Approved 4/1/91
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 WEDNESDAY, MARCH 27, 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:

Nancy Zogleman, Blue Cross Blue Shield
Dick Brock, Kansas Insurance Department
Roland Smith, Wichita Independent Business Association
Jim Schwartz, Kansas Employer Coalition on Health

Chairman Bond called the meeting to order at 9:11 a.m.

HB 2001 - Health insurance: community rating; eligibility for coverage under group policies.

The Chairman explained to the committee that SB 16, 17, 179 and 229, along with HB 2001, all dealt with various aspects of health care insurance but that the chief focus of the committee would be on HB 2001. He requested Senator Feleciano, sponsor of SB 229, to state his opinion with regard to these health care bills. Senator Feleciano said that he would like to see SB 16 and 17 amended into HB 2001 but leave HB 2001 as is. He also said that he would like to see the group size raised to 50.

Senator Walker was asked his desires regarding these bills. Senator Walker said that he agreed with Senator Feleciano and would also be agreeable as he thought HB 2001 was the bill to work. Chairman Bond said that SB 179 had subrogation in it and might present problems for passage. Senator Walker then advised against amending it into HB 2001. (Attachment 1)

Nancy Zogleman, BCBS, appeared before the committee in support of HB 2001. She explained that the bill could be divided into three parts: (1) underwriting for access to group insurance, (2) rate regulation and (3) small group reform (community rating). Ms. Zogleman continued her testimony by explaining the provisions of the bill under each section. (Attachment 2)

Dick Brock, Kansas Insurance Department, informed the committee that the Insurance Department had been actively engaged in the development and support of this bill. Mr. Brock advised that one of the problems that has evolved from the health care cost dilemma is the erosion of the group insurance concept and trying to finance the payment of costs over which we have no control. Mr. Brock also advised that a technical correction needed to be made on page 2, lines 6-7, by striking the language between the words "policy" and "may", thus assuring the bill is applicable to all group policies. Mr. Brock informed the committee that the House amendment requiring the filing of all group insurance rates would make it necessary for them to hire at least one new policy examiner and even this additional personnel would only provide for a cursory review of the 11,000 estimated additional rate filings. (Attachment 3)

Roland Smith, Wichita Independent Business Association, addressed the committee in support of HB 2001. He said that, though this bill was only a small step in solving the problems, his organization supported it because it (1) requires insurance companies doing business in Kansas to take persons with pre-existing conditions in writing group coverage for businesses with fewer than 25 employees, and (2) having companies file

their group health insurance rates with the Kansas Insurance Department. Mr. Smith suggested that the bill could be improved by providing better community group rating and classification language including a 5 year phase-in from both spectrums of high and low rates in order to establish a community group rate at the end of 5 years. Mr. Smith concluded by stating that while they supported HB 2001 they thought it did little to help make health insurance more avoidable. (Attachment 4)

Jim Schwartz, Kansas Employer Coalition on Health, informed the committee that the bill does not provide for pure community rating as the 50% adjustment allowance dilutes much of the bill's impact. He continued that the way to deal with this weakness of community rating is to require that insurers must accept any applying employer group. Mr. Schwartz concluded by stating that HB 2001 does not address the overall cost problem. (Attachment 5)

Written testimony provided by Representative Larry Turnquist and John W. Alquest, Income Support/Medical Services, SRS, was distributed to members of the committee. (Attachments 6 and 7)

Minutes of the March 21, 1991 meeting were approved as written on a motion by Senator Yost with Senator Strick seconding the motion. The motion carried.

The meeting adjourned at 10:00 a.m.

GUEST LIST

SENATE

COMMITTEE: FINANCIAL INSTITUTIONS AND INSURANCE

DATE: Wed. Mar 27, '91

NAME	ADDRESS	ORGANIZATION
Charles Simpka	KS Foundation for Medical Care	
Wendell Strom	Topeka	AARP-CCTF
George Goebel	Topeka	AARP SLC CCTF
Roger D Kirkwood	Topeka	AARP-CCTF
R. A. Cooney	"	CBP Inc
Kalland Arnold	Wichita	WIBA
Chip Wheelen	Topeka	KS Medical Soc.
M. L. Goldman	Kansas City	KS HMO Assn
Joseph A Kun	Topeka	BC/BS of Kansas
Nancy Zogleman	Topeka	BC/BS of Ks
JIM OLIVER	"	PIAK
Rick Friedstrom	Topeka	KALC
Hank Isaac	Topeka	Ks. Bankers Assoc.
Dan Scott	Topeka	Wheatland Group Holdings Inc
Jerry Bonebrake	Manhattan	KS Farm Bureau Life
Lyndon Dunn	Topeka	KDOA
Mary Spinks	Topeka	Health Benefits Admin
Don Hoffer	Topeka	Delta Dental
GARY Robbins	Topeka	KS Opt Assn
Tom Bell	"	KS. Hosp. Assn.
Jerry SCHLAGER	TOPEKA	KMS
ALAN COBB	Wichita	Wichita Hosps
Ken Bahr	Topeka	Ks. Hospital Assn.

GUEST LIST

SENATE

COMMITTEE: FINANCIAL INSTITUTIONS AND INSURANCE

DATE: Wed. March 27 '91
Continued

NAME	ADDRESS	ORGANIZATION
M. Hawver	Topeka	Ca-Jm
Jim Schwartz	Topeka	KECH

DOUG WALKER
SENATOR, 12TH DISTRICT
MIAMI, BOURBON, LINN,
ANDERSON, ALLEN AND
NEOSHO COUNTIES
212 FIRST
OSAWATOMIE, KANSAS 66064
(913) 755-4192 (HOME)
(913) 296-7380 (STATE CAPITOL)

STATE OF KANSAS

TOPEKA

SENATE CHAMBER

COMMITTEE ASSIGNMENTS

MEMBER: CONFIRMATIONS
EDUCATION
ENERGY AND NATURAL RESOURCES
FEDERAL AND STATE AFFAIRS
PUBLIC HEALTH AND WELFARE

MEMORANDUM

March 27, 1991

To: Senator Dick Bond

From: Senator Doug Walker

Re: HB 2001 & SB 179

After reviewing the provisions of HB 2001 and SB 179, I would recommend that the Senate FI & I committee concentrate its efforts on HB 2001 and recommend it favorably for passage. Similar provisions, and indeed the same language, exists in both bills with the house having througherly examined and made appropriate changes in language in HB 2001.

The two major differences in the two bills are that SB 179 provides for a state Medicaid plan and expands the small employer health benefit plan. HB 2001 does not address those issues. Those concepts are, however, contained seperately in HB 2440 and HB 2565.

If it is the desire of the committee, those concepts could be easily amended into HB 2001.

Attachment 1
FI & I
3/27/91

Blue Cross
Blue Shield
of Kansas

1133 S. W. Topeka Boulevard
Topeka, Kansas 66629-0001

Local Corporate Phone #-
(913) 291-7000
Corporate 800 Number -
(800) 432-0216

TESTIMONY ON HOUSE BILL 2001
BLUE CROSS AND BLUE SHIELD OF KANSAS, INC.
March 27, 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.

Before I address specific provisions of HB 2001, I would like to remind the committee of this bills evolution. HB 2001 was recommended by the Special Committee on Insurance after the committee heard considerable testimony, explored possible amendments, listened to staff briefings and reviewed provisions by many groups.

Certain components of this bill are not new. Several provisions in this bill have been before the Insurance Committee in previous sessions. However, in several aspects HB 2001 is very different. This bill combines recommendations from the Insurance Department, the insurance industry, National Association of Insurance Commissioners, and many other groups in order to provide REAL reform. And what I found to be really interesting, is that several other groups, The Governor's Commission on Health Care and the Commission in Access to Services for the Medically Indigent and Homeless, came up with many of the same recommendations which are provided for in this bill.

