Approved 3/24/92
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

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

9:13 a.m./~~p.m.~~ on Monday, March 23, 19 92 in room 529-S of the Capitol.

All members were present except: Senators Bond, Francisco, McClure, Parrish, Reilly, Salisbury, Ward, and Yost.

Committee staff present:

Fred Carman, Revisor
Bill Wolff, Research
June Kossover, Committee Secretary

Conferees appearing before the committee:

Richard Brock, Kansas Insurance Department
Jerry Slaughter, Kansas Medical Society
Chip Wheelen, Kansas Psychiatric Society
Paul Klotz, Association of Community Mental Health Centers
Jackie Rawlings, Kansas Physical Therapy Association
Sharon Huffman, Kansas Commission on Disability Concerns
Brad Smoot, Blue Cross/Blue Shield
Gary Robbins, Kansas Optometric Society
William Sneed, Health Insurance Association of America
Sheryl Sanders, Kansas Assn. for the Mentally Ill

The meeting was called to order by Chairman Bond at 9:13 a.m.

The Chairman opened the hearing on HB 2440. Richard Brock, State Insurance Department, testified in support of HB 2440, which would expand the availability to certain businesses of the small employer health benefit plans by increasing the maximum number of eligible employees from 25 to 50. Although there have been no participants under this plan, there have been inquiries and this bill would make the plan more accessible. There being no further conferees, the hearing on HB 2440 was closed. Senator Salisbury made a motion, seconded by Senator Yost, to move HB 2440 favorably and to place it on the Consent Calendar. The motion carried.

The Chairman opened the hearing on Sub. HB 2511, which creates a new act under which an association, the Kansas Health Insurance Association, would be created to make limited health insurance coverage available for persons who are unable to secure health insurance as a result of meeting one of four different criteria. Mr. Richard Brock, State Insurance Department, appeared before the committee to explain and testify in support of Sub. HB 2511. (Attachment #1.) Mr. Brock requested the committee to consider amending Sec. 10, page 13, lines 7 through 13 to read, "Periodically, the plan shall compare the premiums earned to the losses and expenses sustained by the plan. If there is any excess of losses and expenses over premiums earned, such excess losses and expenses shall be transferred from the uninsurable health insurance plan fund to the plan to pay claims and expenses resulting from its operation. If there is any surplus of premiums earned over losses and expenses, such surplus shall be transferred to the uninsurable health insurance plan fund from the plan," and that the existing language be deleted.

In response to Senator Bond's question concerning page 9, line 34, Mr. Brock explained that this is a flexible basic plan that can have different deductibles and different premiums. Mr. Brock also advised that regarding page 7, line 22, persons under self-insured plans which do not contribute to the plan are, therefore, ineligible to join. In response to Senator Ward's question, Mr. Brock advised that it would be apparent whether or not the plan was being used by the number of policies issued.

Senator McClure asked whether mental health services would be covered. Mr. Brock stated that mandates are not included other than freedom of choice and that some mandates may be included in the development of the plan, and that **Sub. HB 2511** is intended to guarantee basic coverage to persons who have no coverage of any kind. The House amended the bill on page 7, line 36, to strike the language "...other than mental."

Jerry Slaughter, Kansas Medical Society, appeared to testify in support of the bill. (Attachment #2.) Mr. Slaughter requested the committee to consider an amendment to change page 13, lines 40-43, to read, "The board shall establish reimbursement rates for providers which are reasonable." Mr. Wolff of the Research Department suggested that another method to amend the bill to achieve the goals might be appropriate.

In response to Senator Salisbury's question, Chairman Bond advised that the board would be elected by the health care industry in Kansas.

Mr. Chip Wheelen, Kansas Psychiatric Society, appeared in support of **Sub. HB 2511**, and requested the committee to consider an amendment to add, on page 7, line 36, the language, "...including mental illnesses and nervous disorders." (Attachment #3.)

Mr. Paul Klotz, Association of Community Mental Health Centers of Kansas, appeared in support of the bill, but expressed concern for mental health coverage. (Attachment #4.)

