Approved March 23, 1992
Date

MINUTES OF THE House COMMITTEE ON Insurance

The meeting was called to order by Representative Turnquist at
Chairperson

3:30 ~~a.m.~~/p.m. on March 17, 1992 in room 514 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
Ms. Donna L. Whiteman, SRS
Mrs. Shannon Scholler, Wichita
Mr. Don Lynn, Blue Cross/Blue Shield
Mr. Harry Spring, Humana Health Care Plans
Ms. Cheryl Dillard, Kaiser Permanente
Ms. Debra Folkerts, Kansas State Nurses Association
Mrs. Barbara Huff, Keys for Networking, Inc.
Ms. Renee Cristiano, Kansas Society for Clinical Social Work
Mr. Howard Snyder, Kansas Alliance for the Mentally Ill
Mrs. Susan Budd, Kansas Mental Illness Awareness Council

Hearing on SB 561 - Small Employer Group Health Insurance

Mrs. Emalene Correll, Research Department, gave the staff review on the bill. This bill would establish a mechanism to assure the availability of basic health insurance coverage to small employers and their employees. This bill contains a preemption of the statutory provisions that mandate the inclusion of certain benefits and services in accident and sickness insurance policies covering Kansas residents. The purpose of this preemption is to allow the board of directors of the program complete latitude to design a health benefits program that meets the basic needs of small employer groups without being encumbered by benefits and services that are dictated by state law.

The bill contains four major components:

1. Prevents any insurer, HMO, or Blue Cross and Blue Shield plan from declining to insure or renew any applicant for basic or standard small employer group health insurance coverage.

2. In order to attain this objective, a reinsurance pool is established which permits, but does not require, carriers insuring small groups to spread the exposure among all health insurers thereby mitigating any adverse impact on a single company.

3. Imposed underwriting restrictions on small employer groups which parallel those included in 1991 **HB 2001.**

4. Includes rating restrictions designed to further moderate the volatility of small group premiums.

5. Carrier disclosure requirements pertaining to premium rate adjustments, limits on non-renewability and pre-exisiting condition provisions.

Mr. Dick Brock, Insurance Department, appeared as a proponent of the bill. He explained the impact of the proposed amendment requiring that mandated benefits be added to the bill. The lack of flexibility will really and seriously limit the board's ability to design the best, most cost effective benefit plan and Kansas small employers will be the victims. He reviewed the significant provisions of the bill. (See Attachment 1).

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

Ms. Donna L. Whiteman, Secretary of Social and Rehabilitation Services appeared before the committee as a proponent of the bill. SRS believes that minimal criteria for a "basic" health benefit plan should include the following service components: physician services, diagnostic laboratory and radiology services, medical examination services which for women would include both mammograms and pap smears, immunizations for children and young adults, vision, audience, and dental examinations. A "standard" health benefit plan should include all of the above plus prescription drug and limited inpatient and outpatient hospital service. Secretary Whiteman requested that SRS clients be allowed to participate in this plan. (See Attachment 2).

Mrs. Shannon Scholler, a private citizen from Wichita, appeared as a proponent of the bill. She related problems she has encountered with Blue Cross/Blue Shield regarding her daughter Janessa's rare physical condition. Testimony regarding her experiences of being a victim of small group insurance plans was presented to the committee. (See Attachment 3).

Mr. Don Lynn, Vice President of Finance for Blue Cross and Blue Shield of Kansas and a member of the American Academy of Actuaries, appeared as a proponent of the bill. The bill, as amended, contains a limited exemption from mandated services, but not from mandated providers, for the basic plan, but no such exemption for the standard plan and no exemptions from mandates at all for coverages issued to small employers on other than a guaranteed issue basis. This runs counter to trends nationally to increase affordability of health insurance for small employers by exempting their coverage from mandates. The basic and standard benefits are for employers who have not had coverage at all before and the cost of mandated benefits create additional barriers to access. This proposal deals primarily with access to group health insurance and not affordability. The passage of this bill will not result in community rating of small groups. It will result in a narrower spread in rates which means there will be some "rate compression." Community rating does not reduce the aggregate amount of dollars going into the health care system, it merely rearranges it in a more fair manner. In order to lower health care costs, cost containment must be implemented in some form. This plan does not include groups of 1-3 as they are usually proprietorships and if they are not in a group, probably cannot qualify. Rating by association fragments the market and runs counter to the goal of modified community rating. (See Attachment 4).

Mr. Harry V. Spring, Humana Health Care Plans, appeared as a proponent of the bill. This legislation changes the basic way health care benefits are bought and sold in the small group market. Instead of the current system of carriers being allowed to sell to whichever small employers they are willing to write, this legislation allows small employers to purchase health care plans from any small employer carrier they choose. This bill also allows small employers to have total control over when they purchase a health care plan. Including groups of one and two employees would be like guaranteeing individuals the right to purchase fire insurance after a fire has already started in their home or guaranteeing individual farmers the right to purchase crop insurance for their farm half way through a drought. This would cause a disproportionate rate hike among all communities. (See Attachment 5).

Ms. Cheryl Dillard, Public Affairs Manager for Kaiser Permanente in Kansas, appeared as a proponent. SB 561 as it come to the House is not the same legislation that was hammered out over a six-month period by the Commissioner's task force. Mandated providers and mandated benefits have been added to the basic and the standard benefit packages; packages which were intended to be lean and affordable. Nothing prohibits any HMO or insurance company from offering a full range of benefit packages--in addition to the basic and the standard--with all mandates or some mandates included and priced accordingly. Small groups who are interested in offering Kaiser Permanente to their employees are telling us that they want affordable

CONTINUATION SHEET

MINUTES OF THE House COMMITTEE ON Insurance,

room 514 S Statehouse, at 3:30 xxm./p.m. on March 17, 1992, 19__.

no-frills insurance. Ms. Dillard requested the Committee to consider returning SB 561 to its original state with no mandates in either the basic or the standard packages and leave the managing board with the flexibility to design the benefit structure. (See Attachment 6).

Ms. Debra Folkerts, Kansas State Nurses Association, Advanced Practice Conference Group, appeared as a proponent to the bill. She advised the committee of the Rural Health Network known as the Each/Peach Concept. This concept was designed to improve quality, maintain access, and reduce cost by the utilization of mid-level practioneers to provide care in rural primary care hospitals and clinics and refer patients as needed to larger institutions. She urged the committee to maintain **SB 561** as amended regarding provider choice to enable continuity of the Rural Health Network. (See Attachment 7).

Mrs. Barbara Huff, Executive Director, Keys for Networking, Inc., appeared in support of **SB 561** with adding mandated mental health coverage to include both standard and basic coverage. She gave a personal account of a child with both mental and physical illnesses who will soon age out and be dropped from group insurance policies carried by her parents. (See Attachment 8).

Ms. Renee Cristiano, Kansas Society for Clinical Social Work, appeared as a proponent of the **SB 561** as it is amended. The bill strikes a workable compromise by including mental health coverage as a part of the "standard plan." They also strongly endorse the compromise provision which keeps the freedom of choice of health care providers statutes applicable to both the "basic" and "standard" plans. Freedom of choice allows a cost savings, more accessibility to health care, and provides a level playing field for the providers who are themselves small business people. (See Attachment 9).

Mr. Howard Snyder, Kansas Alliance for the Mentally Ill, Prairie Village, appeared as an opponent to the bill in its present form. He stated that the bill is flawed in its present state as it leaves uncovered those who suffer from biological mental illnesses. (See Attachment 10).

Ms. Susan Budd, Coordinator, Kansas Mental Illness Awareness Council, appeared as an opponent to the bill until coverage is mandated for mental illness. She related her personal experience with the illness and its effect on her professional life. Without insurance, the patient nor their family can afford the needed care in a private psychiatric hospital. Many of the psychiatrists in state hospitals and publicly funded mental health centers are licensed by the institutions and do not qualify for state boards. This diminishes the quality of care received with the result that patients do not receive the best treatment and are often unable to get back their health. Self-esteem is important in maintaining the motivation to keep fighting the condition. This leads to a downward spiral which is anything but conducive to good mental health and ultimate recovery. Neither employers nor society can afford the consequences of allowing inadequate and inappropriate treatment of mental illness to occur by default. (See Attachment 11).

Representative Flower moved to approve the minutes of March 16, 1992. Representative Cozine seconded the motion. Motion carried.