Some may criticize this bill for going too far and some may criticize this bill for not going far enough, but until we have at least moved off dead center, we will not know how far we need to go.

This bill can be divided into three parts: (1) Underwriting (or access to group insurance); (2) Rate Regulation; and (3) Small Group Reform (Community Rating). Each of these parts will work independently from the other, but as a whole, they address many of the problems occurring with health insurance today.

1941 50 1991
Years of Caring
for Kansans

Attachment 2
I + I
3/27/91

Underwriting

1. Prohibits excluding persons from eligibility Section 1(A), page 1, lines 25-37

HB 2001 addresses a practice of insurers which creates a substantial barrier to access to health insurance for Kansans, particularly for employees of small employers, and for their dependents.

The practice is that of a health insurer insuring only healthy persons within a group, and refusing to insure persons with current health conditions.

In late December of 1989, Blue Cross and Blue Shield started documenting some cases in which another insurer would replace Blue Cross and Blue Shield coverage and would refuse to accept all persons within the group because of past health conditions. Under most circumstances, where this occurs, Blue Cross and Blue Shield continues coverage for such persons for six months and then offers a conversion privilege at the end of that time, but the conversion coverage is very expensive and frequently not as broad as the group coverage.

Since December of 1989, several hundred cases have been brought to our attention where persons have asked for continued coverage because a carrier replacing our coverage refused to insure persons currently in the group. Some of the reasons cited by those seeking coverage were:

- "The subscriber's wife is overweight and they are a very conservative company."

- "Because of pre-existing, I will not be covered for one to two years."

- "Wife not eligible due to high blood pressure."

- "At first they said I was eligible then three days later said I wasn't eligible due to colon surgery in November, 1989."

• "Hysterectomy and found cancer, doctor stated everything was taken care of, but new insurance won't take her."

• "Considered a health risk -- Brain tumor. Recovered."

The insurers in these situations engage in the group insurance business, but do not insure anyone who is not healthy -- they only insure those who need the insurance least, not those who have a clear need for the insurance.

This provision found in HB 2001 is to prohibit an insurer from excluding a person from coverage under a group policy under these situations. This provision is also extraterritorial which means it applies to both contracts issued in Kansas and those issued outside of Kansas.

Recommended by:
Special Committee on Insurance
National Association of Insurance Commissioner
Governor's Commission on Health Care
Commission on Access to Services for the Medically Indigent

2. Prohibit limiting or excluding benefits for specific conditions
Section 1(A), page 1, lines 37-41

This provision, in addition to not being able to refuse coverage, an insurer also could not place a rider on coverage, saying, for example, "No coverage is available for John Doe for heart conditions." This goes hand-in-glove with the first provision, since as insurer accepting people in a group for coverage but then stripping all that coverage by specific riders would be creating the same practical effect as excluding them. This provision is also extraterritorial.

Recommended by:
Special Committee on Insurance
National Association of Insurance Commissioner
Governor's Commission on Health Care
Commission on Access to Services for the Medically Indigent

3. Waiting period for pre-existing conditions
Section 1(A), page 1-2, lines 41-2

This provision suggests allowing insurers to impose a waiting period for pre-existing conditions for up to one year. That is, it permits the insurer to have some safeguard against persons who previously were eligible but wait to enroll during a later open enrollment period when they know they are going to have claims, or against persons who obtain employment merely to obtain health coverage.

Recommended by:
Special Committee on Insurance
National Association of Insurance Commissioner
Governor's Commission on Health Care

4. Portability of waiting period
Section 1(A), page 2, lines 2-5

The concept of portability suggest that a policy waive a waiting period to the extent it had been served while covered under a prior group accident and sickness coverage with no gap in the coverage. That is, an insured could go from one employer to another, or an employer, could replace current group coverage with another group coverage, without the employees having to re-serve a new one year waiting period for conditions that may have been covered under the prior insurance.

Recommended by:
Special Committee on Insurance
National Association of Insurance Commissioner
Governor's Commission on Health Care
Commission on Access to Services for the Medically Indigent

Rate Regulation

5. Rate Regulation of All Health Insurers
Section 2 (b), page 12, lines 26-32

Blue Cross and Blue Shield of Kansas supports the concept that all insurers should be regulated equally. Currently, because of the

unique way in which Blue Cross and Blue Shield of Kansas is set up, it is the only insurance company doing group business in the State of Kansas which has its rates regulated.

The Kansas Insurance Department currently regulates the rates of at least 642 companies for rates of fire, homeowners, crop damage, liability, auto, malpractice, and all other coverage **except health and life**. (KSA 40-925 et. seq, KSA 40-1111 et. seq) Only HMOs and Blue Cross and Blue Shield currently have their rates regulated. This bill, as amended by the House Committee, would regulate the rates of all insurers of group and blanket health policies. The major commercial insurers, who at this time are unregulated, doing business in the state are:

Metropolitan Life - New York, NY
Aetna Ins. Co. - Hartford, CT
Travelers Ins. Co. - Hartford, CT
Prudential Ins. Co. - Newark, NJ
Principal Mutual - Des Moines, IA
Lincoln National Life - Ft. Wayne, IN
Equitable Life Assurance - New York, NY
Connecticut General Life Ins. - Bloomfield, CT
Fidelity Security Life Ins. - Kansas City, MO
Federated Mutual - Owatonna, MN
Mutual Benefit Life - Newark, NJ
Business Mens Assurance - Kansas City, MO
Northwestern National Life - Minneapolis, MN
United of Omaha - Omaha, NE
Benefit Trust Life - Lake Forest, IL
Association Life - Brookfield, WI
Mutual of Omaha - Omaha, NE
Great-West Life Assurance - Winnipeg, Canada
American Medical Security - Milwaukee, WI
Woodmen Accident and Life - Lincoln, NE

The filing of rates will give the Insurance Department important information in determining if those companies who are offering insurance in the state are complying with legislation, such as HB 2001. The filing of rates would also provide valuable information for those individuals who would like to take advantage of the Open Records process. Additional, if rates are filed, data could be collected to determine how much money is actually being

spent on health care and what is happening with rates. In essence, the filing of rates provides accountability.

In a quick check with some of our surrounding states, I found that Nebraska and Oklahoma currently have "file and use", and Iowa passed legislation last session to provide for "file and use".

This "file and use" provision would apply rates regulation equally to all insurers doing business in the state.

Both the Governor's Commission on Health Care and the Commission on Access to Services for the Medically Indigent/Homeless, recommended that all insurers be subject to the same provisions of law and be equally regulated. Independently, the Special Committee on Insurance came to a similar conclusion when it requested legislation to be drafted which provided for rate regulation and provided for changes in the governance of Blue Cross and Blue Shield. At this time, I would like to remind the committee of SB 16 & 17 which would provide the ability for Blue Cross and Blue Shield to be treated like all other insurers. (amendments)

Recommended by:

Special Committee on Insurance
Governor's Commission on Health Care
Commission on Access to Services for the Medically Indigent

Small Group Reform

6. Community rating for small groups
Section 2 (e)(2)(B), page 13-14, lines 34-32

This provision would provide a similar rate to all groups of 25 or fewer regardless of their individual group's use of medical service. This would allow small businesses, which are not large enough to self-insure, to be pooled with other small businesses in order to spread the risk. Community rating requirements would reduce the cases of some groups experiencing 200% increases in premiums because of that group's claims experience alone, and would spread those costs among all small groups.

Five years phase-in - Because the rate variations we see today, have taken place over many years of rating in the insurance

industry, the Insurance Interim, as well as the House Insurance Committee, believed the best approach back to community rating would be gradual one. It would be a sudden change to a large number of employees if these rates were shifted immediately to a "pure community rate". What would result is a significant rate reduction to some of the high risk groups and also some significant rate increases to the most favorable risk groups.

50% variation - The 50% variation provides some variation of rates to recognize the difference and risks of individual groups. This would also allow some price break for wellness programs, etc.

