Approved February 10, 1992
Date

MINUTES OF THE House COMMITTEE ON Insurance.

The meeting was called to order by Representative Turnquist at
Chairperson

3:40 ~~x.m.~~/p.m. on Wednesday, February 5, 1992 in room 526 S of the Capitol.

All members were present except:
Representative Sebelius - Excused.

Committee staff present:
Mr. Fred Carman, Revisor
Mr. Chris Courtwright, Research
Mrs. Emalene Correll, Research
Mrs. Nikki Feuerborn, Secretary

Conferees appearing before the committee:

Mr. Dick Brock, Insurance Department
Mr. John Holmgreen, Catholid Health Association
Dr. John Gay, St. Francis and Stormont Vail Medical Centers
Mr. William Sneed, Health Insurance Association of America
Mr. Brad Smoot, Blue Cross and Blue Shield
Mr. Jerry Slaughter, Kansas Medical Society
Mr. Robert Epps, SRS

The meeting was called to order by Rep. Turnquist at 3:40 p.m. The meeting was moved to Room 526-S due to the large numbers of conferees and guests.

Hearing on Substitute HB 2511 - Kansas uninsurable health insurance plan.

Mr. Chris Courtwright of Research presented the committee with copies of the balloon for **HB 2511.** (See Attachment 1).

Mr. Dick Brock, Insurance Department, gave the background of the proposed bill which he referred to as a sequel to HB 2001. He also reported on similar bills which have been enacted in Nebraska and Iowa. HB 2511 would make available a joint underwriting association for those individuals who are not eligible to join health group pools. Health care would be limited to hospital-medical-surgical coverage. The emphasis on primary care, the limitation on provider charges, the requirement to incorporate managed care measures, the continuous co-insurance provisions, are all designed to produce lower premiums. Mr. Brock listed the eight unique characteristics of HB 2511: (See Attachment 2)

1. Coverage limited to very basic protection.
2. Premiums to be calculated to cover all claims and expenses for the first two years and be reasonable in relation to benefits thereafter.
3. Plan is exempt from mandated benefit and equality requirements.
4. Exclusion for pre-existing conditions is specifically permitted for specified periods of time.
5. Participants will always be subjected to a co-payment feature.
6. Health care providers must agree to accept the amount allowed by medicaid for covered services.
7. Insurers will be permitted to offset only 80% of their assessment and will be entitled to no offset for assessments during the first two years of operation.
8. Provides for a transfer of $1 million dollars of EDIF revenues to the risk pool fund during its first two years.

Mr. John Holmgreen of Catholic Health Association appeared as a proponent of the bill. He requested that mammography be retained as a mandated benefit of health insurance programs in Kansas. (See Attachment 3).

Dr. John Gay, diagnostic radiologist and member of the medical staff at St. Francis Hospital and Medical Center and Stormont Vail Regional Medical Center, appeared as a proponent of the bill. He encouraged the committee to consider mandating insurance coverage for screening mammography. Access to this important and cost effective means of detection of breast cancer should be made available to those who have previously been uninsurable in addition to those already covered. Dr. Gay stated that breast cancer will occur in 1.86 women out of every 10 women in Kansas. (See Attachment 4).

Mr. William Sneed, Health Insurance Association of America, appeared before the committee as a proponent of the bill. Mr. Sneed's recommendations for improvement in the bill are use of the NAIC Model in defining health insurance, plus an insertion for "disability income" in lieu of the current definition in the bill. He also recommended that the exemptions found in the definition of health insurance somehow be tied into the assessment arrangements, which are further defined by the definition of health insurance association in new Section 3. It is his client's policy that funding for such proposals should be broadly based, preferable from general tax revenues and that those entities who are outside the purview of state law are included in the entire funding mechanism. (See Attachment 5).

Mr. Brad Smoot, Legislative Counsel for Blue Cross and Blue Shield of Kansas, appeared before the committee as a proponent of the bill. Mr. Smoot reviewed the development and importance of **HB 2001** and **HB 2511**. He did stated that it may be better for the Legislature to at least know how the small group plan **(SB 561)** will be written and even how it will work before committing state EDIF moneys and tax credits for the individual risk pool. Even though support in general is indicated, he did ask that the committee remember than any system which relies upon subsidies from health insurers will necessarily cause any losses to be spread to all insureds in the form of premium adjustments. (See Attachment 6).

Mr. Jerry Slaughter, representing the Kansas Medical Society, appeared before the committee as a proponent of the bill. A concern was that such low rate of reimbursement might discourage health care providers from participating the plan, making access to services difficult in many areas. He recommended that the committee not peg reimbursement at the Medicaid levels which can be as low as 30-35% of normal charges, but give the Board of Directors of the Association the flexibility to establish reimbursement for providers at a level that would assure access to necessary services. An amendment to this affect what included in the testimony. The committee recommended that the term "reasonable" regarding payment not be included in the amendment. A utilization review committee could be established to set the charges. (See Attachment 7).

Mr. Robert Epps, Commissioner of Income Support/Medical Services, appeared as a proponent of the bill. He expressed concern regarding the claims payment process which would possibly be duplicated under this plan. Eligibility and then possible termination for the plan was also a major concern. Federal legislative history is clear that congressional intent is that Medicaid be the payer of last resort and be secondary to all other forms of coverage. He urged the committee to remove all references to noncoverage of Medicaid services. (See Attachment 8).

Written testimony from Gary L. Robbins, Executive Director of the Kansas Optometric Association, was presented. (See Attachment 9).

Continued hearings on HB 2511 were rescheduled for Monday, February 10, in Room 526 S.

The meeting adjourned at 4:55 p.m.

GUEST LIST

COMMITTEE: House Insurance DATE: Feb. 5, 1992

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Meyer L. Goldman	Kansas City	Humana Health Care
Jim Oliver	Topeka	PIAK
Jeff Gralheer	Wichita	WIBA
Jay Cole	Wichita	WIBA
Rick Friedstrom	Topeka	NALU & FALU
Larry Magill	Topeka	PIAK
Kit Strom	KC	KS USA Dealers
Dick Brock	Topeka	Ins. Dept
Sheryl Sanders	Topeka	KMHC/Ks AMI
Cheryl Dillard	Overland Park	Kaiser Permanente
William Sneed	Topeka	HIAA
Brad Smoot	"	BCBS + KAHO
John Gay	"	Local physician
John Holmgren	"	Catholic Health Association
Sharon Huffman	"	KCDC
Delvin Holdeman	Wichita	Healthcare America, Inc.
Hilary Rieger	Topeka	KAHO
Bill Pitsenberger	Topeka	Blue Cross/Blue Shield
Fred Palousek	"	"
Paul M. Klotz	Topeka	Assoc. Cont. Ks.
Chip Wheelen	Ks Psychiatric Soc.	Topeka
Jerry Slaughter	Ks Medical Soc.	Topeka
[illegible]	Topeka	KDHE - Intern
John Peterson	Ks Hospital Assn	Topeka
R Epps	SRS	Topeka
Charles Walker	SRS	Topeka

Name	Address	Company
JEFF SONNICH	TOPEKA	KNCSI
Wm W. Abbott, DPM	TOPEKA	KPMA
Wayne Prubasco	"	Ks. Podiatry Assn
James E Reese DPM	Lawrence	Ks Podiatry Assn.
[illegible]	KC.	KS cardiology
David Hanzlick	Topeka	KS Dental Assn
Peter Stan	"	Ks. Pharm. Svc. Corp.
[illegible]	"	SHS

Session of 1991

Substitute for HOUSE BILL No. 2511

By Committee on Insurance

4-2

AN ACT providing for the creation and operation of the Kansas uninsurable health insurance plan; amending K.S.A. 79-4804 and repealing the existing section.

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

New Section 1. This act shall be known and may be cited as the Kansas uninsurable health insurance plan act.

New Sec. 2. As used in this act, unless the context otherwise requires, the following words and phrases shall have the meanings ascribed to them in this section:

(a) "Administering carrier" means the insurer or third-party administrator designated in section 4 of this act.

(b) "Association" means the Kansas health insurance association established in section 3 of this act.

(c) "Board" means the board of directors of the association.

(d) "Commissioner" means the commissioner of insurance.

