Approved 2/13/92
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

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

9:00 a.m./p~~m~~. on Wednesday, February 12, 19 92 in room 313-S of the Capitol.

All members ~~were~~ present ~~except~~:
Senators Bond, Francisco, Kerr, Moran, Parrish, Reilly, Salisbury, Strick, Ward and Yost.

Committee staff present:
Fred Carman, Revisor
Bill Wolff, Research
Greg Glass, Legislative Intern
June Kossover, Secretary

Conferees appearing before the committee:
Ron Todd, Commissioner of Insurance
Dick Brock, State Insurance Department
Tom Miller, Blue Cross/Blue Shield
Don Wilson, Kansas Hospital Association
Jerry Slaughter, Kansas Medical Society
Cheryl Dillard, Kaiser Permanente

The meeting was called to order by Chairman Bond at 9:15 a.m.

The Chairman opened the hearing on **SB 561**.

Ron Todd, Insurance Commissioner, appeared before the committee to testify in favor of **SB 561**. (Attachment #1.)

Dick Brock, State Insurance Department, appeared before the committee to explain the bill in detail. **SB 561** supplements and is a sequel to 1991 **HB 2001**. Mr. Brock offered four "housekeeping" amendments. (Attachment #2.)

Also appearing before the Committee to offer testimony in favor of **SB 561** were:

-Tom Miller, President and CEO, Blue Cross/Blue Shield of Kansas (Attachment #3.)
-Don Wilson, President, Kansas Hospital Association (Attachment #4.)
-Jerry Slaughter, Executive Director, Kansas Medical Society (Attachment #5.)
-Cheryl Dillard, Public Affairs Manager, Kaiser Permanente (Attachment #6.)

Chairman Bond announced that the hearings on **SB 561** will continue on Thursday, February 13, 1992, at 9:00 a.m. in Room 313-S.

Senator Salisbury made a motion, seconded by Senator Strick, to approve the minutes of February 11, 1992, as submitted. The motion carried.

The committee adjourned at 10:00 a.m.

Testimony by

Ron Todd, Commissioner of Insurance

Before the Senate Committee on Financial Institutions and Insurance

Senate Bill No. 561

Following adjournment of the 1991 legislature, I created a task force comprised of representatives from insurance companies, health maintenance organizations, Blue Cross and Blue Shield plans, small employer associations, third party administrators and agents to: (1) provide input if the underwriting restrictions imposed by 1991 House Bill 2001 created a greater problem than anticipated with respect to the group health insurance market; and (2) develop a mechanism that would complement the 1991 legislation by assuring the availability of group coverage for small employers.

Senate Bill 561 is the result of that effort and I believe its enactment would permit the establishment of a practical, attainable market for small employer group coverage that would make basic health insurance accessible to all small employers in Kansas and their dependents.

The bill contains four general components. First, it would prevent any insurer, HMO or Blue Cross and Blue Shield plan from declining to insure or renew any applicant for basic small employer group health insurance coverage. Second, in order that this objective can be attained without irreparable harm to the general health insurance market, a reinsurance pool is established which permits -- but doesn't require -- carriers insuring small groups to spread the exposure among all health insurers thereby mitigating any adverse impact on a single company. Third, the bill imposes underwriting restrictions on small employer groups which parallel those included in 1991 House Bill No. 2001. Finally, although they are not an inextricable part of the guaranteed issue mechanism, Senate Bill 561 includes rating restrictions designed to further moderate the volatility of small group premiums.

Obviously, I support Senate Bill No. 561 since it was introduced at my request. But, much more important than that, I believe Senate Bill 561

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Attachment #1

represents a major, though incremental, step forward in our search for initiatives that will address our worsening health care financing problems.

Enactment of 1991 House Bill 2001 together with enactment of a guaranteed issue requirement as proposed by Senate Bill No. 561 will make basic health insurance coverage available to eligible members of any group as well as small employer groups themselves. In addition, the rating restrictions included in House Bill 2001 together with those included in Senate Bill 561 will do about all that can be done at the present time to address affordability through the insurance mechanism. But one essential component is still needed and that is an availability mechanism for individuals. A vehicle to fill this need is now under consideration by the House Committee on Insurance in the form of Substitute for House Bill 2511.

I, of course, can't presume to know how either bill will fare in the debate and discussion that yet remains but I can dare to hope this session of the legislature would enact both Senate Bill 561 and Substitute for House Bill 2511 because both are conceptually correct and both will meet an obvious public need.

As many of you know, Dick Brock of my staff chaired the task force which developed Senate Bill 561 so I have asked Dick to present a more detailed explanation of its content.

Testimony by

Dick Brock, Kansas Insurance Department

Before the Senate Committee on Financial Institutions and 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 such plans shall be exempt from the requirements of state mandated benefit and equality laws.

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Attachment #2

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

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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 employer 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 and we believe this exposure will be spread sufficiently among insurers and groups that the actual impact will not be significant. Nevertheless, some caution is necessary 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. In my judgement, this issue is not of such significance that it should generate opposition to enactment of Senate Bill 561 but it is a provision that will presumably 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

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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 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.

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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.

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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 26 through 29 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 11 through 20. 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

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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 34 through 39 on page 17 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 20 through 34, 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.

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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. 2-14

Greg Scandlen

Technical Amendments
Senate Bill No. 561

Page 1, line 20 - Delete the word "allocation" and insert the word "reinsurance" in lieu thereof.