The meeting adjourned at 5:30 p.m.

GUEST LIST

COMMITTEE: Insurance DATE: 3/17/92

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Shannon Schaller	602 S. Chautauqua Wichita KS 67211	
Lou & Howard Snyder	4811 W 77 Place Prairie Village 66208	Kansas AMI
Jim Schwartz	Topeka	KECH
[illegible]	Wichita	WIBA
Cheryl Dillard	Overland Park	Kaiser Permanente
Tom Bell	Topeka	KHA
Sharon Huffman	Topeka	KCDC
Russ FREY	TopeKA	Ks Vet Med Assoc
CANDA Byrne	Topeka	KSNA
CharlottE Peake	Belleville	KSNA
John - Kelly Peake	Belleville	—
LISA Getz	Wichita	Wichita Hospitals
Debra Wozniak	Bloomington, IL	State Farm Insurance
Bill Sneed	TOPEKA	HIAA
Patrick J. Hurley	Topeka	McGill Assoc.
Whitney Damron	Topeka	McGill & Associates
Paul M. Klotz	TOPEKA	Assoc. of CMHCs Ks, Inc
Joe Lieber	Topeka	Ks Coop Council
Renée Cristiano	Wichita	Ks Soc. for Clinical Soc. Wk
Bruce Linhos	Lawrence	" "
Martha Hodgesmith	Topeka	KARF
Debbie Folkerts	Concordia Ks	KSNA
Terri Roberts	Topeka	KSNA
SHERYL SANDERS	Topeka	Ks AMI
Lou Snyder	4811 W 77th Pl., P.V.	KS AMI
Chip Wheelen	Topeka	Ks Med. Soc.

NAME	ADDRESS	ORG.
Dick Brock	Topeka	Ins Dept
Harry Spring	Kansas City	Humana
Robert E. Eisler, Jr.	Overland Park	Humana Prime Health
Barbara Huff	Topeka	Keys for Networking
Rena Gardner	Topeka	Governor's Office

Testimony by

Dick Brock, Kansas Insurance Department

Before the House Committee on Insurance

Senate Bill No. 561

Senate Bill No. 561 is --- as I mentioned when I requested its introduction -- a sequel to 1991 House Bill No. 2001. As was discussed when the 1991 legislation was being considered, it was viewed as a means of improving the insurance environment for individuals that are eligible for group coverage but, because of a health condition, an underwriter's whim or some other reason were denied the opportunity to participate. From a broader perspective, House Bill No. 2001 also instituted a new regulatory structure with regard to group health insurance rates by establishing ratemaking standards, requiring the filing of group rates, leveling the regulatory playing field among competitors in the group health insurance marketplace and imposing an overall cap of 75% on rate increases that could be applied to any group in any one year in the absence of a material change in the nature of the risk. What House Bill 2001 did not do was prevent an entire group from being rejected or non-renewed. Therefore, it was known last year that House Bill 2001 could not be the last piece of group health reform. Senate Bill 561 is probably not the last step either but it is the next step and it does address the one vital component House Bill 2001 did not by imposing the following restrictions and requirements:

1) A requirement that each small employer carrier transacting business in the state offer to small employers a basic health care plan and a standard health care plan. This offer must then be accompanied by issuance of one of the plans to every small employer that elects to be covered by the carrier. The two plans are to be developed by a committee appointed by the Commissioner, and in its original form such plans were to be exempt from the requirements of state mandated benefit and equality or freedom of choice laws. As you know or will note, this mandate preemption was amended on the floor of the Senate and I want to take just a little time to explain the real impact of this amendment.

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Attachment 1

First, I must confess that I was surprised that even the most avid advocate of mandated benefits would attempt to impose them on a guaranteed issue mechanism such as that proposed by Senate Bill 561. As many of you will recall, 1990 House Bill No. 2610 which was a previous legislative effort to expand small employer group coverage contained a similar mandate preemption which as far as I can recall was not opposed and I assumed the inclusion of such a provision in Senate Bill 561 would receive the same reception. As the Senate amendment reveals, my assumption was wrong. Therefore, I want to try to explain why subjecting the small employer health care plans contemplated by this proposal to the statutory mandates is so undesirable. In so doing, I hope you received and have had an opportunity to read Commissioner Todd's letter to Senate Bond which tried to address this issue in the Senate. If so, you will note the preemption is not so important from the standpoint of the coverage or delivery systems that are the subject of mandates. As the letter indicates, most and perhaps even all the benefits that are the subject of a mandate would no doubt be included in one or both plans developed by the board. I hasten to add that this doesn't mean exactly the same coverage as the statute dictates but coverage for the same type of medical service or condition would probably be afforded -- in some cases the coverage might even be better. Similarly, the board will obviously want to design such plans so covered services will be delivered as economically as possible so proponents of the freedom of choice mandates shouldn't have a concern. Therefore, in developing Senate Bill 561, neither the task force or the Department wanted to preempt the mandates to avoid offering any particular coverage or directing insureds only to a particular type of health care provider. Rather, we were attempting to gain as much freedom as possible in order that basic health care plans best meeting the needs of small employers at the lowest possible price could be developed. Even the Senate amendment is extremely harmful to this objective. Instead of being able to develop what has become popularly known as a "bare-bones" basic SEHC plan and building on that plan with various enhancements, employers could obtain by purchasing a standard SEHC plan, such enhancements will consist almost if not entirely of the expensive components of mandated benefits such as 30 day inpatient coverage for nervous and mental conditions, drug or

alcohol abuse. Other enhancements such as additional inpatient days for acute care, broader laboratory and x-ray coverage, and outpatient services will need to be added to the "basic" plan because the ability to provide such enhancements by means of the standard plan will be greatly diminished. In other words, the lack of flexibility will really and seriously limit the board's ability to design the best, most cost effective benefit plan and Kansas small employers will be the victims.

Needless to say, the situation would become even worse should the mandated coverage provisions be extended to the basic SEHC plan. In such an event, I would anticipate the fragile consensus of support we were able to develop in Senate Bill 561 in its original form and which has been weakened but not yet shattered by the Senate amendment would disintegrate. I don't know that this would keep the bill from becoming law but it would certainly prevent it from ever becoming an effective tool to help small employers. Even worse, if the bill does not become law, we are left with the underwriting restrictions of 1991 House Bill 2001 but with no way to prevent rejection or non-renewal of entire groups and no prospects for the kind of legislation that would give insurers a reason to stay in the small employer group market in Kansas.

2) Creation of a reinsurance pool which offers insurers the opportunity to spread the exposure presented by a particular group or groups they would otherwise not insure among all health insurers.

3) A requirement that plans be renewable at the option of the employer except for non-payment of premium, fraud or misrepresentation, a decision by the carrier not to renew all of its health benefit plans issued to small employers in a state, or a determination by the Commissioner that the continuation of coverage would not be in the best interests of the policyholders or would impair the carrier's ability to meet its obligations.

4) Premium rate restrictions, both within and between classes of business and year to year restrictions.

5) Carrier disclosure requirements pertaining to premium rate adjustments, limits on non-renewability and pre-existing condition provisions.

6) Underwriting restrictions comparable to those contained in House Bill 2001.

With that brief summary of the bill's principal components, we need to consider some of the most significant provisions of the bill itself.

First, the only reason we have even included a purpose section as found on page 1 of the bill is to officially acknowledge that this bill first and foremost is an availability mechanism. While it contains rating restrictions, these are designed to further compress the rates applied to small groups but, absent provisions that dictate a reduction in the cost and use of health care services, this compression results from a redistribution of costs. As a result, its overall impact will not address the overall problem of affordability and the task force does not want you or your constituents to be misled on that point. Thus, the last one sentence paragraph of Section 1 is an important ingredient.

Section 2 of the bill is also important because Senate Bill No. 561 is intended to be a largely self-contained statutory structure for small employer group coverage. However, as I will attempt to explain later, some reliance on other statutes remains.