(e) "Health insurance" means any hospital and medical expense incurred policy, nonprofit health care service plan contract and health maintenance organization subscriber contract. The term does not include insurance arising out of the workers compensation act 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.

(f) "Health maintenance organization" means any organization granted a certificate of authority under the provisions of the health maintenance organization act.

(g) "Insurance arrangement" means any plan, program, contract or any other arrangement under which one or more employers, unions or other organizations provide to their employees or members, either directly or indirectly through a group-funded pool, trust or third-party administrator, health care services or benefits other than through an insurer.

(h) "Insurer" means any insurance company, fraternal benefit society, health maintenance organization and nonprofit hospital and medical service corporation authorized to transact health insurance

Section 1 -- Names the Act (KUHIPA)

Section 2 -- Defines various terms used in the bill. "Insurance arrangement" and "insurer" are defined broadly.

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Attachment 1

business in this state.

(i) "Medicaid" means the medical assistance program operated by the state under title XIX of the federal social security act.

(j) "Medicare" means coverage under both parts A and B of title XVIII of the federal social security act, 42 USC 1395.

(k) "Member" means all insurers and insurance arrangements participating in the association.

(l) "Plan" means the Kansas uninsurable health insurance plan created pursuant to this act.

(m) "Plan of operation" means the plan to create and operate the Kansas uninsurable health insurance plan, including articles, bylaws and operating rules, adopted by the board pursuant to section 3 of this act.

New Sec. 3. (a) There is hereby created a nonprofit legal entity to be known as the Kansas health insurance association. All insurers and insurance arrangements providing health care benefits in this state shall be members of the association. The association shall operate under a plan of operation established and approved under subsection (b) of this section and shall exercise its powers through a board of directors established under this section.

(b) (1) The board of directors of the association shall be selected by members of the association subject to the approval of the commissioner. To select the initial board of directors, and to initially organize the association, the commissioner shall give notice to all members in this state of the time and place of the organizational meeting. In determining voting rights at the organizational meeting, each member shall be entitled to one vote in person or by proxy. If the board of directors is not selected within 60 days after the organizational meeting, the commissioner shall appoint the initial board. In approving or selecting members of the board, the commissioner shall consider, among other things, whether all members are fairly represented. Members of the board may be reimbursed from the moneys of the plan for expenses incurred by them as members of the board of directors but shall not otherwise be compensated by the plan for their services.

(2) The board shall submit to the commissioner a plan of operation for the association and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the plan. The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under this act must be made available. The commissioner shall, after notice and hearing, approve the plan of operation if it is determined to be suitable to assure the fair, rea-

Section 3 (a) -- Requires all insurers and insurance arrangements (including HMOs, BC/BS, nonprofit dental and optometric health care plans, multiple employer trusts, fraternal benefit societies providing health coverage, group-funded pools, health benefit plans created pursuant to 1990 HB 2610, and other entities providing members health care services or benefits) be members of the new KHIA.

Section 3 (b) (1) -- Provides for selection of the board of directors by members of the KHIA and requires the Insurance Commissioner to select the initial board if members have not done so within 60 days.

Section 3 (b) (2) -- Requires the board to submit a plan of operation for the Commissioner's approval within 180 days of the appointment of the board. The bill requires the Commissioner to implement a plan through rules and regs if the board fails to submit an acceptable plan within the 180 days. (more)

Page 2 of 7

sonable and equitable administration of the plan and provides for the sharing of association losses on an equitable proportionate basis among the members of the association. If the board fails to submit a suitable plan of operation within 180 days after its appointment, or at any time thereafter fails to submit suitable amendments to the plan of operation, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules and regulations as are necessary or advisable to effectuate the provisions of this section. Such rules and regulations shall continue in force until modified by the commissioner or superseded by a plan of operation submitted by the board and approved by the commissioner. The plan of operation shall, in addition to requirements enumerated elsewhere in this act:

(A) Establish procedures for the handling and accounting of assets and moneys of the plan;

(B) select an administering carrier in accordance with section 4 of this act;

(C) establish procedures for the collection of assessments from all members to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made. The level of payments shall be established by the board pursuant to section 5 of this act. Assessments shall be due and payable within 30 days of receipt of the assessment notice;

(D) establish appropriate cost control measures, including but not limited to, preadmission review, case management, utilization review and exclusions and limitations with respect to treatment and services under the plan; and

(E) develop and implement a program to publicize the existence of the plan, the eligibility requirements and procedures for enrollment and to maintain public awareness of the plan.

(c) The association shall have the general powers and authority enumerated by this subsection in accordance with the plan of operation approved by the commissioner under subsection (b). The association shall have the general powers and authority granted under the laws of this state to insurers licensed to transact the kind of health service or insurance included under section 7 of this act, and in addition thereto, the specific authority and duty to:

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

Section 3 (b) (2) (Continued) -- The section also establishes a number of requirements for the plan of operation, including appropriate cost control measures (preadmission review, case management, utilization review, and exclusions and limitations on services and treatments covered under the plan); assessments to be levied against members of the KHIA; and for a program to publicize the existence of the plan.

The KHIA is granted general powers and authority to enter into contracts necessary to carry out the provisions of KUHIPA; to sue and to be sued; and to take legal action necessary to avoid the payment of improper claims.

Page 3 of 4

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 participating members;

(3) take such legal action as necessary to avoid the payment of improper claims against the association or the coverage provided by or through the plan;

(4) establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas and any other actuarial function appropriate to the operation of the plan. During the first two years of operation of the plan, rates shall be established in an amount that is estimated by the board to cover all claims that may be made against the plan and the expenses of operating the plan. In following years, rates for coverage shall be reasonable in terms of the benefits provided, the risk experience and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age, sex and geographic location in claims costs and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices;

(5) assess members of the association in accordance with the provisions of section 5 of this act;

(6) issue policies of insurance in accordance with the requirements of this act; and

(7) appoint from among members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the plan, policy and other contract design, and any other function within the authority of the association.

New Sec. 4. (a) The board shall select an insurer or third-party administrator to administer the plan. The board shall evaluate bids submitted by interested parties based on criteria established by the board which shall include:

(1) The bidder's proven ability to handle individual accident and health insurance;

(2) the efficiency of the bidder's claim paying procedure;

(3) an estimate of total charges for administering the plan; and

(4) the bidder's ability to administer the plan in a cost efficient manner.

(b) The administering carrier so selected shall serve for a period of three years subject to removal for cause. At least one year prior to the expiration of each three-year period of service, the board shall invite all interested parties, including the current administering carrier, to submit bids to serve as the administering carrier for the

The KHIA also is granted the authority to establish appropriate premium rates necessary for the operation of the plan. During the first two years, rates must be established in an amount estimated to cover all claims anticipated against the plan and all operating expenses. In all following years, rates are required to be "reasonable" and may be adjusted for risk factors such as age, sex, and geographic location.

Section 3 (c) (5) grants the KHIA the authority to assess members pursuant to Section 5.

Section 4 -- Requires the board, after receiving bids, to select an insurer or third-party administrator to administer the plan. The administering carrier selected would serve for at least 3 years, subject to removal for cause.

Page 48

succeeding three-year period. Selection of the administering carrier for the succeeding period shall be made at least six months prior to the end of the current three-year period. The administering carrier shall be paid as provided in the plan of operation.

(c) The administering carrier shall perform all administrative, eligibility and administrative claims payment functions relating to the plan, including:

(1) Establishing a billing procedure for collection of premiums from insured persons. Billings shall be made on a periodic basis as determined by the board, which shall not be more frequent than a monthly billing;

(2) performing all necessary functions to assure timely payment of benefits to covered persons under the plan including making available information relating to the proper manner of submitting a claim for benefits to the plan, distributing forms upon which submission shall be made and evaluating the eligibility of each claim for payment under the plan;

(3) accepting payments of premiums from insured persons and transmitting such payments to the state treasurer for credit to the uninsurable health insurance plan fund established in section 10 of this act;

(4) submitting regular reports to the board regarding the operation of the plan. The frequency, content and form of the reports shall be as determined by the board;

(5) determining net written and earned premiums, the expense of administration, and the paid and incurred losses for each year and reporting such information to the board and the commissioner in a form and manner prescribed by the commissioner.

