Approved 4/2/91
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

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

9:00 a.m./~~p.m.~~ on THURSDAY, MARCH 28, 1991 in room 529-S of the Capitol.

All members ~~were~~ present ~~except~~:
Senators Anderson, Francisco, McClure, Moran, Parrish, Reilly, Salisbury, Strick and Yost.

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

Conferees appearing before the committee:
Chip Wheelen, Kansas Medical Society
Jeff Ellis, Governor's Commission on Health Care
Cheryl Dillard, Kaiser Permanente
Bill Sneed, Health Insurance Associaton of America
Merle Peterson, Principal Mutual Life Insurance Company
Jim Petrich, Dorth Coombs Insurance, Inc., Wichita

Chairman Bond called the meeting to order at 9:14 a.m.

HB 2126 - Automobile liability insurance.

Chairman Bond referred the abovementioned bill to a subcommittee comprised of Senators Yost, Moran and Strick. This subcommittee is also considering HB 2138.

HB 2001 - Health insurance.

Chip Wheelen, Kansas Medical Society, presented testimony in support of this bill. He stated that this bill should make health insurance more affordable for many groups. He stated that one important provision of the bill would prohibit the exclusion of individual employees of any group seeking health insurance coverage. (Attachment 1)

Jeff Ellis, Governor's Commission on Health Care, spoke before the committee in support of HB 2001. Mr. Ellis acknowledged that this was a very complex issue and that if you fix one part something else goes wrong. Mr. Ellis advised the committee that experience rating is a practice used by commercial carriers to estimate group claims and establish a rate accordingly. This has resulted in insurers eliminating sick people as bad risks and insuring only the healthy in order to keep costs down. He stated that this practice was in sharp contrast to the early health plans that were founded on the principle of shared risk. Mr. Ellis stated that SB 179 came closer to meeting the objectives of the Governor's Commission on Health Care as well as the Commission on Access. Nevertheless, he supported HB 2001 as being a step in the right direction and he thought the long term impact would be reduced costs and increased coverage. (Attachment 2)

Cheryl Dillard, Kaiser Permanente, expressed support for this bill because it has three key provisions: (1) it spreads the risk among a larger group of carriers, (2) the bill establishes rates using community rating methods, and (3) the bill requires all carriers to have their rates reviewed by the Insurance Department. (Attachment 3)

Bill Sneed, Health Insurance Association of America, addressed the committee in opposition to HB 2001. Mr. Sneed opined that risk classification methods to set premium rates, generally used by health insurance companies, help to maintain the affordibility of health insurance. He stated that the provision in HB 2001 to provide access to all employees in a given group would discourage employers from offering health insurance. According to Mr. Sneed, community rating, as proposed in HB 2001,

would result in higher premiums and a growing number of uninsureds. Mr. Sneed requested the committee to consider an amendment, offered by the HIAA, which would amend section 1 of the bill and delete section 2, substituting the NAIC Model Bill, which, according to Mr. Sneed, would provide a more accurate and fair answer to the issue of affordability. He also recommended that the issue of accessibility be addressed in a summer interim study. (Attachment 4)

Merle Peterson, Principal Mutual Life Insurance Company, was introduced by Mr. Sneed and spoke briefly to the committee in opposition to HB 2001 in its present form and recommended the adoption of the NAIC Model Act.

Jim Petrich, Dorth Coombs Insurance, Inc., Wichita, spoke before the committee in opposition to the proposed legislation. Mr. Petrich advised that the rate filing requirements of the bill, which would incur increased expenses, was among his objections. Mr. Petrich concluded that while HB 2001 is well intentioned, it's passage will drive up health care costs and encourage self-funded alternatives. Mr. Petrich strongly advocated eliminating mandated coverages rather than adding them. (Attachment 5)

Chairman Bond advised the conferees who had amendments to offer to get them to Staff as soon as possible. He requested Dr. Wolff to be prepared to present the amendments in an orderly manner on Tuesday, April 2, when we will continue discussion and action on HB 2001.

Minutes of Tuesday, March 26, were approved as written on a motion by Senator Salisbury with Senator Strick seconding the motion. The motion carried.

The meeting adjourned at 10:01 a.m.

GUEST LIST

SENATE

COMMITTEE: FINANCIAL INSTITUTIONS AND INSURANCE

DATE: Thurs. Mar 28, 91

NAME	ADDRESS	ORGANIZATION
Bill Sneed	Topeka	KIAA
Mark Pedersen	Des Moines Ia	Principal Mutual Life
Bill Weller	Balt. Md.	HIAA
Debra A. Newby	Des Moines, IA	Principal Mutual Life
Mayor L. Goodman	Kansas City	KHAO Assn.
Roger D Kirkwood	Topeka	AARP - CCTF
Gary Gibson	"	AARP
Wendell Strom	Topeka	AARP - CCTF
Pam Scott	Topeka	Wheatland Group Holdings
Gary Robbins	Topeka	Ks Opt Assn
Joe Furjanic	Topeka	K C A
Roland Smith	Wichita	WIBA
Herb Jams	Topeka	Ks. Bankers Asso.
Nate Loewen	Topeka	CBP Inc.
Joseph D. Kern	Topeka	BC/BS of Kansas
Nancy Zogleman	Topeka	BC/BS of Ks
Don Hostton	Topeka	Delta Dental
Larry Magill	"	IIAK
Tom Palace	"	SLST
Dick Brock	"	KID
Cheryl Dillard	Overland Park	Kaiser Permanente
Chip Wheelen	Topeka	Ks Med Soc.
Jim Petrich	Wichita	Dorsh Comms Inc

GUEST LIST

SENATE

COMMITTEE: FINANCIAL INSTITUTIONS AND INSURANCE DATE: Thurs 3/28/91

NAME	ADDRESS	ORGANIZATION
Jeffrey O Ellis	Shawnee Mission	Gov. Cmsn Healthcare
Bill Pitsenberger	Topeka	Blue Cross
Mary Spinks	Topeka	Health Benefits Admin
Jan Bueker	Topeka	K-NASW
Rick Friedstrom	Topeka	KALU
Annette Thornburgh	"	Sunecker-Knipp, Inc
Suzette Whitegon	Topeka Ks	Swecker Knipp Inc
George Goebel	Topeka	AARP-SLC-CCTF
Aaron Rieman	Topeka	KAOM
Lee Jene Schneider	Topeka	HIAA
Art Brown	Kemp	KS Lbr Dealer
Jeff Sonnich	~~KN~~ Topeka	KNLSI

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

March 27, 1991

TO: Senate Financial Institutions and Insurance Committee

FROM: Kansas Medical Society Chris Wheeler

SUBJECT: House Bill 2001; Phased-In Community Rating of Health Insurance Premiums

Thank you for this opportunity to express the support of the Kansas Medical Society for the provisions of HB 2001. We believe that community rating of insurance risks restores the fundamental premise upon which the concept of insurance should be based. This in turn should make health insurance more affordable for many groups, thereby generally increasing access to health care for the people of Kansas. This bill also includes a very important feature that would prohibit the exclusion of individual employees of any group seeking health insurance coverage. We support this provision as well.

Because there was an extensive study of this topic during the 1990 interim as well as further hearings in the House Insurance Committee, there has been abundant input from various interested parties. This is in contrast to some of the other bills on your agenda which are not necessarily the product of consensus. We urge you to recommend HB 2001 for passage. Thank you very much.

/cb

Attachment 1
7 I + I
3/28/91

TESTIMONY BEFORE SENATE FINANCIAL INSTITUTIONS
AND INSURANCE COMMITTEE

March 28, 1991

Mr. Chairman and Members of the Committee, my name is Jeff Ellis. I am an attorney from Johnson County practicing primarily health care law representing hospitals, physicians, and managed care organizations including HMO's and PPO's. My background and experience has provided me the opportunity to serve on two governmental committees, the Commission on Access to Services to the Medically Indigent and Homeless which was legislatively created, and the Governor's Commission on Health Care which was appointed by Governor Hayden in May, 1990.

The Commission on Access to Services began its work in late 1987 and diligently met on almost a monthly basis for two years taking testimony concerning the status of access to health care throughout the state and developing recommendations which have been rendered through three separate reports the last of which was presented to the Legislature in December, 1990. The Governor's Commission on Health Care attempted to build on the extensive investigation and comprehensive recommendations of the Commission on Access and to expand those recommendations to include studies and prioritize recommendations from the Task Force on the Future of Rural Communicites and the Governor's Commission on Children and Families.

The Commission on Access to Services to the Medically Indigent and Homeless was composed of four legislators including Senators Erlich and Anderson, plus five lay members. The Governor's Commission on Health Care was composed of 50 members representing all facets of society imparted by health care decisions including health care providers, payors, the general public, labor, industry and governmental interests. I was fortunate to be one of two members to serve on both Commissions. The approach by each Commission to problem solving in the very difficult health care arena was interesting because of the different make-up of each Commission. In the final analysis, however, the recommendations of both Commissions are consistent and acknowledge the great dilemma the state faces in assuring that all Kansans have access to affordable, quality basic health care.

As noted in the final report of the Commission on Access to Services, the problems associated with access to health care services are no less acute now than they were when the Commission was organized in late 1987. As a matter of fact, public dissatisfaction with the system to which health care is delivered in the United States appears to have grown to the point that polls indicate a majority of respondents believe fundamental changes are necessary to respond to a growing crisis in health care.

Attachment 2
FI & I
3/28/91

I have learned through my work on both Commissions that the crisis in access to health care is growing to be the most significant domestic political issue of the 1990's. A large amount of legislation introduced into the legislative process this term is indicative that the political pressure is being felt, and I commend the Legislature and particularly this Committee, for its careful consideration of various proposals. I also want to commend the new Legislative Joint Committee on Health Care Decisions for the 90's for beginning the very difficult process of providing solutions to the health care crisis.

The legislation under consideration addresses one aspect of the circumstances preventing some Kansans from having access to health care, those without health insurance coverage. You have heard the figures that perhaps 450,000 to 500,000 Kansans are without health care coverage. A large percentage, perhaps two-thirds, of those are employed individuals who, for various reasons, do not have health insurance coverage through their employers or are unable or choose not to purchase health insurance coverage.

There are characteristics of our insurance system that have contributed to the rising cost of insuring against major illness which have caused employers to eliminate health insurance as a benefit for employees and have caused employed individuals to fail to purchase health insurance coverage individually. Experience rating is an underwriting practice used by commercial carriers who attempt to estimate the claims that will be experienced by a group and establish a rate accordingly. Insurers tend to eliminate sick people as bad risks and hold down premium costs by insuring the healthy leaving society to pick up the tab for the uninsured.

This practice is in sharp contrast to the early health plans that were founded on a fundamental insurance principle of shared risk. Under these original plans, all insureds paid the same rate for the same benefits which was called "community rating". Those early plans abandoned community rating in the face of market forces and as a result, two high risk groups, the elderly and the poor, were unable to obtain insurance.

Selective underwriting and enrollment practices exclude from group coverage those persons with current or past health conditions. Cafeteria benefit plans allow employees to choose among cash, health insurance, life insurance or other fringe benefits. Healthy employees tend to not choose health insurance, therefore, there is not a cross section of risk and the price of insurance grows out of reach for those wanting health insurance.

