Approved March 24, 1992
Date

MINUTES OF THE House COMMITTEE ON Insurance.

The meeting was called to order by Representative Turnquist at
Chairperson

3:30 ~~xxx~~/p.m. on March 18, 1992 in room 514 S of the Capitol.

All members were present except:
Representative Sebelius - Excused
Representative Cozine - Excused

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

Conferees appearing before the committee:
Mr. Joe Lieber, Kansas Cooperative Council
Mr. Jim Schwartz, Kansas Employer Coalition on Health
Mr. William Sneed, Health Insurance Association of America
Mr. Paul Klotz, Association of Community Mental Health Centers of Kansas
Mr. Chip Wheelen, Kansas Medical Society & Kansas Psychiatric Society
Ms. Cheryl Sanders, Kansas Alliance for the Mentally Ill
Mr. Gene Johnson, Kansas Association of Alcohol and Drug Program Directors
Kansas Alcohol and Drug Counselors Association
Kansas Community Alcohol Safety Action Project Coordinator
Mr. Roland E. Smith, Wichita Independent Business Association

Continued Hearing on SB 561 - Small employer group health insurance

Mr. Joe Lieber, Executive Vice President of the Kansas Cooperative Council, presented testimony in support of the premise of the bill but requested that the basic plan include mandated coverage. He related incidents of group rates rising almost 300% in one year due to an illness within the group as well as coverage being reduced. (See Attachment 1).

Mr. Jim Schwartz, Consulting Director of the Kansas Employer Coalition on Health, Inc., appeared before the committee as a proponent of the bill. He recommended that the appointed Commission decide what is "basic" and "standard" policies. He suggested leaving the standard plan with mandates as it came from the Senate and allow the Commission to configure the basic policy which would be a minimum product containing only those elements that give the most protection for the dollar. The small group market will then have a choice it presently does not. He re-emphasized that the bill expects carriers to assume risk, to manage that risk, and to resist dumping it into a pool of marginal accountability. (See Attachment 2).

Mr. William Sneed, legislative counsel for Health Insurance Association of America, appeared as a proponent of the bill. He requested that the original language of the bill be reinstated. The bill, as originally designed, simply would allow the board the freedom to design the best possible program, given all the issues that may or may not affect the program. Self-insurers and ERISA plans currently have such freedom. The bill places very strict limitation on rate increases, notwithstanding the amount of claims that will undoubtedly be assessed against the plans. This is an awkward situation for HIAA unless the Senate floor amendment is removed. Other areas which should receive attention are:

1. Individuals as well as groups should be allowed to be placed in the reinsurance pool.

2. Concern as to whether the retention levels set in the bill can treat fairly small companies and large companies. This type of "retention" is difficult to determine relative to what percentage and/or amount is most appropriate.

3. Will the assessment process treat fairly all size carriers who are in the small employer group business? Will the current assessment plan maximize the value of the reinsurance program? (See Attachment 3).

Mr. Paul Klotz, representing the Association of Community Mental Health Centers of Kansas, Inc., appeared as a proponent. He requested that mental illness be covered in exactly the same manner and at the same level as any other illness. Mental Health intervention and treatment must be a part of primary, basic health care. (See Attachment 4).

Mr. Chip Wheelen appeared as a proponent for the Kansas Medical Society. This bill is a step in the right direction along a path which they hope will eventually lead to community rating of health insurance policies. (See Attachment 5).

On behalf of the Kansas Psychiatric Society, Mr. Wheelen distributed copies of proposed language changes in the bill regarding the diagnosis and treatment of mental illness or nervous disorder when treatment is determined medically necessary by a medical doctor. The limits would be the same as for any other illness. The bill would define basic benefits, therefore, the mandates would not be necessary. (See Attachment 5).

Ms. Sheryl Sanders, representing the Kansas Alliance for the Mentally Ill, appeared as an opponent to the bill stating that it was discriminatory against the mentally ill. Kansas AMI seeks coverage equal to that given other physical diseases. (See Attachment 6).

Mr. Gene Johnson, representing the Kansas Association of Alcohol and Drug Program Directors, Kansas Alcohol and Drug Counselors Association, and the Kansas Community Alcohol Safety Action Project Coordinators Association, appeared as an opponent to the bill. By limiting mandated alcohol and drug treatment for those standard policies as provided in this bill, we would tend to erode the partnership of the employee and the employer. An employee with a drug or alcohol program would be encouraged to seek help if coverage were available. If not, the employee would probably be terminated in due time, thus complicating the problem. He urged the committee to replace the mandates in all portions of the bill. (See Attachment 7).