New Sec. 5. (a) Following the close of each fiscal year, the administering carrier shall determine the net premiums, the plan expenses of administration and the incurred losses for the year. Any net loss of the plan determined after taking into account amounts transferred pursuant to subsection (h) of K.S.A. 79-4804, and amendments thereto, investment income and other appropriate gains and losses shall be assessed by the board to all members of the association in proportion to their respective shares of total health insurance premiums received in this state during the calendar year coinciding with or ending during the fiscal year of the association or any other equitable basis as may be provided in the plan of operation. For ealth maintenance organization members and insurance arrangements, the proportionate share of losses shall be determined through application of an equitable formula based upon claims paid on the value of services provided. In sharing losses, the board may abate

Page 5 of 1

Section 5 (a) -- Requires all members to be assessed annually to pay a proportionate share of losses incurred by the plan during the previous year. Any net gains that accure in any year would be held to offset future losses or to reduce future premiums.

or defer in whole or in part the assessment of a member if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. Health insurance benefits paid by an insurance arrangement 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. Net gains, if any, shall be held at interest to offset future losses or allocated to reduce future premiums.

(b) In addition to any assessment authorized by subsection (a) of this section, the board may assess the members of the association for any initial costs associated with developing and implementing the plan to the extent such costs exceed the funds transferred to the uninsurable health insurance plan fund pursuant to subsection (h) of K.S.A. 79-4804, and amendments thereto. Such assessment shall be allocated among the members of the association in the manner prescribed by subsection (a) of this section or any other equitable formula established by the board. Assessments under this subsection shall not be subject to the credit against premium tax under subsection (c) of this section.

(c) Except as hereinafter provided, 80% of any assessment made against a member of the association pursuant to subsection (a) of this section may be claimed by such member as a credit against such member's premium or privilege tax liability imposed by K.S.A. 40-252 or 40-3213 or K.S.A. 1990 Supp. 12-2624, and amendments thereto, for the taxable year in which such assessment is paid. No credit shall be allowed with respect to any assessment made for net losses incurred during the first two years of operation of the plan.

Sec. 6. (a) Except for those persons who meet the criteria set forth in subsection (b) of this section, any person who has been a resident of this state for at least six months prior to making application for coverage shall be eligible for plan coverage if such person is able to provide evidence satisfactory to the administering carrier that such person meets one of the following criteria:

(1) Such person has had health insurance coverage involuntarily terminated for any reason other than nonpayment of premium;

(2) such person has applied for health insurance and been rejected by two carriers because of health conditions;

(3) such person has applied for health insurance and has been quoted a premium rate which:

(A) In the first two years of operation of the plan, is more than 150% of the premium rate available through the plan; or

(B) in succeeding years of operation of the plan, is in excess of the premium rate established for plan coverage in an amount set by

Section 5 (b) -- Provides for an additional assessment the board could make against members to offset initial costs of developing and implementing the plan, but only to the extent that such start-up costs exceed the proposed transfer of funds from the EDIF to the UHIPF (See Section 9 (h) on page 12).

Section 5 (c) -- Allows premiums tax or domestic insurance company privilege tax credits of 80 percent of the assessments made pursuant to Section 5 (a), except that no credits would be allowed for losses incurred during the first two years of operation of the plan. Also, no credits would be allowed for assessments made to offset initial costs pursuant to Section 5 (b).

Section 6 -- Establishes eligibility criteria for coverage under the plan, providing that persons must have been a Kansas resident for at least 6 months and must meet at least one of the following criteria:

1. Had coverage involuntarily terminated other than for nonpayment of premium; or
2. Applied for coverage and been rejected by two carriers because of health conditions; or
3. Been quoted a premium more than 150 pct of the plan's during its first 2 years or in excess of the plan's for all future years; or
4. Been accepted for coverage subject to a permanent exclusion of a preexisting condition.

Page 6 of 7

the board; or

(4) such person has been accepted for health insurance subject to a permanent exclusion of a preexisting disease or medical condition.

(b) The following persons shall not be eligible for coverage under the plan:

(1) Any person who is eligible for medicare or medicaid benefits;

(2) any person who has had coverage under the plan terminated less than 12 months prior to the date of the current application;

(3) any person who has received accumulated benefits from the plan equal to or in excess of the lifetime maximum benefits under the plan prescribed by section 8 of this act;

(4) any person having access to accident and health insurance through an employer-sponsored group or self-insured plan; or

(5) any person who is eligible for any other public or private program that provides or indemnifies for health services.

(c) Any person who ceases to meet the eligibility requirements of this section may be terminated at the end of a policy period.

New Sec. 7. (a) The plan shall offer coverage to every eligible person pursuant to which such person's covered expenses shall be indemnified or reimbursed subject to the provisions of section 8 of this act.

(b) Except for those expenses set forth in subsection (c) of this section, expenses covered under the plan shall include expenses for:

(1) Services of persons licensed to practice medicine and surgery which are medically necessary for the diagnosis or treatment of injuries, illnesses or conditions, other than mental;

(2) services of advanced registered nurse practitioners who hold a certificate of qualification from the board of nursing to practice in an expanded role or physicians assistants acting under the direction of a responsible physician when such services are provided at the direction of a person licensed to practice medicine and surgery and meet the requirements of paragraph (b)(1) above;

(3) services of licensed dentists issued certificates of qualification by the board of dental examiners to practice oral surgery as a dental specialty when such procedures would otherwise be performed by persons licensed to practice medicine and surgery;

(4) emergency care, surgery and treatment of acute episodes of illness or disease as defined in the plan and provided in a general hospital or ambulatory surgical center as such terms are defined in K.S.A. 65-425, and amendments thereto;

(5) medically necessary diagnostic laboratory and x-ray services as limited by the plan; and

Section 6 (Continued) -- The section also provides that no persons would be eligible for coverage if such person is eligible for Medicaid, for Medicare, or for any other public or private program that provides or indemnifies for health services, or if such person has access to health insurance through a self-insured plan or an employer-sponsored group plan, or has been terminated from the Association plan's coverage within the previous 12 months, or has received the maximum accumulated benefits of $500,000.

Section 7 -- Provides that coverage under the plan includes services of persons licensed to practice medicine and surgery if such services are medically necessary for the diagnosis and treatment of health conditions other than mental health conditions; services of ARNPs and physician assistants when they are provided at the direction of persons licensed to practice medicine and surgery; certain services of oral surgeons licensed by the Kansas Dental Board; medically necessary diagnostic lab and x-ray services as limited by the plan; emergency care for episodes of acute illness as defined in the plan; and prescription drugs and controlled substances prescribed by a physician (outpatient prescriptions would be subject to mandatory 50% coinsurance).

Page 7 of 1

(6) drugs and controlled substances prescribed by a physician. Coverage for outpatient prescriptions shall be subject to a mandatory 50% coinsurance provision, and coverage for prescriptions administered to inpatients shall be subject to a coinsurance provision as established in the plan.

(c) Expenses not covered under the plan shall include expenses for:

(1) Illness or injury due to an act of war;

(2) services rendered prior to the effective date of coverage under this plan for the person on whose behalf the expense is incurred;

(3) services for which no charge would be made in the absence of insurance or for which the insured bears no legal obligation to pay;

(4) (A) services or charges incurred by the insured which are otherwise covered by:

(i) Medicare, medicaid or state law or programs;

(ii) medical services provided for members of the United States armed forces and their dependents or for employees of such armed forces;

(iii) military service-connected disability benefits;

(iv) other benefit or entitlement programs provided for by the laws of the United States;

(v) workers compensation or similar programs addressing injuries, diseases, or conditions incurred in the course of employment covered by such programs;

(vi) benefits payable without regard to fault pursuant to any motor vehicle or other liability insurance policy or equivalent self-insurance.

(B) This exclusion shall not apply to services or charges which exceed the benefits payable under the applicable programs listed above and which are otherwise eligible for payment under this section.

(5) Services the provision of which is not within the scope of the license or certificate of the institution or individual rendering such service;

(6) that part of any charge for services or articles rendered or prescribed which exceeds the rate established by section 13 of this act for such services;

(7) services or articles not medically necessary;

(8) care which is primarily custodial or domiciliary in nature;

(9) cosmetic surgery unless provided as the result of an injury or medically necessary surgical procedure;

(10) eye surgery if corrective lenses would alleviate the problem;

(11) experimental services or supplies not recognized by the ap-

Page 8 of 1

Section 7 (c) -- Lists a number of expenses and types of services or charges incurred by insureds which would NOT be covered by the plan.

propriate medical board as the normal mode of treatment for the illness or injury involved;

(12) service of a blood donor and any fee for failure of the insured to replace the first three pints of blood provided in each calendar year; and

(13) personal supplies or services provided by a health care facility or any other nonmedical or nonprescribed supply or service.

