Approved: March 24, 1995
Date

MINUTES OF THE HOUSE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by Chairperson Bill Bryant at 3:30 p.m. on March 14, 1995 in Room 527S of the Capitol.

All members were present except: Representative Tom Sawyer, Excused

Committee staff present: Bill Wolff, Legislative Research Department
Bruce Kinzie, Revisor of Statutes
Nikki Feuerborn, Committee Secretary

Conferees appearing before the committee: Kathy Peterson, Connaught Laboratories
Dr. Steven Potsic, KDHE
Chip Wheelen, Kansas Medical Society
Mary Kopp, Kansas State Nurse's Association
Richard C. Huncker, Kansas Insurance Department
Dr. Sydney Hardman, Kansas Action for Children
Bob Hayes, Health Care Stabilization Fund
Jerry Slaughter, Kansas Medical Society
Lori Callahan, KaMMCO (written only)
Bill Sneed, Am Inv. Life Ins. Co.
Jamie Corkhill, CSE, SRS
Patrick Mulvihill, Kansas Insurance Department
Anita Larson, SBG
Don Gaskill, Kansas Insurance Department

Others attending: See attached list

**Hearing on SB 36--Accident and health insurance mandate for coverage of immunizations**
Kathy Peterson, spokesperson for Connaught Laboratories, emphasized her company's interest in working toward increasing age-appropriate immunization rates in both Kansas and the rest of the United States (Attachment 1). Timely immunization of children can save $10-14 in treatment costs for every dollar spent on vaccines. The result of the implementation of this legislation would be to immunize children by age 2 when they are the most vulnerable instead of waiting until school entry when immunization is mandated by law. The potential modest increase in insurance premiums is more than offset by the cost/benefit ratios vaccines represent.

Dr. Steven R. Potsic, Director of Health of KDHE, stated that this proposal would (Attachment 2):

1. Add immunization benefits to the coverage already required to be made available for newly born children.

2. Specify that such coverage requirement will apply from birth to 36 months of age.

3. Statutorily identify the primary vaccines and dosages to be covered.

4. Provide flexibility for additional vaccines and dosages that may be prescribed by the Secretary of Health.

Dr. Potsic informed the Committee of the importance of timeliness of vaccinations as some diseases occur before certain ages. Public health departments are often late in receiving vaccines and by mandating insurance companies to cover vaccinations, children would receive the immunizations at the proper time at their physician's offices. Even though there may be some cost shifting to insurance companies, the first dollar vaccine coverage would provide additional accessibility without the parental concern of meeting a deductible/coinsurance. This legislation would provide for a joint effort between private and public sectors for meeting the Year 2000 immunization goals.

Chip Wheelen, Kansas Medical Society, relayed information from the physicians regarding their practice of

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



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referring parents to local public health clinics in order to take advantage of lower costs for vaccines for their children (Attachment 3). Interruption in continuity of health care sometimes results in delayed immunization of the children. When parents use the health clinics exclusively, medical evaluations by a physician and other preventive services are often neglected. The Kansas Medical Society recommends that coverage be extended to age five in order to cover the cost of vaccines that are given in a series at periodic intervals. It was suggested that an amendment be included that would list DPT and polio boosters in first dollar coverage rather than setting it up as part of the deductible.

Mary Kopp, Kansas State Nurses Association, related hospitalization costs of diseases vs. vaccine immunization at the proper intervals (Attachment 4). Cost and access are barriers to immunization of Kansas 2 year olds. In Kansas the public/private service delivery is split 35% private and 65% public sector such as federally qualified health centers, city or county health departments, and homeless shelters. Individuals requiring immunizations are often referred elsewhere or the service is interrupted due to lack of vaccine, scheduling, and ineffective record keeping and tracking.

Richard G. Huncker, Kansas Insurance Department, stated their position as believing that benefits derived from this bill would greatly outweigh any additional premium required by the mandate (Attachment 5). Some children are sensitive to vaccines and continued medical care is necessary which would not be available through public health clinics. A fiscal note on the proposed mandate is forthcoming.

Sydney Hardman, Kansas Action for Children, expressed concern that the immunization program is still not reaching 15% of the children (Attachment 6). Regarding cost concerns, Dr. Hardman said she realized that through her premiums she was paying for smokers, drug users, and other people's health choices. Taxes are paying for public health immunizations.

**Hearing on SB 46--Clean up the health care provider insurance availability act**
Bob Hayes, Executive Director of the Health Care Stabilization Fund, reviewed the proposed revisions which would complete the transfer of authority for the operation of the Fund from the Insurance Commissioner to the Board of Governors of the Fund (Attachment 7).

Jerry Slaughter, Kansas Medical Society, supports the transfer of authority to the Fund from the Insurance Department (Attachment 8). There are no state tax dollars in the Fund and it is entirely supported by premiums paid by physicians, hospitals and other health care providers.

Written testimony was presented by Lori Callahan for KaMMCO (Kansas Medical Mutual Insurance Company) (Attachment 9).