Mr. Roland E. Smith, Wichita Independent Business Association, appeared as an opponent to the bill. The three critical issues in addressing the health care insurance crisis for small employers are: (1) accessibility, (2) affordability, and (3) cost containment. The only one addressed in this bill is accessibility. To call the health care insurance for small businesses proposed in this bill "group" health insurance simply changes the meaning of group insurance to be actually modified private policies. Two significant changes would have to be made before WIBA could support the bill: require carriers to pool association and professional societies member risks and change minimum to one in associations. Mr. Smith presented proposed amendments which he said would make the benefits available to twice as many families in small businesses in Kansas. (See Attachment 8).

SB 561 will be discussed on Tuesday, March 24, 1992, in Room 514 S.

The meeting adjourned at 5:10 p.m.

GUEST LIST

COMMITTEE: Insurance DATE: 3-18-92

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Dick Brock	Topeka	Ins Dept
Jim Schwartz	Topeka	KFCH
Leland Smith	Wichita	WIBA
Steve Johnson	Topeka	Alcohol & drug Programs
Sheryl SANDERS	TOPEKA	KS AMI
Paul M. Post	Topeka	Assoc of PMHCs KS Inc
GARY Robbins	Topeka	KS Opt Assn
Cheryl Dillard	Overland Park	Kaiser Permanente
Charles Walker	Topeka	SRS/DMS
Sabrina Wells	Topeka	Budget Division
Joe Furjanic	Topeka	KCA
Terry Larson	Topeka	Kansas alliance for the mentally ill
Diana Baudoin	Topeka	KS Dept of Comm.
BRAD SNOOK	"	BC/BS
Bill Sneed	TOPEKA	NIAA
Art Brown	KC	KS UBA Dealer
Whitney Damron	Topeka	McGill & Associates
Joe Lieber	Topeka	KS Coop Council
Chip Wheelen	Topeka	KS Med. Soc.
Lori Callahan	Topeka	kammco

Testimony on SB 561
House Insurance Committee
March 17, 1992
Prepared by Joe Lieber
Kansas Cooperative Council

Mr. Chairman and members of the Committee, I'm Joe Lieber, Executive Vice President of the Kansas Cooperative Council. The Council has a membership of nearly 200 cooperatives which have a combined membership of nearly 200,000 Kansas farmers and ranchers.

We support SB 561 if it corrects the following problems:

Udall Farmers Union Cooperative Association, Udall, KS
7 employees
Pre 1990 - family monthly premium = $360
Post 1990 - family monthly premium = $900
Currently in a new group = $445
Manager chose not to be covered so employees could get health insurance.

Plains Equity Exchange and Cooperative Union, Plains, Kansas
22 employees
Pre-sickness per family - $344.25
Insurance paid 1/2 up to $1,000. Prescription card $3-$5
New rate family premium - $502.75
Employee pays first $400. After that insurance pays half up to $2,400. Prescription card $5-$15.
Increase cost to co-op - $41,844 per year.

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Kansas Cooperative Council, Topeka

3 employees

Two employees were covered under spouse. One employee used Council health plan.

Employee using the health plan leaves, new person uses spouse's plan.

No one on insurance.

Employee leaves, new employee wants health insurance. We can't get back on plan because they dropped us. All medical problems are controlled by medication.

I know these problems are not as bad as some, but they do show that there are some problems out there.

If SB 561 will correct these problems the Kansas Cooperative Council supports it.

Thank you for your time. I'll attempt to answer questions.

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

Testimony to House Insurance Committee on
SB 561
(Guaranteed issue and other small group reforms)

by James P. Schwartz Jr.
Consulting Director
March 17, 1992

The Kansas Employer Coalition on Health is 100 employers across the state who share concerns about the value of health care we purchase for our 350,000 employees and dependents.

The Coalition supports SB 561 as an important step toward health system reform. Guaranteed issue is a plank of our well-known reform strategy and an element needed to fulfill the intent of HB 2001.

The rating limitations, while stopping short of pure community rating, take a desirable step toward equitable risk spreading.

A few aspects of this bill deserve special attention. First, we are concerned that coverage and practitioner mandates were largely reinstated by Senate amendments. As a state and nation, we sorely need to take an expanded view of this breadth of coverage issue. If certain health coverages are considered essential for insured people, they must be essential for uninsured people, too. How can we justify requiring health plans to be so long and so wide for voluntarily purchasers, when nearly half a million Kansans haven't even a shred of insurance? The most responsible course would be to mandate basic health insurance for all Kansans, subsidize those in need, and cap the costs at the same time. But since we're not going to do that any time soon, we're still dealing with a voluntary system, telling people that only two choices are OK: buy an all-encompassing plan or go bare.

SB 561 gives us a chance to find some middle ground. Our preference would be to let the Commission decide what is "basic" and "standard." But recognizing the pressure you face from provider groups, we suggest this compromise: leave the

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"standard" plan loaded with mandates, as it came from the Senate. But untie the Commission's hands in configuring the basic policy. Let basic really mean what it says: a minimum product containing only those elements that give the most protection for the dollar. The small group market will then have a choice it presently does not.

