

1. Having community group health insurance rates for all businesses in Kansas with 100 or fewer employees. Even businesses with more than 25 that have one major claim in one year can cause their insurance rates to become intolerable. Community group rates being defined as the sum total of the claims experience plus necessary costs and reserves divided by the number of lives with each insurance company doing business in Kansas. The only classification would be single, couple, single parent and family coverage. No tier rating in any form. Several insurance company representatives have told me their company would cease doing business in Kansas. My answer to them would be "Goodbye". The larger the risk pool per remaining companies the better. As it is, we have insurance companies that are only writing the well people and ruin the concept of large risk pools intended in the concept of group health insurance. I am convinced community group rates will not drive up the premium costs to most people in the proportion that has been presented before both the House and Senate Insurance Committees. We do believe community group rates need to be phased in, but not in the method proposed in HB 2001. I did not find anything in SB 229 addressing this issue.

2. Pre-existing conditions need to be accepted in all groups. Many persons are being discriminated against because of health conditions as a lot of businesses cannot afford to hire or keep them when their insurance premiums go out of sight due to the employee's experience in using their plan.

3. The filing of insurance rates without true justification approval by the Kansas Insurance Department, we believe is a serious problem. I have heard most of the arguments about the overload, delays and costs it would incur, but that is a smoke screen in my opinion. Kansas brags about the low auto rates in Kansas, why not control the health insurance rates in a similar way?

Please give careful consideration of these issues and provide some appropriate legislation to help the small businesses in Kansas. Eighty-nine percent of all businesses in Kansas have fewer than 25 employees and provide over 50% of the employees in Kansas. They need your help now!

THANK YOU!

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