Section 3 is the definitions section and, while all of the definitions are of course important to an understanding of the bill, I particularly want to draw your attention to the definition of "Eligible Employee" and "Small Employer". The reason these definitions are important is because when we talk about this bill applying to small <u>employer</u> groups it is not to be confused with the scope of 1991 House Bill 2001 which did, in fact, apply to all groups. Senate Bill No. 561 only applies to groups of 25 or less that are involved in an employer/employee relationship. At some point, the concepts embodied in Senate Bill 561 may be spread to other types of groups but in this early, exploratory stage, it would not have

been productive for the task force to attempt to address, identify or isolate the problems that would be involved in having a guaranteed issue program for non-employer/employee associations and their members. This distinction is made in Section 4 of the bill which really sets forth the eligibility requirements for application of the act. Subsection (a) of this section is the primary eligibility requirement in that the act applies only to groups as defined in K.S.A. 1991 Supp. 40-2209(A). In other words, we have not changed the basic definition of "group" so this is the first criteria that must be met. The second criteria as I've already mentioned is that it must be an employer/employee group. The third criteria is that if the group is an "association" group or a "multiple employer trust" as statutorily defined in 40-2209, employer or member units within the group must have at least 3 employees and not more than 25 employees to be eligible for the guaranteed issue requirement and rating restrictions. This doesn't mean units of less than 3 employees can't be included in a group issued a health benefit plan under this law. It just means the insurer is not statutorily required to cover them.

This is one of the issues where the task force clearly did not arrive at a consensus. I won't attempt to repeat all the arguments for and against this limitation because I assume other conferees will discuss the issue. However, the decision to restrict the minimum number of employees was the result of an actuarial concern. We need to bear in mind that we are moving into uncharted waters. We know any requirement to insure persons with health conditions that are not presently insured will exert an upward pressure on insurance rates. No one knows exactly how severe this pressure will be but, by avoiding an area of potential abuse, we believe this exposure will be spread sufficiently among insurers and groups that the actual impact will not be significant. This does, however, require a cautious approach and avoiding the problems that can result when the minimum number of members of a unit is too small is a risk we don't believe we should take until we have a better idea of what to expect. This is particularly true when put in the insurance environment of an "association" group or "multiple employer trust" because access to group health insurance coverage can be and often is one of, if not the most, attractive reasons for association membership. As a result, single

employers, businesses owned and operated by a husband and wife, and other similar small businesses frequently gravitate to association groups when coverage isn't available elsewhere. There is nothing morally, legally or ethically wrong with this but from a guaranteed issue insurance perspective, the ability to rate a group which has a number of 1 or 2 member firms -- 1 or both of which has a medical condition -- is not actuarially feasible. Again, this doesn't mean they can't be insured. If no medical condition or other adverse situation exists, the 1 and 2 member employee firms can be included. If there is a problem, Substitute for House Bill 2511 is the accessability mechanism for such risks. This issue is not of such significance that it should generate opposition to enactment of Senate Bill 561 but it is a provision that I'm sure will be the focus of objections.

The final point I will make regarding Section 4 is that an association group or multiple employer trust which includes both employee units of less than 3 and more than 25 will be considered a small employer group for purposes of the act.

Section 5 of the bill includes a number of provisions which may be described as administrative details; however, this section does include the underwriting restrictions applicable to small employer groups. Generally, these parallel those included in 1991 House Bill 2001 with two exceptions. First, because these restrictions will now apply exclusively to small employer groups while the 1991 restrictions will apply to all others but primarily large groups, the description of a "preexisting condition" has been changed to apply to conditions revealed during the 6 months preceding the effective date of coverage instead of 90 days. The discussion on this point revolved around the potential difference in premium impact of providing coverage for preexisting conditions on smaller groups versus being able to spread it among the larger population in groups of 25 or more. In terms of its actual effect, it should be remembered that a waiver applies to any waiting periods to the extent a covered person was covered by a prior group policy prior to the effective date of the small employer group coverage. Therefore, I don't know that

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this is a major difference but it is a difference of which you should be aware.

Another important ingredient of Section 5 is subsection (c) which requires the renewal of health benefit plans. This is not an unusual provision given the fact that we are dealing with a guaranteed issue proposal. However, it is important from the standpoint of extra-territoriality which was a central issue in consideration of the 1991 legislation. Without getting into a lot of detail, you should take notice of the fact that, while the underwriting and rating restrictions in Senate Bill 561 apply to contracts issued within or outside the state with respect to Kansas residents the same as House Bill 2001, the guaranteed issue and renewability requirements do not apply to contracts issued outside the state. It seemed to the task force that the ability to apply restrictions, requirements or other provisions designed to benefit Kansas residents with respect to contracts that are issued outside the state but covering Kansas residents has been fairly well established. We cannot say the same with respect to the issuance of a contract in the first place. As a result, we've drawn this distinction in the bill but it should not be a major consideration because the small Kansas employer can avail him or herself with the advantages of the guaranteed issue and renewal requirements by obtaining coverage in this state.

Sections 6 and 7 of the bill consist of the rating restrictions that have been incorporated. These are the rating restrictions adopted by the National Association of Insurance Commissioners (NAIC). Therefore, they are not to be confused with pure community rating. There are basically two reasons the task force chose the NAIC approach. First, although I certainly don't want to imply that there was unanimity, there was general agreement that these restrictions had received the most study and are therefore much less likely to produce unexpected and undesirable adverse results. Second, although the Insurance Department has been one of the strongest proponents of a gradual return to community rating, we have not been able to develop a proposal that would produce this result yet avoid the obvious pitfalls. I have attached to my testimony a copy of an

article which, admittedly, is just an opinion, but nevertheless seems to clearly portray the difficulty of returning to yesterday. This doesn't mean we have to totally discard consideration of a return to community rating. Nevertheless, it does appear that the rating restrictions developed by the NAIC are more appropriate and more desirable at this time.

The rating restrictions themselves are not easy to explain or understand because they do not produce a definite limit beyond which no rate can increase. Therefore, it is very important at the outset to know the task force has addressed the obvious discomfort the absence of an ultimate limit would cause by continuing to rely on the rating provisions of 1991 House Bill 2001. As a result, the rates for small employer groups written under Senate Bill 561 will be subject to the same requirements and restrictions applicable to group health insurance generally. These include the requirement that such rates be filed with the Commissioner -- that rates shall not be unreasonable, unfairly discriminatory or excessive -- and, most important in relation to the restrictions contained in Senate Bill 561, that the rates charged to any group cannot increase by more than 75% during any annual period unless there is a material change in the risk. So as I attempt to describe the rating restrictions imposed by Senate Bill 561 please remember that they are in addition to, not in lieu of, the 75% limitation enacted last year.

In considering these rating restrictions, we need to first look at Section 6 of the bill because this section defines what an insurer may and may not do in establishing the rating classes that can be used. This is important because -- aside from the overall 75% limit -- the rating restrictions apply separately to each class of business. This is more restrictive than it sounds because there are only three reasons an insurer may place business in separate rating classes. They may establish a different rating class for health benefit plans that are marketed or sold on a different basis than others. I don't know of a good actual example but one which is easily understood would be a health benefit plan that is sold by direct mail as opposed to a health benefit plan that is sold and serviced by a company representative. Obviously,

the costs of selling and administering plans marketed in these two ways would be quite different so the law would permit recognition of this difference through the establishment of different rating classes. The second permissible reason for a different rating class relates to the acquisition of business that has already been sold, rated and covered by another insurer. Two insurers may do business quite differently so to avoid sudden and dramatic changes in a group's coverage or rates the law would permit the groups to be included in a separate rating class. Finally, association groups can present markedly different risk characteristics. Therefore, association groups would be permitted to be assigned to different rating classifications.

You will note that the number of rating classifications any insurer is permitted to establish has been subjected to an overall limit of nine. This is the limit included in the NAIC model and the task force did not discuss the possibility of reducing this number. Perhaps other conferees will address the subject but it seems to me that this many rating classifications may not be necessary particularly when the Commissioner is authorized to establish a transition process and timetable with respect to groups acquired from another insurer.

This brings us to Section 7 which incorporates the rating restrictions themselves. In attempting to explain these restrictions, they are easier to understand if you just think of the "index rate" as being the arithmetic average of the lowest rate and the highest rate charged different small employer groups in the same rating classification. In addition, you need to realize that the rates for different groups in the same rating classification may vary because of the geographic location of the group's members, the age and sex of such members and dependents, the number of members and dependents in the group. Variations may also exist because of a difference in the industry classification of each group if the highest rate for any industry classification does not exceed the lowest rate by more than 30% for the first 3 years this law is in effect. After 3 years, this differential is limited to 15%. I realize the bill permits the Commissioner to approve the use of rating

characteristics other than those mentioned but I can assure you this will not be a frequent or easily acquired approval.