As experience rating, selective underwriting and cafeteria benefit plans have systematically excluded individuals from coverage either by choice or by circumstance, a death spiral has

been created although such practices were designed to hold down insurance costs by eliminating bad risks. The bad risks went without health coverage and received health care only in crisis situations through governmental benefits or cost shifting to insured individuals. Health care costs were pushed upwards as costs were shifted to individuals who could pay or were insured. As health care costs rose, more individuals and even more employers have found it impractical, if not impossible, to provide health care benefits for themselves or their employees. The uninsured roll the dice in hopes that they will not need health care benefits. But when they do require health care, the care rendered tends to be more acute and more expensive and society has to pick up the tab.

We have to use every means available to stop and reverse the death spiral. The fundamental premise of health insurance is shared risk; risks spread across the broadest, practical level, with no group bearing a disproportionate amount of the risk. It is also characterized by pluralism, revising the health care system comprehensively but incrementally based on the currently existing structure to the maximum extent possible. Finally, we must consider the market system and propose reform which minimizes reliance on regulatory controls yet works toward the goals of controlling health care costs while providing maximum access to the system of quality health care.

House Bill 2001 is a step in the right direction, but I do not believe it is comprehensive enough to accomplish the objectives sought by the Governor's Commission and the Commission on Access. Senate Bill 179 is more comprehensive and comes closer to meeting the Commissions' objectives. Those objectives include making health care coverage accessible to all Kansans, spreading the ever-increasing cost of health care services across a wider population thus making health care financing more affordable to more citizens, and encouraging more efficient and wiser use of health care services through incentives and disincentives in the mechanisms used to finance health care. All insurers, employers, providers, and insureds must be encouraged and allowed to play by the same rules.

The recommendations regarding insurance system problems which are contained in the Governor's Commission Report are comprehensive and should not be considered out of context. All the recommendations of Phase I and Phase II of the Governor's Commission Report which begin on page 20 should be considered in context. Those recommendations seek to create a level playing field for insurers and provide a comprehensive approach to solving insurance accessibility problems.

Moreover, insurance reform should also be considered in context of other Governor's Commission recommendations and recommendations of the Commission on Access which do take a global view of the health care system. Some of those

recommendations tried to take the burden off of public and private payor systems by enhancing the public health system, by creating volunteer clinics, by reforming the Medicaid system, and a multitude of other recommendations which attempt to reduce the number of uninsured in our state and provide coverage for every Kansan. We must never forget that the object of the exercise is to enhance the health care status of our citizens.

Obviously, this global perspective and comprehensive approach I suggest requires an enormous amount of work and education. We have gone from legislative committee to legislative interim study to commission after commission studying health care issues. I think it is past time that we institutionalize this study and policy formulation process in creating the quasi-governmental agency suggested by the Governor's Commission to work hand-in-hand with the Joint Committee on Health Care Decisions for the 1990's. That agency and the Joint Committee can then consider health insurance reform in context and achieve global reform using a comprehensive plan which can be incremental implemented over time.

The need is acute and the task in enormous. I strongly urge passage of the comprehensive insurance reform before you in Senate Bill 179, or that House Bill 2001 be expanded to included the concepts of insuring all applicant groups, subrogation rights for health insurers and expansion of the state medicaid plan. Once the level playing field is achieved through comprehensive reform, insurers will be able to complete and offer more affordable health insurance to employers and individuals thereby substantially reducing the number of uninsureds in our society. I do think such legislation is dangerous unless it is made a part of a comprehensive plan of insurance reform which will regulate all insurers equally and achieve the comprehensive goals I have identified. Thank you.

2-4

KAISER PERMANENTE

Testimony before the
Kansas Senate Committee on
Financial Institutions and Insurance
House Bill 2001
March 28, 1991

Cheryl Dillard
Government and Community Relations Manager
Kaiser Permanente

Mr. Chairman, I am Cheryl Dillard, Government and Community Relations Manager for Kaiser Permanente in Kansas City. I appreciate the opportunity to appear before you today in support of House Bill No. 2001.

Kaiser Permanente is the oldest and largest HMO in the country, with over 6 million members in 16 states and the District of Columbia. In the Kansas City area, we have 44,000 members who receive care from our physicians practicing in our six medical offices.

Kaiser Permanente has operated for over 45 years in a manner which we believe is consistent with the goal of the legislature and the Insurance Department, that of making health insurance coverage available and affordable for as many Kansans as possible. We believe the provisions of House Bill 2001 move the insurance industry towards that goal.

Regarding preexisting condition clauses, Kaiser Permanente does not and cannot, according to federal law, screen out members of an employers' group based on health status. Federal qualified HMOs, of which Kaiser Permanente is one, must take all persons in a group no matter what their health conditions. Many HMOs operating in Kansas are federally qualified. Kaiser Permanente supports any public policy efforts which return our industry to the basic principals that underlie the equitable provision of health benefits coverage. We welcome the opportunity to spread the risks among a larger group of carriers. House Bill 2001 will do that.

Since our beginnings in the 1940's, Kaiser Permanente has established premium rates based on community rating methods, believing that was the fairest way to charge all our subscribers for care. As our competitors moved away from community rating over the years, it continued to be our corporate philosophy to use that rating method and we opposed changes in the provisions of the federal HMO law which required community rating. It was only two years ago that we reluctantly moved to an adjusted community rating method with groups larger than 100 enrollees. This change was prompted by competitive pressures which we could no longer resist and by repeated requests from national employers who demanded a premium rate based on the actual health services used by their employees. With smaller groups--those with fewer than 100 enrollees in our

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

Attachment 2
FIFI
3/28/91

plan--we continue to establish rates using community rating methods. Groups with under 100 employees represent over half our business. Listed below by size are the employer groups offering Kaiser Permanente:

Group Size (number of employees)	Number of Groups	% of Total Groups
under 25	179	39.3%
26 to 50	74	16.3%
51 to 100	55	12.1%
over 100	147	32.3%
	455	100%

We believe that community rating is the fairest approach to offering health insurance coverage to small employers who operate under the dual disadvantage of narrow operating margins and minimal buying power.

Finally, Kaiser Permanente supports the provision that all carriers be required to have their rates reviewed by the Insurance Department. HMOs in Kansas must get rate approval and believe that there should be regulatory consistency.

MEMORANDUM

TO: Dick Bond
Chairman, Senate Financial Institutions & Insurance Committee

FROM: Bill Sneed
Health Insurance Association of America

DATE: March 28, 1991

RE: H.B. 2001

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I am Legislative Counsel for the Health Insurance Association of America (HIAA). The HIAA is a health insurance trade association consisting of over 325 insurance companies that write over 85% of the health insurance in the United States today. Please accept this memorandum as our testimony in regard to H.B. 2001 and its potential effect in the health insurance marketplace in the state of Kansas.

The HIAA shares the concerns of the Kansas Legislature, employers and consumers concerning the high cost of health care in the United States. Also, we share concern over the problem the small employers have in obtaining and retaining reasonable health care benefits at an affordable price. As you are aware, insurance company premiums reflect the charges made by hospitals, health care practitioners, claims administration costs, premium tax, and, of course, hopefully a profit. However, we must point out that this is just the beginning of everyone's work in regard to addressing this problem. I am sure you are all familiar with the Interim Committee report on Proposal No. 11 -- Health Insurance, and the report prepared by the Governor's Commission on Health Care issued November 28, 1990. In order to fully explain my client's position, I believe it

Attachment 4
7 I ▽ I
3/28/91

is important to look at this situation on several fronts: first, a review of historically how we got to this point today; secondly, a review of H.B. 2001 and why, in our belief, it does not truly address the concerns enumerated by the Legislature; and finally, our recommendation for a substitution for H.B. 2001 by utilizing the attached amendment.

History

As most of you know, the insurance industry is one of a cyclical nature. There are periods of time of high usage, and consequently, high increases in premiums, historically followed by lulls and relatively modest increases in premiums and payments. During the mid- to late 1970's, the health insurance industry was experiencing a period of substantial utilization of the products, and consequently, dramatic increases in premiums. Because of the atmosphere, several things occurred, and although they could arguably have occurred independent of each other, when all put together they played a role in the problems we are faced with today. First, the federal government, under the provisions of the 1974 Employees Retirement Income and Security Act (ERISA), provided that self-insurance plans could be created and be exempt from provisions of state law, including mandates and premium taxes. With the implementation of ERISA, and since many mandates had not yet been enacted by the Legislature, there was very little initial growth by self-insurance plans.

Then, by the end of the 1970's and beginning in the early 1980's, employers became sophisticated with the utilization of self-insurance plans, and fueled by the

4-2

enactment of mandated benefits, which ERISA plans would not have to provide, growth began in the ERISA self-insurance plans.

During this same time period, the industry itself changed with the emergence of HMO's and PPO's. Along with this came the ability of third party administrators and the ability for entities to administer self-insurance plans.

Thus, you have now in the mixing bowl new types of delivery services (HMO's, PPO's, ASO's), new types of facilities to provide coverages (ERISA, MET, group-funded pools and self-insurance plans), and the increase in mandated coverages in traditional health insurance plans. Thus, while all these activities in the short term stabilized the health insurance marketplace as it relates to price, it severely cut into the market share of commercial health insurers, and thus reduced the available "pool" of insurers to spread the various risks incurred by the companies.

Thus, with the diminishing market share upon it, the commercial health insurance industry drew further away from the concept of community rating and moved more into an arena of risk classification methods to set premium rates commensurate with the level of risk an individual or group specifically represents. I will discuss risk classification later in my remarks.

Therefore, the most important point to bring out of this historical analysis is that it is my client's contention that it is an array of reasons which have caused the current status of health insurance, and to appropriately address these concerns, it would be inappropriate to look only at the commercial health insurers for answers. Attached to

my remarks is a chart (exhibit 1) which demonstrates that the commercial insurers compared to the total overall insurance picture play only a small part in this analysis.

Risk Classification

Much has been said about community rating, or the lack thereof, in discussion of the problem of health insurance. Generally speaking, health insurance companies use risk classification methods to set premium rates commensurate with the level of risk an individual or group represents. The use of such techniques by insurers has maintained the affordability of health insurance for many employers, as well as consumer options, since premiums are set at levels that represent the relative risk of insuring a given group or individual.

Risk classification also helps to form a direct link between health care expenditures and the cost of coverage. Since employers who self insure avoid subsidizing other higher cost employer groups, insurers must be able to classify risk in order to offer reasonable prices to clients preferring traditional insurance. Moreover, if insurers were prevented from charging a client the true cost of coverage, a major incentive for employers to hold costs down would be diminished. Employers would have less reason to provide safe work environments, establish wellness programs, or seek efficient providers of care. Without risk classification, every group would pay the same in premiums regardless of their true health care costs. The process of risk classification depends on fairness. Without the ability to use risk classification, insurers may encounter adverse selection, which is the tendency of consumers to buy health insurers only after the onset of illness, or whenever

a likelihood of major illness has become apparent. Adverse selection can seriously threaten insurers' financial stability. In order to insure the financial soundness of the industry, health insurers must be permitted to classify their policy holders according to expected risk of loss. This necessarily includes the use of readily available data about applicants' age, sex, occupation and health status. To ignore data that ties the cost of claims to a fair premium cost is to invite financial failure.