Another aspect of SB 561 that deserves attention is the reinsurance mechanism. That provision gives carriers an opportunity to avoid some responsibility for expensive groups. Granted, the bill contains some protections in this regard. Those protections must be guarded well against efforts to weaken them. The bill's provision for unbundling groups and reinsuring individuals is a clear path to less responsibility for insurers. We hope it is broadly understood that the bill expects carriers to assume risk, to manage that risk, and to resist dumping it into a pool of marginal accountability.

Our last concern is that this legislation might be considered by some to constitute adequate reform of the health funding system. Such conclusions undermine efforts to truly resolve the basic problems of cost and access. This bill, in our opinion, will not have much aggregate effect on the number of uninsureds or the costs. It just makes the present system fairer, and that's good.

MEMORANDUM

TO: Representative Larry Turnquist
Chairman, House Insurance Committee

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

DATE: March 17, 1992

RE: Senate Bill 561

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I am Legislative Counsel for the Health Insurance Association of America ("HIAA"). 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 and support of S.B. 561.

After the enactment of H.B. 2001, the Kansas Insurance Department was directed to create an ad hoc committee to address several issues in regard to the small employer group health insurance issue. My client was named a participant of that ad hoc committee along with several member companies, particularly the Principal Financial Group, who also attended and provided assistance on the work product before you. We believe that the bill as introduced and taken as a whole provides an excellent opportunity for the State of Kansas to address the availability of health insurance to the small employer. This Committee might recall that when debating H.B. 2001, as a part of my testimony we presented the HIAA Model Small Group Reinsurance Pool mechanism as an alternative to the "community rating" provisions that were eventually excluded from H.B.

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2001. Thus, my client has been aggressively addressing this issue in an attempt to find solutions to this problem facing the State of Kansas. It would be inaccurate to say that all parties involved in working on this bill came away satisfied with all of the various components, but taken as a whole, and recognizing the practicality of compromise, we believe the bill as proposed to the Senate takes a step forward in the right direction to find solutions in this area.

Unfortunately, and after much debate, the Senate Committee of the Whole decided that, notwithstanding the delicate balance of the various components of the bill, provisions of current state law regarding mandates were reinstituted in the bill. Other conferees are going to address the cost component that this brings to the bill, and therefore I will simply echo their comments. Further, and in no way belittling the importance of the cost issue, I would like to discuss the overall importance of the entire bill.

First, I urge the Committee to look at the entire proposal and not one issue placed in a vacuum. This bill will guarantee small employer access to a health insurance program. Thus, every small employer will, in essence, have a right to purchase this coverage.

Second, this bill does not prohibit mandates, either service or provider, from being included in the package. The bill, as originally designed, simply would allow the board the freedom to design the best possible program, given all the issues that may or may not effect the program.

Third, it is important to remember that this plan is not the only plan in this state with such freedom. Self-insurers and ERISA plans currently have such freedom.

Finally, the bill places very strict limitations on rate increases, notwithstanding the amount of claims that will undoubtedly be assessed against the plans.

Thus, without the removal of the Senate floor amendments, my client is placed in the awkward position of opposing S.B. 561 in its current form.

Assuming that the House reinstates S.B. 561 in its original form, I must state for the record that my client plans to continue to work with the governing board that is established by this bill on certain areas that we believe still need to be addressed. Although I will not attempt to provide a laundry list, there are certain areas I feel are important to mention to the Committee.

1. The bill currently allows groups and not individuals to be placed in the reinsurance pool. We believe, for several reasons, that individual risks should be allowed to be placed in the reinsurance pool. We acknowledge that as a part of the compromise, after a year of operation the governing board will re-evaluate this area, and it is our belief that individuals should be allowed to be placed in the reinsurance pool.

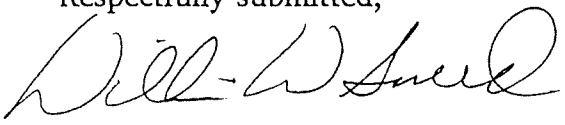
2. The bill has attempted to compromise the amount of risk that an individual company must retain before the reinsurance pool is activated. This type of "retention" is difficult to determine relative to what percentage and/or amount is most appropriate. We have concerns as to whether the retention levels set in the bill can fairly

treat small companies and large companies, and it is thus our intent to continue to monitor this area and work with the governing board and/or the Legislature in the future.

3. The bill also provides an assessment mechanism in an attempt to cover any losses that the premium for the reinsurance pool did not anticipate. Again, we are concerned as to whether this particular assessment process will (a) fairly treat all size carriers who are in the small employer group business; and (b) whether the current assessment plan will maximize the value of the reinsurance program.