(d) The plan may contract for coverage within the scope of this act notwithstanding any mandated coverages otherwise required by state law. The provisions of K.S.A. 40-2,100 to 40-2,105, inclusive, 40-2,114, 40-2209 and K.S.A. 1990 Supp. 40-2229, 40-2230 and 40-2250, and amendments thereto, shall not be applicable with respect to any coverage provided by the plan.

New Sec. 8. (a) Coverage under the plan shall be subject to both deductible and coinsurance provisions set by the board. The plan may offer applicants for coverage thereunder a choice of deductible and copayment options or combinations thereof. At least one option shall provide for a minimum annual deductible of $5,000. Coverage shall contain a coinsurance provision for each service covered by the plan, and such copayment requirement shall not be subject to a stop loss provision. However, such coverage may provide for a percentage or dollar amount of coinsurance reduction at specific thresholds of copayment expenditures by the insured.

(b) Coverage under the plan shall be subject to a maximum lifetime benefit of $500,000 per covered individual.

(c) In the first two years of operation of the plan, coverage thereunder shall exclude charges or expenses incurred during the first 12 months following the effective date of coverage as to any condition which manifested itself during the six-month period immediately prior to the application for coverage in such manner or would cause an ordinarily prudent person to seek diagnosis, care or treatment or for which medical advice, care or treatment was recommended or received in the six-month period immediately prior to the application for coverage. In succeeding years of operation of the plan, coverage of preexisting conditions thereunder may be excluded as determined by the board except that no such exclusion shall exceed 12 months.

(d) (1) Benefits otherwise payable under plan coverage shall be reduced by all amounts paid or payable through any other health insurance, or insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workers compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any

Section 7 (d) -- Stipulates that mandates otherwise applicable to health insurance coverage would NOT apply to coverage offered under the plan.

Section 8 -- Provides that all coverage is to be subject to copyaments and deductibles set by the board, and that the board may provide various options, at least one of which must involve a minimum annual deductible of $5,000. Preexisting conditions would not be covered for 12 months for the first 2 years of the plan, and the amount of time excluding coverage for such conditions would be set by the board for all future years. The maximum lifetime benefit per covered individual is capped at $500,000 under the plan.

Page 9 of 1

state or federal law or program.

(2) The association shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not covered expenses. Benefits due from the plan may be reduced or refused as a set-off against any amount recoverable under this section.

Sec. 9. K.S.A. 79-4804 is hereby amended to read as follows: 79-4804. (a) An amount equal to 60% of all moneys credited to the state gaming revenues fund shall be transferred and credited to the state economic development initiatives fund which is hereby created in the state treasury. Expenditures from the state economic development initiatives fund shall be made in accordance with appropriations acts for the financing of such programs supporting and enhancing the existing economic foundation of the state and fostering growth through the expansion of current, and the establishment and attraction of new, commercial and industrial enterprises as provided by this section and as may be authorized by law and not less than 1/2 of such money shall be distributed equally among the five congressional districts. On and after July 1, 1990, an amount equal to 90% of all moneys credited to the state gaming revenues fund shall be transferred and credited to the state economic development initiatives fund created by this section. Except as provided by ~~subsection~~ *subsections* (g) *and (h)*, all moneys credited to the state economic development initiatives fund shall be credited within the fund, as provided by law, to an account or accounts of the fund which are created by this section.

(b) There is hereby created the Kansas capital formation account in the state economic development initiatives fund. All moneys credited to the Kansas capital formation account shall be used to provide, encourage and implement capital development and formation in Kansas.

(c) There is hereby created the Kansas economic development research and development account in the state economic development initiatives fund. All moneys credited to the Kansas economic development research and development account shall be used to promote, encourage and implement research and development programs and activities in Kansas and technical assistance funded through state educational institutions under the supervision and control of the state board of regents or other Kansas colleges and universities.

(d) There is hereby created the Kansas economic development endowment account in the state economic development initiatives fund. All moneys credited to the Kansas economic development

endowment account shall be accumulated and invested as provided in this section to provide an ongoing source of funds which shall be used for economic development activities in Kansas, including but not limited to continuing appropriations or demand transfers for programs and projects which shall include, but are not limited to, specific community infrastructure projects in Kansas that stimulate economic growth.

(e) Except as provided in subsection (f), the pooled money investment board may invest and reinvest moneys credited to the state economic development initiatives fund in obligations of the United States of America or obligations the principal and interest of which are guaranteed by the United States of America or in interest-bearing time deposits in any commercial bank located in Kansas, or, if the board determines that it is impossible to deposit such moneys in such time deposits, in repurchase agreements of less than 30 days' duration with a Kansas bank or with a primary government securities dealer which reports to the market reports division of the federal reserve bank of New York for direct obligations of, or obligations that are insured as to principal and interest by, the United States government or any agency thereof. All moneys received as interest earned by the investment of the moneys credited to the state economic development initiatives fund shall be deposited in the state treasury and credited to the Kansas economic development endowment account of such fund.

(f) Moneys credited to the Kansas economic development endowment account of the state economic development initiatives fund may be invested in government guaranteed loans and debentures as provided by law in addition to the investments authorized by subsection (e) or in lieu of such investments. All moneys received as interest earned by the investment under this subsection of the moneys credited to the Kansas economic development endowment account shall be deposited in the state treasury and credited to the Kansas economic development endowment account of the state economic development initiatives fund.

(g) In each fiscal year beginning on and after July 1, 1990, the director of accounts and reports shall make transfers in equal amounts on July 15 and January 15 which in the aggregate equal $2,000,000 from the state economic development initiatives fund to the state water plan fund created by K.S.A. 82a-951. No other moneys credited to the state economic development initiatives fund shall be used for: (1) Water-related projects or programs, or related technical assistance; or (2) any other projects or programs, or related technical assistance, which meet one or more of the long-range goals, objec-

Page 11 of 1

tives and considerations set forth in the state water resource planning act.

(h) On July 15, 1991, and July 15, 1992, the director of accounts and reports shall make transfers of $1,000,000 each from the state economic development initiatives fund to the uninsurable health insurance plan fund created by section 10 of this act.

New Sec. 10. There is hereby created in the state treasury a fund to be known and designated as the uninsurable health insurance plan fund. All premium payments transmitted by the administering insurer and all moneys from assessments made pursuant to section 5 of this act and deposited by the commissioner shall be credited by the state treasurer to the uninsurable health insurance plan fund. All moneys credited to the uninsurable health insurance plan fund shall be used to pay claims and expenses of the operation of the plan. All expenditures from the uninsurable health insurance plan fund shall be made in accordance with appropriation acts upon warrants of the director of accounts and reports issued pursuant to vouchers approved by the commissioner or a person or persons designated by the commissioner.

New Sec. 11. (a) Not later than July 1, 1992, and July 1 of each succeeding year, the board shall submit an audited financial report for the plan for the preceding calendar year to the commissioner in a form provided or prescribed by the commissioner.

(b) The financial status of the plan shall be subject to examination by the commissioner or the commissioner's designee. Such examination shall be conducted at least once every three years beginning January 1, 1994. The commissioner shall transmit a copy of the results of such examination to the legislature by February 1 of the year following the year in which the examination is conducted.

New Sec. 12. The association or a member insurer thereof shall provide every applicant for health coverage under the provisions of this act with a form for making a declaration directing the withholding or withdrawal of life-sustaining procedures in a terminal condition in substantial conformance with subsection (c) of K.S.A. 65-28,103, and amendments thereto. If such applicant elects to execute such declaration the applicant shall submit a copy of such declaration to the association or member insurer thereof, and such copy shall be retained and made a part of the applicant's permanent records.

New Sec. 13. Unless otherwise specified by the plan, as a prerequisite for payment from the plan, each provider of health services to persons covered under the plan shall enter into a provider agreement with the association under which reimbursement for services provided shall be at the rates the state reimburses such providers

Section 9 -- Provides for a $1 million transfer from the EDIF the the UHIPF during each of the first 2 years of the plan's proposed operation.