Mandated Benefits

As was pointed out in the summer hearings, the list of state mandated benefits and providers has grown dramatically. While the merits of any particular benefit or provider group can be vigorously defended by its proponents, the cumulative effect is a hodgepodge of state laws that increase the cost of health insurance, particularly to the small employers who are most in need of relief from the high cost of health care.

State mandated benefit laws do not apply equally to all health plans. ERISA exempts self-insurance plans from state mandated benefit laws. Thus, mandated benefits have encouraged firms to self-insure, and thereby escape state oversight from mandated benefits, reserve and financial solvency requirements, and premium tax. Again, this adds fuel to the fire of insureds leaving the traditional market, thus reducing the "pool" of insureds available to spread the risk within the group.

Those employers, large and small, who decide to go through a self-insured program, are allowed the ability to pick and choose the benefits that are most desirable and cost effective for their employees. Employers too small to self insure, however, do not

4-5

have that flexibility, thus making it less likely that they will offer health insurance at all. Putting all of this together, then, it becomes obvious that the burden of mandated benefits is placed squarely on the backs of small employers.

House Bill 2001

With the above rationale as our basis, we will attempt to go item by item through my client's objections to various provisions of H.B. 2001. I will not reiterate those reasons given above with each particular provision inasmuch as we believe the information provided to you in the initial part of our comments gives you the overall rationale for the basis of our objections.

Pages 1-2, lines 25-43 and 1-5. This amendment is an attempt to provide access to group coverages by all employees in a given group. While this sounds like a noble concept, it is fraught with problems. As it relates to new policies, the law would require that an insurer must write 100% of all employees and dependents, i.e., all or none. If that is the case, insurers will be required to assign a rate to that group commensurate with the healthiness of the group. It is our position that this will discourage employers from initially offering health insurance if the high cost of a particular employee or dependent with a pre-existing condition is going to be added into the group. Also, the provision providing for a one-year exclusion does not answer this problem, but simply delays when the cost would be incurred. Further, it appears to require dependent coverage even if coverage is not being provided to the employee.

4-6

In an attempt to cover contracts issued outside of the state of Kansas, there is a provision for extra-territorial coverages. However, we would submit that large employers who provide health insurance on a nation-wide basis will simply change the format of their coverages (self-insurance), and again reduce the available market share.

Page 12, lines 26-43. This amendment would require the forms and rates of all group policies to be filed and approved by the Commissioner of Insurance. Again, we point out the chilling effect this will have on large employers who issue group policies on a nation-wide basis. These plans are substantially negotiated as it relates to benefits and premiums, and as such, employers, having once agreed upon a plan, will not be interested in availing themselves of Department review and approval.

Page 13, lines 11-29. We earlier discussed our concerns relative to risk classification and the reasons we believe this amendment is unnecessary.

Community rating advances an artificial and counter-productive "one size fits all" notion. Thus, it is fundamentally flawed, as it operates to thwart the objective of any rating scheme which is to produce a rate that is adequate, competitive and equitable.

Community rating can inspire churning, rate instability and inequity. A simple example helps to illustrate this point:

> Carrier A community rates. It insures 50 computer programmers and 50 coal miners. The costs incurred by computer programmers average $100 per month and the costs incurred by coal miners average $200 per month, so Carrier A can cover its costs with a community rate of $150.
>
> Carrier B's costs also run at $100 for computer programmers and $200 for coal miners, but it insures 75 computer programmers and 25 coal miners so it needs a community rate of $125 to cover its costs.

> All of Carrier A's customers see the better deal offered by Carrier B except 10 coal miners who like Company A's claim service. Carrier A is left with 10 coal miners generating cost of $200 per month while paying premiums of only $150 per month. Carrier A is left with two options--go out of the business or raise its rates to $200. Carrier B is faced with problems as well. It now insures 125 computer programmers with an average cost of $100 per month and 65 coal miners with an average cost of $200 per month. therefore, Carrier B now has overall average costs of $134 per month compared to its community rate of $125. It too will be forced (artificially) to raise rates.
>
> Community rating clearly leads to unfair cross-subsidization (e.g., coal miners subsidized by computer programmers). It ignores appropriate risk elements and encourages artificially high claim payments (at a time when the opposite should be encouraged).

Finally, my client contends that community rating will increase the number of uninsureds in two different areas. First, those who are uninsured by choice will grow. This group tends to be composed of younger, healthier individuals who choose not to spend wages on health insurance until they are approaching a definitive need. If rates are averaged (as under community rating), the rates for this particular group (young and healthier) will increase, thus putting further strain on this group's willingness to obtain coverage.

Secondly, the increased loss of the young and healthy will by its absence place a further burden on the community rate, thus increasing the overall cost to the group. This places the employer in a position of dropping its group coverage because of cost, or leaving the traditional marketplace. Therefore, the vicious circle begins, and only ends with higher premiums and a growing number of uninsureds. To corroborate this

point, we are attaching a copy of an April 1, 1991 article from Forbes magazine (exhibit 2).

Page 13, lines 34-43; page 14, lines 1-32. This is an attempt by the Legislature to answer concerns relative to the small group employer. It is our contention that the NAIC "small group rating and renewability" proposal is a more appropriate answer to the problems faced by the small group employer. It is important to note that this model bill has been worked on by regulators and industries over the last eighteen months to address this problem. Further, it was prepared on a more global front so that there would be a commonality between the various states as this issue was addressed. Finally, although the bill does not specifically address availability, it does address large, dramatic increases in premiums that would appear to us to be the major concern of the small group employer.

Recommendations

The HIAA would respectfully request that this Committee consider amending Section 1 of H.B. 2001 and deleting Section 2 in its entirety (exhibit 3) and substituting in its place the attached proposal (exhibit 4). This proposal, the NAIC Model Bill, would, in our opinion, provide a more accurate and fair answer to what we believe is the main issue of affordability.

Attached as Exhibit 2 is a bulletin by my client which highlights the NAIC Model bill. As stated earlier, the model bill would create a consistent pattern with other state regulations so insurers can implement the law efficiently, and thus keep administrative expenses at a minimum. The Model Bill also provides for Insurance Department

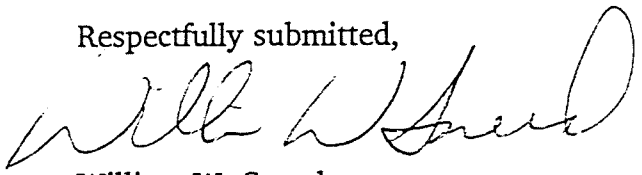
regulation. Finally, the Model Bill avoids many of the problems H.B. 2001 will cause to large employers in areas like the need to modify benefit packages and rates as agreed to by the employer and insurer. The remainder of the exhibit is the NAIC Model Bill, which we request to be substituted for Section 2 of H.B. 2001.

In regard to the accessibility issues generated in H.B. 2001, we would urge the Legislature to review the HIAA Guaranteed Availability proposal (exhibit 5). This will directly impact on the issues of small employer coverage. Inasmuch as S.B. 205 will be reviewed this summer, we believe that this subject should be included in this summer study. Further, if we assume the work on H.B. 2511 (assigned risk plans) will not be concluded this legislative session, it also can be referred to the summer study and the entire area of accessibility can be reviewed.

Conclusion

On behalf of my client, again let me thank you for allowing us the opportunity to appear before this Committee. It is our hope that these remarks and attachments will provide the Legislature a positive approach to the health insurance concerns that are being reviewed by the Legislature. We stand ready to provide any additional assistance, technical or otherwise, in reaching this goal.

Respectfully submitted,



William W. Sneed
Legislative Counsel
Health Insurance Association of America

4-10

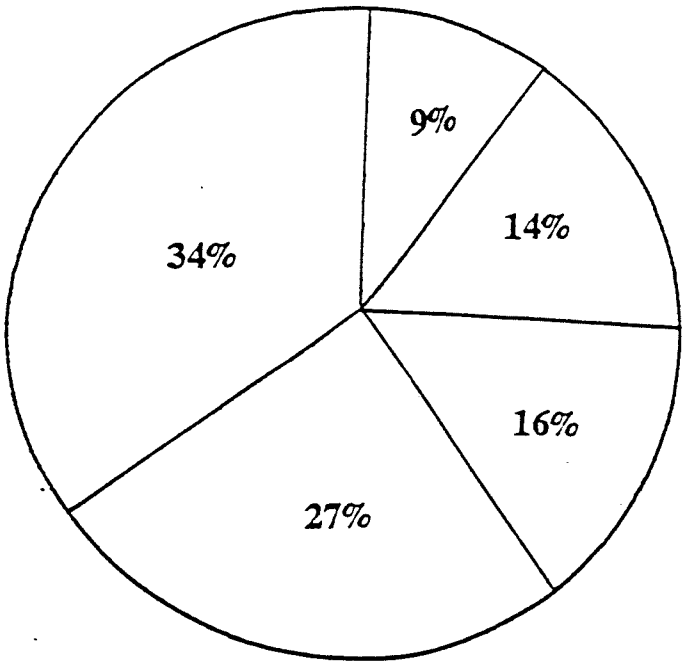


Figure 1

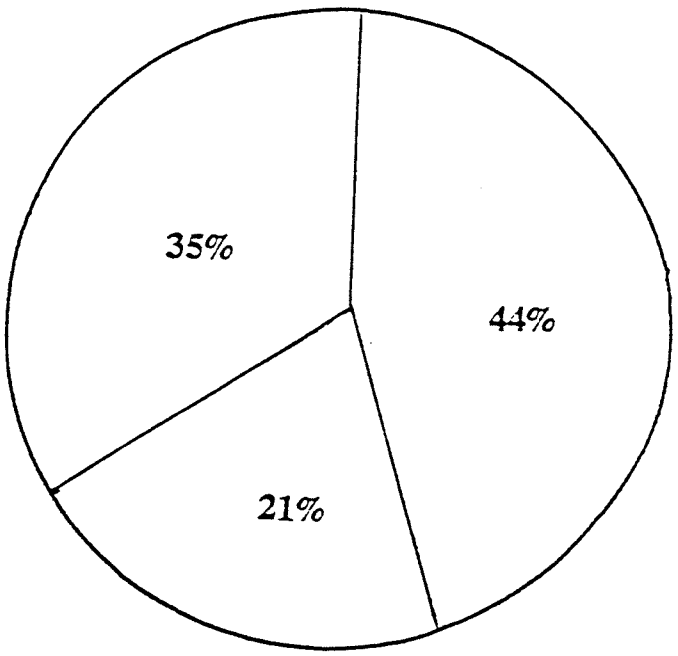


Figure 2

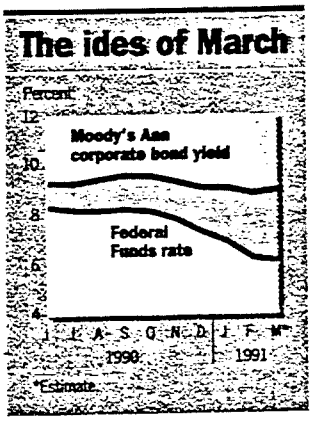
PERCENTAGES OF INSURANCE MARKETPLACE IN KANSAS				
TYPE OF PROGRAM	# OF INDIVIDUALS WITHIN PROGRAM	% AS OPPOSED TO TOTAL POPULATION (Figure 1)	TOTAL NUMBER OF INDIVIDUALS	% AS COMPARED TO "INSURANCE" MARKETPLACE (Figure 2)
Self Insurance	840,027	34%	1,907,733	44%
BC/BS	667,706	27%		35%
Traditional Insurance	400,000	16%		21%
Public Assistance	222,981	9%		
Uninsured	346,860	14%		
Total	2,477,574	100%		100%

The cuts stop here

SOMEBODY OUT THERE is worried about inflation or a cascading dollar, or both. The credit market has given the Federal Reserve a signal that, for now, there has been enough cutting of short-term rates. After the latest quarter-point cut in the Federal Funds rate (to 6% on news of February's higher unemployment), a full point was cut from the price of 30-year Treasury bonds.