As stated earlier, this bill has been comprised of a great deal of give-and-take and compromise. I urge the Committee to take the bold, and yes, difficult step, and reinstate the original language of S.B. 561 so that the integrity of the bill that has been compromised can remain intact. We believe this will go a great distance in an attempt to resolve the problems at hand.

Respectfully submitted,



William W. Sneed
Legislative Counsel
Health Insurance Association of America

Association of Community
Mental Health Centers of Kansas, Inc.
835 SW Topeka Avenue, Suite B, Topeka, KS 66612
Telephone (913) 234-4773 Fax (913) 234-3189

March 17, 1992

Dear Member House Insurance Committee:

This Association strongly supports the concept of providing quality basic health care to Kansas citizens, particularly where none now exists. Such coverage, in part, is found in **S.B. 561** for small groups and **S.H.B. 2511** for individuals. These bills represent steps in the right direction. However, if basic and/or standard health coverage does not cover mental illness, it is not health coverage. Mental health intervention and treatment must be a part of primary, basic health care. Mental illness must be covered in exactly the same manner and at the same level as any other illness.

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

March 17, 1992

TO: House Insurance Committee

FROM: Kansas Medical Society

SUBJECT: SB 561; Small Employers Group Insurance Coverage

The Kansas Medical Society appreciates the opportunity to express support for SB 561, which would improve the availability of health insurance to certain small employer groups. We think SB 561 is a step in the right direction along a path which we hope will eventually lead to community rating of health insurance policies. While SB 561 does not get there, it should make coverage available to small employers who in the current environment have the most difficult time obtaining health insurance.

We generally support the basic concept in the bill, and appreciate the opportunity to offer these comments. Thank you.

CW:ns

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Health Insurance Mandates Under Kansas Law

Provider Reimbursement Mandates

40-2,101
physicians and chiropractors

40-2,100
dentists, optometrists, and podiatrists

40-2,104
Ph.D. psychologists

40-2,114
clinical social workers

40-2250
advanced registered nurse practitioners

Coverage Mandates

40-2,102
newborn infants including adoption

40-2229 and 2230
mammograms and pap smears

40-2,105
mental illness, alcoholism, and drug addiction

trary, all health benefit plans shall make coverage available to all the eligible employees of a small employer without a service waiting period. The decision of whether to impose a service waiting period for eligible employees of a small employer shall be made by the small employer, who may only choose from the service waiting periods offered by the carrier. No service waiting period shall be greater than 90 days or three calendar months and shall permit coverage to become effective no later than the first day of the month immediately following completion of the service waiting period.

(i) The benefit structure of any health benefit plan subject to the provisions of this act may be changed by the carrier to make it consistent with the benefit structure contained in health benefit plans developed by the board for marketing to new groups but this shall not preclude the development and marketing of other health benefit plans to small employers.

(j) (1) Except as provided in subsection (h), requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier.

(2) A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(3) (A) Except as provided in provision (B), in applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage ***in a health benefit plan sponsored by another employer*** in determining whether the applicable percentage of participation is met.

(B) With respect to a small employer, a small employer carrier may consider employees or dependents who have coverage under another health benefit plan sponsored by such small employer in applying minimum participation requirements.

Sec. 6. From and after January 1, 1993: (a) A small employer carrier may establish a class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following reasons:

(1) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers;

(2) the small employer carrier has acquired a class of business from another small employer carrier; or

Draft amendment by Chip Wheelen
on behalf of Kansas Psychiatric Society

(k) Any such health benefit plan shall provide coverage for diagnosis and treatment of mental illness or nervous disorders when treatment is determined medically necessary by a person licensed to practice medicine and surgery in this state who has recently evaluated the patient's condition or had an established physician-patient relationship within the previous sixty days of authorizing the treatment.

(l) Any requirements for financial participation by the insured or coverage limits for treatment of mental illness or nervous disorders shall be substantially the same as other coverages under such health benefit plan.

KANSAS AMI
KANSAS ALLIANCE FOR THE MENTALLY ILL
112 S.W. 6th, Ste. 305 • P.O. Box 675
Topeka, Kansas 66601
913-233-0755

DATE: March 17, 1992
TO: Members, House Insurance Committee
FROM: Sheryl Sanders, Kansas Alliance for the Mentally Ill
SUBJECT: SB 561

Kansas Alliance for the Mentally Ill fully supports efforts to address the desperate need for health care financing such as that embodied in SB 561. Reform is coming, and whether it is resolved through a national plan or through individual state plans, there is intense pressure on policymakers to take action now, and we wish to support that and contribute constructive suggestions where possible.

What is not possible, however, is support for any plan that discriminates against the mentally ill. Hence, our opposition to SB 561. SB 561 was amended on the Senate floor to provide coverage in the "standard" plan, while the "basic" plan still excludes this coverage. But as Representative Nancy Brown said in floor debate on HB 2511, the coverage codified in Kansas law IS BASIC COVERAGE. While it is minimal, its inclusion should not even be in question.