Recommended by:

Special Committee on Insurance
Governor's Commission on Health Care
Commission on Access to Services for the Medically Indigent

	HB 2001 (Ins. interim) *as amended by House Committee	SB 179 (Walker & others)	HB 229 (Feleciano)
Underwriting:			
A. Must insure everyone in group.	YES	YES	YES
B. Prohibits riders for medical conditions.	YES	YES	YES
C. Portability of waiting period.	YES	YES	YES
Rate regulation of all health insurance	*YES-file & use	YES-file & use	YES-prior approval
Community Rating:			
A. Size of group.	25 or fewer	50 or fewer	25 or fewer
B. Applies to employer units of associations, METs.	YES	YES	YES
C. Phase in period.	YES-five years	YES-five years	NO
D. Variance from community rate permitted.	50% over average community rate	50% over average community rate	No variance
Other provisions:			
A. Must insure any group which applies	-	YES	-
B. Expands Small Employer Health Benefit Plan	-	YES-to 50 employees (HB 2440)	-
C. Subrogation rights	-	YES	-
D. State Medicaid Plan	-	YES (HB 2565)	-
Prepared by BC/BS of Kansas			

income protection policy.

~~(d)~~ ~~(f)~~ (g) The commissioner may at any time, after a hearing of which not less than 20 days' written notice shall be given to the insurer, withdraw approval of any such form ~~on any of the grounds stated in this section~~ *or* disapprove any *rate* filed in accordance with subsection (a) *in the event the commissioner finds such filing no longer meets the requirements of this section or of article 22 of chapter 40 of the Kansas Statutes Annotated, and amendments thereto*. It shall be unlawful for the insurer to issue such form or use it in connection with any policy after the effective date of such withdrawal of approval.

~~(g)~~ (h) *Violations of subsection (e) shall be treated as violations of the unfair trade practices act and subject to the penalties prescribed by K.S.A. 40-2407 and 40-2411 and amendments thereto.*

~~(e)~~ ~~(h)~~ (i) Hearings under this section shall be conducted in accordance with the provisions of the Kansas administrative procedure act.

Sec. 3. K.S.A. 1990 Supp. 40-19c09 is hereby amended to read as follows: 40-19c09. Corporations organized under the nonprofit medical and hospital service corporation act shall be subject to the provisions of the Kansas general corporation code, articles 60 to 74, inclusive, of chapter 17 of the Kansas Statutes Annotated, applicable to nonprofit corporations, to the provisions of ~~K.S.A. 1990 Supp. 40-2250 and 40-2251 and to the provisions of~~ K.S.A. 40-214, 40-215, 40-216, 40-218, 40-219, 40-222, 40-223, 40-224, 40-225, 40-226, 40-229, 40-230, 40-231, 40-235, 40-236, 40-237, 40-247, 40-248, 40-249, 40-250, 40-251, 40-252, 40-254, 40-2,100, 40-2,101, 40-2,102, 40-2,103, 40-2,104, 40-2,105, 40-2,116, 40-2,117, 40-2a01 *et seq.*, 40-2111 to 40-2116, inclusive, ~~40-2216~~ *40-2215* to 40-2220, inclusive, 40-2401 to 40-2421, inclusive, and 40-3301 to 40-3313, inclusive, and amendments thereto, and to the provisions of K.S.A. ~~1989~~ 1990 Supp. 40-2221a, 40-2221b, 40-2229 ~~and~~, 40-2230, 40-2250 and 40-2251, and amendments thereto, except as the context otherwise requires, and shall not be subject to any other provisions of the insurance code except as expressly provided in this act.

Sec. 4. K.S.A. 1990 Supp. 40-19c07, 40-19c09, 40-2209 and 40-2215 are hereby repealed.

Sec. 5 This act shall take effect and be in force from and after January 1, 1992, and its publication in the statute book.

Sec. 3. K.S.A. 1990 Supp. 40-19c03 is hereby amended to read as follows: 40-19c03. Nonprofit corporations may be organized under the nonprofit medical and hospital service corporation act for the purpose of entering into contracts with participating health care providers and participating hospitals to provide professional and hospital services for subscribers as may be designated in subscription agreements. Such corporations shall also indemnify subscribers as designated in subscription agreements for services which may be received from nonparticipating health care providers or nonparticipating hospitals. Such corporations may also provide service or indemnity for other health services or facilities but not to exceed reasonable and customary charges that a subscriber may incur for these services. The affairs of any such corporation shall be managed by a board of directors ~~of not less than 15 members as specified by the articles of incorporation composed of: Persons licensed under the Kansas healing arts act and trustees or administrators of hospitals who participate in providing professional and institutional service to subscribers and members of the public exclusive of persons licensed under the Kansas healing arts act and hospital trustees or administrators who, at the time of their election, are subscribers. Beginning with the election of directors immediately following the effective date of this act, the board of directors at all times shall include at least one person licensed under the Kansas healing arts act to practice allopathic medicine and surgery, osteopathic medicine and surgery and chiropractic. Two members of the public who are subscribers shall be appointed to the board of directors by the governor of the state of Kansas. The members of the public, exclusive of physicians and hospital trustees or administrators, shall at all times comprise a majority of the membership of the board of directors~~. *The number, qualifications, terms of office and appointment of directors shall be as provided in the bylaws of the corporation.* The directors shall take the oath of office as in other corporations and duplicates of such subscribed oaths shall be forwarded at the time of election to the commissioner of insurance for filing. The bylaws shall specify the number of directors necessary to constitute a quorum which shall not be less than ~~10 members~~ *one more than one-half of the number of directors*.

K.S.A. 40-19c03 and

income protection policy.

~~(d)~~ ~~(f)~~ (g) The commissioner may at any time, after a hearing of which not less than 20 days' written notice shall be given to the insurer, withdraw approval of any such form ~~on any of the grounds stated in this section~~ or disapprove any *rate* filed in accordance with subsection (a) *in the event the commissioner finds such filing no longer meets the requirements of this section or of article 22 of chapter 40 of the Kansas Statutes Annotated, and amendments thereto.* It shall be unlawful for the insurer to issue such form or use it in connection with any policy after the effective date of such withdrawal of approval.

~~(g)~~ (h) *Violations of subsection (e) shall be treated as violations of the unfair trade practices act and subject to the penalties prescribed by K.S.A. 40-2407 and 40-2411 and amendments thereto.*

~~(e)~~ ~~(h)~~ (i) Hearings under this section shall be conducted in accordance with the provisions of the Kansas administrative procedure act.

Sec. ~~3.~~ 4 K.S.A. 1990 Supp. 40-19c09 is hereby amended to read as follows: 40-19c09. Corporations organized under the nonprofit medical and hospital service corporation act shall be subject to the provisions of the Kansas general corporation code, articles 60 to 74, inclusive, of chapter 17 of the Kansas Statutes Annotated, applicable to nonprofit corporations, to the provisions of ~~K.S.A. 1990 Supp. 40-2250 and 40-2251 and to the provisions of~~ K.S.A. 40-214, 40-215, 40-216, 40-218, 40-219, 40-222, 40-223, 40-224, 40-225, 40-226, 40-229, 40-230, 40-231, 40-235, 40-236, 40-237, 40-247, 40-248, 40-249, 40-250, 40-251, 40-252, 40-254, 40-2,100, 40-2,101, 40-2,102, 40-2,103, 40-2,104, 40-2,105, 40-2,116, 40-2,117, 40-2a01 *et seq.*, 40-2111 to 40-2116, inclusive, ~~40-2216~~ *40-2215* to 40-2220, inclusive, 40-2401 to 40-2421, inclusive, and 40-3301 to 40-3313, inclusive, and amendments thereto, and to the provisions of K.S.A. ~~1989~~ 1990 Supp. 40-2221a, 40-2221b, 40-2229 ~~and~~, 40-2230, 40-2250 and 40-2251, and amendments thereto, except as the context otherwise requires, and shall not be subject to any other provisions of the insurance code except as expressly provided in this act.