The chart below shows the yield curve—the relationship between interest rates on securities of various maturities, and an important indicator to the Federal Reserve of the need for looser or tighter monetary policy—which is now the steepest it has been since July 1988, says John Lonski, senior economist at Moody's Investment Service.

Conventional 30-year mortgage rates have moved up to 9.5% from a recent low of 9.25%; this will dampen the incipient recovery in real estate.



The yield curve (the difference between Moody's Aaa corporate bond yield and the Federal Funds rate) is the widest it has been since mid-1988

Adding to the Fed's caution will be the recent upward trend in commodities prices, especially for metals. This is another indicator the central bank watches closely. However, it seems less a warning of higher inflation to come (normally associated with a steepening yield curve), and more an anticipation that the end of the Gulf war will see higher demand as the economy picks up steam.

These speculators may prove to be a bit premature. Companies don't have much spare cash or borrowing capacity right now, which will inhibit new capital investment and new jobs— important elements in consumer confidence, says Lonski. "In 1990 we downrated 4.4 corporate bonds for every 1 that we raised. So far this year, it's averaged over 5."

So why has the dollar been showing such surprising strength, despite lower U.S. rates? Look no further than the $25 billion to $30 billion the Saudi Arabians and Kuwaitis need to pay for their share of the war and for rebuilding. That's a substantial short-term demand for greenbacks. When it's filled, however, it could well mean that the dollar will ease again—good news for U.S. exports, but not so good for creditors holding IOUs in dollars.

Reasonable forecast: The Fed will not cut rates again anytime soon unless the economic news turns very nasty indeed.

Unintended consequences

THERE'S A DOWNSIDE to proposals to reform health insurance policies sold to businesses with fewer than 25 employees. The reforms, which have to be approved by state legislatures, could increase the premiums for perhaps four in ten small businesses.

Insurers have been swamped by criticism from small businesses about the way rates can now double when one employee gets seriously sick. The National Association of Insurance Commissioners, Blue Cross and the for-profit health insurers have all proposed limiting how much extra an insurer can charge to small companies with ailing workers. How would this be financed? Through relatively higher premiums for small companies with healthy workers.

The increases for the healthy groups could be substantial. One actuary who has analyzed the proposed reforms says the increased premiums "could be as much as 35% in a few cases, and 15% to 20% increases would be common." Typically, a business employing, say, 20 reasonably healthy workers could find an extra $12,000 a year tacked onto a $60,000-a-year health insurance bill.

One aim of reform is to spread the availability of health insurance to the 9 million workers in small firms who currently don't have it. Health insurers would be forced to take on even the sickest groups, which in some areas can't now get coverage at any cost. The insurers could then palm off the very worst risks into a pool whose losses would be financed by a surcharge on the premiums charged all small businesses. But some reformers fret that the proposals could in the end swell the ranks of the uninsured because three times as many businesses would see a premium increase as a decrease. The fact is that the vast majority of uninsured small businesses haven't been turned down for health insurance for medical reasons; they simply can't afford to pay the premiums. —JANET NOVACK

As Amended by House Committee

Session of 1991

HOUSE BILL No. 2001

By Special Committee on Insurance

Re Proposal No. 11

12-28

AN ACT relating to insurance; concerning ~~accident and~~ sickness and accident insurance providing hospital, medical or surgical expense benefits and the regulation of the rates thereof by the commissioner of insurance; concerning eligibility for coverage under group policies; amending K.S.A. 1990 Supp. 40-19c09, 40-2209 and 40-2215 and repealing the existing sections; also repealing K.S.A. 1990 Supp. 40-19c07.

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

Section 1. K.S.A. 1990 Supp. 40-2209 is hereby amended to read as follows: 40-2209. (A) Group sickness and accident insurance is declared to be that form of sickness and accident insurance covering groups of persons, with or without one or more members of their families or one or more dependents, ~~or one or more members of their families or one or more dependents, and.~~ *Except at the option of the employee or member and except employees or members enrolling in a group policy after the close of an open enrollment opportunity, no individual employee or member of an insured group and no individual dependent or family member may be excluded from eligibility or coverage under a policy providing hospital, medical or surgical expense benefits both with respect to policies issued or renewed within this state and with respect to policies issued or renewed outside this state covering persons residing in this state. For purposes of this section, an open enrollment opportunity shall be deemed to be a period no less favorable than a period beginning on the employee's or member's date of initial eligibility and ending* 31 days thereafter. *No group policy providing hospital, medical or surgical expense benefits issued or renewed within this state or issued or renewed outside this state covering residents within this state shall limit or exclude benefits for specific conditions existing at or prior to the effective date of coverage thereunder. Such policy may impose a waiting period, not to exceed one year for benefits for conditions, including related conditions, for which diagnosis, treat-*

ADD:

A group policy providing hospital, medical or surgical expense benefits with respect to policies issued or renewed within this state shall at the time of issue provide coverage for all eligibile employees and the dependents of such employee if dependent coverage is offered. Notwithstanding the above, every employee shall have the option of rejecting coverage.

Delete

Delete

ADD:

Except as specifically provided by the contract terms applicable to all employees or members

ment or advice was sought or received in the 90 days prior to the effective date of coverage. Such policy shall waive such a waiting period to the extent the employee or member or individual dependent or family member was covered by a group sickness and accident policy prior to the effective date of coverage with no gap in coverage. ~~*Such policy*~~ Any group policy providing hospital, medical or surgical expense benefits may impose participation requirements, define full-time employees or members and otherwise be designed for the group as a whole through negotiations between the group sponsor and the insurer to the extent such design is not contrary to or inconsistent with this act and *may be* issued *to such group* upon the following basis:

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

ADD: providing similar benefits under the previous policy

4-14

is in effect at the time the benefits under the converted policies are determined or redetermined in lieu of those required in condition (10).

(18) The insurer may elect to provide group insurance coverage which complies with this act in lieu of the issuance of a converted individual policy.

(19) A notification of the conversion privilege shall be included in each certificate of coverage.

(20) A converted policy which is delivered outside this state must be on a form which could be delivered in such other jurisdiction as a converted policy had the group policy been issued in that jurisdiction.

(21) The insurer 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 during the six-month continuation period in accordance with rules and regulations adopted by the commissioner of insurance.

~~Sec. 2. K.S.A. 1990 Supp. 40-2215 is hereby amended to read as follows: 40-2215. (a) No individual policy of accident and sickness insurance as defined in K.S.A. 40-2201 and amendments thereto shall be issued or delivered to any person in this state nor shall any application, rider or endorsement be used in connection therewith, until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto, have been filed with the commissioner of insurance.~~

DELETE SECTION 2

~~*(b) No group or blanket policy* or certificate *of accident and sickness insurance* providing hospital, medical or surgical expense benefits *shall be issued or delivered to any person in this state, nor shall any application, rider or endorsement be used in connection therewith, until a copy of the form thereof* and of the classification of risks and the premium rates pertaining thereto *has been filed with the commissioner of insurance.*~~

DELETE SECTION 2

~~(b) *(c)* No such policy shall be issued, nor shall any application, rider or endorsement be used in connection therewith, until the expiration of 30 days after it has been filed unless the commissioner gives written approval thereof.~~

~~(c) *(d)* The commissioner may, within 30 days after the filing of any such form *required to be filed pursuant to subsection (a)*, disapprove such form: (1) If, in the case of any form required to be filed pursuant to subsection (a), the benefits provided therein are unreasonable in relation to the premium charged; or (2) if, in the case of any form required to be filed pursuant to subsection (a) or (b), it contains a provision or provisions which are unjust,~~

HIAA

Health Insurance Association of America

The NAIC adopted a model for Small Group Rating and Renewal Requirements which:

- Effectively limits the relationship between the highest and lowest rates a carrier can charge groups of 25 lives or less. Within a class the maximum difference is 25% (plus or minus) of the average.

- Effectively limits rate increases on existing in-force small group plans to 15 percent over the increase in the lowest rate the carrier is currently offering within the class. (Assumes no change in demographics).

- Eliminates selective cancellation of a group because of bad experience by requiring a carrier to renew all business or cease to renew all business in a class. Also provides notification procedures.

- Requires disclosure of rating practices to small employers before issue of the extent premium rates in the future will reflect duration and/or health experience or status.

1025 Connecticut Avenue, NW Washington, DC 20036-3998 202/223-7780 Telecopier 202/223-7897

4-16

SUBSTITUTE FOR HOUSE BILL 2001

AN ACT relating to health insurance; concerning the availability of health insurance coverage to small employers, to prevent abuse rating practices, to require disclosure of rating practices to purchasers, to establish rules for continuity of coverage for employers and covered individuals, and to improve the efficiency and fairness of the small group health insurance marketplace.

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

Section 1. Sections 1 through 9 shall be known and may be cited as the Premium Rates and Renewability of Coverage for Health Insurance Sold to Small Groups Act.

Section 2. As used in sections 1 through 9:

(A) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of Section 4 of this Act, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the carrier in establishing premium rates for applicable health benefit plans.

(B) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or which could have been charged under a rating

system for that class of business, by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

(C) "Carrier" means any person who provides health insurance in this state. For the purposes of this Act, carrier includes a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, a multiple employer welfare arrangement or any other person providing a plan of health insurance subject to state insurance regulation.

(D) "Case characteristics" mean demographic or other relevant characteristics of a small employer, as determined by a small employer carrier, which are considered by the carrier in the determination of premium rates for the small employer. Claim experience, health status and duration of coverage since issue are not case characteristics for the purposes of this Act.

(E) "Class of business" means all or a distinct grouping of small employers as shown on the records of the small employer carrier.

(1) A distinct grouping may only be established by the small employer carrier on the basis that the applicable health benefits plans:

(a) Are marketed and sold through individuals and organizations which are not participating in the marketing or sale of other distinct groupings of small employers for such small employer carrier;

(b) Have been acquired from another small employer carrier as a distinct grouping of plans;

4-18

(c) Are provided through an association with membership of not less than four small employers which has been formed for purposes other than obtaining insurance; or

(d) Are in a class of business that meets the requirements for exception to the restrictions related to premium rates provided in Subsection A(1)(a) of Section 4.

(2) A small employer carrier may establish no more than two (2) additional groupings under each of the subparagraphs in Paragraph (1) on the basis of underwriting criteria which are expected to produce substantial variation in the health care costs.

(3) The commissioner may approve the establishment of additional distinct groupings upon application to the commissioner and a finding by the commissioner that such action would enhance the efficiency and fairness of the small employer insurance marketplace.