Section 10 -- Creates the UHIPF.

Section 11 -- Requires the board to submit an annual financial report to the Insurance Commissioner and requires the Commissioner to conduct a financial examination of the plan at least once each 3 years.

Section 12 -- Requires that applicants for coverage be given a declaration form with respect to the withholding or withdrawal of life-sustaining procedures under terminal conditions pursuant to the Kansas Natural Death Act.

Section 13 -- Requires providers of services to enter into agreements with the plan under which reimbursement for covered services is limited to the rate at which Kansas reimburses the providers under Medicaid. No additional fee or charge could be collected from insureds.

Page 12 of 1

for services rendered under medicaid pursuant to rules and regulations of the secretary of social and rehabilitation services. Providers shall not charge persons covered under the plan with the exception of authorized deductible and co-pay requirements and noncovered services if the recipient has been informed in advance of the noncoverage.

Sec. 14. K.S.A. 79-4804 is hereby repealed.

Sec. 15. This act shall take effect and be in force from and after its publication in the Kansas register.

Page 134

Testimony by
Dick Brock, Kansas Insurance Department
Before the House Committee on Insurance
Substitute for House Bill No. 2511

The Insurance Department first proposed legislation to establish a health risk pool in 1976. That exercise has been repeated several times since then with varying ideas and approaches but the same unsuccessful result. In 1991 we again approached this committee with two quite different approaches to establishment of a health risk pool but with the qualification that our primary objective in bringing the proposals forward was to simply get the issue on the table. Although this probably had little bearing on subsequent events, the fact remains that a subcommittee was appointed, diligently pursued their charge and, as you heard last week, brought back a practical and innovative recommendation which, if enacted, will serve as another vehicle to reduce the number of uninsured or underinsured Kansans.

This intended and anticipated result is even more important now that the Kansas legislature is aggressively pursuing initiatives with respect to group health insurance coverage. The 1991 session as you will all recall enacted House Bill 2001 which addressed a number of issues but its dominant characteristic was the underwriting and rating restrictions it imposed. These restrictions effectively prevent an insured group from excluding any eligible person from coverage under the group, excluding coverage for a specific medical condition or applying surcharges to individual group members because of a medical condition. Our short description of House Bill 2001 is that "It puts 'group' back in group".

The sequel to House Bill 2001 has now been introduced and it takes the group reform process a step farther by requiring the issuance of basic coverage to employer groups or units with fewer than 25 employees. Thus, if this latest proposal is enacted, the availability issue with respect to most individuals eligible for employer sponsored group coverage will have been effectively addressed.

Ins. Cmtee
2-5-92
Attachment 2

However, neither 1991 House Bill 2001 or its follow-up are of help to individuals who do not have access to group coverage. Therefore, to complete our efforts to enhance availability we must have a residual market mechanism -- health risk pool, joint underwriting association, or whatever one wants to call it -- for individuals. Substitute for House Bill No. 2511 would fill this void.

As I stressed in my testimony on House Bill 2001; will do on its 1992 sequel; and, as Ms. Correll noted last week, neither the group reforms or Substitute for House Bill 2511 are a panacea. They will not make health insurance affordable or more affordable and the coverage will be more limited than many applicants would prefer. Nevertheless, the hospital-medical-surgical coverage that would be made available pursuant to Substitute for House Bill 2511 would give persons with the resources to do so the opportunity to purchase basic health insurance protection. Furthermore, as Ms. Correll mentioned in her briefing last week, there are several features in the bill that are designed to hold the premiums down. The emphasis on primary care, the limitation on provider charges, the requirement to incorporate managed care measures, the continuous coinsurance provision, are all designed to produce lower premiums. Obviously, "lower premiums" is a relative term but the battle in which we are engaged does not permit a more positive description when we are dealing only with the financing or insurance side of the equation. Admittedly, these features result in lower premiums because the insured relinquishes some freedom to seek health care services whenever, however, and from whomever they choose in addition to sharing in the cost of the medical services obtained. But these have become standard, if not totally accepted, health care management techniques designed to encourage the efficient use of health care services and health care dollars.

And while I'm on this point, I know some are not convinced that a $5,000 deductible, the one option actually required by dollar amount, is any health insurance coverage at all. In some cases, this might be true but,

to many people, the existence of health insurance with a $5,000 deductible at a premium they can afford should be much more preferable than no coverage at all. Although $5,000 is a significant amount of money, it would not constitute a debt so large that it would be beyond the realm of possibility to repay yet the cost of even a moderate illness or injury can reach the hopeless level in a short period of time. The current semi-private room rate at one of the hospitals in Topeka is $351 per day and this doesn't include the cost of medication, special services or equipment or physician charges. Consequently, if this option will make this availability mechanism a useful alternative to a broader population of people, it will be a valuable component.

Not only is it a valuable component from the perspective of individual applicants but it is also relevant to at least a part of the legislature's historical reluctance to put a health risk pool in place. Because of the existence of group coverage, the somewhat limited nature of the coverage and the probable above average cost, some skepticism has perennially persisted regarding the number of Kansas citizens that would actually benefit. Attached to my testimony is a table extracted from an annual analysis published by an organization called "Communicating for Agriculture". This is a leading proponent of health risk pools and has advocated their formation for a number of years. Frankly, I don't know that these figures actually prove anything except that none of the pools are empty; however, comparisons with Nebraska and Iowa should be somewhat informative.

On the other hand, as far as I know, neither Nebraska or Iowa have enacted the underwriting restrictions contained in 1991 House Bill 2001 or are considering the expansion of group reform to include a guaranteed issue requirement. These initiatives will obviously reduce the number of Kansans who might otherwise apply for coverage from a pool. Nevertheless, according to information provided this committee last year by Mr. Sneed on behalf of the Health Insurance Association of America,

Page 3 of 2

there are an estimated 347,000 uninsured individuals in Kansas. Needless to say, a sizeable portion of these are probably uninsured by choice, another segment should now or following this session might be covered by a group plan, and another segment probably falls within the medically indigent category and can't afford whatever we make available. However, when we begin with approximately 14% of the population, there can be a number of different people in a number of different categories and still be a more than sufficient number that would benefit from the existence of a health risk pool. For example, if the small employer group guaranteed issue proposal is enacted in its current form, employer units of less than 3 would not be eligible. Consequently, the single self-employed individual, a business operated by a husband and wife or an employer and one employee would be candidates for coverage from the risk pool. Similarly, for reasons we will discuss if and when the bill gets here, it applies only to employer sponsored groups. Therefore, groups sponsored by social organizations, support groups and so forth would have the House Bill 2001 protections but the group itself might be rejected. And, of course, there are individuals who simply don't have access to a group of any kind who might find the coverage available from a health risk pool beneficial. Thus, I don't believe concern about the number of people who would benefit from establishment of a health risk pool should be a consideration. Even without solid numbers, the experience in other states indicates that such mechanisms are meeting a need.

Another historic and obviously a more serious legislative concern has been a fear that a health risk pool without state subsidy would produce unacceptable increases in premiums for employers and other persons purchasing coverage in the voluntary market. The alternative of a state subsidy through a premium tax offset or direct general fund appropriation raised an equally serious concern about embarking on a program that would become an unacceptable burden on state resources yet prove very difficult to discontinue. The ultimate response to this concern obviously lies with the legislature and the Governor because that is where the spending

priorities are established. To give you some idea of the magnitude of the cost shifting or state subsidy or combination experienced in other states, I have attached to my testimony another table prepared by Communicating for Agriculture. However, before you draw any conclusions from these numbers or others, there are, I believe, some unique characteristics of Substitute for House Bill No. 2511 that deserve consideration.

First, the coverage will be limited to very basic, no-frills protection yet will adequately meet the health care financing needs of most participants and will be of significant benefit to others.

Second, the bill requires the premiums to be calculated to cover all claims and expenses for the first two years of the plan and be reasonable in relation to benefits thereafter which is a very narrow distinction. Thus, the prospect of substantial subsidies is intentionally limited. Also, unlike most, perhaps all, health risk pools in other states, there is no arbitrary cap on premiums i.e. 150% of premium for similar coverage in voluntary market.