Sec. ~~4.~~ 5 K.S.A. 1990 Supp. 40-19c07, 40-19c09, 40-2209 and 40-2215 are hereby repealed.

Sec. ~~5.~~ 6 This act shall take effect and be in force from and after January 1, 1992, and its publication in the statute book.

New Sec. 3 - Any nonprofit medical and hospital service corporation organized pursuant to the provisions of article 19c of chapter 40 of the Kansas Statutes Annotated, may, at its option and without reincorporation, adopt and become subject to the provisions of article 5 of chapter 40 of the Kansas Statutes Annotated, governing mutual life insurance companies, or of article 12 of chapter 40 of the Kansas Statutues Annotated, governing mutual companies other than life, by the adoption of a resolution of its board of directors declaring the election of the nonprofit medical and hospital service corporation to become subject to the provisions of article 5 or 12 chapter 40 of the Kansas Statutes Annotated. After the adoption of such resolution, the board of directors shall adopt such amendments to the articles of incorporation and bylaws of the corporation as shall be necessary and shall file the same with the commissioner of insurance, together with a plan for mutualization setting forth provisions for fulfilling the conditions necessary to effect the mutualization and a designated date upon which such mutualization shall become effective if such conditions are fulfilled. Upon the designated date set forth in the plan, the nonprofit medical and hospital service corporation shall be subject to the provisions of law so elected, and shall not be governed by article 19c of chapter 40 of the Kansas Statutes Annotated thereafter. The existing contract rights and obligations of such corporation, of subscribers and of health care providers shall not be impaired by such conversion to mutual status.

2-10

February, 1991

EXAMPLE OF SMALL GROUP RATING POOL OF TEN GROUPS

I. Current Rate Distribution: (5 Family Contracts Per Group)

1 Group at $200 per month per family contract
2 Groups at $300 per month per family contract
3 Groups at $400 per month per family contract
2 Groups at $700 per month per family contract
1 Group at $900 per month per family contract
1 Group at $1,200 per month per family contract
10 Groups at an average rate of $550 per month per contract

(Above rates would produce Total Premiums of $27,500 per month)

II. H.B. 2001 would establish a maximum variation in rates of 50% above the average rate. Any group with rates above the maximum rate would have no rate adjustments made until five years or until their rates were below the maximum rate.

A. First year adjustments with an annual 10% increase to the pool

($550 Average Rate X 110% = $605) ($605 Average Rate X 150% = $908 (Maximum rate)

	Current Rates		1st Yr. Rates	Increase $ Amount	Increase Percentage
1 Group at	$ 200 per month per contract	would go to	$ 230	$ 30	16%
2 Groups at	$ 300 per month per contract	would go to	$ 348	$ 48	16%
3 Groups at	$ 400 per month per contract	would go to	$ 464	$ 64	16%
2 Groups at	$ 700 per month per contract	would go to	$ 812	$ 112	16%
1 Group at	$ 900 per month per contract	would go to	$ 908	$ 8	1%
1 Group at	$ 1,200 per month per contract	would go to	$ 1,200	$ 0	0%
Total Premium	$27,500 per month		$30,250		

B. Second year adjustments with an annual 10% increase to the pool

($605 Average Rate X 110% = $666) ($666 Average Rate X 150% = $999 (Maximum rate)

		1st Yr. Rates		2nd Yr. Rates	Increase $ Amount	Increase Percentage
1	Group at	$ 230	per month per contract would go to	$ 261	$ 31	13%
2	Groups at	$ 348	per month per contract would go to	$ 393	$ 45	13%
3	Groups at	$ 464	per month per contract would go to	$ 524	$ 60	13%
2	Groups at	$ 812	per month per contract would go to	$ 918	$ 106	13%
1	Group at	$ 908	per month per contract would go to	$ 999	$ 91	10%
1	Group at	$ 1,200	per month per contract would go to	$ 1,200	$ 0	0%
Total Premium		$30,250 per month		$33,270		

C. Third year adjustments with an annual 10% increase to the pool

($666 Average Rate X 110% = $733) ($733 Average Rate X 150% = $1,100 (Maximum rate)

		2nd Yr. Rates		3rd Yr. Rates	Increase $ Amount	Increase Percentage
1	Group at	$ 261	per month per contract would go to	$ 296	$ 35	13%
2	Groups at	$ 393	per month per contract would go to	$ 443	$ 50	13%
3	Groups at	$ 524	per month per contract would go to	$ 590	$ 66	13%
2	Groups at	$ 918	per month per contract would go to	$ 1,034	$ 116	13%
1	Group at	$ 999	per month per contract would go to	$ 1,100	$ 101	10%
1	Group at	$ 1,200	per month per contract would go to	$ 1,200	$ 0	0%
Total Premium		$33,270 per month		$36,600		

D. Fourth year adjustments with an annual 10% increase to the pool

($733 Average Rate X 110% = $806) ($806 Average Rate X 150% = $1,209 (Maximum rate)

		3rd Yr. Rates		4th Yr. Rates	Increase $ Amount	Increase Percentage
1	Group at	$ 296	per month per contract would go to	$ 332	$ 36	12%
2	Groups at	$ 443	per month per contract would go to	$ 498	$ 55	12%
3	Groups at	$ 590	per month per contract would go to	$ 662	$ 72	12%
2	Groups at	$ 1,034	per month per contract would go to	$ 1,160	$ 126	12%
1	Group at	$ 1,100	per month per contract would go to	$ 1,209	$ 109	10%
1	Group at	$ 1,200	per month per contract would go to	$ 1,209	$ 9	1%
Total Premium		$36,600 per month		$40,260		

E. Fifth year adjustments with an annual 10% increase to the pool

($806 Average Rate X 110% = $887) ($887 Average Rate X 150% = $1,330 (Maximum rate)

		4th Yr. Rates		5th Yr. Rates	Increase $ Amount	Increase Percentage
1	Group at	$ 332	per month per contract would go to	$ 366	$ 34	10%
2	Groups at	$ 498	per month per contract would go to	$ 548	$ 50	10%
3	Groups at	$ 662	per month per contract would go to	$ 728	$ 66	10%
2	Groups at	$ 1,160	per month per contract would go to	$ 1,276	$ 116	10%
1	Group at	$ 1,209	per month per contract would go to	$ 1,330	$ 121	10%
1	Group at	$ 1,209	per month per contract would go to	$ 1,330	$ 121	10%
Total Premium		$40,260 per month		$44,290		

Testimony By

Dick Brock, Kansas Insurance Department

Before the Senate Committee on Financial Institutions and Insurance

on House Bill No. 2001

March 27, 1991

Much of my testimony on House Bill No. 2001 is old news to many members of this committee. You heard it at the January 30, 1990 joint meeting of this committee and your House counterpart. You heard it again when the Department testified last year on House Bill No. 3012. Those of you on the interim committee heard it again last summer during the information gathering phase of your work. And some of you have heard some of what I am going to say more times than that because the Insurance Department has been an advocate of some of the issues addressed by House Bill No. 2001 as far back as 1972 with respect to Blue Cross and Blue Shield and 1979 for other health insurers. So, I apologize in advance for the repetition but I just don't know how to otherwise address the changes contained in House Bill No. 2001.

I will begin with the new language which appears on page 1. This amends what we commonly refer to as the accident and sickness insurance group law -- the statute which describes and defines the various kinds of groups in Kansas that are eligible for a group accident and sickness insurance contract in Kansas. In effect, the new language does three things. First, it will prohibit insurance companies from excluding otherwise eligible group members from group accident and sickness coverage. Second, to prevent circumvention of this prohibition by writing the coverage through an out-of-state group or trust, the new prohibition applies on an extraterritorial basis which means it applies to all accident and sickness policies covering Kansas residents regardless of where the policy was issued. And, third, the prohibition also extends to "condition riders" whereby the group insurer might otherwise insure an individual under the group contract but attach a

Attachment 3
F I & I
3/27/91

rider or endorsement excluding coverage for a specific medical condition. The House Committee amendment simply defines the term "open enrollment opportunity" for purposes of the underwriting restriction appearing in lines 28-30.