Jackie Rawlings, Kansas Physical Therapy Association, appeared before the committee to request an amendment to **Sub. HB 2511**, to allow coverage for physical therapy treatment. (Attachment #5.)

Sharon Huffman, Legislative Liaison for the Kansas Commission on Disability Concerns, testified in support of **Sub. HB 2511**, and urged the committee to further amend the bill so that services would not be limited to persons licensed to practice medicine and surgery. (Attachment #6.)

Brad Smoot representing Blue Cross and Blue Shield, appeared in support of **Sub. HB 2511**, as amended by the House. (Attachment #7.)

Gary Robbins, Kansas Optometric Association, appeared in support of **Sub. HB 2511**. (Attachment #8.)

Mr. William Sneed, Health Insurance Association of America, appeared as a proponent of the bill, and requested the committee to consider amending the definition of "health insurer" on page 7, line 21, to correspond with the NAIC definition of health insurance. (Attachment #9.)

Sheryl Sanders, Kansas Alliance for the Mentally Ill, appeared in support of the intent of **Sub. HB 2511**, but requested an amendment that would specifically include mental coverage at parity with other coverages to be included in the plan. (Attachment #10.)

There being no further conferees, the Chairman declared the hearing on **Sub. HB 2511** closed. The Chairman requested committee members to consider the amendments requested by the conferees and advised that the bill will be considered for action at Tuesday's meeting.

Senator McClure made a motion, seconded by Senator Salisbury, to approve the minutes of the meeting of March 19 as submitted. The motion carried.

The committee adjourned at 10:01 a.m.

GUEST LIST

SENATE

COMMITTEE: FINANCIAL INSTITUTIONS AND INSURANCE DATE: March 23

NAME	ADDRESS	ORGANIZATION
Chip Wheelen	Topeka	Ks Psychiatric Soc.
Pat O'Brien	KC.	KS Bankers
PAUL M. KLOTZ	Topeka	~~Assoc of C M H C's~~ Ks, Inc.
Joe Furjanic	Topeka	KCA
Cindy Krueger	Kansas City	SBA
Marsha Gabehart	Topeka	KDHE/CDC
Jackie Rendina	Manhattan	KS Phys Therapy Assn.
Sharon Huffman	Topeka	KCDC
Brad Smoot	11	BeBS
ALAN COBB	Wichita	Delta Dental
Bob Harder	Topeka	Self
CHARLES WALKER	Topeka	SRS/DMS
Lee Wright	Overland Park	Farmers Ins. Group
GARY Robbins	Topeka	Ks Opt Assn
LISA Getz	Wichita	Wichita Hospital
Bill Sneed	Topeka	KHA and KMS
Jerry SAULSBERY	Topeka	

Testimony by

Dick Brock, Kansas Insurance Department

Before the Senate Committee on Financial Institutions and Insurance

Substitute for House Bill No. 2511

The Insurance Department first proposed legislation to establish a health risk pool in 1976. That exercise has been repeated several times since then with varying ideas and approaches but the same unsuccessful result. In 1991 we again approached the House Insurance Committee with two quite different approaches to establishment of a health risk pool but with the qualification that our primary objective in bringing the proposals forward was to simply get the issue on the table. Although this probably had little bearing on subsequent events, the fact remains that a subcommittee was appointed, diligently pursued their charge and brought back a practical and innovative recommendation which is now before you as Substitute for House Bill 2511. If enacted, this measure will serve as another vehicle to reduce the number of uninsured or underinsured Kansans.

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

The sequel to House Bill 2001 -- Senate Bill 561 which has now passed this body and is scheduled for House Committee consideration tomorrow -- takes the group reform process a step farther by requiring the issuance of basic coverage to employer groups or units with fewer than 25 employees. Thus, if Senate Bill 561 becomes law, the availability issue with respect to most individuals eligible for employer sponsored group coverage will have been effectively addressed.