Third, the plan is exempt from mandated benefit and equality requirements in order that the ability to develop the most economical but effective benefit plan possible will not be restricted.

Fourth, an exclusion for pre-existing conditions is specifically permitted for specified periods of time. In fact, this provision may even go too far in its present form.

Fifth, as noted earlier, participants will always be subjected to a co-payment feature of some kind thereby avoiding the temptation to utilize medical services unnecessarily "because the annual deductible and coinsurance requirements have been met".

Page 5 of 2

Sixth, as a pre-requisite for payment from the plan, health care providers must agree to accept the amount allowed by medicaid for covered services.

Seventh, although insurance companies are subject to an annual assessment for net losses incurred by the pool, a shift of these costs to the policyholders in the voluntary market is minimized by a premium tax offset. This, of course, transfers this obligation to the state general fund and therefore the general public. However, this impact is also minimized by the economic factors previously mentioned as well as the fact that the pool has not been exempted from payment of premium taxes. As a result, because most, if not all, people procuring coverage from the pool will be new buyers the premium tax collected on pool coverage will represent new revenue and the direct effect on the general fund will therefore be reduced. Last but not least, the bill provides that insurers will be permitted to offset only 80% of their assessment and will be entitled to no offset for assessments during the first two years of operation.

Eighth, Substitute for House Bill 2511 provides for a transfer of $1 million dollars of "EDIF" revenues to the risk pool fund during its first two years.

Last, but certainly a major consideration, is the fact that the cost of medical services delivered to uninsured Kansans are going to be paid in some way. A health risk pool is a way that those individuals can meet their own financing needs or, at least, make effective use of the resources they have. Thus, it would be a big mistake to believe that a health risk pool is some kind of give away program or will represent an expenditure of resources for services that are not now delivered.

In summary, after considering a significant number of different plans and proposals over a period of 15 years, House Bill No. 2511 is, we believe,

the best vehicle yet developed to address the needs of uninsured individuals in this state. There may be some technical corrections needed but, conceptually, it contains the ingredients for meeting a long-standing, persistent, and growing problem.

"QUICK CHECK"

RISK POOL PARTICIPATION
Compiled by
Communicating for Agriculture

The following statistics are the number of participants with in-force policies in state risk pools. All statistics are for the end of 1990, unless otherwise noted.

State	Participants	Year Operational
California	8,901*	1991
Colorado	**Became Operational April, 1991**	1991
Connecticut	2,200*	1976
Florida	5,934*	1983
Georgia	**Not Yet Operational — Passed in 1989**	——
Illinois	4,370	1989
Indiana	3,080	1982
Iowa	1,971	1987
Louisiana	**Not Yet Operational — Passed in 1990**	——
Maine	400	1988
Minnesota	25,272	1976
Mississippi	**Not Yet Operational — Passed in 1991**	——
Missouri	**To Become Operational — November, 1991**	1991
Montana	304	1987
Nebraska	2,904	1986
New Mexico	1,303	1988
North Dakota	1,656	1982
Oregon	1,211*	1990
South Carolina	1,072	1990
Tennessee	4,121	1987
Texas	**Not Yet Operational — Passed in 1989**	——
Utah	**To Become Operational — August, 1991**	1991
Washington	2,793	1988
Wisconsin	9,287	1981
Wyoming	94*	1991

**Notes: California thru June, 1991; Connecticut 1989 figures; Florida 1989 figures; Oregon FY 1990/91; Wyoming thru April, 1991.*

Page 8 of 2

"QUICK CHECK"

RISK POOL OPERATIONS
Compiled by
Communicating for Agriculture

Operational statistics of state risk pools. Statistics for end of 1990, unless otherwise noted.

State	Premiums Collected	Claims Paid	Assessments To Members	Admin. Costs
California	$ N/A	$ N/A	$ 0*	$ N/A
Colorado	Became Operational April, 1991			
Connecticut*	4,495,872	10,438,000	6,522,349	567,826
Florida*	12,443,960	17,425,025	8,057,403	2,810,723
Georgia	Not Yet Operational — Passed in 1989			
Illinois	11,951,968	24,138,119	0*	1,730,348
Indiana	8,376,736	16,978,462	7,316,933	715,188
Iowa	4,574,013	5,053,843	2,088,517	375,432
Louisiana	Not Yet Operational — Passed in 1990			
Maine	512,525	1,154,193	748,388	129,762
Minnesota*	25,734,981	49,469,692	22,167,000	3,057,482
Mississippi	Not Yet Operational — Passed in 1991			
Missouri	To Become Operational — November, 1991			
Montana	629,463	569,834	0	28,954
Nebraska	4,422,717	6,760,239	4,000,000	302,917
New Mexico	2,854,825	4,205,865	2,513,710	219,674
North Dakota	2,571,307	4,312,535	1,699,380	203,683
Oregon*	1,332,469	1,132,952	1,150,000	374,067
South Carolina	1,636,144	1,794,927	90,400	N/A
Tennessee	10,775,374	17,121,200	3,000,000	477,000
Texas	Not Yet Operational — Passed in 1989			
Utah	To Become Operational — August, 1991			
Washington	4,718,231	7,186,956	2,999,470	565,083
Wisconsin	10,561,456	17,569,449	11,000,016	1,486,083
Wyoming*	20,690	548	80,800	6,892

**Note: CA and IL funded by state appropriation; Wyoming through April, 1991. Oregon thru June 90/91FY; MN is preliminary audit; CT and FL figures are 1989.*

Catholic Health Association of Kansas

John H. Holmgren • Executive Director
Jayhawk Tower, 700 Jackson, Suite 801 / Topeka, KS 66603 / (913) 232-6597

TESTIMONY

Insurance Committee
Larry Turnquist, Chairman
Galen Weiland, Vice Chairman

Wednesday, February 5, 1992

Ref: Sub House Bill 2511

HB 2511 covers a limited, primary care program for presently uninsured Kansans. Those include not only those who cannot afford primary care but also those not acceptable to any present insurance program. The concept is timely, but we object to several omissions.

If this bill is passed, or any like version in the Senate, in this Session, we urge you to consider coverage of screening mammography for women over 40 as a vital primary care tool. This cost is now $45 for the technical component and $25 or less for the professional interpretation component. Also it is important that such tests be performed in accredited facilities.

Ins. Cmttee
2-5-92
Attachment 3

I quote from my prior testimony before this Committee on Feb. 12, 1990:

Mammography must be retained as a mandated benefit of health insurance programs in our state. The value of mammography in women 40 years and older has been widely and repeatedly documented in the medical literature. Savings derived from a reduction in cost of treatment of earlier stages of breast cancer are greater than the cost of mammography, yielding a net monetary savings. The following is quoted from two authorities:

> "It is now well accepted that breast cancer screening in which mammography has a major role can result in substantial reductions in breast cancer mortality -- about 30%". 1.

Because of the benefit to the women of our state and a well documented positive cost-benefit, this mandated coverage should be included in the bill.

> "The financial benefits of mammographic screening include a reduction in costs of health care and disability payments achieved through less radical treatment of earlier stage tumors and decreased costs related to hiring and training of new employees. Furthermore, society benefits from the continued productivity of women who are able to remain in the workforce". 2.

Thank you for this opportunity.

John H. Holmgren
Executive Director
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1 Eley, J. William, MD "Analyzing costs and Benefits of Mammography Screening in the Workplace" AAORN Journal, May 1989, Vol. 37, No. 5, P. 171.

2 Shapiro, Sam, "General Motors Cancer Research Foundation, Chas. F. Kettering Prize: Determining the Efficacy of Breast Cancer Screening, Cancer, May 15, 1989.

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TESTIMONY BEFORE THE HOUSE COMMITTEE ON INSURANCE
2/5/92

RE: Substitute House Bill 2511

My name is John Gay. I am a diagnostic radiologist and member of the medical staff at St. Francis Hospital and Medical Center and Stormont Vail Regional Medical Center. I have been involved in breast imaging for the detection of breast cancer in Topeka for the past eighteen years.

I strongly encourage the Committee to consider mandating insurance coverage for screening mammography under this new act.