Variations in the rates for an individual group are not permitted because of claim experience, health status or duration of coverage since issue. These are essentially the same but somewhat broader prohibitions than those contained in House Bill 2001 which provide that rating classifications within a group based on medical condition cannot be used. As we discussed last year, it is the use of health status or medical condition and claims experience on individual groups that has been largely responsible for the unacceptable premium increases. Therefore, the inability to use claims experience, health status, and duration of coverage in developing the rates for an individual group means the rates for all groups within a rating classification are, in effect, community rated. In other words, the rates for all groups within a given class will be based on their combined experience with no adjustments for health status or how long a particular group has been insured. Furthermore, to the extent the rating restrictions prevent the rates for a given classification from reflecting the total effect of past experience, the residue will naturally be spread among other rating classifications. So, even though these restrictions are far removed from the concept of pure community rating, they will produce a community rating effect.

The first percentage restriction provides that the average rate for any given rating classification cannot exceed the average rate for any other classification by more than 20%.

The second restriction provides that specific groups with the same or similar demographic characteristics within a rating classification cannot vary from the average rate for that class by more than 25%.

The third restriction is more complicated but its net result is to prohibit the rates charged to any individual group from increasing more than the annual percentage change in the rate applicable to new business plus a maximum of 15% due to claims experience of the class plus any rate

change dictated by a change in coverage or the group's demographic characteristics.

Unlike community rating, these restrictions permit a broad variation in rates between groups. For example, an older group in a class with bad claims experience may have average per employee rates that are more than double the rates for a younger group with good claims experience. However, by placing limits on the extent of rate variations between classes and groups within a class plus tying rate increases for existing groups to the rates charged to new groups, the effect is obviously an overall compression of rates over the entire book of small employer group business. Nevertheless, the 75% limitation on increases included in House Bill 2001 is a definitive safeguard so we have left it in place.

One final note on the rating restrictions is to remind you of the concern expressed by some insured groups with respect to the community rating provisions originally included in House Bill No. 2001 last year. This concern largely centered on the possibility that groups with an established rating and risk management program would be adversely affected by the imposition of new rating requirements. Obviously, the public interest is not well served by statutory requirements that disrupt rather than stabilize the fundamental structure of existing groups. Therefore, a provision has been included in lines 34 through 37 on page 11 which permits the Commissioner and group policyholders to avoid these situations.

The operative provisions directed toward the primary focus of the bill -- guaranteed issue -- is contained in Section 10, page 13, lines 19 through 28. These provisions require all insurers issuing health benefit plans to small employers to offer each small employer a choice of two plans -- either a basic health care plan or a basic health care plan with some coverage enhancements. If the small employer elects to be covered by such a plan, it is required to be issued by the insurer.

Because the guaranteed issue requirement will obviously result in the issuance of policies to groups the insurer would not voluntarily accept,

Section 11 of the bill creates a reinsurance mechanism. At the insurer's option, small employer groups may be reinsured which, in effect, permits the insurer to spread the exposure presented by a particular group among all insurers writing health insurance business in Kansas.

It is in this area of the bill that unanimous agreement among task force members was illusive. The guaranteed issue programs in effect in the 3 or 4 states that have them as well as the NAIC and health insurance industry models all permit insurers to reinsure individual members of the group or their dependents. The majority of the task force including the Insurance Department were quite hesitant to "follow the crowd" and thereby assure that the reinsurance pool could not be self-sustaining. Rather, it was and is our opinion that, by permitting only the entire group to be reinsured, the reinsurance pool will not only contain both "good" and "bad" risks but those in good health should be a very substantial majority of the population. As a result, the ability to establish the rates insurers will pay for the reinsurance without direct, planned and unavoidable subsidization might be possible. We know we could not even hope for this result if primary insurers are permitted to "keep" the healthy individuals and reinsure the unhealthy. Nevertheless, because Senate Bill 561 establishes a new mechanism with no historical experience, no one can predict the end result with any degree of certainty. Therefore, we have included the provision appearing in lines 42 and 43 on page 17 and lines 1 through 19 on page 18 of the bill which authorizes the board responsible for the operation of the reinsurance pool to, with the approval of the Commissioner, permit insurers to reinsure individuals after the plan has been in operation for 12 months if it is determined that such a change would be in the best interest of everyone affected. Another provision of the reinsurance mechanism in Senate Bill 561 that is somewhat different are the provisions in lines 28 through 42, page 18. These are what are called the retention requirements and basically spell out what portion of the risk must be retained by the primary insurer even though a group has been reinsured in the pool. These retention provisions require such insurer to pay the first $10,000 of any covered claim for each individual plus 10% of the next $50,000 in each calendar year to encourage greater attention to

managed care techniques and reduce the pool exposure. The NAIC model and others establish the first retention level at $5,000 instead of $10,000 and some members of the task force prefer the lower amount. In addition, Senate Bill 561 places an aggregate limitation on the retention liability of any single insurer in an amount equal to 20% of the insurers total premium on small employer groups. This component is not present in other similar plans. This is designed as a safeguard for smaller insurers but there is not complete unanimity that such a limit is necessary or appropriate.

Despite the efforts to make the reinsurance pool self-sustaining, a provision has been made to recoup losses if reinsurance payments exceed receipts. The first recoupment mechanism would be an assessment on insurers utilizing the reinsurance pool in proportion to their total small employer group premium. Theoretically, a deficit would occur only if the premiums paid for reinsurance are inadequate. Thus, this first assessment could be viewed as simply a charge for the reinsurance that is necessitated by the fact that an insufficient initial premium was charged at the time the reinsurance was procured. This assessment is capped at an amount equal to 5% of the insurers small group premium.

If the first assessment is not adequate to cover the deficit, a second assessment is authorized. This assessment would be apportioned against all insurers writing health benefit plans in this state. This would include an additional assessment on those initially assessed but their small group premium would be deducted from their assessment base. This latter assessment cannot exceed an amount equal to 1% of any insurer's total premium for health benefit plans. No premium tax offset or other direct means of recouping this assessment is included.

The final provisions of the bill that seem to warrant specific comment are those found in Section 12. These are often referred to as anti-gaming provisions and are designed to produce a level and equitable competitive environment for all insurers in the small employer group market.

That completes the testimony on Senate Bill 561; however, in addition to the bill, the task force did suggest that consideration should be given to a repeal of the exemption from state insurance laws that was enacted last year with respect to certain multiple employer welfare arrangements. Underlying this suggestion is the notion that if Senate Bill 561 is enacted, those organizations will be assured of the availability of coverage. An actual legislative proposal has not been prepared and, in fact, it might be premature to do so until Senate Bill No. 561 is enacted and implemented. Nevertheless, this was a suggestion of the task force and I assumed the responsibility of bringing it to your attention.

Commentary:

MANDATORY COMMUNITY RATING:

A sure-fire way to increase the numbers of uninsured

The phrase "community rating" has a warm and fuzzy ring to it, connoting nurturing concepts like home and family. Perhaps that is why it has become so popular among liberal policy makers in Washington and in some states (see article on page one.)

Certainly the popularity of the idea cannot be attributed to the effect it will have on the problem of the uninsured. Mandatory community rating of small group health insurance could be the single worst action government could take in addressing this problem. It would inevitably result in substantial increases in the number of people without private health insurance.

There are two reasons mandatory community rating is a bad idea, one is practical, the other philosophical.

The practical reason is that it would increase, not decrease, the number of uninsured. The outstanding characteristic of the uninsured today is that they are good risks. For the most part they are young and actively at work. The reason they are uninsured is not because they are denied coverage by insurance companies, but because they don't have much money. Since they feel healthy, spending their money on health insurance it is not a high priority.

Community rating would raise the cost of coverage for young, healthy people. It would make coverage even less affordable for them than it is today and result in more of them deciding to spend their money on something other than health insurance. Something of more immediate value like food or housing.

Currently, in most states, there is a very wide spread of rates for small group health insurance. Lisa Carroll, Vice President of Health Services at the Small Business Service Bureau in Worcester, Massachusetts, reports that she is aware of groups paying from $300 to $1200 per employee for similar coverage.

Community rating would average those rates, so that all groups would pay $750 per month. That would be good news for the groups currently paying $1200, which would receive a decrease of 37.5% in their rates, but very bad news for the groups paying $300 — in fact, this latter group would receive an immediate rate increase of 250%!