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Attachment #1

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

As I stressed in my testimony on House Bill 2001 last year and Senate Bill 561 more recently, neither the group reforms or Substitute for House Bill 2511 are a panacea. They will not make health insurance affordable or more affordable and the coverage will be more limited than many applicants would prefer. Nevertheless, the hospital-medical-surgical coverage that would be made available pursuant to Substitute for House Bill 2511 would give persons with the resources to do so the opportunity to purchase basic health insurance protection. Furthermore, there are several features in the bill that are designed to hold the premiums down. Its primary emphasis is on primary care, it contains a limitation on provider charges, it requires the use of managed care measures, and it contains a continuous coinsurance provision, all of which are designed to produce lower premiums. Obviously, "lower premiums" is a relative term but the battle in which we are engaged does not permit a more positive description when we are dealing only with the financing or insurance side of the equation. Admittedly, these features result in lower premiums because the insured relinquishes some freedom to seek health care services whenever, however, and from whomever they choose in addition to sharing in the cost of the medical services obtained. But these have become standard, if not totally accepted, health care management techniques designed to encourage the efficient use of health care services and health care dollars.

And while I'm on this point, there will be other, lower deductible options but one of those will be a $5,000 deductible. I know some are not convinced that a $5,000 deductible, which is the one option actually

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

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

On the other hand, as far as I know, neither Nebraska or Iowa have enacted the underwriting restrictions contained in 1991 House Bill 2001 or are considering the expansion of group reform to include a guaranteed issue requirement. These initiatives will obviously reduce the number of Kansans who might otherwise apply for coverage from a pool.

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Nevertheless, according to information provided this committee last year by Mr. Sneed on behalf of the Health Insurance Association of America, there are an estimated 347,000 uninsured individuals in Kansas. Needless to say, a sizeable portion of these are probably uninsured by choice, another segment should now or following this session might be covered by a group plan, and another segment probably falls within the medically indigent category and can't afford whatever we make available. However, when we begin with approximately 14% of the population, there can be a number of different people in a number of different categories and still be a more than sufficient number that would benefit from the existence of a health risk pool. For example, if Senate Bill 561 is enacted in its current form, employer units of less than 3 would not be eligible. Consequently, the single self-employed individual, a business operated by a husband and wife or an employer and one employee would be candidates for coverage from the risk pool. Similarly, as you will recall, Senate Bill 561 applies only to employer sponsored groups. Therefore, groups sponsored by social organizations, support groups and so forth would have the House Bill 2001 protections but the group itself might be rejected. And, of course, the primary focus is on those individuals who simply don't have access to a group of any kind who might find the coverage available from a health risk pool beneficial. Thus, I don't believe concern about the number of people who would benefit from establishment of a health risk pool should be a consideration. Even without solid numbers, the experience in other states indicates that such mechanisms are meeting a need.

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

to discontinue. The ultimate response to this concern obviously lies with the legislature and the Governor because that is where the spending priorities are established. To give you some idea of the magnitude of the cost shifting or state subsidy or combination experienced in other states, I have attached to my testimony another table prepared by Communicating for Agriculture. However, before you draw any conclusions from these numbers or others, there are, I believe, some unique characteristics of Substitute for House Bill No. 2511 that deserve consideration.

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

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

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

Fourth, an exclusion for pre-existing conditions is specifically permitted for specified periods of time.

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

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

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

Eighth, Substitute for House Bill 2511 provides for an interest free loan from the pooled money investment board of $500,000 per year for the first four years of the plan's operation to fund its start-up costs. Any amounts borrowed from the pooled money investment board must be repaid in 10 years.

In reviewing the bill, you will note the PMIB loan mechanism is the product of a floor amendment. I am advised there were good reasons for this change and the Department has not involved itself in the determination of this policy. However, as currently drafted, it appears the Commissioner would be responsible for the day to day conduct of the plan's business. This obviously is not what was originally envisioned. Therefore, attached to my testimony is a balloon amendment we believe

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would provide the necessary protection of state resources yet permit administration of the plan to be performed in the private sector.

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

In summary, after considering a significant number of different plans and proposals over a period of 15 years, House Bill No. 2511 is, we believe, the best vehicle yet developed to address the needs of uninsured individuals in this state.