In the course of hearings on the various access bills, we have heard the same arguments repeatedly used as to why policies are being developed without providing mental health coverage. I will briefly address some of those now.

THEORY: This coverage is a "frill."
REALITY: This coverage is a frill only if coverage for heart disease is a frill; only if coverage for cancer or Parkinson's disease is a frill. To repeat what has been stated before this committee many times, brain diseases such as schizophrenia or manic-depression ARE PHYSICAL illnesses and continue to be discriminated against (as are the people WITH these diseases) in proposal after proposal.

THEORY: These add too much to the cost of policies.
REALITY: In California, unlimited coverage for these brain diseases is projected to add $.78 per month per person cost to a policy. In Maryland, the figures are $.50 per month per person in indemnity plans and around $1.00 per month for HMOs. In Maryland the added cost would also be approximately $1.00 per person per month. The Maryland figures are the most recent and are based on actual utilization rates for the year 1989, adjusted for provider rate increases that have taken place in the interim.

THEORY: People not receiving this coverage can just go into the public system.
REALITY: The public system has traditionally maintained its ability to serve state citizens, in spite of shrinking state revenues, by ALSO receiving payments from insurors. As was explained by the chief accountant for Topeka State Hospital in testimony before the House Ways

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and Means Subcommittee on Human Services, those revenues have dropped dramatically as insurance companies have refused to pay. Admissions with insurance went from 14.6% in 1990 to 7.4% in 1991. The resulting shortfall means either reduced services and people served or increased taxes to meet the costs or some combination thereof.

Clearly, the finance problem exists regardless of WHERE the people are served. YOU AND I pay premiums or taxes, and the costs in the public system are usually greater because a person without insurance will not usually seek out or get assistance until quite ill. Early intervention is more difficult or non-existent and more expensive treatment modalities such as inpatient care must be used.

THEORY: The boards of these plans need the flexibility to determine what will be covered.
REALITY: Prior to state intervention on the behalf of its citizens, only 23% of insured people were given mental health coverage. It is not likely that coverage will now be offered when such was rarely the case before.

THEORY: The way the bill has been amended, people will be able to choose the "Standard" policy if they want mental health coverage.
REALITY: A small group employer looking for any possible way to decrease costs will more often than not choose the lower cost "Basic" policy. And unless the bill is somehow amended, employers now have the incentive to drop policies they may currently have which do provide minimal mental health coverage and replace them with this policy.

THEORY: Many people do not feel they will need this coverage.
REALITY: Unless there is an obvious family history of mental illness, no one thinks they need this coverage, until they need it and it is too late. No one plans for schizophrenia. Most of this is due to the stigma and ignorance regarding serious mental illness; ideas which are perpetuated by our public policies which say this is optional coverage.

THEORY: If we do not get something in place, we could soon be forced to go to a system of rationing, as in Oregon.
REALITY: What we have here IS rationing. Covertly inserted into all these insurance bills, and not equitably distributed, but rationing nonetheless.

Kansas AMI only seeks coverage equal to that given other physical diseases. We respectfully request that the committee amend SB 561 to correct its discrimination.

Thank you.

TESTIMONY

HOUSE INSURANCE COMMITTEE

SENATE BILL 561

MARCH 18, 1992

To: Representative Larry Turnquist, Chairman, Kansas House Insurance Committee

Dear Mr. Chairman:

My name is Gene Johnson and I represent the Kansas Association of Alcohol and Drug Program Directors, Kansas Alcohol and Drug Counselors Association and the Kansas Community Alcohol Safety Action Project Coordinators Association. We appear today in opposition of Senate Bill 561 as to the language which actually limits coverage provided for alcohol and drug treatment. In 1986 this Legislature decided that insurance companies should be mandated to provide care for those afflicted with alcoholism or drug addiction. Up until that point it had been on a voluntary basis on the part of the insurance carrier to provide such coverage. Also it fell on the State of Kansas, thru their public facilities such as State Hospitals, to provide alcohol and drug treatment for those individuals who were, for the most part, in the chronic stages of alcoholism.

Since 1986 we have come a long way in the State of Kansas as far as meeting the needs of those afflicted with alcoholism and/or drug addiction. It used to be that a treatment process that was inpatient and at least 30-days in length now has become largely an outpatient program, with possibly some partial hospitalization for detoxification purposes. Through experience, and being better qualified in the field of alcohol and drug addiction, we have been able to develop programs that will allow people to obtain adequate treatment through partial hospitalization and in outpatient. This allows those individuals to maintain their employment with employers on a good partnership basis.