If the uninsured, and the people who employ them, cannot afford to purchase coverage today at $300 per employee, how will they be able to afford it at $750?

Short of a mandatory, tax-based health system, people will pay for coverage only an amount equal to its perceived value. The reality is that higher-risk people place a greater value on health insurance than healthy people do, and so are willing to pay more for it. It is true that these insurance buyers are angry and frustrated that their costs are so high and health care costs must be addressed. But doubling the premiums for people who place little value on health insurance coverage is not the way to do it. As healthier people drop their coverage, rates will increase for those who remain, creating a cost spiral worse than what exists today.

The philosophical reason for opposing mandatory community rating is that it is appropriate for people who use more services to pay more for them. People who drive more have higher gasoline bills than other people. People who have many accidents pay more for auto insurance. And people who consume more health services should pay more for health insurance.

Of course, the job of insurance is to spread risk, and no one would argue that high utilizers should pay an amount equal to their use of services. In fact, that doesn't happen. Experience and demographic rating cause high utilizers to pay more than low utilizers, but substantial subsidies still exist.

The other job of insurance is to manage risk, and one way of doing that is by discouraging excess use of services by keeping premiums low for low utilizers, and higher for high utilizers.

It may be true that these rate differentials have gone too far and need to be restrained. The NAIC has adopted a model bill to do just that. But that is a far cry from arguing that every insurance consumer should pay the same as every other consumer, regardless of their risk or use of services.

Community rating is a lot like Section 89 and Medicare catastrophic. It sounds awfully good in the abstract, but if it becomes law, watch out for the angry consumers.

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Greg Scandlen

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

Committee on House Insurance
Testimony on Senate Bill 561

March 17, 1992

Mr. Chairman, Members of the Committee, thank you for this opportunity to address you on Senate Bill 561. The Department of Social and Rehabilitation Services (SRS) endorses the concepts of expanding health insurance coverage to persons otherwise unable to obtain such coverage as envisioned in this bill.

As amended, Senate Bill 561 would require that every insurance carrier issuing or maintaining health plans for small employers provide a basic and a standard health care plan to any small employer group in Kansas seeking such coverage. This bill generally defines a small employer as an employer with 25 or fewer employees. The health benefit plans envisioned in this bill would be designed by the board of directors of the small employer health care program and would identify benefit levels to be provided along with co-insurance criteria, deductible amounts, exclusions and other limitations.

The Department of Social and Rehabilitation Services believes that minimal criteria for a "basic" health benefit plan should at a minimum, include the following service components: physician services, diagnostic laboratory and radiology services, medical examination services which for women would include both mammograms and pap smears, immunizations for children and young adults, vision examinations, audiological examinations, and dental examinations.

The Department further believes that a "standard" health benefit plan should include all of the components described for the basic plan plus prescription drug and limited inpatient and outpatient hospital service.

Based on FY 1991 expenditure data for the State's Medical Services program (Medicaid and MediKan) the State spent $64.9 million for primary and preventive type services. Virtually all State Medicaid programs have increased dramatically over the last decade and there are no clear signs that this trend will not continue into the future. We believe that SB 561 has the potential to partially control the drain of State resources on health care services by providing reasonable basic and standard health benefit packages to the employees and family members of small employers in Kansas who would otherwise not be able to afford health insurance coverage.

Once again, SRS is ready to assist the Committee with Senate Bill 561. Thank you for the opportunity to comment on this bill.

Donna L. Whiteman
Secretary

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Members of the Senate, my name is Shannon Scholler. Thank you for the opportunity to speak before you today. My nine year old daughter, Janessa, suffers from Central Hypo-Ventilation Syndrome, which prevents her from breathing at night without the assistance of a ventilator. Our family must have continued health care coverage, in order to afford her nightly nursing care, as well as the ongoing medical care, prescriptions and ventilator that sustains her life. Currently, I am locked in an ongoing battle with my health care provider, Blue Cross Blue Shield of Kansas, that has drained my family both emotionally and financially. It has cost me my marriage and may very well cost my daughter, her life. Let me share my health care nightmare with you.

My employer, Downtown Daycare, had a comprehensive major medical contract with Blue Cross Blue Shield. On July 1, 1991, due to income received versus claims filed, BCBS felt an 80% rate hike was in order. This method, whereby the overall increase in rates are distributed over the groups in the pool based on the individuals group's loss ratio is a common health insurance industry practice. The groups with little or no claims expense are given a lower amount of increase while groups with high medical expense are subject to a larger amount of an increase. However, due to House Bill 2001, effective July 1, 1991, BCBS was limited to a 75% increase. Could any individual afford to pay a thousand dollars a month for health insurance? As it stands, all Downtown Daycare employees are without health insurance coverage. Downtown Daycare has been turned down by twelve other insurance companies. Blue Cross Blue Shield has recommended to my employer that if they eliminated their high risk employee, then they would be able to provide Downtown Daycare with a reasonable group policy, Fortunately, for me, they did not choose to do so.

Social workers and state officials have suggested that one: my husband and I divorce, which would reduce our income; two, reduce my income to $470.00 a month, which would qualify for welfare; or that I relingquish custody of Janessa to the State of Kansas, which would make her a ward of the state or a foster child. She would be placed back in our home as a foster child, given a medical card, and the state would pay for her care.

A temporary solution for my problem materialized in the form of the State Of Kansas Special Home and Community Based Services Program for Technology-Assisted Children. This program was funded for one year only, beginning in March, 1991, and may not be funded for 1992. It is my only means of keeping my child alive, until insurance reform takes place in Kansas. Meanwhile, Blue Cross Blue Shield has offered me a

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policy which costs $4,527.00 a year with a $4,000.00 deductible. They also offered an insurance policy with a $2,000.00 monthly premium. I only make $10,000.00 a year. Any policy amount or subsequent premium increase would be paid by the Kansas Special Home and Community-Based Services Program, if it receives funding. As I stated, I can't pay it. In my opinion, the health insurance industry is not only sticking it to me but the state of Kansas as well. My daughter is caught in the middle. She is depending on you for her life. She has become a pawn in the health care crises. The stakes are too high, the premiums are too high, and that is why I am here today. I pray with all my heart that you can supply your constituents with bold legislation, a solution not a bandaid to the Kansas health care crisis. I wish I could depend on Ron Todd to help me, but he received $49,274.00 from insurance agents, executives, agencies and political action committees. he will receive perhaps even more this next election, as health care issues dominate the election forefront. In closing, I would like to say that our children should not have their faces on billboards and fund raising flyers, forcing them to become poster children for national and local health care reform. We can't depend on the sympathy of the public with fund raisers for transplants and ongoing health care costs on every corner. Please legislate the necessary reform that will help your constituents and benefit your own families and loved ones. Janessa and I thank you for listening. We truly appreciate the opportunity to share our story with you today.

Thank you

Shannon Schaller

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BLUE CROSS AND BLUE SHIELD OF KANSAS, INC.
TESTIMONY ON SENATE BILL 561
Before House Insurance Committee
March 17, 1992
DON LYNN

Mr. Chairman, members of the Committee:

My name is Don Lynn. I am the Vice President of Finance for Blue Cross and Blue Shield of Kansas, and a member of the American Academy of Actuaries. I served on the committee convened by the Insurance Department that drafted SB 561.

Our President, Tom Miller, apologizes for his inability to be here today. He had a prior out-of-town business engagement.

I am testifying today as a proponent of Senate Bill 561.

The passage of HB 2001 last year was the beginning of legislation needed to bring about small group health insurance reform. Senate Bill 561, I believe, is another step in the right direction that will bring about more equitable health insurance coverage and financing for small groups. I want to compliment the Insurance Department for bringing together interested parties and for working out the major objections in advance of submitting this proposal. Health insurance and health insurance reform are complicated issues and having interested parties resolve major conflicts prior to submitting proposals I believe will help hasten passage of important legislation such as Senate Bill 561.

I think it is important to describe what impact we believe this legislation will have on our Blue Cross and Blue Shield of Kansas existing market. That is what will be the real impact of this legislation on some of your constituents.