**Hearing on SB 126--Late enrollees for group health and accident insurance**
Richard G. Huncker, Kansas Insurance Department, said the bill would permit certain individuals, under specific circumstances, to enroll in group sickness and accident plans after the end of an open enrollment period without being required to provide evidence of insurability (Attachment 10). Only minimal or no premium adjustments will result due to passage of the bill. If there was always open enrollment, healthy people would probably not enroll until health problems developed.

Bill Sneed, Health Insurance Association of America, expressed concern that without some gatekeeping mechanism, the total insured population would not be protected from adverse selection (Attachment 11). HIAA is opposed to the cafeteria plan section as it would allow individuals to move through plans not during the time of enrollment and select a bare-bones policy and prior to a known event, switch over to a low dollar deductible, high benefit package in order to cover a specific and/or anticipated event.

Jamie L. Corkhill, Policy Counsel of the Child Support Enforcement Division of SRS, explained the OBRA law of 1993 which requires that the non-custodial parent who is required to furnish health insurance be able to enroll the child without any regard to any enrollment season restrictions (Attachment 12). The proposed limitation on enrollment puts Kansas at serious risk of being out of compliance with state plan requirements for Title XIX (Medicaid). Ultimate penalties of $350,00 to $250 million per year could be adjudged against Kansas. Ms. Corkhill presented an amendment which would delete the following language in Lines 10 and 11 on Page 2 of the bill: "and request for enrollment is made within 31 days after issuance of such court order."

**Hearing on SB 125--Limitation on investments in certain money market mutual funds by insurance companies**
Patrick Mulvihill, Assistant Chief Examiner of the Kansas Insurance Department, explained that the bill would allow insurance companies to invest in money market mutual funds which in turn invest in repurchase agreements (Attachment 13). Since insurers can directly invest in repurchase agreements, it is logical to allow them to place their moneys in money market mutual funds which invest in repurchase agreements.

Repurchase agreements is a short term investment contract where an entity such as a bank agrees to sell an asset (typically securities, bonds or notes) and to also repurchase that asset at the expiration of the agreement.

Bill Sneed, American Investors Life Insurance Company, supports the amendment which would clarify the current statute on such investments and would maintain with insurance companies the ability to invest funds in an area that has generally been accepted for insurance company investments (Attachment 14).

Anita Larson, Security Benefit Group, confirmed their support of the bill.

**Hearing on SB 345--Life insurance company investments in financial futures**

Bill Sneed, American Investors Life Insurance Company, explained that this bill is the latest language developed by the National Association of Insurance Commissioners (Attachment 15). This proposal will allow any domestic life insurance company to invest, subject to review of the KID and statutory restrictions, in financial instruments which provide hedging transactions and certain income generation transactions. In essence, this bill allows an insurance company to invest in financial instruments which provide safeguards from interest rate volatility. This is a way for insurance companies to buy insurance on its investments.

Don Gaskill, Chief Examiner of the KID, said the bill would provide life insurance companies with more flexibility in managing their investment portfolio by allowing them to invest in additional types of financial futures contracts (Attachment 16). The Department believes the bill should be amended to provide additional limitations of 110% of the excess of the insurance company's capital and surplus over the statutory minimum capital and surplus requirements in such investments. They also requested that the subsection requiring insurers to set up documented policies and procedures and record keeping systems for the investment in financial futures contract prior to engaging in such transactions be retained.

Anita Larson, Security Benefit Group, said that the bill would allow life insurers to continue to invest in financial futures, plus grant additional authority to invest in other financial instruments (Attachment 17). They support the bill because it allows insurers to diversify and "hedge" or reduce their risks, especially interest rate risk.

The meeting adjourned at 5:00 p.m. The next meeting is scheduled for March 15, 1995.

# HOUSE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE GUEST LIST

DATE: 3/14/95

| NAME | REPRESENTING |
|---|---|
| Bill Sneed | Am Inv Life Ins Co. |
| Mark Heitz | Am Inv Life Ins Co. |
| Tim Reimer | American Investors Life Ins Co. |
| Sydney Hardman | KS Action for Children |
| Dawn Reid | Ks State Nurses Assoc. |
| Mary Kopp | KSNA |
| Kevin Davis | Am. Family Ins. Group |
| L M CORNISH | Ks Assn of P/C Insurance |
| Jerry Slaughter | KS MEDICAL SOCIETY |
| Chip Wheelen | KS Medical Soc. |
| TAN KRAMAR | SECURITY BENEFIT |
| ANITA LARSON | " " |
| D. Gill | Ins Dept |
| Carriann Richey | Golden Rule Insurance Co. |
| Rich Huncker | KS Ins. Dept. |
| Frank Caro | Merck + Co. Inc. |
| John Federico | Pete McGill + Assoc. |
| Jamie Corkhill | SRS/CSE |
| Patrick Mulvihill | KS. Ins. Dept. |

# HOUSE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE GUEST LIST

DATE: 3/14/95

| NAME | REPRESENTING |
| --- | --- |
| Steven R. Potsic | KDHE |
| Bob Hayes | HCSF |
| Mary Smith | Health Benefits Admin |
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CONNAUGHT LABORATORIES, INC.
A PASTEUR MÉRIEUX COMPANY

Representative Bryant and Members of the House Financial Institutions and Insurance Committee:

My name is Sanford Kaufman, Director of Public Health Sector Policy for Connaught Laboratories, Inc., a Pasteur Mérieux Company. On behalf of Connaught Laboratories, Inc. I wish to thank you for the opportunity to testify on behalf on Senate Bill 36, The Children's Immunization Reform Act.