By limiting mandated alcohol and drug treatment for those standard policies as provided in Senate Bill 561, we would tend to erode the partnership of the employee and the employer. If an employer determines that his employee is missing too many Mondays or his work performance is not up to standard, he may suggest to the employee that he seek professional assistance for what might be a serious problem with alcohol or a drug

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addiction. If that employer provides insurance coverage for the individual, he is in the position to salvage that particular employee and return him to the work force as a rehabilitated employee. Should the employer choose not to provide coverage for alcohol/drug addiction, he will only put up with that employee until time comes to terminate him. Therefore, we have an employee out of work, probably on unemployment, and possibly on public welfare. His drinking gets considerably worse and consequently he winds up in the general hospitals because of other conditions agitated by his alcohol or drug consumption. He then becomes the burden of the taxpayers of the State of Kansas to pay all the medical bills plus any possible rehabilitation measures for his primary illness of alcohol and drug addiction.

We would hope that this Committee would consider replacing the mandates in all portions of this bill in this legislative session. Our field has not yet been convinced that the cost that we have seen in the past 6 years in treating those individuals with alcohol and drug addiction, is that enormous that we should consider removing it at this time.

Thank you,

Gene Johnson

Gene Johnson
Legislative Lobbyist
Kansas Association of Alcohol and Drug Abuse Program Directors
Kansas Community Safety Action Project Coordinators Association
Kansas Alcohol and Drug Addiction Counselors Association

WICHITA INDEPENDENT BUSINESS ASSOCIATION
Riverview Plaza Suite 103 • 2604 W. 9th St. N. • Wichita, Kansas 67203-4794
(316) 943-2565 FAX (316) 943-7631

ROLAND E. SMITH, *Executive Director*

March 17, 1992

STATEMENT TO: House Insurance Committee
FROM: Roland Smith, Executive Director, Wichita Independent Business Association
SUBJECT: Senate Bill No. 561 relating to health insurance for small employers

Chairman Turnquist and Members of this Committee, I would like to thank you for this opportunity to speak regarding Senate Bill 561. So you might have a better understanding of where we coming from, I want to define WIBA a little more even though all of you are receiving the WIBA monthly newsletter. WIBA is in it's 61st year of trying to help preserve the existence of independent businesses. To survive in todays economy the independent business must find a nitch that the larger businesses don't serve well or the mass merchandiser has not yet dominated. Health insurance costs, property taxes and workmans compensation costs are having their toll on most small independent businesses in Kansas. Many marginal businesses are going under. No other business organization in the State of Kansas, that I know of, has 95% or more of its membership in the category of businesses being dealt with in this proposed legislation, that is businesses that have fewer than 25 employees. WIBA membership is made up of locally owned businesses in the Wichita trade area.

One of the benefits offered to WIBA member businesses is sponsoring group health care coverage. At the present WIBA sponsors two Health Maintenance Organization (HMO) plans for small business members with fewer than 25 employees, CIGNA Healthplan of Kansas and Healthcare America Plans, Inc. and they are covering many of our member businesses very well. I, personally, "Thank the Lord" for these HMO's as they have met the needs of many employers who have an employee or employees that are considered by many small group insurance carriers as uninsurable. What is hard for us to accept on this issue from the insurance industry is... if the HMO's can provide adequate health care coverage and be profitable in this small business market, without a risk pool to fall back on, then why can't the indemnity carriers do it? Frankly, they can, but won't unless all other health insurance carriers are required to in Kansas by legislation. Sad, but true! No indemnity health insurance carrier or Preferred Provider Organization (PPO) plan marketed by health insurance carriers want to have anything to do with associations like WIBA unless they can pick and choose who they insure and/or individually rate each business and most cases even rate the individual employees. During the past five years, I have personally interviewed representatives from over 20 insurance companies that market health insurance in the small business market with indemnity and\or PPO products. The story has always been the same... they want to pick and choose who to insure within the association membership and at various premium rates depending on the type of business, age and other factors. Fortunately, our HMO carriers have given us the opportunity to have our members covered at a uniform rate, which is a modified community rate determined by the demographics of the entire association. The premium rates for our members are not the lowest in the market place, but are far from the highest.

There are three critical issues in addressing the health care insurance crisis for small employers. (1) accessibility, (2) affordability and (3) cost containment. The only one attempted to be addressed in this bill is accessibility. The Insurance Commissioner's Task Force that served as a resource for the drafting of this bill did a lot of hard work over a period of several months trying to find a resolution for the multitude of problems small employers face in the health insurance area. I appreciated the opportunity to have served on the task force representing the small employers. The task force was, however, dominated by the insurance industry and the end product, I believe you will realize, reflects that. There are a lot of good parts of this bill to protect the Insurance Companies, but very little else for the small employer other than limited access.