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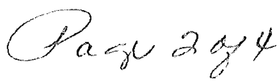
<u>Testimony on Senate Bill 561</u>
Don Lynn
Blue Cross and Blue Shield of Kansas

Section 4 of the proposal includes some useful cost containment provisions for small employers. In particular, it provides that any existing laws which inhibits insurers from contracting with providers for health care services or which restrict the capacity of insurers to negotiate with health care providers regarding the levels or methods of reimbursement are inapplicable to policies for small employers. For a number of years, Blue Cross and Blue Shield has relied upon its contracts with providers to limit its costs and thus the premiums it charges to subscribers. It has done so by making direct payment to contracting providers but paying subscribers when they receive services for non-contracting providers. That ability will continue as Blue Cross and Blue Shield becomes a mutual insurance company on July 1 due to the provisions of last year's HB 2001, which allows it to continue its contracting methodology. However, other insurers might otherwise face limitations on the methodologies they can use to contract for prices with health care providers in the absence of these provisions. Additionally, these provisions clarify the capacity of all insurers to make cost-effective providers the exclusive source of covered services for their insureds under their insurance contracts.

Other than giving carriers these tools for negotiation, however, the proposal does not limit the amount of dollars flowing into the health care system.

The bill as amended contains a limited exemption from mandated services, but not from mandated providers, for the basic plan, but no such exemption for the standard plan and no exemptions from mandates at all for coverages issued to small employers on other than a guaranteed issue basis.



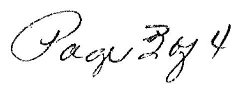
This runs counter to trends nationally to increase affordability of health insurance for small employers by exempting their coverage from mandates. We need to recognize that the basic and standard benefits are for employers who have not had coverage at all before, and that the cost of mandated benefits create additional barriers to access.

We can expect to see an overall increase in the cost of health care in the small group market as a result of SB 561. Why do I say this? Because this proposal, like other small group reform proposals, deals primarily with access to group health insurance and not affordability. The passage of SB 561 will bring into the small group market people who have previously been rejected by health insurers due to their adverse claims experience.

This added population will likely increase the total claims cost in the small group pool. One effect of this expected increase in expense, and subsequently rates, is that some existing groups that are currently enjoying low rates may simply dissolve their group and purchase lower rated non-group products that are available for healthy individuals. When these groups leave the small group pool, the pool will become relatively less healthy resulting in higher rates, but we will have improved the access to health insurance.

We would not want to give you the impression that passage of this bill will result in community rating of small groups. It will result in a narrower spread in rates which means there will be some "rate compression".

Under this bill, the rates may vary from group to group based upon characteristics such as age, sex, geography, type of industry and by 15% based on each group's claims' experience.



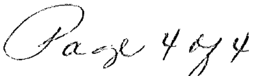
Therefore, the rates for a group consisting of young subscribers in a low use industry (for example, clerical workers) with good claims' experience could be much lower than a group consisting of older subscribers in a high use industry (for example, construction) with high claims' experience.

Because of these rating requirements, your constituents will likely experience substantial differences in rates from one group to another. This bill recognizes changes will result and has incorporated a three-year phase-in of the rating provisions. This will help ease the transition from an insurer's current rating methodology to that required under this bill. There will be rate gainers and losers using this methodology. Under this bill, Blue Cross and Blue Shield of Kansas will place more emphasis on each group's characteristics and less on the group's past experience. However, the spread in rates from highest to lowest will be reduced.

The closer we come to true community rating, the more society recognizes the responsibility of its healthy citizens helping those who are ill. This is the basic concept upon which Blue Cross and Blue Shield was founded.

As a continuation of small group reform we would expect over time that a more restrictive community rating concept may be considered.

As I mentioned, this bill addresses accessibility and not affordability. Currently, overall the health care costs (charge and use) being billed by providers for health care services provided to Blue Cross and Blue Shield of Kansas are about 18% higher than they were one year ago. This means that for a group that had an adequate rate last year and has experienced an average use of health care services during the current year can expect a rate increase of 18% next year.



Testimony on Senate Bill 561
Don Lynn
Blue Cross and Blue Shield of Kansas

As a society, in order to preserve health insurance , we must find a way to prevent cost shifting from inadequately financed categories (such as the uninsured, Medicaid and Medicare) to the health insurance industry. In addition, we must find ways that will reduce the total dollars going into the health care system. One thing is certain.....we can't put less money into health care and still have everyone (providers, patients, insurance companies, etc.) getting the same things that they are today.

Community rating doesn't reduce the aggregate amount of dollars going into the health care system, it merely re-arranges it in a way that many believe is more fair.

So, if we are going to lower the amount of money that goes into the health care system, we must engage in cost containment in some form. This is the next major challenge of the health care system which insurers, providers, consumers, and legislators will have to address.

Senate Bill 561 is a bill which is delicately balanced between assuring access to health insurance to many employers in Kansas while not creating such an adverse health insurance climate in Kansas that carriers will not do business in this market. There are likely to be proposals to amend SB 561, as there were in the Senate, in ways that would destroy this balance, and we need to make very certain this Committee and the House as a whole understands the concepts and problems posed by these kinds of amendments.

Some have asked why the bill does not include employer units of one and two. Let me begin by noting that a group size of from 3 to 25 is the same as that developed by the NAIC after two years of effort.

Testimony on Senate Bill 561
Don Lynn
Blue Cross and Blue Shield of Kansas

Group insurance is based on the principle of insuring both the healthy and the unhealthy. That was one of the primary concepts of last year's House Bill 2001 in prohibiting insurers from refusing to insure individuals within a group.

When it comes to employers of size one and two - primarily individual proprietorships - if they currently lack insurance, it is probably because they cannot qualify for insurance in the non-group market due to current or past health conditions. If insurers were required to issue coverage to persons in such a situation, the insurers are likely going to enroll only unhealthy persons, and no additional healthy persons to counterbalance this.

What would this do? It would drive up the rates for all others in the small group market substantially - especially where it is so hard to describe who constitutes a legitimate sole proprietor enterprise. Insurers who felt the risks posed by doing business in Kansas were unacceptable in that sort of an underwriting situation would simply pull up stakes and concentrate their resources in states which followed the NAIC model.

One and two person employers are truly suitable for the non-group market, not the group market. On the non-group side, we have House Bill 2511 this year to provide access to health insurance for this category.

Another proposed amendment in the Senate was to treat an association as though it were an employer, or a single class of business. This, too, was a concept which would require that insurers guarantee issue to employers of size one and two, but in a more obscure way. It would also complicate the rate reform approach of SB 561.

Testimony on Senate Bill 561
Don Lynn
Blue Cross and Blue Shield of Kansas

If we allow rating by association - allow associations to be a class of business - a lot of things happen, all bad. Two groups in the same town, in essentially the same industry with essentially the same employee make-up would wind up paying different rates merely because they belong to different associations. Groups can and would move from association to association, creating instability in the rates. Finally, rating by each association fragments the market and runs counter to the goal of modified community rating.

As I stated, SB 561 is delicately balanced. If changes such as the above are made, we would unalterably oppose the bill, but as it exists, we can wholeheartedly support it.

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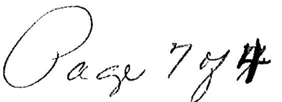

Testimony by

Harry V. Spring, Humana Health Care Plans

Before the House Committee on Insurance

Senate Bill No. 561

Senate Bill No. 561 is the product of many months of work by a taskforce set up by the Kansas Insurance Department. I would like to thank and acknowledge the hard work of Dick Brock and Ron Todd in developing this legislation. They literally spent hundreds of hours forging this piece of legislation. I believe Senate Bill 561 is good public policy for Kansas in addressing the needs of small business employees and employers as they relate to access to purchase health care coverage. I agree with Dick Brock's earlier comments in support of Senate Bill 561 as originally introduced. It is important to give the board, created by this legislation, as much flexibility as possible in designing benefit plans so they can address the needs of small employers. Also important is to understand the reasons for the group size eligible for guarantee issue, to be no smaller than three.

This legislation changes the basic way health care benefits are bought and sold in the small group market. Instead of the current system of carriers being allowed to sell to whichever small employers they are willing to write, this legislation allows small employers to purchase health care plans from any

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small employer carrier they chose. Further, this allows small employers to have total control over when they purchase a health care plan.

This basic reform is appropriate and needed to increase the number of small employers who provide health benefit plans to their employees. However, when making this change in the market, we must become aware of how this impacts the decision to purchase health plans by small employers. It is common sense that people purchase insurance for two basic reasons, which are:

1) To insure against losses due to possible future health care costs.