Connaught Laboratories is a major developer and manufacturer of both pediatric and adult vaccines. We obviously have a strong commitment to research and development of vaccines in the U.S. But we have also been asked to provide expertise and support for activities that will help bolster immunization rates. As such we are deeply interested in working toward increasing age-appropriate immunization rates in both Kansas and the rest of the United States.

Inclusion of immunization in insurance coverage increases the likelihood children will get vaccines on time and where they usually receive their healthcare. The cost - benefit ratio for vaccines is widely acknowledged and, according the Centers For Disease Control and Prevention, can save $10-14 in treatment costs for every dollar spent on vaccines. This is one reason for the increased focus and attention being paid to expanding insurance coverage for immunization services. In 1994, three additional states enacted similar legislation, adding to the two other states with statues already in place. In addition, the Centers for Disease Control and Prevention lists expanded immunization insurance coverage among it's key policy objectives for 1995.

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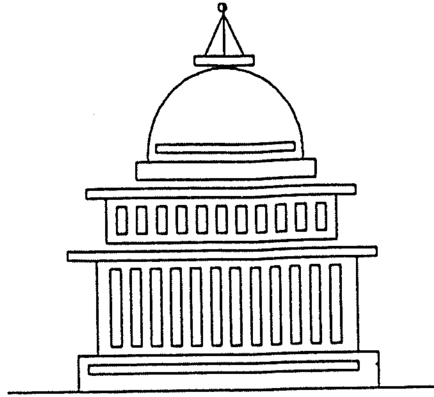
Financial Inst. & Ins.
3-14-95
Attachment 1

At a recent meeting sponsored by the new Sabin Foundation and attended by many experts in the field of immunization, including representatives of the National Vaccine Program Office, insurance coverage of immunizations emerged as a key issue needing attention and one which the group felt should become a primary objective. In addition, Partnership For Prevention, a national coalition of employers and providers supporting a range of scientific initiatives, supports coverage for immunizations.

The key role which will be played by Senate Bill 36 will be to eliminate one more barrier to the timely immunization of children. As noted in the social and financial impact statement, the net result of this legislation will be to get children immunized by age 2, when they are most vulnerable, instead of waiting until school entry when immunization is mandated by law. Therefore, as the impact statement concludes, the potential modest increase in insurance premiums is more than offset by the cost/benefit ratios vaccines represent.

We strongly support and urge the passage of Senate Bill 36.



# CHILDREN'S IMMUNIZATION REFORM ACT

## SOCIAL AND FINANCIAL IMPACT STATEMENT

Prepared by

Mr. Richard Brock
Consultant/former Chief Assistant
Office of the Commissioner of Insurance
State of Kansas
January, 1995

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**EXPLANATION**
**IMMUNIZATION REQUIREMENT**

The attached legislative proposal amends K.S.A. 40-2,102. This is the statute which requires insurance policies to include coverage for newborn infants who are ill, injured, or born with a congenital defect or birth abnormality. By amending this particular statute the attached proposal is intended to: (1) add immunization benefits to the coverage already required to be made available for newly born children; (2) specify that such coverage requirement will apply from birth to 2 years of age; (3) statutorily identify the primary vaccines and dosages to be covered; and (4) provide flexibility for additional vaccines and dosages that may be prescribed by the Secretary of Health and Environment.

**LEGISLATIVE PROPOSAL**
**IMMUNIZATION REQUIREMENT**

AN ACT relating to insurance accident and sickness insurance; immunizations; deductibles and coinsurance requirements prohibited; amending K.S.A. 40-2,102 and repealing the existing section.

BE IT ENACTED BY THE LEGISLATURE, State of Kansas:

Section 1. K.S.A. 40-1,102 is hereby amended to read as follows: 40-2,102. (a) All individual and group health insurance policies providing coverage on an expense incurred basis and individual and group service or indemnity contracts issued by a profit or nonprofit corporation which provides coverage for a family member of the insured or subscriber shall, as to, such family members' coverage also provide that the health insurance benefits payable with respect to a: (1) newly born child of the insured or subscriber from the moment of birth; (2) newly born child adopted by the insured or subscriber from the moment of birth if a petition for adoption as provided in K.S.A. 59-2129 was filed within 31 days of the birth of the child; or (3) child adopted by the insured or subscriber from the date the petition for adoption as provided in K.S.A. 59-2129 was filed.