These are important new restrictions because one of the most obvious problems that has evolved from the health care cost dilemma is the erosion of the group insurance concept. Beyond that, however, it just isn't fair and isn't right that two people can be employed at the same place or belong to the same association and one of them can fully participate in group coverage and the other can't. Finally, and probably most important, we have to remember that through this whole exercise we are attempting to finance the payment of costs over which we have no control. The possibilities are not numerous but one way to address our problems is to spread these costs over a larger population and the way to do this in accident and sickness is through group insurance. So, the more people we can accommodate under the group concept, the fewer people we have to try to find some other help for.

Not only is individual selectivity in a group inherently a problem, it multiplies. As more companies underwrite individuals into or out of a proposed group, other insurers are literally forced to do the same thing. Consequently, the practice not only spreads but the number of people who find themselves on the outside looking in quickly multiply. In 1988, the legislature addressed the issue of arbitrarily excluding individuals from group coverage but during the course of the legislative process, the legislation was amended to apply only to replacement policies for groups formed under the auspices of a single employer. The language which is deleted on page 2 of House Bill 2001 is the 1988 provision. This 1988 action left multiple employer trusts, associations and others free to sponsor groups which can and do leave individual

members and/or dependents outside the group coverage. Section 1 of House Bill 2001 will finish what was started in 1988 by placing necessary restrictions on this practice with respect to all groups and prevent a further erosion of the group concept that can be attributed to the individual underwriting of a group's members. The House Committee amendment on lines 6-11, page 2, basically consist of a relocation of the language that previously applied only to single employer groups. However, in drafting the amendment, it inadvertently limited group policies to those providing hospital, medical or surgical expense benefits. these provisions define the permissible groups for all A&H policies. Therefore, the bill needs to be amended to delete the words "providing hospital, medical or surgical expense benefits" from lines 6 and 7 on page 2.

Section 2 of House Bill No. 2001 deals with ratemaking on group accident and sickness insurance products by establishing certain standards rates must meet with respect to group policies and certificates covering Kansas residents. The general standards included in this section are that rates shall not be unreasonable, excessive or unfairly discriminatory. These are the same standards as now apply to Blue Cross and Blue Shield rates and the kinds of property and casualty insurance that are subject to rate regulation. However, section 2 goes beyond the customary standards by: (1) prohibiting rate discrimination against individuals eligible for participation in a group; (2) with the House Committee amendment, permitting the establishment of any rating classifications within a group except those based on medical conditions; and, (3) inserting provisions intended to address the rate volatility many small groups are experiencing.

The prohibition against individual rate discrimination is contained in lines 40 and 41, page 12 of the bill and is necessary to complement the

prohibition introduced on page 1 regarding a limitation or exclusion of benefits for specific conditions. Unless we address the rating aspect of this prohibition, it can be effectively circumvented by including coverage for a specific condition but applying a premium surcharge for the condition that produces the same result.

In its original form, House Bill No. 2001 addressed the practice called tier rating -- the technique of placing individual group members and their dependents in a separate rating category within the group based on experience, some arbitrary description of medical condition or some other factor -- in lines 41 through 43, page 12 and lines 1 and 2, page 13 of the bill where the establishment of rating classifications within a group was prohibited except with respect to those necessary to accommodate the distinction between single and family or dependents coverage. Because this was a very rigid restriction which would not have even permitted internal classifications to recognize participation in a wellness program, smoker/nonsmoker rates et cetera and because the tier rating classes that have been most damaging and most arbitrary are those based on medical condition, the House Committee removed the nearly blanket prohibition and inserted the restriction relating to medical condition.

Another version of this practice works a little differently but produces quite similar results. Some of us are old enough to remember when insurers combined the experience of smaller groups -- for example groups of 25 or fewer members -- and used the combined experience of all small groups to develop community rates. It is becoming increasingly common, however, for insurers who will even write small groups to rate them on or largely on the basis of their own loss experience. Thus, because of the small size of the group, one moderately serious illness to one group member can produce a very dramatic premium increase. Neither of these techniques -- tier rating or the change in rating small groups is

inherently evil. In fact, they are somewhat laudable because they are an attempt to keep health insurance coverage available to as many people as possible at the lowest possible rates despite the rising cost of health care. Nevertheless, the fragmentation of the rates applied to small groups obviously amplifies the adverse effect of a serious illness or accident among the members of the group effected. It is no secret that insurance and actuarial principles function better when losses can be spread among a large number of risks. Thus, when a group is divided into different categories or a community of risks is reduced to a number of small groups, premiums can fluctuate dramatically. This is the source of many of the horror stories we have all heard about tremendous premium increases some groups experience from one year to the next.

Subsection (e)(2)(B) of House Bill No. 2001 reintroduces by statutory requirements a return to what is referred to as community rating. Under these provisions, each insurer would be required to develop a single rate based on the aggregate experience of all small groups covering Kansas residents that are insured by that company or prepaid service plan. Through this means, the rates for small groups should be stabilized because the claims are spread among a larger population. As a result, a small group is not nearly as susceptible to the massive premium fluctuations we know occur.

There is a concern that must be addressed. However, because in the real world today small groups are rated as small groups and, as horrendous as some of the stories are, it is a relatively few groups in relation to the total that have been subjected to mind-boggling increases. Therefore, if our effort to return to a community rating structure stopped at this point, we would create many more problems than we would solve because the vast majority of risks would receive a significant premium increase and only a few risks would receive a decrease. Many, probably most, of that

3-5

vast majority are simply borrowing time because sooner or later one or more of their members are going to incur significant medical expenses and when that happens one of you as well as the Insurance Commissioner will have another constituent complaint. Therefore, it is in the best interest of every small group to support some means of achieving greater premium stability but we need to do so in a way that does not make a bad problem worse. House Bill No. 2001 attempts to do this by using 150% of the community rate as a benchmark. Small groups whose premium rate exceeds 150% of the community rate could not be subjected to a rate increase until their premium falls below the benchmark.

During House Committee consideration of the bill, it became apparent that the intent of these provisions was not clear. For example, some conferees did not realize that rates for individual groups could be below the community rate and the actual impact of the 5 year transition period seemed to mean different things to different people. Most of the House Committee amendments to subsection (e) of the bill were designed to clarify the intent. However, in addition to the one I discussed regarding rating classifications, 2 are quite significant. The first of these appears on lines 42 and 43 on page 13 and continues through the first part of line 5 on page 14.

Obviously, there are some groups large enough to be rated primarily on their own experience. Therefore, the House Committee amendment which begins on line 1 and ends on line 5 on page 14 exempts most association groups from the community rating provisions. They remain subject to the other underwriting and rating restrictions contained in the bill.

The second significant amendment appears in lines 10 through 13 on page 14 which establishes an 80% "per group" cap on the amount of increase in

rates that can be applied during any annual period even though the group's rates may be below the overall 150% limitation.

In addition to these amendments, the House Committee inserted a requirement that requires the filing of all group insurance rates. Although, this is a file and use mechanism, it is not anticipated that we can simply assign a file clerk the task of receiving these rating filings and storing them in a file. Rather, because of the limitations and standards imposed on such rates, we cannot simply ignore these standards and limitations once the rates are in our custody. This does not mean they will be scrutinized to the extent a prior approval mechanism would require but it does mean this additional responsibility will have a fiscal impact. Therefore, we have notified the Budget Division that this amendment will generate the need for one new policy examiner. We seriously question that one person can provide even a cursory review of the 11,000 estimated additional rate filings we estimate we will receive but we have held our request to an absolute minimum.