Early detection of breast cancer is possible with mammography and there is proof from screening studies that the mortality rate from breast cancer can be reduced by at least 30% if routine screening is utilized. Some breast cancer is curable - especially those cancers discovered early when they are small. In this country, the mortality statistics for breast cancer have not changed significantly in sixty years. This is because there is poor compliance with recommendations for screening mammography.

Access to this important and cost effective means of detection of breast cancer should be made available to those who have previously been uninsurable in addition to those who are already covered. This is currently our only chance to favorably impact the disease of breast cancer.

JDG:jkb

Ins. Comittee
2-5-92
Attachment #

MEMORANDUM

TO: Representative Larry Turnquist
Chairman, House Insurance Committee

FROM: William W. Sneed
Legislative Counsel
Health Insurance Association of America

DATE: February 5, 1992

RE: Substitute for House Bill 2511

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 a substitute for H.B. 2511. You will recall that last year my Association was actively involved in the enactment of H.B. 2001, and we are aware of the other health insurance-related bills, specifically, S.B. 561, which relates to a guaranteed issue health insurance proposal for small groups. Because of our involvement, we are aware of the legislature's concern relative to access and affordability of health insurance for those people who desire health insurance but are unable to procure it.

After H.B. 2511 was introduced, you directed a subcommittee to work on the bill, and the result from the subcommittee is now encompassed in the current substitute. Basically, this bill enacts an uninsurable health insurance plan which would provide insurance for those individuals unable to procure insurance through "traditional" means.

Ins. Cmttee
2-5-92
Attachment 5

To begin, my client's position on these types of pools is generally that we believe insurers should be allowed to retain their ability to underwrite. We support state legislative to establish voluntary risk pools for individuals who are denied coverage because of poor health or medical conditions. Further, we believe that funding for these pools should be broadly based. In addition, HIAA maintains that cost controls and managed care should be incorporated into pool administration.

Thus, we support substitute for H.B. 2511; however, we would bring to the Committee's attention several points for your consideration.

1. New Section 2(e) defines health insurance, and it would be my client's recommendation that the NAIC Model, plus an insertion for "disability income," should be used in lieu of the current definition in the bill. We believe that this provides consistency inasmuch as many states throughout the country are reviewing this type of legislation.

2. In regard to assessments, which begins on page 5 of the bill, line 29, the bill encompasses assessments being made against members of the Association. That in turn will ultimately refer you back to new Section 3, which is found on page 2, line 14, which creates the Association. The Association is "all insurers and insurance arrangements providing health care benefits in this state . . . " It would be our recommendation that the exemptions found in the definition of health insurance somehow be tied back into the assessment arrangements, which are further defined by the definition of health insurance association in new Section 3.

3. In regard to the funding, it is my client's policy that funding for such proposals should be broadly based, preferably from general tax revenues. However, last year during our work with the subcommittee, we recognized that there are various components of this bill which provide give-and-take from all sides. However, we believe that a mechanism that is established to provide assistance to citizens of this state should be funded by a mechanism that would share the cost among all citizens in the state. Thus, those entities who are outside the purview of state law are in that regard included in the entire funding mechanism.

As stated earlier, we believe it is important to keep this bill in mind and in coordination with S.B. 561. We recognize that the House is not locked into making its decisions based upon action taken by the Senate; however, we believe it is important to not only this legislative body, but to the citizens of Kansas, to coordinate this bill with S.B. 561 when trying to decide the ultimate outcome of providing health care for the citizens of Kansas.

We appreciate the opportunity to make these comments, and we look forward to working with this Committee on this very important issue.

Respectfully submitted,

William W. Sneed
Legislative Counsel
Health Insurance Association of America

DEFINITION OF "HEALTH INSURANCE" UNDER NAIC
MODEL HEALTH INSURANCE POOLING MECHANISM ACT

"Health insurance" means any hospital and medical expense incurred policy, nonprofit health care service plan contract and health maintenance organization subscriber contract. The term does not include short term, accident, fixed indemnity, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, **[disability income,]** 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.

BRAD SMOOT
ATTORNEY AT LAW

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**Statement of Brad Smoot, Legislative Counsel
Blue Cross & Blue Shield of Kansas to the House Committee
on Insurance regarding 1991 Sub House Bill 2511**

February 5, 1992

I am Brad Smoot representing Blue Cross & Blue Shield of Kansas, a Kansas company providing health insurance coverage to individuals and groups in 103 counties since 1938.

We appear today in general support of Sub HB 2511. It is obvious that this committee, a sub committee from last year, staff and the insurance department have invested considerable time and effort in a proposal to address the problem of individual access to health insurance coverage. Although we do not know how many Kansans might benefit from such a bill, we do believe that there are a number of persons who, because of medical conditions, have not been able to acquire coverage from the current employer-based or public financed health insurance systems.

We would note that with the enactment of HB-2001, the Kansas legislature began the process of reforming the private sector health insurance system. That bill, as you all know, accomplished a number of reforms, including the limiting of underwriting options for carriers. As a result of HB 2001, carriers offering insurance in Kansas cannot exclude individual members from groups or permanently exclude preexisting conditions when writing group coverage.

Just this week, another element of reform was introduced at the request of the Kansas Insurance Department, namely, the small employers group health coverage act, SB 561. As you know, this proposal is the product of months of work between the insurance department, employers and insurers to arrive at a plan for the guaranteed issue of insurance to small groups of 5 to 25. Required coverage for such groups should go a long way toward providing health care coverage to persons not covered by large employers, associations, medicare and medicaid.

Ins. Cmte
2-5-92
Attachment 6

Sub HB 2511 may also play a part in filling in gaps in available coverage. Our only reservation about HB 2511 is that it may be better considered after, or simultaneously with, the small employer group reforms just discussed. In particular, we would note that the small group reforms may capture many of the persons who would be eligible under HB 2511. Consequently, just how HB 2511 should be crafted may well depend on the need remaining and the structure and products used in the small employer group bill. In other words, it may be better for the Legislature to at least know how the small group plan will be written and even how it will work before committing state EDIF moneys and tax credits for the individual risk pool envisioned by HB 2511.

For example, it would probably be important for both acts to agree on such matters as "preexisting condition" (see New Section 8(c) of HB 2511 and Section 3(t) of SB 561). You may also wish to examine the definition of "health insurance," since it does not expressly include indemnity policies. This would be relevant in determining the pro rata share of losses. In addition, the Legislature may wish for the governing boards of both plans to be similarly structured.

Finally, although we generally support the loss financing method provided by HB 2511, we do believe it is important for the committee to remember that any system which relies upon subsidies from health insurers will necessarily cause any losses to be spread to all insureds in the form of premium adjustments.

Again, we commend the committee for is efforts and work product. HB 2511 may well be a very important and workable method of assisting individual Kansans gain access to health care heretofore unavailable to them. We suggest only that you consider this proposal in the context and timing of small employer group reforms being considered.

I would be happy to respond to questions.

KMS
KANSAS MEDICAL SOCIETY
623 W. 10th Ave. • Topeka, Kansas 66612 • (913) 235-2383
WATS 800-332-0156 FAX 913-235-5114

February 5, 1992

TO: House Insurance Committee

FROM: Jerry Slaughter
Executive Director

SUBJECT: Substitute for HB 2511; Concerning the Creation of a Health Insurance Risk Pool

The Kansas Medical Society appreciates the opportunity to comment on HB 2511, which creates a health insurance risk pool for uninsurable Kansans.

First, we generally support the concept of establishing a risk pool to provide basic benefits health insurance coverage to Kansans who are unable to secure such coverage through the private market because of pre-existing medical conditions or other risk factors which make such persons uninsurable. While we are generally supportive of the concept, we do have a couple of concerns about provisions in the bill.

In section 6, page 6, beginning at line 28, the criteria are set forth for persons who would be eligible for the plan. While the plan appears to be intended to reach uninsurable Kansans, as we read the bill it would also include many Kansans who are otherwise insurable, but who may not have insurance coverage provided by their full-time employer. For example, in subsection (3) at line 38, such persons would be eligible for coverage if they had applied for health insurance and been quoted a rate in excess of the rate charged under the risk plan, even though the private insurance costs were based on benefits which are substantially different than those benefits offered in the risk plan. In other words, the comparison of the cost of coverage in the private market and that of the plan would not necessarily be an "apples to apples" comparison. Additionally, to make the plan available to any Kansan who is otherwise insurable would appear to substantially broaden the numbers of persons who would be eligible for coverage, which may not be what was originally intended.