The coverage for newly born children shall consist of: (1) coverage of injury or sickness including the necessary care and



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treatment of medically diagnosed congenital defects and birth abnormalities and (2) routine and necessary immunizations for all newly born children of the insured or subscriber. For purposes of this subsection "routine and necessary immunizations" shall consist of at least 3 doses of vaccine against diphtheria, pertussis, tetanus and polio; 1 dose of vaccine against measles, mumps, and rubella; and such other vaccines and dosages as may be prescribed by the Secretary of Health and Environment. The required benefits shall apply to immunizations administered to each newly born child from birth to 2 years of age and shall not be subject to any deductible, copayment or, coinsurance, requirements.

If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child or the filing of a petition for adoption and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within 31 days after the date of birth or the filing of the petition for adoption in order to have the coverage continue beyond the 31- day period. (b) All individual and group health insurance policies providing coverage on an expense incurred basis and individual and group service or indemnity contracts issued by a profit or nonprofit corporation which provides coverage for a family member of the insured or subscriber, as to such family members' coverage, shall also offer

an option whereby the health insurance benefits shall include delivery expenses at birth of the birth mother of a child adopted within 90 days of birth of such child by the insured or subscriber subject to the same limitations contained in such policy or contract applicable to the insured or subscriber. Such offer of an option regarding such delivery expense shall be made to the insured and, to the individual subscribers in the case of a group health insurance policy.

Section 2. K.S.A. 40-2,102 is hereby repealed.

Section 3. This act shall take effect and be in force from and after its publication in the statute book.

SOCIAL and FINANCIAL IMPACT
LEGISLATIVE PROPOSAL
IMMUNIZATION REQUIREMENT

This social and financial impact statement conforms to the requirements of K.S.A. 40-2248 and provides the information required by K.S.A. 40-2249. Specifically, such statement accompanies and supports a legislative proposal which , if enacted, will make "first dollar" insurance coverage for "routine and necessary" immunizations available in health insurance policies covering Kansas children from birth to 2 years of age.

Since this proposal would, in fact, impose a requirement on the content of health insurance policies, it does fall within the traditional definition of a statutory mandate and is therefore subject to the provisions of the aforementioned statutes. It should be noted, however, that this so-called mandate is not directed toward the treatment of a particular disease or illness. Rather, it is directed toward immunizations, a long-standing, common and accepted means of preventing, as opposed to treating, disease. This is an important distinction because this statement will not seek to support a redirection of insurance benefits to a particular type of health condition or provider. In fact, since the state of Kansas already requires immunizations for all school-age children, it can and should be viewed as a reinforcement of an existing public policy.

SOCIAL IMPACT;

<u>K.S.A. 40-2249 (a) (1) The extent to which the treatment or service is generally utilized by a significant portion of the population</u>

Immunizations are, of course, widely utilized and are even required by law in certain instances. Therefore, whether or not they are widely used is not an issue. For purposes of the legislative proposal the question is more narrow in that it seeks to increase the delivery of immunizations before the age of 2. According to the latest available information more than half of all 2 year olds in the United States were immunized against diphtheria, tetanus, pertussis, measles, rubella and mumps in 1991. Specifically, 66.6% of the 2 year olds had received at least 3 doses of vaccine against diphtheria, tetanus and pertussis; 80.4% had been vaccinated for measles and, either alone or in some combination measles/rubella, measles/mumps or measles, mumps and rubella.[1]

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1. 1993 Statistical Abstract of the United States

For the same year 52.2% of the 2 year olds had received 3 or more doses of polio vaccine[1] The same statistical breakdown is not available for Kansas. However, a retrospective review of immunization records of kindergarten children in the school year 1990-91 indicated that 48.7% of Kansas kindergartners had not been immunized by age 2 and more than 60% of children had not been fully immunized by age 2 in 22 Kansas counties. Corresponding numbers for the 1993-94 school year show some improvement but there were still 44.8% that had not been fully immunized by age 2 and less than 50% of the 2 year olds in 37 Kansas counties had been adequately immunized.[2] By any measure these are not acceptable numbers. Therefore, it seems clear that a public policy goal of 100% adherence to the immunization schedule recommended by The American Academy of Pediatrics (Exhibit One) or the Centers for Disease Control which recommends 4 doses of DTP, 3 polio doses and 1 dose of Measles/Mumps/Rubella before a child's second birthday is appropriate.

<u>K.S.A. 40-2249(a) (2) The extent to which such insurance coverage is already generally available</u>

Extensive data measuring this factor is not available. Kansas law requires all accident and sickness contracts to be filed with and approved by the Kansas Insurance Department prior to their sale to Kansas residents. The Insurance Department's files are not maintained in a way that segregates and/or accumulates different coverage components or contractual provisions. Thus specific information regarding the content of these filings is not readily available and a manual search would be so difficult and time consuming as to be prohibitive.