Page 4, lines 25-27 - Delete the definition of "rating period" and substitute the following: "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect but any period of less than one year shall be considered as a full year.

Page 7, line 23 - Insert the words "employee or" immediately preceding the word "dependent".

Page 8, line 23 - Insert the words "in a health benefit plan sponsored by another employer" immediately following the word "coverage".

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TESTIMONY ON SENATE BILL 561
Blue Cross and Blue Shield of Kansas, Inc.
Senate Public Health and Welfare Committee
February 12, 1992

Mr. Chairman, members of the committee. My name is Tom Miller and I serve as President and CEO of Blue Cross and Blue Shield of Kansas.

I have with me today, Mr. Don Lynn, Vice President of Finance for Blue Cross and Blue Shield of Kansas and a member of the American Academy of Actuaries. Don has served on the Insurance Department Committee that has worked on this proposal and he is available to testify on the more technical issues.

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.

It should be pointed out that this proposal does not contain any substantial cost containment elements. It will not have any substantial impact on the aggregate amount of dollars being spent on health care services for small groups.

FI+I 2-12-92
Attachment #3

Testimony on Senate Bill
Thomas L. Miller
Blue Cross and Blue Shield of Kansas

This bill does contain an exemption for mandated benefits and a prohibition on limiting the use of utilization review activities. This will have some cost containment effect. On the other hand, we can still expect to see an overall increase in the cost of health care in the small group market. 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
Thomas L. Miller
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.

February 10, 1992
TLM/lou

KANSAS HOSPITAL ASSOCIATION

Donald A. Wilson
President

February 11, 1992

TO: Senate Financial Institutions and Insurance Committee

FROM: Kansas Hospital Association

RE: SB 561

The Kansas Hospital Association appreciates the opportunity to testify regarding the provisions of Senate Bill 561. We support this bill as a continuation of the health insurance reform measures enacted by the Kansas Legislature in 1991.

There are two basic models for health insurance. The "casualty insurance" model, which usually refers to automobile collision, residential fire or similar risks, is premised on the idea that premiums should be set according to expected loss. The "social insurance" model provides for more cross-subsidization among different risk groups and does not rely so much on expected loss. What has happened in recent years is that the influence of the casualty model in health insurance has increased. This has led to exclusions of individuals from groups and even exclusions of entire groups.

FI&I 2/12/92
Attachment #4

1263 Topeka Avenue • P.O. Box 2308 • Topeka, Kansas 66601 • (913) 233-7436 • FAX (913) 233-6955

In 1991 the Legislature passed HB 2001. This bill dealt with some of the discriminatory underwriting practices that had become commonplace in the health insurance industry. It also paved the way for Kansas to move toward the concept of community rating.

SB 561, which is the result of the efforts of a task force created by the Insurance Commissioner, would continue the work started by HB 2001. It would go far toward guaranteeing small groups access to health insurance. It also creates controls on the premium rates that could be charged for the plans developed under the bill. In this way the bill provides another step toward community rating. We think the Legislature must continue to focus on community rating as a goal. We agree the move toward community rating must be a gradual one, but it nevertheless should remain as the ultimate goal.

Another goal should be to bring as much efficiency as possible to the health insurance system. SB 561 helps to do this, but we think there are other considerations. For example, we are very interested in determining whether the idea of "paperless claims" can help to make the system more efficient. We think this idea has some merit and we will be discussing it with other interested parties.

Thank you for your consideration of our comments.

KANSAS MEDICAL SOCIETY
623 W. 10th Ave. • Topeka, Kansas 66612 • (913) 235-2383
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February 12, 1992

TO: Senate Financial Institutions and Insurance Committee

FROM: Jerry Slaughter
Executive Director

SUBJECT: SB 561; Concerning Small Employers Group Insurance Coverage

The Kansas Medical Society appreciates the opportunity to appear today in support of SB 561, which would guarantee 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 available health insurance to small employers who in the current environment have the most difficult time obtaining health insurance.

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

JS:ns

FI+I 2/12/92
Attachment #5

KAISER PERMANENTE

Testimony Before
Kansas Senate Committee on
Financial Institutions and Insurance
Senate Bill 561
Kaiser Permanente
February 12, 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.

Before I discuss some key aspects of this legislation from the HMO perspective, I'd like to make some comments about how this bill arrived before you today. With the passage in 1991 of House Bill 2001, the Kansas legislature made an important beginning on the path toward health care reform. But, as all admitted at the time, House Bill 2001 was only a first step. This past summer, other important steps were taken. The Insurance Commissioner convened a work group of carriers, HMOs, insurance agents and small employer representatives to work toward small group insurance market reform. After various and countless commissions and committees had recommended reform to improve the access to coverage for employers 25 and under, there was finally a process underway to come up with that reform. It was not always an attractive process - but it was remarkable. Many of us in those meeting rooms are current or potential competitors. Some of us, like Kaiser Permanente, focus on the small group market now, and any reform, while good public policy, could mean a possible loss of business when other carriers are encouraged to come into the market. None the less, over a six month period, a consensus developed to support Senate Bill 561. This is complex legislation with many interlocking facets. I am extremely hopeful that the consensus to support this legislation holds together.

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.

FI+I 2/12/92
Attachment #6

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

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." HMOs, 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.

In summary, Kaiser Permanente believes Senate Bill 561 is sound public policy. It accomplishes the goal of expanding access to coverage for small Kansas employers while, at the same time, avoiding undue burdens on insurers and HMOs who will then be more encouraged to enter this market.