3-1

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

ROLAND E. SMITH, *Executive Director*

March 27, 1991

STATEMENT TO: Senate Financial Institutions and Insurance Committee
FROM: Roland Smith, Executive Director, Wichita Independent Business Association
SUBJECT: House Bill 2001 as amended and passed by the House

Chairman Bond and Members of this Committee, I would like to thank you for this opportunity to speak regarding HB2001. I am, Roland Smith, Executive Director for the Wichita Independent Business Association. WIBA is an Association of locally owned independent businesses in the Wichita trade area. Over 90% of our members have fewer than 25 employees. WIBA is a typical representation of Kansas in comparing sizes of businesses, as 89% of all the businesses in Kansas have fewer than 25 employees. These businesses employee over 50% of the employees in the state. Businesses of this size are faced with the lack of available and affordable health insurance for their employees. If States don't take positive action soon in this area, we are bound for a national health insurance plan in a very short time.

Because insurance companies have been insuring only the well employees of small businesses and have been unwilling to cover those with pre-existing conditions, HB2001 was created. This need was expressed last session and during the Special Insurance Interm Committee hearings last summer. I have seen, over the past several years, insurance companies continue to exclude those people for which the concept of group health insurance was conceived. Group Health Insurance for small employers, as it is marketed today, is not group insurance as it was intended. The insurance companies no longer want to insure an employee that is a health risk except when the risk pool is large. Enlarging the risk pool is the idea behind associations, like ours, sponsoring group health insurance as a method of widening the risk pool through membership participation. However, most insurance companies now tier rate each association member business thus negating the large risk pool concept.

HB2001, as amended and passed by the House, is only a small step in solving the problems we face. WIBA supports it in as much as it does do two things. (1) It requires insurance companies doing business in Kansas to take persons with pre-existing conditions in writing group health coverage for businesses with fewer than 25 employees. Several insurance company representatives have told me if this bill passes, their company would stop writing

Attachment 4
FI + I
3/27/91

group health insurance in Kansas. My answer to them was "So be it!" It could, I believe, improve the situation in the fact that there would be fewer companies writing health insurance in Kansas so the risk pools would be larger and possibly resulting in a smaller spread on premium rates. Small business could then better compete with larger businesses. (2) Having Insurance Companies file their group health insurance rates with the Kansas Insurance Department. This is an improvement and a step forward, however, we believe they should also send supporting documents to support their rates and have them justified and approved.

It is our belief, after reviewing the section dealing with community group rating and classifications of this House amended bill, that this section of the bill does little to help anyone. However, if less than 15% of those insured are high risks with extra high premiums, the true community group rate for an insurance company would not be greatly affected when spread over several thousand insured persons and the current provisions in this bill are not needed. The current provisions relating to rating and classification actually guts the community group rating concept. As it appears to us, the language on rating and classification is not very far from current practices and would have little impact on solving the real problem. We believe there is a way to provide lower rates for those businesses with wellness programs etc., but this bill opens the door to all sorts of tier rating systems, although it does not say so outright. We think this bill could be improved by providing better community group rating and classification language. The language could provide a five-year phase-in from both spectrums of high and low rates in order to reach the community group rate by the end of the five years. A premium credit could be given for wellness programs, non-smokers etc., from the community rate, but would not allow age or occupational ratings as the current language does.

The subrogation language in Section 5 of Senate Bill 179, which is the Senate version of this bill, should be included in HB2001.

There is concern among the larger employers that come under COBRA that the 12 months waiting period on pre-existing conditions when employees change employers should be increased to 18 months as they could be covered under COBRA for the 18 months. We support this change where it applies to those businesses under COBRA. The language on page 2 lines 2 through 5 poses a problem for large employers where employees change jobs because they have used up all their benefits with their previous employer. If true community group rates were to be used it would not pose a problem for small employers, however if the current provision for rating stays in this bill, we would support removing the provision in lines 2 through 5 on page 2 for businesses of 25 or fewer employees.

I think it needs to be said that unless there is other legislation to curb the rising costs of health care, this bill will only be a band-aid to a very serious problem that is about to hemorrhage. If

HB2001 is passed with its current language, it will help to get more people insured, but it does little to help make it more affordable.

In closing, WIBA supports HB2001 hoping it can be ammended before passage to improve its effectiveness in helping to solve some parts of the overall problems in providing available and hopefully affordable health care coverage for small businesses in Kansas..

I will be glad to answer any questions.

Kansas Employer Coalition on Health, Inc.
1271 S.W. Harrison • Topeka, Kansas 66612 • (913) 233-0351

Testimony to Senate Committee on Financial Institutions and Insurance on HB 2001 (Prohibiting individual exclusions and requiring community rating for small groups)

by James P. Schwartz Jr.
Consulting Director
March 27, 1991

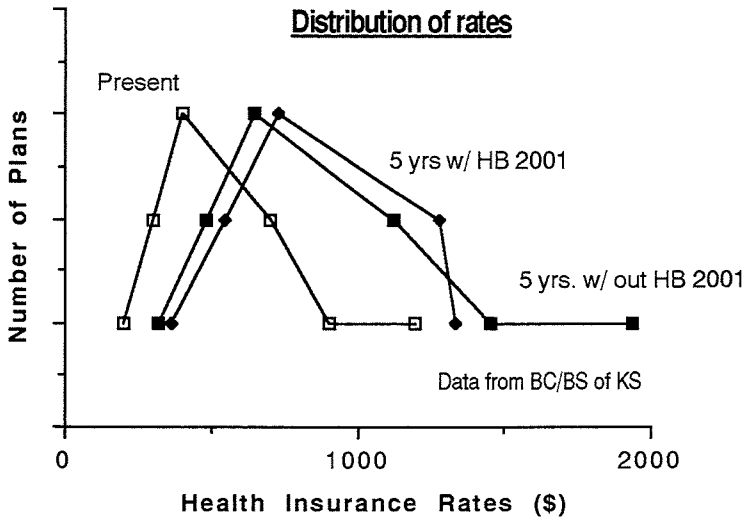
I am Jim Schwartz, consulting director for the Kansas Employer Coalition on Health. The coalition is 100 employers across Kansas who share concerns about the cost-effectiveness of healthcare we buy for our 350,000 Kansas employees and dependents.

Although members of this coalition are not unanimous in their reaction to HB 2001, our board voted in December to support the general principles contained in the bill. We acknowledge, though, that the coalition tends to comprise larger healthcare purchasers who would not be so affected by the bill as would smaller companies.

You're probably aware that we've authored a paper describing a possible restructuring of the healthcare system. Part of that paper, and perhaps the only part amenable to early implementation, involves insurance reform consistent with the provisions of HB 2001. A stated principle in our paper is, "The insurance system should spread the risks for medical expenses across the widest practical base, thus assuring that no individual or group bears a disproportionate exposure." That principle was also adopted by Governor Hayden's Commission on Health Care.

It should be noted that community rating, as prescribed in HB 2001, is a far cry from pure community rating where every group pays the same premium for equal coverage. The 50% adjustment allowance dilutes much of the bill's impact. Below is a depiction of rate distributions at present and in five years, with and without HB 2001. The chart is from data and assumptions by BC/BS of Kansas. As you can see, the primary effect is to place a lid on rate increases for groups paying the highest rates. One might still ask whether anyone should be required to pay $1200 monthly premiums. As you can see, HB 2001 permits almost a three-fold difference in rates between the highest and lowest-paying groups into year 5.