Notwithstanding the lack of extensive data, some measure of available insurance coverage for immunizations was obtained during the April 1994 phase of Kansas Operation Immunize 1993-94. Of 5677 respondents at the April 1994 sites, only 17.7% knew their private health plan covered immunizations; 54.7% knew it did not provide such coverage and 27.6% did not know.[3] At the same time, this data revealed that 70.4% of the 5677 respondents knew their child or children were covered by private health insurance.[4] From this limited data, it is apparent that

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1. 1993 Statistical Abstract of the United States

2. Immunization 2 Year Retrospective Survey; 4/11/94; KDHE Bureau of Disease Control

3. Kansas Operation Immunize; April 1994; KDHE

4. Ibid.

few health insurance plans cover immunizations. This numb- would, no doubt, be even further reduced if the number of hea plans waiving or otherwise not applying deductibles, copayments or coinsurance features as called for by the legislation had been ascertained. Support for this observation can also be found in a paper prepared for the American Academy of Pediatrics. In this paper it was reported that a survey of 1364 persons at 3 different sites conducted in the early 1980s found that only 30% of adults and 23% of children had preventive coverage in their health insurance plans.[1]

These numbers are not surprising. Insurance companies have not historically demonstrated great interest in using health insurance product design as a means of promoting healthy behavior. In fact, until the mid 1970s and the large scale advent of health maintenance organizations, insurers designed their products solely on the basis of the most marketable way to address the economic consequences of illness or injury. Even Kansas statutes, as do the statutes of most states, refer to "accident and sickness" insurance. It was not until the insurance community was faced with the competition produced by health maintenance organizations, preferred provider networks and other innovations designed to reduce the cost/use of medical care that society began to think of insurance as a means of reducing health care costs by promoting preventive services, wellness programs and other devices to enhance good health. Concurrent with this evolving concept the term "health insurance" began to have real meaning.

K.S.A. 40-2249 (a) (3) If coverage is not generally available the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatment

A contention that the general nonavailability of insurance coverage for immunizations results in persons being unable to obtain immunizations cannot be supported. Public health facilities, Medicaid coverage, relatively low costs, projects like Kansas Operation Immunize 1993-94 and similar considerations argue persuasively that immunizations are widely available and generally accessible in Kansas.

Unfortunately, numerous authorities point to parental apathy, a lack of parental responsibility, inadequate information about the importance of early prevention and other similar factors as playing a very significant role in producing the inadequate immunization rates. On the other hand, 50% of the April 1994 participants in Kansas Operation Immunize indicated they chose that opportunity

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1. Premiums for Preventive Pediatric Care Recommended by the American Academy of Pediatrics; Actuarial Research Corporation; February 1991

because of its "free/low cost status.[1] This simply confirm known fact about human nature but it also provides some empirical evidence that the lack of insurance coverage or the absence of first dollar coverage may contribute to low immunization rates.

K.S.A. 40-2249 (a) (4) If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment

Generally speaking, if children are covered by a basic hospital, medical, surgical health insurance plan, the relatively low cost of immunizations would preclude the argument that the lack of insurance results in an unreasonable financial hardship. Yet, if the chain of potential circumstances is followed a bit further, it is quite plausible that the lack of insurance coverage can result in the lack of timely and adequate immunizations. If a preventable disease strikes, as can and does happen, financial hardship and great emotional distress can be the ultimate consequence.

K.S.A. 40-2249 (a) (5) The level of public demand for the treatment or service

If the level of public demand for early immunization opportunities was substantially higher, the numerous initiatives undertaken to increase immunization rates would not be necessary. Consequently, since the real focus of the legislation under review is to remove barriers that might result in a higher and earlier public demand for immunizations, the information sought by this statutory provision is not relevant.

K.S.A. 40-2249 (a) (6) The level of public demand for individual or group insurance coverage of the treatment or service

If the level of public demand for early immunizations is inadequate, it follows that the demand for insurance coverage within the context of this inquiry is also not high. Again, however, the objective of the proposed legislation is to raise the demand for early immunizations by removing some of the financial barriers that exist. Therefore, neither the lack of public demand for increased access to immunizations or the absence of a demonstrable interest in insurance coverage for immunizations should detract from the merits of the proposal.

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1. Kansas Operation Immunize; April 1994; KDHE

K.S.A. 40-2249 (a) (7) The level of interest of collect' bargaining organizations in negotiating privately for inclus of this coverage in group contracts

Information regarding this topic is unavailable but it can be presumed that any broadening of insurance coverage at no identifiable increase in cost would be welcomed.

K.S.A. 40-2249 (a) (8) The impact of indirect costs which are costs other than premiums and administrative costs, on the question of the costs and benefits of coverage

According to information reported by the Kansas Legislature's 1992 Special Committee on Children's Initiatives " early immunization for a variety of childhood diseases saves $10 in future medical costs for every dollar invested...."[1] The American Academy of Pediatrics cites various sources which proclaim a benefit/cost ratio of more than 14:1 for measles, mumps,rubella vaccine; 11:1 for pertussis vaccine given in combination with diphtheria and tetanus; and 10:1 for polio immunization. (Exhibit Two) These savings would almost all be realized in the form of indirect costs as defined in this statutory provision that would no longer be incurred. Such savings are the goal of the proposed legislation.