(F) "Commissioner" means the Commissioner of Insurance.

(G) "Department" means the Department of Insurance.

(H) "Health benefit plan" or "plan" means any hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract. Health benefit plan does not include accident-only, credit, dental or disability income insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical-payment insurance.

4-19

(I) "Index rate" means for each class of business for small employers with similar case characteristics the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(J) "New business premium rate" means, for each class of business as to a rating period, the premium rate charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(K) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier.

(L) "Small employer" means any person, firm, corporation, partnership or association actively engaged in business who, on at least fifty percent (50%) of its working days during the preceding year, employed no more than twenty-five (25) eligible employees. In determining the number of eligible employees, companies which are affiliated companies or which are eligible to file a combined tax return for purposes of state taxation shall be considered one employer.

(M) "Small employer carrier" means any carrier which offers health benefit plans covering the employees of a small employer.

Section 3.

(A) Except as provided in Subsection (b) of this section, the provisions of this Act apply to any health benefit plan which provides coverage to one or more employees of a small employer.

(B) The provisions of this Act shall not apply to individual health insurance policies which are subject to policy form and premium rate approval as provided in K.S.A. 40-2215.

Section 4.

(A) Premium rates for health benefit plans subject to this Act shall be subject to the following provisions:

(1) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent (20%). Paragraph (1) shall not apply to a class of business if all of the following apply:

(a) The class of business is one for which the carrier does not reject, and never has rejected, small employers included within the definition of employers eligible for the class of business or otherwise eligible employees and dependents who enroll on a timely basis, based upon their claim experience or health status;

(b) The carrier does not involuntarily transfer, and never has involuntarily transferred, a health benefit plan into or out of the class of business; and

(c) The class of business is currently available for purchase.

(2) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates which could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than twenty-five percent (25%) of the index rate.

4-21

(3) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day for the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate;

(b) An adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the carrier's rate manual for the class of business; and

(c) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.

(4) In the case of health benefit plans issued prior to the effective date of this Act, a premium rate for a rating period may exceed the ranges described in Subsection a(1) or (2) of this section for a period of five (5) years following the effective date of this Act. In that case, the percentage increase in the premium rate charged to a small employer in such a class of business for a new rating period may not exceed the sum of the following:

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In

4.22

the case of a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate; and

(b) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.

(B) Nothing in this section is intended to affect the use by a small employer carrier of legitimate rating factors other than claim experience, health status or duration of coverage in the determination of premium rates. Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business.

(C) A small employer carrier shall not involuntarily transfer a small employer into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration since issue.

Section 5.

(A) Except as provided in Subsection b of this section, a health benefit plan subject to this Act shall be renewable to all eligible employees and dependents at the option of the small employer, except for the following reasons:

(1) Nonpayment of required premiums;

4.23

(2) Fraud or misrepresentation of the small employer, or with respect to coverage of an insured individual, fraud or misrepresentation by the insured individual or such individual's representative;

(3) Noncompliance with plan provisions;

(4) The number of individuals covered under the plan is less than the number or percentage of eligible individuals required by percentage requirements under the plan; or

(5) The small employer is no longer actively engaged in the business in which it was engaged on the effective date of the plan.

(B) A small employer carrier may cease to renew all plans under a class of business. The carrier shall provide notice to all affected health benefit plans and to the commissioner in each state in which an affected insured individual is known to reside at least ninety (90) days prior to termination of coverage. A carrier which exercises its right to cease to renew all plans in a class of business shall not:

(1) Establish a new class of business for a period of five (5) years after the nonrenewal of the plans without prior approval of the commissioner; or

(2) Transfer or otherwise provide coverage to any of the employers from the nonrenewed class of business unless the carrier offers to transfer or provide coverage to all affected employers and eligible employees and dependents without regard to case characteristics, claim experience, health status or duration of coverage.

Section 6. Each small employer carrier shall make reasonable disclosure in solicitation and sales materials provided to small employers of the following:

4-24

(A) The extent to which premium rates for a specific small employer are established or adjusted due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer;

(B) The provisions concerning the carrier's right to change premium rates and the factors, including case characteristics, which affect changes in premium rates;

(C) A description of the class of business in which the small employer is or will be included, including the applicable grouping of plans; and

(D) The provisions relating to renewability of coverage.

Section 7.

(A) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation which demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(B) Each small employer carrier shall file each March 1 with the commissioner an actuarial certification that the carrier is in compliance with this section and that the rating methods of the carrier are actuarially sound. A copy of such certification shall be retained by the carrier at its principal place of business.

(C) A small employer carrier shall make the information and documentation described in Subsection A of this section available to the commissioner upon request. The information shall be considered proprietary and trade secret information and shall not

be subject to disclosure by the commissioner to persons outside of the department except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

Section 8. The commissioner may suspend all or part of Section 4 as to the premium rates applicable to one or more small employers for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner that either the suspension is reasonable in light of the financial condition of the carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

Section 9. The provisions of this Act shall apply to each health benefit plan for a small employer that is delivered, issued for delivery, renewed or continued in this state after the effective date of this Act. For purposes of this section, the date a plan is continued is the first rating period which commences after the effective date of this act.

Section 10. This Act shall take effect and be in force from and after its publication in the statute book.

4-26

Guaranteed Availability Draft

AN ACT CONCERNING HEALTH CARE BENEFITS FOR SMALL EMPLOYERS

Section 1. Preamble

The Legislature declares that an unacceptable number of residents of this state are without appropriate health care because of, among other reasons, the rapid increase in the cost of health care, the lack of access, and the lack of availability of coverage. The legislature further declares that the maintenance of a proper environment for the coverage of employees and dependents of employees of small employers under health benefit plans is important to assuring the availability of appropriate health care for the residents of this state and for more stability and predictability of both rate increases and coverage continuation.

Section 2. Definitions

As used in this Act,

(a) "Adjusted average market premium price" means, as determined by the Board, the arithmetic mean of all guaranteed issue carriers premium rates for a given SEHC plan sold to groups with similar case characteristics by all carriers or MEWA's selling SEHC plans in the state.

(b) "Base premium rate" means:

(1) As to any health benefit plan covering one or more employees of a small employer, the lowest new business premium rate prescribed by the carrier or MEWA for the same or similar coverage under a plan or arrangement covering any small employer with similar case characteristics; and

(2) As to any carrier or MEWA not issuing new health benefit plans to a small employer, the lowest rate charged a small employer for the same or similar coverage under a plan covering any small employer with similar case characteristics.

(c) "Board" means the Board of Directors of the Program.

(d) "Carrier" means any insurance company, health service

4.27

corporation, hospital service corporation, medical service corporation, or health maintenance organization, as these terms are defined by state law, authorized to issue health benefit plans in this state.

(e) "Case characteristics" means with respect to a small employer, the geographic area in which the employees reside, the age and sex of the individual employees and their dependents, the appropriate industry classification as determined by the carrier, MEWA, or other benefit arrangement, the number of employees and dependents and such other objective criteria as may be established by the carrier, MEWA, or other benefit arrangement.

(f) "Commissioner" means the Insurance Commissioner.

(g) "Department" means the Insurance Department.

(h) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health benefits plan covering such employee.

(i) "Eligible employee" means an employee and who works on a full-time basis, with a normal work week of 30 or more hours and includes a sole proprietor, a partner of a partnership or an independent contractor, provided such sole proprietor, partner or contractor is included as an employee under a health benefit plan of a small employer but does not include an employee who works on a part-time, temporary or substitute basis.

(j) "ERISA" means the Employment Security Act of 1974, as amended.

(k) "Financially impaired" means, for purposes of this Act, a member which after the effective date of this Act, is not insolvent but is:

(1) deemed by the Commissioner to be potentially unable fulfill its contractual obligations; or

(2) placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(l) "Guaranteed issue carrier" means a carrier which must, pursuant to Section 5, offer a SEHC plan to any small employer requesting such plan.

(m) "Health benefit plan" means any hospital or medical expense policy, health, hospital or medical service corporation contract, a plan provided by a MEWA, and health maintenance organization contract offered by an employer and does not include policies covering only accident, credit, dental, disability income, long-term care, hospital indemnity, Medicare supplement, specified disease, vision care, coverage

issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(n) "Initial enrollment period" means the period of time specified in the health benefit plan during which an individual is first eligible to enroll in a small employer health benefit plan. Such period of time shall not be less than thirty days but no more than sixty days commencing on the day following the end of any service waiting period required by the small employer of all employees before the employees are eligible to participate in a health benefit plan.

(o) "Late enrollee" means an eligible employee or dependent who requests enrollment in a small employer's health benefit plan following the initial enrollment period provided under the terms of the first plan for which such employee or dependent was eligible through such small employer, provided an eligible employee or dependent shall not be considered a late enrollee if:

(1) the individual:

(A) was covered under another employer-provided health benefit plan at the time the individual was eligible to enroll;

(B) states, at the time of the initial eligibility, that coverage under another employer health benefit plan was the reason for declining enrollment;

(C) has lost coverage under another employer health benefit plan as a result of the termination of employment, the termination of the other plan's coverage, death of a spouse, or divorce; and

(D) requests enrollment within thirty-one days after the termination of coverage under another employer health benefit plan, or

(2) the individual is employed by an employer who offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period, or

(3) a court has ordered coverage to be provided for a spouse or minor child under a covered employee's plan and request for enrollment is made within thirty-one days after issuance of such court order.

(p) "Member" means all carriers issuing health benefit plans and

all MEWAs and, to the extent permitted by ERISA, other benefit arrangements providing health benefit plans in this state on or after the effective date of this Act.

(q) "MEWA" means any "multiple employer welfare arrangement," as defined in Section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, except for any such arrangement which is fully insured within the meaning of Section 514(b)(6) of said Act, as amended.

(r) "Midpoint rate" means for small employers with similar case characteristics and plan designs, as determined by the applicable carrier or MEWA for a rating period, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(s) "Other benefit arrangements" means any health benefit plan offered by an employer who is in whole, or in part, self-insured.

(t) "Plan of operation" means the articles, bylaws and operating rules of the program adopted by the Board pursuant to section 6 of this Act.

(u) "Pre-existing conditions provision" means a policy provision which excludes or limits coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage as to a condition which, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received or as to a pregnancy existing on the effective date of coverage.

(v) "Program" means the (Insert name of state) Small Employer Health Reinsurance Program, established under section 6 of this Act.

(w) "Service waiting period" means a period of time after full time employment begins before an employee first is eligible to enroll in any applicable health benefit plan offered by the small employer.

(x) "Small employer" means any person, firm, corporation, partnership or association actively engaged in business whose total employed work force consisted of, on at least fifty per cent of its working days during the preceding year, more than two but no more than twenty-five eligible employees, the majority of whom were employed within the state. In determining the number of eligible employees, companies which are affiliated companies, or which are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer. Except as otherwise specifically

provided, provisions of this Act which apply to a small employer which has a health benefit plan shall continue to apply until the plan anniversary following the date the employer no longer meets the requirements of this definition.

(y) "SEHC plan" means the (insert state) small employer health care plan which shall be a health benefit plan for small employers, established by the Board in accordance with section 6 of this Act.