Attachment 5
III + I
3/27/91



Another limitation with community rating as presented is the potential for worsening the problem of cherry picking by insurers. To the extent that community rating is applied (and I've already admitted it's pretty weak in this case), insurers will have more incentive than ever to select only healthy groups in order to keep rates attractive. In other words, if insurers can't pass on the cost of higher risks to the groups that incur those risks, then the easiest way for them to keep the community rate low is to do business only with healthy groups. As we know, this kind of competition has contributed heavily to the present, polarized rate structure. A way to deal with this weakness of community rating is to require in addition that insurers must accept any applying employer group. That provision was included in this coalition's paper, the Governor's Commission report, and US Senator Durenberger's current bill before Congress.

Finally, it should be understood widely that the provisions of this bill do not address the overall cost problem. Rather, they simply narrow some of the inequities a bit.

Notwithstanding these limitations, we..... believes that HB 2001 deserves favorable consideration. For all its shortcomings, it represents a much-needed first step toward a reformed system that could deal more comprehensively with the profound problems of soaring costs and high numbers of uninsureds.

LARRY F. TURNQUIST
REPRESENTATIVE, SIXTY-NINTH DISTRICT
SALINE COUNTY
815 HANSON HOLLOW
SALINA, KANSAS 67401-4866

STATE OF KANSAS

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
RANKING MINORITY MEMBER: INSURANCE
JOINT COMMITTEE ON ADMINISTRATIVE
RULES AND REGULATIONS
MEMBER: APPROPRIATIONS

Members of the Senate FI&I Committee. I would like to register my support for HB 2001.

HB 2001 is the work product of the Special Committee on Insurance of which I was a member. The Committee looked at SB 445 and HB 3012, from last session, which addressed underwriting prohibitions and rate regulation of insurance companies. We built upon this foundation with recommendations from the Kansas Insurance Department, the National Association of Insurance Commissioners, Health Insurance of America Association, Blue Cross and Blue Shield, and many other groups.

At the same time, the Governor's Commission on Health Care and the Commission on Medical Services for the Medically Indigent and Homeless, were developing recommendations very similar to ours.

As Chairman of the House Insurance Committee, I held numerous hearings on HB 2001 to receive input from all viewpoints to arrive at a measure that would help end some of the accessibility problems now facing many Kansans. HB 2001 passed my committee with no dissenting votes and passed the House as a whole with a vote of 120-4.

I believe HB 2001 is a step in the right direction. I would like to thank the committee for allowing me the time to testify in support of HB 2001 and would encourage you to pass HB 2001.

Larry Turnquist
69th District

Attachment 6
FI + I
3/27/91

STATE OF KANSAS

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

915 S.W. Harrison, Docking State Office Building, Topeka, Kansas 66612-1570

JOAN FINNEY, *Governor*

March 26, 1991

The Honorable Richard Bond
The State Senate
Statehouse, Room 128-S
Topeka, Kansas 66612

Dear Senator Bond:

This is follow-up to my discussion with you concerning Senate Bill 179. In addition to the insurance provisions, Senate Bill 179 has a new Section 6 which proposes a new state funded health benefits program. This program is nearly identical to that proposed in House Bill 2565 and last year's Senate Bill 444. The major difference is that House Bill 2565 proposes eligibility at 85% of the Federal poverty level and Senate Bill 179 sets that ceiling at 150%.

You had indicated that you would not be considering the new Section 6 in Senate Bill 179 at this time. I am providing you with a copy of our testimony on House Bill 2565 which was presented to the House Public Health and Welfare Committee on Monday. In reviewing the fiscal information related to this health benefits program please keep in mind that the costs are only for the purpose of illustration. The actual costs for such a program would depend on how the program was designed. The wild card is determining the intent of "limited hospital services, to include emergency services." Until such determination is made it is difficult to assess a fiscal impact.

Sincerely,

John W. Alquest
Acting Commissioner
Income Support/Medical Services

JWA/pc
cc: Dr. Robert C. Harder

Attachment 7
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3/27/91

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Robert C. Harder, Acting Secretary

House Public Health and Welfare Committee
Testimony Regarding: House Bill 2565

This bill establishes a Kansas Health Benefits program which is designed to serve persons who do not otherwise have health coverage through either private or government sources. The program would replace the current MediKan program and provide limited health coverage to those individuals and families whose income does not exceed 85% of the federal poverty level. Only physician, pharmacy, and limited emergency hospital services would be provided in the first two years.

Before looking more closely at the program being proposed in this bill, it is important to note what medical coverage currently exists through the Department. Medicaid benefits are available to individuals and families who are eligible for cash assistance under the federal Aid to Families With Dependent Children (AFDC) and Supplemental Security Income (SSI) programs. This includes families where one or more children are deprived of parental support due to the absence, disability, or unemployment of one of the parents, and individuals who are aged (65 and older), blind, or disabled based on Social Security criteria. The program also covers children in foster care and subsidized adoptions, pregnant women and infants up to age 1 whose family income does not exceed 150% of the federal poverty level, and children ages 1 to 6 whose family income does not exceed 133% of poverty. Effective July 1, 1991, coverage will become available to children ages 6 and above who were born on or after October 1, 1983 and whose family income does not exceed 100% of poverty.

For those persons who are ineligible for AFDC or SSI benefits because of excess income and who do not fall under one of the poverty level groups described above, Medicaid coverage is still potentially available based on what is called a "spenddown" procedure. This allows the individual to reduce his or her excess income by deducting medical expenses. The person's income is compared to an income standard and the amount by which the income exceeds the standard creates the spenddown. The spenddown is similar to an insurance deductible in that the person does not gain eligibility until he or she has medical expenses which meet the spenddown amount. The income standards currently used in this program are approximately 50% of poverty for a family of three and approximately 42% of poverty for a family of four.

The Medicaid program provides coverage of most medical services including hospitalization, physician and pharmacy services, and mental health and substance abuse treatment. It is approximately 59% funded by the federal government.

The State has also provided medical coverage to its General Assistance cash population through the State-funded MediKan program. The General Assistance (GA) program serves those individuals who do not qualify for the federal AFDC or SSI programs and who meet certain eligibility criteria. This primarily includes single adults and childless couples where the individuals are age 55 or older or are physically or mentally incapacitated. However, the program also serves families where neither parent meets AFDC qualifications (i.e. both parents are present and neither meet the AFDC disability or unemployment criteria). Single

adults and childless couples who are otherwise employable do not qualify for the GA program.

The MediKan program provides coverage of most medial services including hospitalization and physician and pharmacy services but to a more limited degree than Medicaid. It is totally state-funded. Only those persons who are eligible for a GA cash grant can receive Medikan currently. The standards used in the program are fairly low equating to approximately 36% of poverty for a single incapacitated person and 44% of poverty for a family of three. If the person's or family's income exceeds these standards, there is no further medical coverage available.

As extensive as these programs have been, there is still a substantial number of Kansans who have no health coverage either through public or private sources. The State Commission on Access to Services for the Medically Indigent and Homeless has estimated that as many as 400,000 Kansans are without health insurance coverage either because of cost or the lack of available health plans through the work place. Most of these individuals are unable to obtain basic health care services and generally wait until they are acutely ill before presenting themselves or their children at the hospital emergency room where they presume they cannot be turned away. This not only leads to a decline in the health and well-being of our population but also leads to increased costs for the physicians, hospitals, and the State as acute care is more expensive to fund than preventive medicine.

House Bill 2565 addresses these problems by providing an opportunity for Kansas residents whose incomes do not exceed 85% of the federal poverty level to obtain limited medical coverage geared toward preventive care as well as emergency acute care needs. Besides the current General Assistance population, the program would also be available to any individual or family whose income falls within the 85% of poverty level. That level equates to the following standards:

Household Size	Amount Income 85% of Poverty	Amount Income 100% of Poverty
1	$ 5,627	$ 6,620
2	$ 7,548	$ 8,880
3	$ 9,469	$11,140
4	$11,390	$13,400

Individuals participating in the program would be required to pay monthly premiums and meet certain copay requirements. In addition, the Secretary has the authority to also establish deductible requirements.