This finding makes it instructive to again remember that the legislative proposal deals with the prevention of disease not treatment. Moreover, the prevention produced by proper and timely immunization is a time tested and proven safe harbor against childhood diseases. Measles, mumps rubella, polio, pertussis and diphtheria are now rare in the United States. Nevertheless, they aren't unheard of and they aren't harmless. For example, information compiled by the Centers for Disease Control indicates that the incidence of measles rose to about 46,000 cases during the period 1989 through 1991 from a record low of 1,497 cases in 1983. Approximately 89 deaths were attributed to measles during this outbreak.[2]

All states, including Kansas, already recognize the value of immunization by requiring proof of immunization before allowing children to enter kindergarten or first grade. However, there is a problem with waiting until children are entering school to require immunization. In 1990, approximately half of reported

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1.Report on Kansas Legislative Interim Studies to the 1992 Legislature; Special Committee on Children's Initiatives; December 1991

2.Removing the Barriers; A New Look at Raising Immunization Rates; Robert Goldberg PhD; The Gordon Public Policy Center; Brandeis University

measles cases were among preschool children.[1] The medical literature agrees the diseases that immunizations protect against t to be more severe in very young children. Consequently, both . . Centers for Disease Control and the American Academy of Pediatrics recommend an immunization schedule which begins at the age of 2 months and is completed by the age of 15 to 18 months with periodic and selected booster shots following at various ages thereafter. In 1979, the Surgeon General set a goal of 90% of 2 year olds immunized against common diseases by 1990.[2] Yet, as indicated by the results noted elsewhere in this statement, neither the U.S. or the State of Kansas have come close to reaching this goal. It seems obvious, therefore, that any initiative or requirement which would result in more children receiving necessary immunizations at an earlier age than they do now would produce significant reductions in the indirect costs, both economic and emotional, than could otherwise accrue.

FINANCIAL IMPACT;

K.S.A. 40-2249 (b) (1) The extent to which insurance coverage of the kind proposed would increase or decrease the cost of the treatment or service

Requiring insurance contracts to include first dollar coverage for immunizations against childhood diseases cannot increase the cost of immunizations. Despite the unacceptable rate of immunizations by age 2, 97% of all children are immunized as required by the time they enter school.[3] Consequently, even though it would be a welcome result, enactment of the proposed legislation will probably not increase the number of children now immunized. Accordingly, enactment of the legislation cannot measurably change the units of the relevant vaccines that are sold or the provider costs associated with their administration.

K.S.A. 40-2249 (b) (2) The extent to which the proposed coverage might increase the use of the treatment or service

Since immunizations are already required for entry into Kansas schools, their use is assumed to be virtually universal. Therefore, enactment of the proposed legislation will not increase the

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1.Removing the Barriers; A New Look at Raising Immunization Rates; Robert Goldberg PhD; The Gordon Public Policy Center; Brandeias University

2.Report on Kansas Legislative Interim Studies to the 1992 Legislature; Special Committee on Children's Initiatives; December 1991

3.Removing the Barriers: A New Look at Raising Immunization Rates; Robert Goldberg PhD; The Gordon Public Policy Center; Brandeis University

use of immunizations. It should and is intended to result in the earlier use of immunizations by at least some of the 45% Kansas children who are not now immunized by the age of 2 , this factor will have no effect on the ultimate amount of vaccine administered or the number of vaccinations delivered.

<u>K.S.A. 40-2249 (b) (3) The extent to which the mandated treatment or service might serve as an alternative for more expensive treatment or service</u>

In 1990 approximately half of reported measles cases were among preschool children.[1] In the 1980s a resurgence of mumps was attributed to a failure to immunize all susceptible persons.[2] Also in the 1980s, 10 large cases (>100 cases) of pertussis outbreaks occurred in the U.S.[3] Given these examples and these numbers, it is no wonder the 1991 legislative review found that early immunization saves $10 in future medical costs for every dollar invested.[4] Presumably, these reported savings already recognize the infectious nature of most childhood diseases but, if not, such savings would be multiplied several times.

Even without these numbers, the economic advantages of immunization are obvious. Smallpox, the virus which led to the development of the first successful vaccine almost 200 years ago[5] has become so rare that relatively recently scientists were reportedly discussing the wisdom of allowing the virus to become extinct. In 1952 there were 58,000 reported cases of polio but, because of immunization, this number shrank to 8 cases in 1986.[6] The value of immunization is not debatable and the legislative proposal under consideration is simply intended to encourage greater utilization of this resource by a segment of our preschool population that is still at risk.