Section 3. Applicability

(a) Any individual or group health benefit plan shall be subject to the provisions of this Act if it provides health care benefits covering three or more employees of a small employer and if any one of the following conditions are met:

(1) Any portion of the premium or benefits is paid by a small employer or any covered individual is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the premium; or

(2) The health benefit plan is treated by the employer or any of the covered individuals as part of a plan or program for the purposes of Section 162 or Section 106 of the United States Internal Revenue Code.

(b) Notwithstanding subsection 3(a) above, subsections 4(c), (j), (k), (l), and (m) shall not apply to individual health benefit policies sold to small employers which are subject to approval for policy form and premium rates by the Commissioner.

[The above provision may vary by state depending upon whether there is Department regulation in these areas. HIAA staff, in conjunction with the domestic industry and interested foreign insurers, will make a determination as to whether there is in fact effective regulation of rates. In making that determination staff should analyze the Department's practices rather than relying solely on the statutory authority in place in a particular state.]

(c) Except as expressly provided for in this Act, no law requiring the coverage or the offer of coverage of a health care service or benefit and no law requiring the reimbursement, utilization, or consideration of a specific category of a licensed or certified health care practitioner shall apply to any health benefit plan offered or delivered to a small employer.

(d) Except as expressly provided for in this Act, no health benefit plan offered to a small employer shall be subject to:

(1) Any law that would inhibit any carrier, MEWA, or other benefit arrangement from contracting with providers or groups of providers with respect to health care services

or benefits;

(2) Any law that would impose any restriction on the ability to negotiate with providers regarding the level or method of reimbursing care or services provided under the health benefit plan;

(3) Any law that would require any carrier, MEWA, or other benefit arrangement to either include a specific provider or class of provider when contracting for health care services or benefits, or to exclude any class of provider who are generally authorized by statute to provide such care.

Section 4. Underwriting and Rating Requirements

Health benefit plans covering small employers and, to the extent permitted by ERISA, other benefit arrangements covering small employers shall be subject to the following provisions, as applicable:

(a) Pre-existing conditions provisions shall not exclude or limit coverage for a period beyond twelve months following the individual's effective date of coverage and may only relate to conditions which had, during the six months immediately preceding the effective date of coverage, manifested themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received or as to a pregnancy existing on the effective date of coverage.

(b) In determining whether a pre-existing condition limitation provision applies to an eligible employee or dependent, all health benefit plans shall credit the time such person was covered under a previous employer based health benefit plan provided by a carrier or MEWA if the previous coverage was continuous to a date not more than thirty days prior to the effective date of the new coverage, exclusive of any applicable service waiting period under such plan.

(c) Any such health benefit plan and, to the extent permitted by ERISA, other benefit arrangements, subject to the provisions of this Act, shall be renewable with respect to all eligible employees or dependents at the option of the policy-holder, contract-holder, or small employer, as the case may be, except for:

(1) nonpayment of the required premiums by the policy-holder, contract-holder, or employer; or

(2) fraud or misrepresentation of the policy-holder, contract-holder, or employer or, with respect to

coverage of individual insureds, the insureds or their representatives; or

(3) noncompliance with health benefit plan provisions; or

(4) when the total number of insured individuals covered under all of the health benefit plans of any one employer is less than the total number of individuals or percentage of individuals required by participation requirements under any specific health benefit plan of that employer; or

(5) when the carrier or MEWA ceases doing business in the small employer market; provided, however, that the following conditions are met:

(A) Notice of the decision to cease to do business in the small employer market is provided to the Department, the Board, to either the policy-holder or contract-holder, and the employer;

(B) health benefit plans subject to this Act shall not be canceled by the carrier or MEWA for one year after the date of the notice required under subparagraph (A) above unless the business has been sold to another carrier; and

(C) a carrier or MEWA that ceases to do business in the small employer marketplace is prohibited from re-entering the small employer marketplace for a period of five years from the date of the notice required under subparagraph (A) above.

(d) Notwithstanding subsection (c) above pertaining to renewability, any such health benefit plan or any coverage provided to any individual covered by such a plan subject to the provisions of this Act may be rescinded for fraud, material misrepresentation, or concealment by an applicant, employee, dependent, or small employer.

(e) A carrier, MEWA, and, to the extent permitted by ERISA, any other benefit arrangement shall not exclude any eligible employee or dependent, who would otherwise be covered under a health benefit plan on the basis of an actual or expected health condition of such person; provided, however, that a carrier, MEWA, other benefit arrangement shall be allowed to exclude a late enrollee, for the greater of eighteen months or the remainder of the three year reinsurance period, as defined in Section 6 of this Act.

(f) Every carrier or MEWA doing business in the small employer market retains the authority to underwrite and rate small employer groups using accepted underwriting and actuarial

practices. Small employer groups which are declined because they fail to satisfy a carrier or MEWA's underwriting requirements shall be notified by the carrier or MEWA:

(1) that the carrier or MEWA will not issue a health benefit plan to the small employer;

(2) that the small employer is eligible for a SEHC plan provided by a guaranteed issue carrier; and

(3) of a list, prepared by the Board, of the address, telephone number, and service area of all guaranteed issue carriers.

(g) No health benefit plan issued by a carrier or provided by a MEWA or, to the extent permitted by ERISA, any other benefit arrangement may limit or exclude, by use of a rider, or amendment, applicable to a specific individual, coverage by type of illness, treatment, medical condition, or accident, except for preexisting conditions or diseases as permitted under section 4(a) of this Act.

(h) All health benefit plans and, to the extent permitted by ERISA, other benefit arrangement shall make coverage available to all the eligible employees of a small employer without a service waiting period. The decision of whether to impose a service waiting period for eligible employees of a small employer shall be made by the small employer, who may only choose from the service waiting periods offered by the carrier or MEWA, which shall not be greater than a maximum ninety day service waiting period.

(i) The benefit structure of any health benefit plan subject to the provisions of this Act may be changed by the carrier or MEWA to make it consistent with the benefit structure contained in health benefit plans being marketed to new groups.

(j) With respect to any health benefit plan of a carrier or MEWA, the premium rates charged or offered for a rating period for the same or similar coverage under a health benefit plan covering any small employer with similar case characteristics as determined by such carrier or MEWA shall not vary from the applicable midpoint rate by more or less than thirty-five percent of such midpoint rate, as to:

(1) all health benefit plans issued on or after the effective date of this Act; and

(2) within three years from the effective date of this Act for all health benefit plans issued prior to the effective date of this Act.

(k) With respect to health benefit plans issued prior to the

effective date of this Act, in any case where, with respect to any carrier or MEWA, the premium rates charged or offered for the same or similar coverage under a health benefit plan covering any small employer with similar case characteristics as determined by such carrier or MEWA exceeds the applicable midpoint rate by more or less than thirty-five points of such midpoint rate, no increase in premium rates for a new rating period may exceed the sum of:

(1) any percentage change in the base premium rate measured from the first day of the prior rating period to the first day of the new rating period plus,

(2) any adjustment due to change in case characteristics or plan design of the small employer, as determined by the carrier or MEWA.

(l) Premium rates may not vary by more than fifteen percent by industry classification.

(m) Subject to the provisions of subsections (j), (k), and (l) of this section, no increase in premium rates for a new rating period may exceed the sum of:

(1) any percentage change in the base premium rate measured from the first day of the prior rating period to the first day of the new rating period plus fifteen per cent, adjusted on a pro rata basis for rating periods greater or lesser than one year, of the base premium rate for such new rating period, and

(2) any adjustment due to change in case characteristics, or coverage of the small employer, as determined by the carrier or MEWA.

(n) In connection with the offering for sale of any health benefit plan to a small employer, each carrier or MEWA shall make a reasonable disclosure, as part of its solicitation and sales materials, of:

(1) the extent to which premium rates for a specific small employer are established or adjusted in part based upon the actual or expected variation in claims costs or actual or expected variation in health condition of the employees and dependents of such small employer;

(2) the provisions concerning such carrier's or MEWA's right to change premium rates and the factors other than claims experience which affect changes in premium rates; and

(3) provisions relating to renewability of policies and contracts.

(o) Compliance with the underwriting and rating requirements

contained in this Act shall be demonstrated through actuarial certification. Carriers and MEWAs offering health benefit plans to small employers shall file annually with the Commissioner an actuarial certification stating that the underwriting and rating methods of the carrier and MEWA:

(1) comply with accepted actuarial practices;

(2) are uniformly applied to health benefit plans covering small employers; and

(3) comply with the provisions of this Act.

Section 5. Guaranteed Issue Carriers

(a) Guaranteed issue carriers are:

(1) The top ten carriers, based on total premium volume in the small employer market as determined by the Board.

(2) Any other carrier that informs the Board that the carrier wishes to become a guaranteed issue carrier; provided, however, that any carrier wishing to become a guaranteed issue carrier must notify the Board of its intention to become a guaranteed issue carrier one year in advance of the carrier becoming a guaranteed issue carrier.

(b) Guaranteed issue carriers must offer at least a SEHC plan to any small employer requesting such a plan and must provide at least the coverage of a SEHC plan to any small employer requesting such coverage.

(c) Guaranteed issue carriers may reinsure individuals with a group or an entire group subject to the provisions of section 7,

(d) As provided for in the Program's plan of operation, guaranteed issue carriers may:

(1) require advance premium deposits for poor credit risks, and

(2) make special arrangements to cover employees in small employer groups with exceptionally high employee turnover rates.

(e) Guaranteed issue carriers may appeal to the Board for finding that the guaranteed issue carrier is experiencing an unfair share of administrative or credit risks. Where the Board determines that a guaranteed issue carrier has experienced such an unfair burden, the Board may grant the guaranteed issue carrier a decreased reinsurance

price to offset administrative expenses or temporarily suspend the guaranteed issue carrier's requirement to guarantee issue.

Section 6. Small Employer Health Care (SEHC) Plans

(a) Subject to approval by the Commissioner, the Board shall design the SEHC plans which shall be eligible for reinsurance under the Program. The Board shall establish the form and level of coverage(s) to be made available by carriers, MEWAs, and to the extent permitted by ERISA, other benefit arrangements in the SEHC plans. In designing the SEHC plans the Board shall also establish benefit levels, deductibles, coinsurance factors, exclusions, and limitations for the SEHC plan. The forms and levels of coverage established by the Board shall specify which components of a health benefit plan offered by a small employer carrier may be reinsured.

(b) The Board shall submit such plans to the Commissioner for the Commissioner's approval within one hundred eighty days after the appointment of the Board pursuant to section 6 of this Act. Such SEHC plans may include cost containment features including, but not limited to:

(1) utilization review of health care services, including review of medical necessity of hospital and physician services;

(2) case management benefit alternatives;

(3) selective contracting with hospitals, physicians, and other health care providers;

(4) reasonable benefit differentials applicable to participating and nonparticipating providers; and

(5) other provisions for the cost effective management of SEHC plans.

(c) The SEHC plan established for use by health maintenance organizations shall be consistent with the basic method of operation of health maintenance organizations.