We have another concern with the language in new section 13, beginning on page 12, wherein health care providers participating in the plan must agree to accept reimbursement at a level which the Medicaid program reimburses providers. While we understand the thrust of the bill is to set up a risk pool where all participants involved

Ins. Comm.
Attachment 7
2-5-92

agree to some subsidy for services provided uninsurable Kansans, we believe setting reimbursement rates at Medicaid levels is unfair in that it asks health care providers to accept a disproportionate share of caring for this population. While they do not like it, health care providers generally go along with substantially reduced reimbursement in the Medicaid program because they feel it is an obligation to partially subsidize the cost of care for indigent Kansans. However, this bill would substantially broaden the application of Medicaid reimbursement levels to a population that is by definition not indigent (the program will not cover persons eligible for Medicaid or other public insurance programs; section 6(b).

Additionally, such low rates of reimbursement could discourage health care providers from participating in the plan, making access to services difficult in many areas. In many cases, Medicaid reimbursement levels can be as low as 30-35% of normal charges, which does not even cover overhead expenses in most physicians offices. We would strongly encourage the committee not to peg reimbursement at the Medicaid levels, but give the Board of Directors of the Association the flexibility to establish reimbursement for providers at a level that will assure access to necessary services. We have attached a proposed amendment which would give the Board of Directors of the Association the authority to establish a schedule of reasonable fees for services provided under the program.

In summary, we would like to compliment the subcommittee for its work in developing this concept. Before acting on the bill, you may want to give some consideration to how this program would fit into the efforts underway already by the Kansas Commission on the Future of Health Care, the so-called 403 Commission, which was established by the Legislature last year to study and make recommendations on health care system reform in Kansas. The 403 Commission has been meeting regularly for the past several months in a process that will eventually lead to comprehensive recommendations on health system reform in Kansas. The concept contained in this bill will most certainly be a subject of discussion and action by the 403 Commission, and you may want to give consideration to coordinating your efforts to avoid duplication.

JS:ns

tives and considerations set forth in the state water resource planning act.

(h) On July 15, 1991, and July 15, 1992, the director of accounts and reports shall make transfers of $1,000,000 each from the state economic development initiatives fund to the uninsurable health insurance plan fund created by section 10 of this act.

New Sec. 10. There is hereby created in the state treasury a fund to be known and designated as the uninsurable health insurance plan fund. All premium payments transmitted by the administering insurer and all moneys from assessments made pursuant to section 5 of this act and deposited by the commissioner shall be credited by the state treasurer to the uninsurable health insurance plan fund. All moneys credited to the uninsurable health insurance plan fund shall be used to pay claims and expenses of the operation of the plan. All expenditures from the uninsurable health insurance plan fund shall be made in accordance with appropriation acts upon warrants of the director of accounts and reports issued pursuant to vouchers approved by the commissioner or a person or persons designated by the commissioner.

New Sec. 11. (a) Not later than July 1, 1992, and July 1 of each succeeding year, the board shall submit an audited financial report for the plan for the preceding calendar year to the commissioner in a form provided or prescribed by the commissioner.

(b) The financial status of the plan shall be subject to examination by the commissioner or the commissioner's designee. Such examination shall be conducted at least once every three years beginning January 1, 1994. The commissioner shall transmit a copy of the results of such examination to the legislature by February 1 of the year following the year in which the examination is conducted.

New Sec. 12. The association or a member insurer thereof shall provide every applicant for health coverage under the provisions of this act with a form for making a declaration directing the withholding or withdrawal of life-sustaining procedures in a terminal condition in substantial conformance with subsection (c) of K.S.A. 65-28,103, and amendments thereto. If such applicant elects to execute such declaration the applicant shall submit a copy of such declaration to the association or member insurer thereof, and such copy shall be retained and made a part of the applicant's permanent records.

New Sec. 13. Unless otherwise specified by the plan, as a prerequisite for payment from the plan, each provider of health services to persons covered under the plan shall enter into a provider agreement with the association ~~under which reimbursement for services provided shall be at the rates the state reimburses such providers for services rendered under medicaid pursuant to rules and regulations of the secretary of social and rehabilitation services.~~ Providers shall not charge persons covered under the plan with the exception of authorized deductible and co-pay requirements and noncovered services if the recipient has been informed in advance of the noncoverage.

The board shall establish reimbursement rates for providers which are reasonable and sufficient to assure availability of medically necessary services to persons covered under the plan.

Sec. 14. K.S.A. 79-4804 is hereby repealed.

Sec. 15. This act shall take effect and be in force from and after its publication in the Kansas register.

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Donna L. Whiteman, Secretary

House Insurance Committee
Testimony on Substitute House Bill 2511

Mr. Chairman, Members of the Committee, thank you for this opportunity to address you on Substitute House Bill 2511. The Department of Social and Rehabilitation Services (SRS) endorses the concept of providing health insurance coverage to persons otherwise unable to obtain such coverage. The Agency would like to offer a number of observations and suggestions.

A major concept in the insurance plan under this bill is the claims payment process. New Sec. 13 requires that services reimbursed by the plan be at the rate the state reimburses providers of service under the Medicaid program. This would require early, close and frequent involvement of SRS staff. The Kansas Medicaid Management Information System (KMMIS) claims processing subsystem is a complex operation. The accurate payment of claims depends on many factors in addition to the specific rates set by the Secretary. For the plan to achieve the claims payment objectives, much of the KMMIS claims processing subsystem would need to be duplicated.

The second area of SRS involvement is concerned with eligibility and coverage. The plan proposes to exclude from enrollment and coverage any person eligible for Medicaid benefits. As the stated purpose of the plan is to provide coverage to those persons who have no other medical coverage, the agency can agree that a person eligible for Medicaid at the time application is made to the plan, does have "other medical coverage" and would not be eligible to enroll.

Individuals would gain Medicaid eligibility by incurring a sizeable medical expense through the deductible and coinsurance provisions of the plans coverage. To terminate them from the plan at that point would be to deny benefits for which premiums have been collected.

Federal legislative history is clear that Congressional intent is that Medicaid be the payer of la1st resort and as such, be secondary to all other forms of coverage. Kansas statutes also support this premise. [K.S.A. 1991 Supp. 39-719a] Section 7(c)(4)(A)(i) appears to be contrary to congressional intent and state statutes by declaring services covered by Medicaid to be noncovered by the plan. The agency feels to do so would be to set an undesirable precedent and

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2-5-92

Attachment 8

would urge the Committee to remove all references to noncoverage of Medicaid services.

Once again, SRS is ready to assist the Committee as you refine HB2511 and thanks you for the opportunity to comment on this bill.

Robert L. Epps
Commissioner
Income Support/Medical Services
296-6750

2/3/92

Kansas Optometric Association

1266 SW Topeka Blvd., Topeka, KS 66612
913-232-0225

February 4, 1992

The Honorable Larry Turnquist, Chairman
House Insurance Committee
State House
Topeka, KS 66612

Dear Larry:

I am writing to express my concern about the provision of a substitute for House Bill 2511 which would exempt KSA 40-2, 100 from applying to the Kansas Uninsurable Health Insurance Plan. Specifically, we are concerned about pre-empting KSA 40-2, 100 in line 10 on page 9 of this bill.

I am concerned about the inclusion of the insurance equality or freedom of choice statutes within the term "mandated benefits." Optometrists are included in KSA 40-2, 100 along with dentists and podiatrists. There are several misconceptions about this statute which require clarification. KSA 40-2, 100 requires that optometrists be reimbursed if services are offered under an insurance policy that are within the scope of practice of an optometrist. This law does not mandate coverage. Unlike mandated benefits, it simply allows qualified providers to render services already covered by an insurance policy. This law does not mandate a dental or a vision plan. When insurance companies complain about reimbursing optometrists, podiatrists and dentists for services, it should be stressed that these procedures would have been performed by some qualified provider anyway because the insurance carrier voluntarily covered those procedures.

Thank you for taking a few moments to read our concerns.

Sincerely,

Gary L. Robbins, CAE
Executive Director

GLR/DAC

cc Members, House Insurance Committee

Affiliated with
American Optometric Association™

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2-5-92
Attachment 9