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1. Removing the Barriers; A New Look at Raising Immunization Rates; Robert Goldberg PhD; The Gordon Public Policy Center

2. Ibid.

3. Ibid.

4. Report on Kansas Legislative Interim Studies to the 1992 Legislature; December 1991

5. Fighting Disease, The Complete Guide to Natural Immune Power; Rodale Press; 1989

6. Life-Span Plus 900 Natural Techniques to Live Longer; Rodale Press; 1990

K.S.A. 40-2249 (b) (4) The extent to which insurance coverage of the health care service or provider can be reasonably expected to increase or decrease the insurance premium and administrative expenses of policyholders

Insurer reaction to a legislative proposal of this kind is difficult to predict but it should hae no measureable impact on insurance premiums.

Available information indicates that the total cost of immunizations that would be required by age 2 in the private sector is $525.[1] In view of the fact that the legislative requirement would affect only a very small segment of the insured population (birth to 2 years of age) and involves a very modest increase in individual claim costs even if no coverage whatsoever is currently provided, the impact should be statistically insignificant.

Notwithstanding the fact that this hypothesis seems reasonable when based solely on the anticipated impact of the proposed mandate, it may be somewhat misleading. While the proposal would affect only children from birth to 2 years of age, it is doubtful that insurers would restrict the coverage to these ages. As a result, the premium impact should probably be based on the assumption that insurers would incorporate immunization coverage for all dependents regardless of age. Consequently, the segment of the insured population affected by enactment of the legislation would be significantly larger. When applied to this population, the 1991 actuarial projection provided the American Academy of Pediatrics estimates that an additional premium of $1.83 per month per family would be necessary to cover immunizations in employer-sponsored commercial insurance plans.[2] Similar information is not available with respect to non-group plans but some information is available with respect to a much greater range of preventive services (Exhibit Three). It appears a charge of $4 to $5 additional premium per month is rather standard for non-group coverage that includes physical examinations, height, weight and blood pressure measurements, patient histories, vision and hearing screening, laboratory tests, accident prevention information and counseling in addition to immunizations. However, the Academy's actuaries were unable to test the reasonableness of these charges. They did note that 3 insurers in the survey indicated they made no additional charge for the preventive coverage and were able to verify the accuracy of this indication in one case but did not test the other two.

--------------------

1. Removing the Barriers; A New Look at Raising Immunization Rates; Robert Goldberg PhD; The Gordon Public Policy Center; Brandeis University

2. Premiums for Preventive Pediatric Care Recommended by the American Academy of Pediatrics; Actuarial Research Corporation; February 1991

Despite the possibility that some modest premium increases might be attributed to enactment of the proposed legislation, it is imperative to recognize that the credible and authoritative cost/benefit ratios cited elsewhere in this statement obviously more than offset this impact.

K.S.A. 40-2249 (b) (5) The impact of this coverage on the total cost of health care

To the extent enactment of the subject legislation has a measurable effect on the total cost of health care, it will be favorable. As indicated earlier, the cost of immunizations is quite modest and is, in fact, already incurred by the time children enter school. Therefore, the only measurable effect the proposal could have on total health care costs would be the savings produced by the difference between the costs of immunization and the costs of treating those who contract the disease because they weren't immunized.

EXHIBIT C

# Immunization Protects Children

Routine checkups at your doctor's office or local health clinic are the best way to keep children healthy.

By ensuring that your child gets immunized on schedule, you can provide the best available defense against dangerous childhood diseases. Childhood immunization provides protection against nine major diseases: hepatitis B, polio, measles, mumps, rubella (German measles), pertussis (whooping cough), diphtheria, tetanus (lockjaw), and *Haemophilus influenzae* type b. Is your child fully protected from these diseases?

The chart below includes immunization recommendations from the American Academy of Pediatrics. Check with your doctor or health clinic to find out whether your child needs additional booster shots or if other new vaccines

(continued on back)

**Immunization Schedule Recommended by**

American Academy of Pediatrics

| | DTP[1] | Polio[2] | MMR | Hepatitis B[3] | Haemophilus[1] | Tetanus-Diphtheria |
|---|---|---|---|---|---|---|
| Birth | | | | ✔ | | |
| 1-2 months | | | | ✔ | | |
| 2 months | ✔ | ✔ | | | ◆ | |
| 4 months | ✔ | ✔ | | | ◆ | |
| 6 months | ✔ | | | | ◆ | |
| 6-18 months | | ✔ | | ✔ | | |
| 12-15 months | | | ✔ | | ◆ | |
| 15-18 months | ● | | | | | |
| 4-6 years | ● | ✔ | | | | |
| 11-12 years | | | ★ | # | | |
| 14-16 years | | | | # | | ✔ |

[1] The HbOC-DTP combination vaccine may be substituted for separate vaccinations for Haemophilus and DTP.

[2] Children in close contact with immunosuppressed individuals should receive inactivated polio vaccine.

[3] Infants of mothers who tested seropositive for hepatitis B surface antigen (HBsAg+) should receive hepatitis B immune globulin (HBIG) at or shortly after the first dose. These infants also will require a second hepatitis B vaccine dose at 1 month and a third hepatitis B vaccine injection at 6 months of age.