"QUICK CHECK"

RISK POOL PARTICIPATION
Compiled by
Communicating for Agriculture

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

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

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

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"QUICK CHECK"

RISK POOL OPERATIONS
Compiled by
Communicating for Agriculture

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

State	Premiums Collected	Claims Paid	Assessments To Members	Admin. Costs
California	$ N/A	$ N/A	$ 0*	$ N/A
Colorado	Became Operational April, 1991			
Connecticut*	4,495,872	10,438,000	6,522,349	567,826
Florida*	12,443,960	17,425,025	8,057,403	2,810,723
Georgia	Not Yet Operational — Passed in 1989			
Illinois	11,951,968	24,138,119	0*	1,730,348
Indiana	8,376,736	16,978,462	7,316,933	715,188
Iowa	4,574,013	5,053,843	2,088,517	375,432
Louisiana	Not Yet Operational — Passed in 1990			
Maine	512,525	1,154,193	748,388	129,762
Minnesota*	25,734,981	49,469,692	22,167,000	3,057,482
Mississippi	Not Yet Operational — Passed in 1991			
Missouri	To Become Operational — November, 1991			
Montana	629,463	569,834	0	28,954
Nebraska	4,422,717	6,760,239	4,000,000	302,917
New Mexico	2,854,825	4,205,865	2,513,710	219,674
North Dakota	2,571,307	4,312,535	1,699,880	203,683
Oregon*	1,332,469	1,132,952	1,150,000	374,067
South Carolina	1,636,144	1,794,927	90,400	N/A
Tennessee	10,775,374	17,121,200	3,000,000	477,000
Texas	Not Yet Operational — Passed in 1989			
Utah	To Become Operational — August, 1991			
Washington	4,718,231	7,186,956	2,999,470	565,083
Wisconsin	10,561,456	17,569,449	11,000,016	1,486,083
Wyoming*	20,690	548	80,800	6,892

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

from the uninsurable health insurance plan fund over the period of 10 fiscal years after fiscal year 1994 in accordance with appropriation acts. Amounts loaned under this section shall not bear interest.]

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

~~New~~ Sec. 11. (a) Not later than July 1, ~~1992~~ 1993, and July 1 of each succeeding year, the board shall submit an audited financial report for the plan for the preceding calendar year to the commissioner in a form provided or prescribed by the commissioner.

(b) The financial status of the plan shall be subject to examination by the commissioner or the commissioner's designee. Such examination shall be conducted at least once every three years beginning January 1, ~~1994~~ 1995. The commissioner shall transmit a copy of the results of such examination to the legislature by February 1 of the year following the year in which the examination is conducted.

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

~~New~~ Sec. 13. Unless otherwise specified by the plan, as a prerequisite for payment from the plan, each provider of health services to persons covered under the plan shall enter into a provider agreement with the association under which reimbursement for services provided shall be at the rates the state reimburses such providers for services rendered under medicaid pursuant to rules and regulations of the secretary of social and rehabilitation services. Providers

Periodically, the plan shall compare the premiums earned to the losses and expenses sustained by the plan. If there is any excess of losses and expenses over premiums earned, such excess losses and expenses shall be transferred from the uninsurable health insurance plan fund to the plan to pay claims and expenses resulting from its operation. If there is any surplus of premiums earned over losses and expenses, such surplus shall be transferred to the uninsurable health insurance plan fund from the plan.

Delete

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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 23, 1992

TO: Senate Committee on Financial Institutions and Insurance

FROM: Jerry Slaughter
Executive Director

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

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

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

In section 6, page 6, beginning at line 37, the criteria are set forth for persons who would be eligible for the plan. While the plan appears to be intended to reach uninsurable Kansans, as we read the bill it would also include many Kansans who are otherwise insurable, but who may not have insurance coverage provided by their full-time employer. For example, on page 7 in subsection (3) at line 4, such persons would be eligible for coverage if they had applied for health insurance and been quoted a rate in excess of the rate charged under the risk plan, even though the private insurance costs were based on benefits which could be substantially different than those benefits offered in the risk plan. In other words, the comparison of the cost of coverage in the private market and that of the plan would not necessarily be an "apples to apples" comparison.