(d) After the Commissioner's approval of the SEHC plans submitted by the Board, and in lieu of any procedure to the contrary established by law, any carrier, MEWA, or, to the extent permitted by ERISA, other benefit arrangement may certify to the Commissioner, in the form and manner prescribed by the Commissioner, that the SEHC plans filed by the carrier, MEWA, or other benefit arrangement are in substantial compliance with the provisions in the corresponding approved Board plan. Upon receipt by the Department of such certification, the carrier, MEWA, or other benefit arrangement may use such

certified plans until such time as the Commissioner, after notice and hearing, disapproves their continued use.

Section 7. Reinsurance Program

(a) There is established a non-profit entity to be known as the "State Small Employer Health Reinsurance Program." All carriers issuing health benefit plans and all MEWAs and, to the extent permitted by ERISA, other benefit arrangements providing health benefit plans in this state on or after the effective date of this Act shall be members of the Program.

(b) Within sixty days following the effective date of this Act, the Commissioner shall give notice to all members of the time and place for the initial organizational meeting, which shall take place within one hundred twenty days following the effective date of this Act. The members shall select the initial Board, subject to approval by the Commissioner. The Board shall consist of nine members who shall serve staggered terms as determined by the Program's plan of operation. At least two-thirds of the members of the Board shall be small employer carriers; in the event that there are not sufficient small employer carriers to serve on the Board the remaining seats may be filled by any member. At least one member of the Board shall be, to the extent possible:

(1) a carrier whose principal health insurance business is in the small employer market;

(2) a carrier whose principal health insurance business is the large employer market;

(3) a health service corporation, hospital service corporation, or medical service corporation;

(4) a health maintenance organization; and

(5) an other benefit arrangement.

The Commissioner shall be an ex-officio member of the Board. In approving the selection of the Board, the Commissioner shall assure that all members of the Program are fairly represented. The membership of all Boards subsequent to the initial Board shall, to the extent possible, reflect the same distribution described above.

(c) If the initial Board is not elected at the organizational meeting, the Commissioner shall appoint the initial Board within fifteen days of the organizational meeting.

(d) Within one hundred eighty days after the appointment of the initial Board, the Board shall submit to the Commissioner a plan of operation, and thereafter any amendments thereto necessary or suitable, to assure the fair, reasonable and

equitable administration of the Program. The Commissioner shall, after notice and hearing, approve the plan of operation provided the Commissioner determines it to be suitable to assure the fair, reasonable and equitable administration of the Program and provides for the sharing of Program gains or losses on an equitable and proportionate basis in accordance with the provisions of subsection (m) of this section. The plan of operation shall become effective upon approval in writing by the Commissioner consistent with the date on which the coverage under this section shall be made available. Any plan of operation, or amendments thereto, submitted to the Commissioner by the Board pursuant to this subsection shall be deemed approved by the Commissioner if not expressly disapproved in writing by the Commissioner within ninety days of its receipt by the Commissioner.

(e) If the Board fails to submit a suitable plan of operation within one hundred eighty days after its appointment, the Commissioner shall, after notice and hearing, adopt and promulgate a temporary plan of operation. The Commissioner shall amend or rescind any plan adopted by the Commissioner under this subsection at the time a plan of operation is submitted by the Board and approved by the Commissioner.

(f) The plan of operation shall establish rules, conditions, and procedures for:

(1) the handling and accounting of assets and moneys of the Program and for an annual fiscal reporting to the Commissioner;

(2) filling vacancies on the Board, subject to the approval of the Commissioner;

(3) selecting an administering insurer which shall be a carrier as defined in section 2(d) of this Act and setting forth the powers and duties of the administering insurer;

(4) reinsuring risks in accordance with the provisions of this section;

(5) collecting assessments subject to subsection (m) of this section from all members to provide for claims reinsured by the Program and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made;

(6) providing protection for guaranteed issue carriers from the financial risk associated with small employers that present poor credit risks;

(7) establishing standards for the coverage of small

employers that have high turnover employees

(8) establishing an appeals process for guaranteed issue carriers to seek relief when a guaranteed issue carrier has experienced an unfair share of administrative and credit risks;

(9) determining the adjusted average market premium prices for SEHC plans sold in this state;

(10) establishing participation standards at issue and renewal for reinsured cases;

(11) establishing and maintaining a list of guaranteed issue carriers as provided for under Section xx;

(12) establishing standards for those conditions under which a guaranteed issue carrier would not be required to write business received from a particular agent or broker; and

(13) any additional matters at the discretion of the Board.

(g) The Program shall have the general powers and authority granted under the laws of the State to insurance companies licensed to transact health insurance except the power to issue insurance. In addition the Board shall have the specific authority to:

(1) enter into contracts as are necessary or proper to carry out the provisions and purposes of this section, including the authority, with the approval of the Commissioner, to enter into contracts with similar Programs of other states for the joint performance of common functions, or with persons or other organizations for the performance of administrative functions;

(2) sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against any Program or Board member;

(3) take such legal action as necessary to avoid the payment of improper claims against the Program;

(4) design the array of health coverage products for which reinsurance will be provided, and issue reinsurance policies, in accordance with the requirements of this Act;

(5) establish rules, conditions and procedures pertaining to the reinsurance of members' risks by the Program;

(6) establish appropriate rates, rate schedules, rate

adjustments, rate classifications and any other actuarial functions appropriate to the operation of the Program;

(7) assess members in accordance with the provisions of subsection (m) of this section, and to make such advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any such interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year;

(8) appoint from among members appropriate legal, actuarial and other committees as are necessary to provide technical assistance in the operation of the Program, policy and other contract design, and any other function within the authority of the Program; and

(9) borrow money to effect the purposes of the Program. Any notes or other evidence of indebtedness of the Program not in default shall be legal investments for carriers and may be carried as admitted assets.

(h) Any member may reinsure coverage of an eligible employee of a small employer, or any dependent of such an employee with the Program, provided:

(1) with respect to a SEHC plan, the Program shall reinsure the level of coverage provided;

(2) with respect to other plans issued to small employers, the Program shall reinsure the level of coverage provided up to, but not exceeding, the level of coverage provided in a SEHC plan;

(3) with respect to the coverage provided to small employers, the carrier, MEWA, or, to the extent permitted by ERISA, other benefit arrangement shall be required to use high-cost case management, hospital precertification techniques, and other cost containment techniques as established by the Program;

(4) with respect to eligible employees, and their dependents, who are hired subsequent to the commencement of such employer's coverage by a carrier, MEWA, or other benefit arrangement and who are not late enrollees, coverage may be reinsured by a non-guaranteed issue carrier within sixty days of the commencement of their coverage under the plan except in the case of late enrollees.

(5) with respect to eligible employees, and their dependents, who are hired subsequent to the commencement of such employers's coverage by a guaranteed issue carrier and who are not late enrollees, coverage may be reinsured by the guaranteed issue carrier:

(A) within sixty days of the commencement of their coverage under the plan except in the case of late enrollees; or

(B) commencing on a date established by the Board, but no later than eighteen months after the Program becomes operational, on the first plan anniversary after the small employer's coverage has been in effect with the small employer carrier for at least

have been made for services provided during that calendar year for that reinsured employee or dependent, which payments would have been reimbursed through said reinsurance in the absence of said annual five thousand dollar deductible. The amount of said deductible shall be reviewed periodically by the Board and may be adjusted for appropriate factors as determined by the Board.

(9) If an employer group is covered under a plan other than a SEHC plan and the carrier chooses to reinsure the group subsequent to the initial coverage period, or if a new individual joins the group and the carrier wants to reinsure that individual, the carrier cannot force the employer to change to a small employer health care benefit plan. The carrier must allow the employer to maintain the same benefit plan and reinsure only the portion of the plan consistent with a SEHC plan.

(i) Except as provided in subsection (j) of this section, premium rates charged for coverage reinsured by the Program shall be established as follows:

(1) For whole group reinsurance coverage 1.5 times the adjusted average market premium price established by the Program for that classification or group with similar characteristics and coverage, with respect to the eligible employees, and their dependents, of a small employer, all of whose coverage is reinsured with the Program, minus a ceding expense factor determined by the Program.

(2) For individual reinsurance coverage 5.0 times the adjusted average market premium price established by the Program for an individual in that classification or group with similar characteristics and coverage, with respect to an eligible employee, or his or her dependents, minus a ceding expense factor determined by the Program.

(j) Premium rates charged for reinsurance by the Program to a health maintenance organization which is approved by the Secretary of Health and Human Services as a federally qualified health maintenance organization pursuant to 42 U.S.C. 300 et seq., and as such is subject to requirements that limit the amount of risk that may be ceded to the Program, may be modified to reflect the portion of risk that may be ceded to the Program.

(k) In any case where health benefit plan coverage for a small employer is entirely or partially reinsured with the Program, the premium charged to the small employer for any rating period for the coverage issued in accordance with this section shall be no more than 1.5 times the adjusted average market

premium price established by the Program for that classification or group with similar characteristics and coverage.

(1) (1) Following the close of each fiscal year, the administering insurer shall determine the net premiums, the Program expenses for administration and the incurred losses, if any, for the year, taking into account investment income and other appropriate gains and losses. For purposes of this section, health benefit plan premiums earned by MEWAs and other benefit arrangements shall be established by adding paid claim losses and administrative expenses of the MEWA or other benefit arrangement. Health benefit plan premiums and benefits paid by a member that are less than an amount determined by the Board to justify the cost of collection shall not be considered for purposes of determining assessments. For purposes of this subsection, "net premiums" means health benefit plan premiums, less administrative expense allowances.

(2) Any net loss for the year shall be recouped first by assessments of members to the extent provided below:

(A) Assessments shall first be apportioned by the Board among all members in proportion to their respective shares of the total premiums net of reinsurance premiums paid for coverage under this Program earned in this State from health benefit plans covering small employers and to the extent permitted by ERISA, other benefit arrangements covering small employers during the calendar year coinciding with or ending during the fiscal year of the Program, or on any other equitable basis reflecting coverage of small employers as may be provided in the plan of operation. An assessment shall be made pursuant to this subparagraph against a health maintenance organization which is approved by the Secretary of Health and Human Services as a federally qualified health maintenance organization pursuant to 42 U.S.C. 300e et seq., subject to an assessment adjustment formula adopted by the Board and approved by the Commissioner for such health maintenance organizations which recognizes the restrictions imposed on such health maintenance organizations by federal law. Such adjustment formula shall be adopted by the Board and approved by the
Commissioner prior to the first anniversary of the Program's operation.

(B) Assessments under paragraph (A) above shall be capped at four percent of such premium for health

benefit plans covering small employer.

[To the extent that second tier financing is necessary, HIAA supports a range of alternative broad sources of financing. These would include, but are not limited to, general revenues, hospital or other provider based taxes, and assessments against all health benefit plans]

(3) If assessments exceed actual losses and administrative expenses of the Program, the excess shall be held at interest and used by the Board to offset future losses or to reduce Program premiums. As used in this subsection, "future losses" includes reserves for incurred but not reported claims.

(4) Each member's proportion of participation in the Program shall be determined annually by the Board based on annual statements and other reports deemed necessary by the Board and filed by the member with the Board. MEWAs and other benefit arrangements shall report to the Board claims payments made and administrative expenses incurred in this state on an annual basis on a form prescribed by the Commissioner.

(5) Provision shall be made in the plan of operation for the imposition of an interest penalty for late payment of assessments.