To call the health care insurance for small businesses proposed in SB 561 bill "group" health insurance simply changes the meaning of group insurance to be actually modified private policies, a practice that has emerged over the past eight or so years among all health insurance company carriers and is given more credence in this bill if passed. It is not providing any group insurance if group insurance is defined as the sharing of risks over a larger number of persons to the benefit the insured with a uniform group rate structure. It is my opinion this bill fails to do

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Attachment 8

that because of the multiple classifications of businesses and tiering within those classifications. The risk pool concept shares the insurance companies risks and does little more other than making possible limited access for some small businesses on the insurance companies terms.

SB 561 does provide a small part in solving a part of the problems small employers in Kansas face in health care insurance coverage as it relates to access. There are two significant changes that would have to be made before WIBA could support it and I know the health insurance carriers are greatly opposed to any of these changes and they were rejected in the Senate. Explanations of the proposed amendments and suggested wording are as follows:

No.1. "Association Class of Business" The purpose for an association sponsoring health care insurance is to increase the risk pool to the extent that many businesses may band together as a group and benefit by spreading the risk over a large number of persons within the business association and other associations or professional societies doing business with that carrier in Kansas to achieve a rate structure. Community rating within the individual carriers' small business market would even be better in spreading the risks, however there seems to be little support for any concept of community rating. At least then, a provision should be added to this bill requiring carriers to pool association and professional societies member risks. The proposed amendment would accomplish this. Sadly this bill allows a carrier to place the individual business in different classes of business within an association and rate them accordingly. That is not group insurance! This bill in reality actually allows the continuation of the current practice of classification. This bills allows a carrier to have nine "business classifications" and within those classifications they can tier the rates by age and other factors other than health condition and even more with the approval of the Commissioner. WIBA has over 400 types of businesses. In this bill there can be no uniform rate for association members unless the carrier wants to offer it and chances of that happening, unless included in the bill, is next to nothing.

The proposed amendment to help correct this would be added on page nine after line five creating a new (c) and we suggest it would read as follows: "The small employer carrier shall establish a class of business for an association of businesses and professional societies. The carrier shall provide the same premium rate structure for all businesses within this class that are eligible to participate in the "SECP" as members of the business association or professional society. The premium rates are to be determined by a composite of the various demographics and risk factors within the business associations or professional societies as a whole. The methodology for establishing the rates for this class are subject to approval by the commissioner."

No.2. "Change minimum to one in associations" On page five, lines 34 thru 37 of the Senate amended copy of this bill excludes association member businesses with less than three employes from participating. This excludes over 90% of the WIBA member businesses from even being eligible to participate. Some one in the Senate discussion of the bill estimated that over half of the business in Kansas may have less than three employees. We know from State provided figures to WIBA in 1990 that stated 77.1% of all businesses in Kansas have fewer than ten employees. WIBA member businesses in our HMO sponsored plans average 1.9 employees in one plan and 2.9 in the other. This bill eliminates too many businesses in Kansas and should be changed to include the one-person self-employed person businesses. Our proposed amendment would change the wording on page five line 35 by deleting "more than two" and inserting "one or more".

This bill has other problems too! One is the make up of the risk pool board where it may be possible for Blue/Cross Blue/Shield to have as many as five representative on that board unless changed. No one organization or insurance company should have more than one seat. Small business has only one seat and only at WIBA's request during the task force meetings. The cost of the risk pool concept will add another layer of costs to be included in the premium structure. Another is that those businesses currently with very high premium rates, is that their rates will not go down to the new rates at once, but only 30% a year until it reaches the new rates.

This statement is not saying there is nothing of value in this bill. There are some advances for small businesses mainly those with five to twenty-five employees. There is little advantage for associations to sponsor any of this coverage unless it goes down to a one-person business. There is an "access" advantage for those businesses that have an employee or employees with preexisting conditions and their businesses are not located in an area where an association sponsored HMO is available. So some health insurance coverage would be available to them that they cannot now access. This bill does reduce the range from the highest to the lowest premium rates between

the all classifications and control to some degree the annual increases. Mandated coverages are not in the basic policy and would help keep the premiums lower. I fear there will still be many businesses that cannot afford to get the coverage as the rates in their given classification and age ratings will cause the premiums to be too high. Also the perceptions being created, if passed, will lead many people to believe the bill provides a significant step forward. WIBA does not believe it offers very much to meet the actual needs for the majority of small businesses with twenty five or fewer employees.

However, if this bill were amended as WIBA proposes, it could make the benefits available to twice as many families in real small businesses in Kansas as associations and professional societies could then help many small businesses outside the HMO service areas with obtaining guaranteed issue of indemnity type health care coverages for those with one to four employees plus uniform rates for those with one to twenty-five employees as members of an association or professional society which sponsors the plans.