We have another concern with the language in section 13, on page 13, lines 37-43, wherein health care providers participating in the plan must agree to accept reimbursement at a level which the Medicaid program reimburses providers. While we understand the thrust of the bill is to set up a risk pool where all participants involved agree to some subsidy for services provided uninsurable Kansans, we believe setting reimbursement rates at Medicaid levels is unfair in that it asks health care providers to accept a disproportionate share of caring for this population. While they do not like it,

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Attachment #2

health care providers generally go along with substantially reduced reimbursement in the Medicaid program because they feel it is an obligation to partially subsidize the cost of care for indigent Kansans. However, this bill would substantially broaden the application of Medicaid reimbursement levels to a population that is by definition not indigent (the program will not cover persons eligible for Medicaid or other public insurance programs; section 6(b)(1), on page 7.

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

Thank you for the opportunity to comment on HB 2511.

JS:cb

from the uninsurable health insurance plan fund over the period of 10 fiscal years after fiscal year 1994 in accordance with appropriation acts. Amounts loaned under this section shall not bear interest.]

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

~~New~~ Sec. 11. (a) Not later than July 1, ~~1992~~ 1993, and July 1 of each succeeding year, the board shall submit an audited financial report for the plan for the preceding calendar year to the commissioner in a form provided or prescribed by the commissioner.

(b) The financial status of the plan shall be subject to examination by the commissioner or the commissioner's designee. Such examination shall be conducted at least once every three years beginning January 1, ~~1994~~ 1995. The commissioner shall transmit a copy of the results of such examination to the legislature by February 1 of the year following the year in which the examination is conducted.

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

~~New~~ Sec. 13. Unless otherwise specified by the plan, as a prerequisite for payment from the plan, each provider of health services to persons covered under the plan shall enter into a provider agreement with the association ~~under which reimbursement for services provided shall be at the rates the state reimburses such providers for services rendered under medicaid pursuant to rules and regulations of the secretary of social and rehabilitation services.~~ Providers

The board shall establish reimbursement rates for providers which are reasonable.

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Kansas Psychiatric Society

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Chip Wheelen
Public Affairs Contact
(913) 235-3619

March 23, 1992

TO: Senate Financial Institutions and Insurance Committee

FROM: Kansas Psychiatric Society Chip Wheelen

SUBJECT: Substitute House Bill 2511; Kansas Health Insurance Association

Thank you for this opportunity to express our general support for the concept of a risk pool to provide access to health insurance for Kansans who cannot purchase affordable coverage in the commercial market. The Kansas Psychiatric Society expressed opposition to the original unamended substitute bill because it specifically excluded coverage for mental illnesses.

You will note at line 36 of page 7 that the House Committee corrected the flaw by deleting "other than mental". We believe this stricken language is a clear reflection of the intent of the House in passing the bill, but such an amendment would not be printed in the 1992 Session Laws nor the statutes. Therefore we respectfully request that you clarify legislative intent by adding "including mental illnesses and nervous disorders" as described on the attached page.

Although our requested amendment would not restore the statutory mental health mandate, it would make it clear that our Legislature is sufficiently enlightened to ensure that no distinction should be made between health insurance coverage for mental illnesses and other categories of illness. We trust that you will appreciate the need for this clarifying amendment.

Thank you for considering our concerns and our requested amendment.

CW/cb

Attachment

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Attachment #3

terminated for any reason other than nonpayment of premium;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) services of licensed dentists ~~issued certificates of qualifi-~~

amendment drafted by Chip Wheelen
on behalf of Kansas Psychiatric Society

3-2

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 23, 1992

Dear Member, Financial Institution and 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.H.B. 2511** for individuals and **S.B. 561** for small groups. 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.

FI&I 3/23/92
Attachment #4

Kansas Physical Therapy Association

KPTA

Substitute HB 2511

Mr. Chairman and Members of the Senate Insurance Committee:

I am Jackie Rawlings, a registered physical therapist, working in Kansas since 1963 and past president of the Kansas Physical Therapy Association. Our association represents nearly 700 physical therapists and physical therapists assistants in Kansas.