2) To pay for known future loses due to health care needs.

Basic reason 1 is the traditional reason for purchasing insurance. Under this, employer groups of 3 to 25 will consider possible loss among their workforce and decide to purchase insurance if they feel it is appropriate to provide health care benefits to their employees. However, if employers of one or two people (i.e. sole proprietors or husband and wife partnerships) are allowed to be covered under this guarantee issue law, they will act much differently. There will be no reason for these one and two employee groups to purchase a health care plan to insure against future possible loss because they will be able to wait until they are in need of health care services and at that time

force a small group carrier to provide coverage through this law. These employers can then cancel this plan once they are healthy and purchase a new one when they are sick. Including groups of one and two employees would be like guaranteeing individuals the right to purchase fire insurance after a fire has already started in their home or guaranteeing individual farmers the right to purchase crop insurance for their farm half way through a drought. Requiring this type of guarantee would be bad public policy for Kansas.

Allowing groups of less than three will assure substantial loss to carriers. Under the rating requirements of the bill, the small employer carriers would be forced to spread most of the costs of this guaranteed loss amongst all small employers in Kansas, thus raising the rates to all small employers to an unacceptably high level.

Thank you for the opportunity to testify in support of the original Senate Bill 561. I urge you to pass it without any amendments.

Testimony Before
Kansas House Insurance Committee
Senate Bill 561
Kaiser Permanente
March 17, 1992

Mr. Chairman, I am Cheryl Dillard, Public Affairs Manager for Kaiser Permanente in Kansas City. Kaiser Permanente is the largest and most experienced health maintenance organization in the country, with over 6.5 million members in 16 states and the District of Columbia.

We were pleased to have been part of the Commissioner's work group that developed Senate Bill 561 and welcome the opportunity to appear before you today in support of the legislation.

There are several aspects of this bill that are extremely important from the point of view of health maintenance organizations who, as you know, both finance and provide health care. The bill recognizes that HMOs operate differently from indemnity insurers, so there are separate provisions dealing with HMO benefit plans, which tend to be more comprehensive and dealing with limited geographic service areas. HMOs are licensed by the Commissioner to operate in designated areas generally consistent with the outer limits of our health care provider networks. Under a guarantee issue requirement, HMOs need this special recognition.

Senate Bill 561 permits HMOs to purchase reinsurance coverage through the pool mechanism. However, many of us will probably elect to be what are referred to as "risk-assuming carriers." HMO's like Kaiser Permanente, have demonstrated success in managing care, particularly high cost care, and will not need to reinsure any groups. The two-tiered assessment system accommodates those HMOs who will be assuming all risks and, therefore, should not be in the first tier of reinsuring carriers who should be required to pay for the pool losses.

Because we will be assessed in the second tier if the pool losses are too great, we have a strong interest in the responsible management of the pool. We're pleased that there will be an HMO representative on the pool board and that those carriers who purchase reinsurance will be required to use the cost containment techniques that are standard operation for any HMO.

House Insurance
3-17-92

Kaiser Foundation Health Plan of Kansas City, Inc.
10561 Barkley, Suite 200 Overland Park, Kansas 66212 (913) 967-4600

Senate Bill 561, as it comes to the House Insurance Committee, is not the same legislation that was hammered out over a six-month period by the Commissioner's task force. Mandated providers and mandated benefits have been added to the basic and the standard benefit packages; packages which were intended to be lean and affordable. You will hear, over the next few days, from well-intended advocates of special interests that more mandates means better treatment. I'd point out to you that nothing in Senate Bill 561 prohibits any HMO or insurance company from offering a full range of benefit packages - in addition to the basic and the standard - with all mandates or some mandates included and priced accordingly. In our industry, we strive to sell what our customers want. Those small groups who are interested in offering Kaiser Permanente to their employees are telling us that they want affordable no-frills insurance.

I strongly urge this Committee to consider returning Senate Bill 561 to its original state with no mandates in either the basic or the standard packages and leave the managing board with the flexibility to design the benefit structure that will serve the needs of small employers. In summary, Kaiser Permanente believes Senate Bill 561 is sound policy. It has the potential of accomplishing the goal of expanding access to coverage for small Kansas employers, and we urge you to help this legislation achieve this potential.

TESTIMONY: SENDATE BILL 561

DEBRA J. FOLKERTS, A.R.N.P.

KANSAS STATE NURSES ASSOCIATION

ADVANCED PRACTICE CONFERENCE GROUP

Mr. Chairman, Members of the Committee:

My name is Debra Folkerts and I represent the Kansas State Nurses Association, Advanced Practice Conference Group. I testify today as a proponent of S.B. 561 in its amended version, to retain provider choice.

I practice at the Glasco Family Clinic in Glasco, Kansas. The clinic was featured on ABC's American Agenda as an alternative to providing access to health care in rural areas. At the time, the town's only physician was retiring and could not be replaced. Therefore, a Nurse Practitioner was recruited to provide health care to the town and surrounding areas.

Currently, I encounter 400 patient visits per month and I am the town's sole health care provider. A physician sees patient consultations twice monthly. To continue to provide this service, provider choice must be retained to enable reimbursement for my services.

This type of provider alternative is a new concept for rural areas. Kansas is one of seven states chosen to receive funding by 1990 Federal Legislation to develop a Rural Health Network known as the Each/Peach Concept. With 112 of

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132 hospitals in Kansas being Rural and rural hospitalization volumes declining 50-80%, this concept was designed to improve quality, maintain access, and reduce cost. The mechanism to achieving this is by the utilization of mid-level practitioners like myself to provide care in Rural Primary Care Hospitals and Clinics and refer patients as needed to larger institutions. Presently 13 Rural Primary Care Sites are participating in this network.

SB 561 first and foremost purpose as communicated by Dick Brock of the Kansas Insurance Department is to provide an availability mechanism for insurance. I certainly support this concept; however insurance availability is of no consequence if the sole provider is not recognized as reimbursable. This will truncate access to health care in rural areas.

I would urge the committe to maintain SB 561 as amended to enable continuity of the Rural Health Network.

House Insurance Committee
Testimony
By
Barbara Huff
Executive Director
of
Keys For Networking, Inc.

March 17, 1992

Mr. Chairman and Members of the committee,

Thank you for this opportunity to testify today on behalf of families in Kansas who have children with serious emotional and behavioral disorders.

I offer testimony today as a consumer of mental health services, as a mother of a daughter who is seriously emotionally disturbed and as the Executive Director of Keys For Networking. We would like to offer support for Senate Bill 561, however, we believe that Mental Health Services should be covered in both basic and standard insurance policies. We believe that it is discriminatory to offer mandates for other illness without offering a mandate for mental health. The outpatient benefits for families as they stand today are less than satisfactory.

We would encourage you to support Senate Bill 561 with adding mandated mental health coverage to include both standard and basic coverage.

Sincerely,

Barbara Huff

Barbara Huff
Executive Director
Keys For Networking, Inc.

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KANSAS SOCIETY FOR CLINICAL SOCIAL WORK

HOUSE INSURANCE COMMITTEE
S.B. 561

My name is Renee Cristiano. I am very pleased to be appearing before the House Insurance Committee today to speak in favor of SB 561 on behalf of the Kansas Society for Clinical Social Workers. As health care professionals we strongly support the intent of SB 561, which is to extend health coverage to a larger group of individuals, namely those working in small companies of 25 or fewer employees.

Senate bill 561, in its present form, draws a distinction between mandated mental health coverage in the "Basic" and "Standard" plans. While we support the need for mental health coverage as an important part of all health care planning, we also recognize the critical importance of addressing the needs of the large group of employed individuals in our state who currently have no health care coverage. We question whether ignoring coverages such as of substance abuse will not ultimately prove more costly to employers, but we also believe that compromise is an important ingredient in finding a way to begin to extend at least some basic health care coverage to a wider number of working Kansans. SB 561, we believe, strikes a workable compromise by including mental health coverage as a part of the "standard plan".

We also strongly endorse the compromise provision in SB 561 which keeps the freedom of choice of health care providers statutes applicable to both the "basic" and "standard" plans. Confusion seems to have frequently surrounded this issue tying it somehow to an increase in benefits or services. What freedom of choice really does is when a particular benefit is provided by an insurance policy, it allows the recipient of a health care service the opportunity to choose among providers licensed by the state to provide that service.