There is overwhelming pressures not to amend this bill in any fashion from the insurance industry and a number of legislators. Senator Bond, chairman of the Senate Insurance Committee, has stated several times this is a very fragile bill and opening it up to amendments would kill it. I regret his position and also the number of unfortunate remarks made on the Senate floor regarding WIBA and our desire to make this a viable bill for businesses the bill was suppose to help. This bill, we believe, is actually designed to protect the health insurance carriers and give small business a few crumbs to make it look like a big step forward. I have called SB 561 a "smoke screen" to real progress in a letter to the Wichita Eagle Editors and firmly believe, along with HB 2511 just passed by the House, is more in the interests of protecting insurance companies and continuing their current practices with some modifications to share the risks, than the consumers for whom it is being promoted.

It is of great concern to all of us that some meaningful legislation on health care and health care insurance come out of this session. This bill, even with the proposed changes, may only delay a mandated national health plan for a somewhat longer time as it falls far short of what is really needed. This legislation, if passed in its present form, will help some, but for WIBA it could cause more adverse selection in our WIBA sponsored HMO plans and in all probability drive up the costs for WIBA members even higher as a result.

It is disappointing for me not to be able to support SB 561 in its present form, having spent considerable time serving on the task force trying to develop an acceptable legislative measure. It seems WIBA is almost alone in trying to make SB 561 a more viable measure.

As an organization of small independent businesses, WIBA urges members of this committee and the entire House of Representatives to study SB 561 in depth more carefully than the members of the Senate did before acting on it. Doing this, I believe you may find yourselves and many others reaching some of the same conclusions that I have presented to you today. This should not be a partisan issue.

In closing we ask you to consider carefully SB 561 and support the WIBA proposed amendments. WIBA would support this bill only if the attached amendments become a part of the final legislation. WIBA realizes this bill at best, even with these amendments, is only a band aid solution to the larger problem. Until the other needed changes regarding accessibility are made and the two ingredients of affordability and cost containment are addressed this legislation, if passed, just helps to prolong the crisis in health care for small business and the citizens of Kansas.

Thank You! I'll be glad to answer any question that I can.

No.1

(c)

"The small employer carrier shall establish a class of business for an association of businesses and professional societies. The carrier shall provide the same premium rate structure for all businesses within this class that are eligible to participate in the "SECP" as members of the business association or professional society. The premium rates are to be determined by a composite of the various demographics and risk factors within the business associations or professional societies as a whole. The methodology for establishing the rates for this class are subject to approval by the commissioner."

(3) the small employer carrier provides coverage to one or more association groups that meet the requirements of subsection (f) of K.S.A. 40-2209 and amendments thereto.

(b) A small employer carrier may establish up to nine separate classes of business under subsection (a).

(e) The commissioner may adopt rules and regulations to provide for a period of transition in order for a small employer carrier to come into compliance with subsection (b) in the instance of acquisition of an additional class of business from another small employer carrier.

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

Sec. 7. From and after January 1, 1993: (a) Premium rates applicable to Kansas residents for health benefit plans subject to this act shall be subject to the following provisions:

(1) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than 20 percent.

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

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

(A) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, if such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;

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

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ployed work force consisted of, on at least 50 percent of its wo
days during the preceding year, no more than 25 eligible employees, the majority of whom were employed within the state. In determining the number of eligible employees, companies which are affiliated companies or which are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer. Except as otherwise specifically provided, provisions of this act which apply to a small employer which has a health benefit plan shall continue to apply until the plan anniversary following the date the employer no longer meets the requirements of this definition.

(aa) "Standard small employer health care plan" means a basic SEHC plan with specified benefit enhancements and such deductible and coinsurance provisions as may be developed by the board pursuant to section 10.

(bb) "Affiliate" or "affiliated" means an entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

Sec. 4. (a) Any individual or group health benefit plan issued to a group authorized by subsection (A) of K.S.A. 40-2209 and amendments thereto shall be subject to the provisions of this act if it provides health care benefits covering employees of a small employer and if it meets any one of the following conditions:

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

(2) the health benefit plan is treated by the employer or any of the covered individuals as part of a plan or program for the purposes of section 106 or section 162 of the United States internal revenue code.

(b) For purposes of this act an aggregation of two or more small employers covered under a trust arrangement or a policy issued to an association of small employers pursuant to subsection (A)(3) or (5) of K.S.A. 40-2209 and amendments thereto shall permit employee or member units of ~~more than two~~ but less than 26 employees or members and their dependents to participate in any health benefit plan to which this act applies. Any group which includes employee or member units of 25 or fewer employees shall be subject to the provisions of this act notwithstanding its inclusion of employee or member units with more than 25 employees or members.

(c) Except as expressly provided for in this act, no law requiring the coverage or the offer ~~or~~ *of* coverage of a health care ser
benefit ~~and no law requiring the reimbursement, utilizati~~

No. 2

one or more

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