(6) A member may seek from the Commissioner a deferment, in whole or in part, from any assessment issued by the Board. The Commissioner may defer, in whole or in part, the assessment of a member if, in the opinion of the Commissioner payment of the assessment would endanger members ability to fulfill its contractual obligations.

(7) In the event an assessment against a member is deferred in whole or in part, the amount by which such assessment is deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in this subsection. The member receiving such deferment shall remain liable to the Program for the amount deferred. The Commissioner may attach appropriate conditions to any such deferment.

(n) Neither the participation as members of the Program or as Board members, the establishment of rates, forms, or procedures for coverage issued by the Program, nor any other joint or collective action required by this Act shall be the basis of any legal action, criminal or civil liability or penalty against the Program, the Board, or any of its members either jointly or separately.

Section 8. Effective Date

This Act shall take effect sixty days after adoption; provided, however, that the provisions of subsections 4(b) and 5(b) shall not take effect until sixty days after the date that the Program becomes operational, as determined by the Commissioner.

DORTH COOMBS INSURANCE, INC.
A CORROON & BLACK COMPANY

DORTH COOMBS INSURANCE, INC.
Actuarial Consulting • Employee Benefits • Property & Casualty

March 26, 1991

The Honorable Dick Bond, Chairman
Financial Institutions and Insurance Committee
State Capitol Building
Topeka, KS 66612

RE: House Bill #2001

Dear Mr. Bond:

Corroon & Black/Dorth Coombs Insurance, Inc. is an international Insurance Brokerage and Consulting Firm with over 11,000 employees. Our Wichita, Kansas office provides group insurance for over 2,500 Kansas businesses, represents over 20 insurance carriers and actually pays health claims on behalf of seven different health insurance carriers (using their checkbook) doing business in the State of Kansas. It is our opinion that proposed House Bill #2001 is unworkable in its present form due to the following:

1. We get approached every week by Employers who want us to quote their group health insurance coverage, but whose employee participation levels do not meet insurance company requirements (generally 75% or more of the eligible group must participate in order for an insurance company to underwrite the risk). In lieu of declining to quote coverage altogether, the insurance carrier often times will provide coverage on just those requesting coverage, subject to satisfactory Evidence of Insurability (Evidence of Insurability would not have been required if 75% or more of the eligible employees were participating in the Plan). We provide coverage to thousands of participants on this basis. Insurance Carriers would be forced to terminate coverage on these existing participants due to the overall poor employee participation level of the Employer Group, rather than provide coverage on groups with participation problems. Due to the horrible antiselection involved, when groups have less than the generally accepted 75% participation level, some Evidence of Insurability requirement must be available to insurors. Without this we will have a new group of people who currently have insurance who may not be able to continue to be offered insurance after the House Bill goes into effect.

(316) 264-5311 • Facsimile (316) 264-8077
300 W. Douglas • 800 R. H. Garvey Bldg. • P.O. Box 2697 • Wichita, Kansas 67201

Attachment 5
FI & I
3/28/91

DORTH COOMBS INSURANCE, INC.
A CORROON & BLACK COMPANY

2. Insurance Carriers currently accepting a given risk based on their current premium rate structure should not be forced to go back retroactively to cover poor health risks previously declined. The House Bill should only apply to new eligible participants on or after the effective date of the House Bill (Insurance Carriers again may be forced to terminate coverage on existing groups if they were being forced to cover previously declined applicants).

3. The House Bill indicates all group premium rates must be filed with the Insurance Department before use. Prior rate filing would add to administrative costs and have the possibility of discouraging competition. Only a very small fraction of the group health insurance premium written by national commercial group insurance carriers is actually attributable to Kansas Groups. The actual profits (group insurance target profit margins are figured at anywhere from 1-5%, depending on the size of group) from these Kansas Groups are so minuscule that many quality commercial group insurance carriers may bail out of Kansas under the proposed House Bill requirements, as it would not be worth all the time and expense associated with doing business in Kansas under the proposed House Bill (we are not talking about Blue Cross and Blue Shield of Kansas where virtually all of their group premium comes from Kansas Groups).

   In addition, to my knowledge, the Kansas Insurance Department has no group actuaries currently on staff to properly evaluate filed premium rates. What are they going to do with the filed rates? Will they drive up health care costs by hiring or contracting with a Group Actuarial Firm to evaluate premium rates when complaints arise? Who is going to pay of the additional expense associated with unnecessary rate filing requirements, calls, storage, etc.?

4. The Pre-Existing Conditions Limitation should be expanded to include treatment received, recommended or sought within one year (in lieu of 90 days) of a person's effective date, to prevent consumer claims manipulation and abuse, which will again drive up health care costs.

DORTH COOMBS INSURANCE, INC.
A CORROON & BLACK COMPANY

5. The House Bill requires an insurance carrier to waive any pre-existing conditions limitation on new participants who were covered under a prior Employer's group health plan. In an effort to hold down health care costs, we believe an employee changing jobs should be subject to the pre-existing conditions limitation of the new Employer's Plan.

6. The House Bill should also apply to HMO's.

While this House Bill has many good intentions, it will obviously drive up health care costs and continue the heavy trend of Employers seeking self-funded alternatives to avoid the many costly state mandates. We should be eliminating not adding mandated coverages.

Sincerely,

Dorth Coombs Insurance, Inc.

James R. Petrich, FLMI
Vice President of Group Operations

JRP/ghp

5-3

ment or advice was sought or received in the ~~90 days~~ prior to the effective date of coverage. ~~Such policy shall waive such a waiting period to the extent the employee or member or individual dependent or family member was covered by a group sickness and accident policy prior to the effective date of coverage with no gap in coverage.~~ ~~Such policy~~ Any group policy providing hospital, medical or surgical expense benefits may impose participation requirements, define full-time employees or members and otherwise be designed for the group as a whole through negotiations between the group sponsor and the insurer to the extent such design is not contrary to or inconsistent with this act and *may be* issued *to such group* upon the following basis:

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

Delete

one year period

Add: this section applies only to employees or members or family members who are first eligible for coverage on or after January 1, 1992.

For purposes of this section, a group sickness and accident policy may require insurance to be subject to satisfactory Evidence of Insurability if less than 75% of the eligible class of employees or members are participating under the policy.

is in effect at the time the benefits under the converted policies are determined or redetermined in lieu of those required in condition (10).

(18) The insurer may elect to provide group insurance coverage which complies with this act in lieu of the issuance of a converted individual policy.

(19) A notification of the conversion privilege shall be included in each certificate of coverage.

(20) A converted policy which is delivered outside this state must be on a form which could be delivered in such other jurisdiction as a converted policy had the group policy been issued in that jurisdiction.

(21) The insurer 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 during the six-month continuation period in accordance with rules and regulations adopted by the commissioner of insurance.

Sec. 2. K.S.A. 1990 Supp. 40-2215 is hereby amended to read as follows: 40-2215. (a) No individual policy of accident and sickness insurance as defined in K.S.A. 40-2201 and amendments thereto shall be issued or delivered to any person in this state nor shall any application, rider or endorsement be used in connection therewith, until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto, have been filed with the commissioner of insurance.

(b) No group or blanket policy or certificate *of accident and sickness insurance* providing hospital, medical or surgical expense benefits *shall be issued or delivered to any person in this state, nor shall any application, rider or endorsement be used in connection therewith, until a copy of the form thereof* ~~and of the classification of risks and the premium rates pertaining thereto~~ *has been filed with the commissioner of insurance.*

~~(b)~~ *(c)* No such policy shall be issued, nor shall any application, rider or endorsement be used in connection therewith, until the expiration of 30 days after it has been filed unless the commissioner gives written approval thereof.

~~(c)~~ *(d)* The commissioner may, within 30 days after the filing of any ~~such~~ form ~~*required to be filed pursuant to subsection (a),*~~ disapprove such form: (1) If, in the case of any form required to be filed pursuant to subsection (a), the benefits provided therein are unreasonable in relation to the premium charged; or (2) if, in the case of any form required to be filed pursuant to subsection (a) or (b), it contains a provision or provisions which are unjust,

Delete

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.

Delete

~~*(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.

Table I

IOWA GROUPS, EMPLOYEES AND INSUREDS
DISTRIBUTED BY SUBJECT TO AND EXEMPT FROM MANDATES

	Subject to Mandate			Exempt From Mandate			
Employee Group Size	No. of Group Contracts	No. of Covered Employees	No. of Insureds	No. of Group Contracts	No. of Covered Employees	No. of Insureds	Exempt Insureds as % of All Insureds
1,000 or more	18	66,461	150,814	34	78,586	189,045	55.67
500-999	22	15,550	31,079	35	24,284	56,895	64.70
250-499	44	15,414	36,079	44	16,298	42,196	53.90
100-249	155	22,265	51,336	115	17,312	41,818	44.90
10- 99	2,194	56,636	131,323	587	17,930	42,989	24.70
Less than 10	7,662	26,935	60,705	413	1,610	3,727	5.80
Totals	10,095	203,261	461,336	1,228	156,020	376,670	44.90%

Source: Ralston, A., M.L. Power and S. McGinnis "State Legislatively Mandated Life and Health Insurance Coverages," The Legislative Extended Assistance Group of the Iowa General Assembly, January 1988, p. 37.

(55.1%) of the group insureds, are not exempt and, therefore, are subject to both state compliance with mandates and the provisions of ERISA. A key aspect demonstrated by the data is that the regulatory inequality is of substantial proportions. That is, the data show that it is not merely a small percentage of the group insured population that is in plans subject concurrently to state and federal regulation. Instead, there are substantial numbers of insureds on each side. The situation in Iowa probably is replicated in all other states.

The second important point regarding discrimination and regulatory inequality drawn from the data in Table I involves the question of the small versus the large employer. Clearly, the data show that it is the relatively small employer instead of the relatively large employer that will be subject to both state and federal regulation. The totals for the number of group contracts provide the initial evidence. The term *contracts* includes both insured and self-funded plans. Even if self-funded, a contractual relationship exists between the employer and employees in a plan. As shown in Table I, although the numbers of insureds in the *subject to* and *exempt* categories are divided approximately 55/45, 10,095 group contracts fall within the *subject to* category, while only 1,228 contracts fall within the *exempt* category. Those in the *exempt* category are, in effect, self-funded plans and, therefore, subject only to ERISA regulation. Most likely, the considerable number of *exempt* smaller employers in the table reflect participation in self-funded multiple employer trusts.

The basis of the disparity is the large number of small employers that have insured group plans. For example, in Table I, employers with 99 or fewer employees account for 9,856 or 87.0% of all contracts (10,095 plus 1,228) or 97.6% of the insured contracts (10,095). Thus, the data in Table I show that the larger the firm, the less likely the welfare benefits plan will be subject to state MHBL. This puts a significant potential cost burden on small employers relative to large employers. Small employers are more likely to provide health insurance through a contract of insurance and, therefore, be required to meet the MHBL requirement.

The Nebraska Law

The state of Nebraska, after identifying and analyzing the inequality described above, chose to enact legislation that specifically ties state and ERISA regulation. In 1986, Nebraska's governor signed a law that provides:

> No legislative proposal to mandate or require the offering of health care coverages or services shall apply to any insurer unless the proposal applies equally to employee welfare benefit plans described in ERISA.[12]

5-1