The KPTA supports Substitute House Bill 2511. However, the KPTA requests one addition to this bill. On page 8, line 10 add the following:

#6 medically necessary physical therapy services as provided by or under the direction of a registered physical therapist. Then make #6, #7.

Physical therapy is instrumental in the recovery of persons who suffer heart attacks, strokes, have musculoskeletal injuries or joint replacements. It is necessary to help these people alleviate pain, regain function and become independent.

Physical therapy services are currently reimbursible by all major insurance companies and by Medicare.

Please amend Substitute HB 2511 to allow coverage for physical therapy treatment.

Thank you.

FI+I 3/23/92
attachment #5

9102 West 98th Terrace • Overland Park, Kansas 66212 • (913) 648-5004

Kansas Department of Human Resources

Joan Finney, Governor
Joe Dick, Secretary

Commission on Disability Concerns
1430 S.W. Topeka Boulevard, Topeka, Kansas 66612-1877
913-296-1722 (Voice) -- 913-296-5044 (TDD)
913-296-4065 (Fax)

TESTIMONY IN SUPPORT OF SUB. HB 2511
SENATE FINANCIAL INSTITUTIONS AND INSURANCE

by Sharon Huffman, Legislative Liaison
on March 23, 1992

Thank you for the opportunity to testify in support of Substitute House Bill (HB) 2511. HB 2511 would create the Kansas Health Insurance Association in order to make limited health insurance coverage available to a large group of persons who are currently either unable to obtain coverage, or are unable to afford the cost of premiums for health insurance.

The statutory mission of the Kansas Commission on Disability Concerns (KCDC) is to carry on a continuing program to promote a higher quality of life for all persons with disabilities. A predominant complaint that we receive in our office is that persons have been denied health insurance coverage due to either their own or a family member's disability. Without health insurance coverage families are forced to become dependent upon state or federal programs for support. HB 2511 would address this issue by providing health insurance coverage to those who have been rejected by two carriers because of health conditions or been accepted subject to a permanent exclusion of a preexisting condition.

KCDC would urge your support of the House Committee amendment deleting the exclusion of mental health services. We would also propose a further amendment that would not limit the services to those provided only by a person licensed to practice medicine and surgery. It would be more cost effective for a person to use the services of a mental health center when appropriate, than to use a medical doctor or surgeon.

Thank you for the opportunity to testify today.

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FI&I 3/23/92
Attachment #6

BRAD SMOOT
ATTORNEY AT LAW

1200 WEST TENTH STREET
TOPEKA, KANSAS 66604-1291
(913) 233-0016
FAX (913) 233-3518
PLEASE REPLY TO TOPEKA OFFICE

10200 STATE LINE, SUITE 230
LEAWOOD, KANSAS 66206
(913) 649-6836
FAX (913) 381-6965

Statement of Brad Smoot, Legislative Counsel
Blue Cross & Blue Shield of Kansas to the Senate Committee
on Financial Institutions and Insurance
regarding Sub House Bill 2511

March 23, 1992

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

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

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

During this Session, another element of reform has now passed the Kansas Senate, namely, the small employers group health coverage act, SB 561. As you know, this proposal provides for the guaranteed issue of insurance to small groups of 3 to 25. Required coverage for such groups should go a long way toward providing health care coverage to persons not covered by large employers, associations, medicare and medicaid.

You may wish to consider a few technical aspects of the bill, including the definition of "preexisting condition" (see New Section 8(c) of HB 2511) which differs from the definition contained in Section 3(t) of SB 561. You may also wish to examine the definition of "health insurance," since it does not expressly include indemnity policies. This would be relevant in determining the pro rata share of losses.

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

Again, we endorse Sub HB 2511 as amended. It may well be a very important and workable method of assisting some individual Kansans gain access to health care heretofore unavailable to them. We suggest only that you consider the technical suggestions I have mentioned and the purpose of this proposal in the context of small employer group reforms being considered by the Legislature.