For the most part, this bill is identical to a similar measure which was introduced in the last legislative session, Senate Bill 444. There were primarily three main issues which surfaced in working with that bill over the course of the session and which apply equally to this bill.

The first was in regards to the services to be covered in the program. Hospital services were to be limited to emergency services only and we would recommend this for House Bill 2565 as well. The attached information sheet explains this in more detail. Pharmacy services were not defined last year but should remain as currently covered for MediKan, which is more restrictive than Medicaid.

Physician services were very restricted during the discussion of Senate Bill 444 and as an alternative we would recommend preventive and primary care.

Preventive and primary care provided by a physician means care which avoids illness or complication of illness through early intervention and which alleviates uncomplicated presenting illnesses or other medical conditions.

This care encompasses services such as periodic history and physical examinations, immunizations, health education, office visits, basic laboratory and radiology, surgical procedure or pharmaceutical treatment.

Second, the authority under federal Medicaid regulations to gain approval for a demonstration project is severely limited. Prior to passage of the Omnibus Budget Reconciliation Act (OBRA) of 1990, there were no provisions for pursing a federally funded demonstration project regarding this new program. OBRA 1990 does allow for the funding of 3 or 4 state projects to serve the medically indigent and the Kansas Health Benefits program could potentially qualify. However, in order to apply for funding the State must first provide Medicaid coverage to infants up to age 1 and pregnant women at 185% of the federal poverty level. This would add substantially to the fiscal impact of this proposal. In addition, even if the State did so there is no guarantee that the project would be approved since only 3 or 4 programs are to be funded. No other authority exists for demonstration project funds for this type of program.

Finally, is the issue of the program's fiscal impact. While SRS has long recognized the need for a medical program to meet the needs of the State's medically indigent population, we cannot ignore the budgetary constraints that the agency is facing in the coming fiscal year. In terms of the budget limitations being specified in S.B. 162 for the agency, there are not sufficient funds for this program. As such, in light of the agency's projected funding for the coming year and the multiple demands being placed upon the limited resources which will be available, we cannot recommend passage of H.B. 2565. If such a program was established, there is a danger that other needed programs operated by SRS would have to be cut or eliminated altogether.

John W. Alquest
Acting Commissioner
Income Support/Medical Services
(913) 296-6750

3-22-91

Senate Bill 444 - Emergency Hospital Services

Limited hospital services, to include emergency services, have been defined by the Department to cover inpatient and outpatient emergency services for one of the following diagnoses or conditions.

Emergency Services

Services provided in a hospital emergency room after the sudden onset of a medical condition manifested by symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: 1. placing the patient's health in serious jeopardy, 2. serious impairment to bodily functions, or 3. serious dysfunction of any bodily organ or part.

Covered Services for the Following Conditions:

Diabetic/hypoglycemic coma
Retinal detachment
Myocardial infarction
Pulmonary embolism
Cerebrovascular accident (stroke)
Ruptured aortal aneurysm
Esophageal varices
Spontaneous pneumothorax
Perforation of esophagus
Gastric ulcer with hemorrhage/perforation
Duodenal ulcer with hemorrhage/perforation
Acute appendicitis
Perforation/obstruction of colon
Acute cholecystitis
Perforation/obstruction of gallbladder
Kidney stone not passed
Twisted ovarian cyst
Vaginal hemorrhage
Emergency labor and delivery
Comatose when admitted
Convulsions-undetermined cause and first time
Fracture
Intracranial injury
Internal injury of chest, abdomen and pelvis
Ruptured spleen
Open wound of head, neck or trunk
Open wound of upper limb
Open wound of lower limb
Injury to blood vessels
Crushing injuries
Second or third degree burns
Injury to spinal cord
Poisoning or drug overdose
Meningitis/Encephalitis
Critical medical condition such as adrenal crisis, systemic infection, ventricular tachycardia
Strangulated hernia

Limitation of hospital days allowed or level of reimbursement may be imposed to stay within a target of $5,000,000.

03-25-91

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ESTIMATED COST OF THE KANSAS HEALTH BENEFITS PROGRAM
AS DEFINED IN HOUSE BILL # 2565

AT 85% FPL MAXIMUM

	TOTAL POTENTIAL POPULATION	PROBABLE PARTICIPATION LEVEL	CURRENT ANNUAL $ PER M'KAN ADULT	FY 1991 ESTIMATED COST
*EMERG HOSPITAL	23,352	17,514	?	$5,000,000
PHYSICIAN SVS	23,352	17,514	$460	8,056,440
PHARMACY	23,352	17,514	$190	3,327,660
BENEFIT COST	23,352	17,514	?	$16,384,100

ADMINISTRATIVE COST (Includes 26 Field Staff, Space and Equipment, and Fiscal Agent contract modifications.)	1,340,523
TOTAL COST	$17,724,623
LESS 20% CO-PAY	(3,276,820)
LESS 17,514 ANNUAL PREMIUMS @ $360	(6,305,040)
NET SGF COST UNDER ABOVE CO-PAY/PREMIUM SCENARIO....	8,142,763

* Emergency Hospital includes very limited inpatient and out-patient care and are capped at $5,000,000 by way of example.

CALCULATION OF POTENTIAL PARTICIPANTS

1980 85% OF POVERTY FOR AGES 18-65	103,352
8.4 % FACTOR FOR KANSAS POP GROWTH	2,000
ESTIMATED PRESENT DAY POTENTIAL POP	105,352
NUMBER AGES 18-65 NOW ON MEDICAID	(82,000)
POTENTIAL GROUP NOT NOW ON MEDICAID	23,352
PROBABLE PARTICIPATION LEVEL (75%).....	17,514

6W JA '91
F-INL
AB365

ADMINISTRATIVE COSTS ASSOCIATED WITH A POVERTY
LEVEL BASED MEDICAL PROGRAM FOR THE UNINSURED

HB 2565-85% FPL

IT IS ASSUMED THAT THE 12,514* NEW PARTICIPANTS WILL COME IN THE FORM OF APPROXIMATELY 6,000 CASES. THE ELIGIBILITY DETERMINATION PROCESS AND THE ONGOING MONITORING OF CONTINUED QUALIFICATION FOR THIS PROGRAM WILL HAVE THE SAME DEGREE OF DIFFICULTY AS A GA CASELOAD. THIS MEANS THAT EACH NEW IM WORKER SHOULD BE RESTRICTED TO 300 CASES. THIS IS ESPECIALLY TRUE WHEN CONSIDERING THE POTENTIAL FOR PROBLEMS AND FREQUENT CASE TURNOVER ASSOCIATED WITH PAYING A MONTHLY PREMIUM.

6,000 DIVIDED BY 300 YEILDS A IM WORKER NEED OF 20 NEW POSITIONS. AT A MINIMUM THERE SHOULD BE ONE CLERICAL SUPPORT STAFF FOR EACH 7 POSITIONS AND ONE SUPERVISOR FOR EACH 7 POSITIONS. THIS WOULD DICTATE THE FOLLOWING EXPENSES:

(* There are only 12,514 new clients because 5,000 adults are already on current GA program.)

PERSONNEL	
IMW I- 20 x $20,544 (18C)	$410,880
OA II-3 x $14,256 (11B)	42,768
IMW III- 3 x $25,596 (22D)	76,788
FRINGE BENEFITS @ 20%	106,087
	$636,523
EQUIPMENT/ SPACE	
DESK, CHAIRS, ETC 26 x $500	$13,000
CAECSES ELIGIBILITY TERMINALS/DESK PRINTERS @ $2500	65,000
FLOOR SPACE 100 sq ft x 26 x $7.00	18,200
	$96,200
TRAVEL/TRNG/ETC AT $300	$7,800
CONTRACT MODIFICATIONS TO FISCAL AGENT CONTRACT	$500,000
CONTRACT MODIFICATION TO UTIL REVIEW CONTACT	$100,000
TOTAL	$1,340,523 (ALL SGF)

7-7