The freedom of choice of provider statutes as they apply to mental health services in Kansas have the following advantages in regard to clinical social workers:

◆ COST SAVINGS: Treatment is more effective and often less costly if the patient goes to a specialist. Clinical social workers frequently specialize in family therapy and were the first provider group in Kansas to develop outpatient treatment programs for sexual abuse.

In addition, social workers charge less than psychologists or psychiatrists. Many insurance companies, after exploring cost effectiveness have decided to include licensed clinical social workers as

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providers. Some of these companies are Aetna,Champus, Prudential, and Medicare.

◆ **ACCESSIBILITY TO HEALTH CARE:** Without freedom of choice provider statutes, the availability of mental health services to more rural areas of our state would be seriously diminished. For example, there are twice as many clinical social workers in Kansas as licensed psychologists. Relaxing the freedom of choice provision would only further hamper the delivery of mental health care.

◆ **PROVIDING A LEVEL PLAYING FIELD:** The freedom of choice provider statutes provides a level playing field for the providers, who are themselves small business people. What we and all providers seek is simply an equal chance to compete rather than being excluded arbitrarily by an insurance company decision. Not having the freedom of choice of provider statutes apply to small groups would have a serious impact on clinical social workers ability to earn a living. Although social workers provide more than half of the mental health services in the United States, because of tradition (psychiatrists and psychologists, being on the scene longer), a good number of insurance companies still do not reimburse clinical social workers unless required by law. If social workers are going to be able to compete freedom of choice statutes must remain in place. With hundreds of companies in and out of state offering health insurance to Kansans, it would be a practical impossibility for us to try to deal with each company individually.

The Kansas Legislature carefully studied one by one the freedom of choice provider statutes and found them to be in the best interest of the citizens of Kansas. Just last week, the House as a whole included language in HB 2511 which parallels the language in SB 561 on the freedom of choice providers statutes. These statutes provide no cost to insurance companies since they don't add benefits, only the freedom to choose among providers licensed by the state to provide the benefits already offered.

On behalf of the 1,000 licensed clinical social workers in Kansas, we urge this committee's support SB 561 as amended by the Senate.

March 17, 1992

KANSAS ALLIANCE FOR THE MENTALLY ILL

112 S.W. 6th, Ste. 305 • P.O. Box 675
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March 17, 1992

My name is Howard Snyder, and I'm from Prairie Village. I'm testifying today as Past President of the Kansas Alliance for the Mentally Ill (KS AMI). We are a statewide organization of over 400 families and friends of Kansans suffering from mental illness. I have a 33 year old son who suffers from a bioloical brain disease-schizophrenia. Before he became ill at age 19, he was an Eagle Scout, twice an exchange student in France, and was named top Freshman at the U. of Arizona in the school Geology. He was unable to graduate, and today is severly disabled and living in a nursing home, because he is unable to live on his own.

Today I am experiencing "deja vu". I appeared before this committee several times in 1984, 1985 and 1986 during the long hard battle to achieve minimal mandated insurance coverage. Today the "Hun's are at the gates," and chipping away at even that little coverage.

I want to make clear that we support the concept of SB561, and the effort to get more people covered for their health needs. However, the bill as it stands is flawed, because it leaves uncovered your fellow Kansans who will suffer from the biological mental illnesses. These Kansans will get to pay for other people's babies, other people's cancer, other people's heart problems and other people's gall bladders, but they will be totally unprotected when they contract one of the mental disorders. This is an obviously unfair and discriminatory treatment of many of the citizens you represent.

In 1986 this Legislature decided that mental health insurance was so necessary and so important that it should be required. The need behind that decision has not changed. Leaving out brain coverage while covering all other parts of the body is analogous to an electrician replacing or repairing the old wiring in your house, and not replacing or repairing the malfunctioning fuze box.

In 1990 this Legislature embarked on a new course in the treatment of mentally ill Kansans with the passage of comprehensive Mental Health Reform legislation. The state has taken on a major commitment to move from an inpatient oriented public mental health treatment system to the development of necessary services and treatment in the patient's community. This has entailed a commitment of funding as well as a major change in treatment philosophy. Now it is time for the private sector to commit to it's fair share.

One of the critical elements of successful treatment of a mental disorder is early intervention. A person without insurance coverage is often reluctant to seek treatment until hospitalization is the only medical alternative. When this happens, and remember these people have no insurance coverage, they will end up in the state inpatient system, causing great stress on the state hospitals, which are now being downsized. The planning for and commitment to Mental Health Reform did not envision this Legislature backing away from its previous decision that Kansans need mental health insurance coverage.

In a 1990 interim study concerning the repeal of all mandates, I and others testified that the mandate dollar mix for inpatient vs. outpatient treatment was skewed far too much to inpatient the most costly treatment. I suggested that that mix should be revisited and consideration given to a single capped amount, which could be used as needed by the policy holders. It is likely that this change would promote more useage of outpatient which is the less expensive treatment.

In closing I would say that the basic decision is whether the state is going to become more and more involved in the cost of treatment of the mental disorders, or is the private sector going to have to take on it's fair share. The mandates were legislated for a good purpose, which has not changed. They should be a part of this bill.

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Howard W. Snyder, KS AMI
Howard W. Snyder

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TESTIMONY

to the

House Insurance Committee

March 17, 1992

by

Susan Estelle Budd, Coordinator
Kansas Mental Illness Awareness Council

I remember the day they told me to quite graduate school, that I was chronically mentally ill, that I would be in and out of psychiatric hospitals for the rest of my life. I remember the panic which settled over me when I thought of my mind as forever impaired. I remember the death of my spirit.

I did, however, graduate with a Master of Science Degree in Biology form Southern Connecticut State College, without being able to concentrate well enough to comprehend the long and involved sentences of scientific texts. Psychotropic medication does that to you. But, I was lucky. I had friends who were willing to read the texts to me. I took lecture notes in short understandable phrases. Ironically, I had no trouble writing or typing my thesis, Adaptation of the Radioimmunoassay Method to the Measurement of Luteinizing and Follicle-Stimulating Hormones. I defended this thesis orally and I graduated. I ultimately found employment with a kindly pediatric endocrinologist, who was willing to let me work the hours when I was most productive and was understanding and tolerant of my wide mood swings.

I give you this background so that you can understand something of who I am. I come to you today representing the Kansas Mental Illness Awareness Council, a state-wide organization of mental health consumers, clients, ex-patients and psychiatric survivors. I have come to talk about insurance coverage for mental illness.

Mental Illness is a devastating PHYSICAL illness. As a registered medical technologist and former research assistant, I can tell you that the brain is an organ like any other in our bodies and like all organs there are things which can go wrong with it. As organs go, it is in all probability the most delicate and complex. Small wonder, then, that up to one in five individuals in American society will suffer a mental illness sometime in their lifetime. Some of us will suffer many bouts of psychiatric symptoms before we die and for many of us those symptoms

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are debilitating. Without insurance, we cannot get adequate care. Let me tell you why.

First, without insurance, neither we nor our families can afford our care in private psychiatric hospitals. This is especially true if our illness is severe and persistent. Yet, the more debilitating our condition, the more urgent our need for quality care. The medication balance needed to maintain people with severe and persistent mental illness in a productive role in their community is often extremely delicate requiring the most able of specialists. However, the more disabled we become, the less likely we are to be able to afford such care. Without this care, we are lost as potential contributors to our communities. This loss is profoundly expensive to society, as more and more tax dollars must be channelled into less and less quality of care. If we slide into the state system of care because of increasing poverty, we find that many of the psychiatrists in our state hospitals and publicly funded mental health centers are licensed by the institution and do not qualify for state boards. Needless to say, this diminishes the quality of care received, with the result that we often are unable to get back our health. This is appalling.

Second, we need to be able to keep up our self esteem in order to maintain the motivation to keep fighting our condition. But when we are stripped of all our financial resources, we find ourselves homeless, undernourished and completely dependent on the welfare and social security disability systems for survival. Often under these conditions, we loose our will to fight and the self esteem we so need to get well and we become an ever increasing burden upon those around us. This downward spiral is anything but conducive to good mental health and ultimate recovery.

For these reasons, we are opposed to S.B. 561 until coverage is mandated for mental illness. Neither employers nor society can afford the consequences of allowing inadequate and inappropriate treatment of mental illness to occur by default. The cost in employee productivity and social welfare is just too high.