FI+I 3/23/92
Attachment #7

Kansas Optometric Association

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

I am Gary Robbins, Executive Director of the Kansas Optometric Association. I am appearing to express our support of Substitute for H.B. 2511. We strongly believe that the availability of health insurance to uninsured Kansans is a crucial issue. We are pleased that the insurance equality or freedom of choice statutes are not preempted in Substitute for House Bill 2511 with the other mandates. As you are aware, optometrists are included in KSA 40-2, 100 along with dentists and podiatrists. There are several misconceptions about the provider equality statutes which require clarification. KSA 40-2, 100 requires that optometrists be reimbursed only if services are offered under an insurance policy that are within the scope of practice of an optometrist. This law does not mandate coverage; it simply allows qualified providers to render services already covered by an insurance policy. It should be stressed that these procedures would have been performed by some qualified provider anyway because the insurance carrier voluntarily covered those procedures. The original language preempting the provider statutes was deleted by the House on Page 9 of the bill.

In summary, the inclusion of the insurance equality statutes currently in Substitute for H.B. 2511 will have several desirable effects. First, costs would likely decrease due to increased competition among providers, cost-effective providers could be utilized and consumers' out-of-pocket expenses would be decreased due to reduced travel costs for services for patients. Second, inclusion of the optometrists and dentists in providing emergency eye and dental care will decrease emergency room expense if these services are included.

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

FI+I 3/23/92
Attachment #8

MEMORANDUM

TO: Senator Richard Bond
Chairman, Senate Financial Institutions and Insurance Committee

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

DATE: March 23, 1992

RE: Substitute for House Bill 2511

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I am Legislative Counsel for the Health Insurance Association of America ("HIAA"). The HIAA is a health insurance trade association consisting of over 325 insurance companies that write over 85% of the health insurance in the United States today. Please accept this memorandum as our testimony in regard to a substitute for H.B. 2511. You will recall that last year my Association was actively involved in the enactment of H.B. 2001, and we are working on other health insurance-related bills, specifically, S.B. 561, which relates to a guaranteed issue health insurance proposal for small groups. Because of our involvement, we are aware of the legislature's concern relative to access and affordability of health insurance for those people who desire health insurance but are unable to procure it.

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

FI+I 3/23/92
Attachment #9

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

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

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

2. In regard to assessments, which begins on page 5 of the bill, line 37, the bill encompasses assessments being made against members of the Association. That in turn will ultimately refer you back to new Section 3, which is found on page 2, line 17, which creates the Association. The Association is "all insurers and insurance arrangements providing health care benefits in this state . . . " It would be our recommendation that the exemptions found in the definition of health insurance somehow be tied back into the assessment arrangements, which are further defined by the definition of health insurance association in new Section 3.

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

As stated earlier, my client supports this bill and would recommend a close review of section 7(e)(13) and section (d) found on page nine.

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

Respectfully submitted,

William W. Sneed
Legislative Counsel
Health Insurance Association of America

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

"Health insurance" means any hospital and medical expense incurred policy, nonprofit health care service plan contract and health maintenance organization subscriber contract. The term does not include short term, accident, fixed indemnity, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, **[disability income,]** or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

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 23, 1992
TO: Members, Senate Financial Institutions and Insurance Committee
FROM: Sheryl Sanders, Kansas Alliance for the Mentally Ill
SUBJECT: Substitute for HB 2511

The Kansas Alliance for the Mentally Ill supports the intent of substitute for HB 2511 to provide limited health insurance for Kansans unable to secure coverage.

However, the insurance offered may only cover those expenses enumberated in the bill. To be able to support the bill, we seek an amendment that would specifically include mental coverage at parity with other coverages to be included in the plan. If certain injuries are to be covered at low levels, we ask for the same consideration for mental. If prioritization of treatments will occur for heart diseases, the same should be done with mental illness.

The primary reason to amend the bill in this way is to correct the discrimination of placing "physical" over "mental" in establishing these plans. The priorities we establish now set precedents for future decisions about health care in Kansas. There will continue to be debate about what constitutes "basic" care. While we agree with Senator Bond that tough decisions will need to be made, they should center on levels of coverage. We do not believe that the inclusion of mental coverage as basic health care should even be debated.

Thank you.

FI&I 3/23/92
Attachment #10