◆ Depends on which *Haemophilus influenzae* type b vaccine was given previously.

● For the fourth and fifth dose, the acellular (DTaP) pertussis vaccine may be substituted for the DTP vaccine.

★ Except where public health authorities require otherwise.

# For children who did not get this vaccination in the first 18 months of life, the hepatitis B vaccine series of three shots should be given at preadolescence or at adolescence.

have been recommended. For the best possible protection against diphtheria, tetanus, and pertussis, your child needs a series of five shots of the combination diphtheria-tetanus-pertussis (DTP) vaccine. These doses should be given at 2, 4, 6, 15 to 18 months of age, and a final booster dose given before school entry (4 to 6 years). For the fourth and fifth dose, the acellular (DTaP) vaccine may be substituted for the DTP vaccine. The DTP vaccine is also available as a combination vaccine with Hib. This combination vaccine can be used in infants scheduled to receive separate injections of DTP and Hib.

For protection against polio, your child needs the series of four oral polio vaccine doses at: 2, 4, 6 to 18 months, and a final dose before school entry at 4 to 6 years of age.

To be completely protected against hepatitis B, your child needs to be vaccinated with a series of three hepatitis B virus (HBV) vaccine shots: at birth, at 1 to 2 months, and again at 6 to 18 months of age. For children who did not get this vaccination in the first 18 months of life, the hepatitis B vaccine series of three shots should be given at preadolescence or at adolescence.

Several vaccines are available for protection against *Haemophilus influenzae* type b. The Academy recommends that your child receive doses at 2, 4, and possibly 6 months of age, with a final dose at 12 to 15 months depending on which vaccine is used. If your child is late getting the first Hib conjugate dose, the total number of doses received may differ from this AAP schedule.

At 12 to 15 months, your child should have a combination shot against measles, mumps, and rubella (MMR). A second MMR vaccination, primarily to boost measles protection, should be given to children 11 to 12 years or older who have not had measles. If there is a measles outbreak in your community or if you live in a high-risk area, the MMR shots may be given on a different schedule.

If you don't have a pediatrician, call your local public health department. Public health clinics usually have supplies of vaccine and may give shots free.

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

American
Academy of
Pediatrics

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# Immunizations have repeatedly been demonstrated as effective in reducing the incidence of childhood diseases. Today, children receive routine vaccinations against eight diseases: diphtheria, tetanus, pertussis (whooping cough), polio, measles, mumps, rubella (German measles), and serious infections caused by *Haemophilus influenzae* type b (Hib).

- The benefit-cost ratio of measles-mumps-rubella vaccine is more than 14:1.[1]
- A 20-year study of measles vaccination revealed cost savings totaling more than $5 billion.[2]
- The benefit-cost ratio of pertussis vaccine given in combination with diphtheria and tetanus is 11:1.[3]
- For polio immunization, the benefit-cost ratio is 10:1.[4]
- For the 18-month Hib vaccine, vaccination of 60% of all children would yield a savings of $207 million.[5,*]
- The benefit-cost ratio for the Hib vaccine given at 18 months is about 3.6:1.[5,*]


1. White CC, Koplan JP, Orenstein WA. Benefits, risks and costs of immunization for measles, mumps and rubella. *Am J Public Health.* 1985;75(7):739-744
2. Bloch AB, Orenstein WA, Stetler HC. Health impact of measles vaccination in the United States. *Pediatrics.* 1985;76(4):524-532
3. Hinman AR, Koplan JP. Pertussis and pertussis vaccine, reanalysis of benefits, risks, and costs. *JAMA.* 1984;251(23): 3109-3113
4. Fudenberg HH. Fiscal returns of biomedical research. *J Invest Dermatol.* 1973;61: 321-329
5. Hay JW, Daum RS. Cost-benefit analysis of *Haemophilus influenzae* type b prevention: conjugate vaccination at eighteen months of age. *Pediatr Infect Dis.* 1990;9(4):246-252


* In October 1990, the recommended schedule for the *Haemophilus influenzae* type b conjugate vaccine was changed to 2, 4, and 6 months with a booster at 15 months. Since such a high percentage of infections caused by the Hib bacteria occur in the first 12 months of life, it is anticipated that the revised schedule will result in even greater savings.

American Academy of Pediatrics

Table 7

**Non-group Individual Health Insurance**
**Premiums for Child Supervision**

| Insurance Company | Product Name | State | Charge for Child Supervision Services Per Child Per Month | Effective Date |
|---|---|---|---|---|
| American Association of Lutherans | Total Med II | FL | $4.17 | Jan 1989 to present |
| Benefit Trust | Telemed | AR, FL, MA MN, RI | $5.00 | Current ($4 in 1989) |
| Central States Health and Life | Individual Major Medical | Fl | $5.00 | Dec 1989 to present |
| Pyramid Life | G91 | FL | $5.00 | Current |
| Pyramid Life | G91 | AR | $5.58 | Current |
| Pyramid Life | G91 | MN | $4.58 | Current |
| Washington National | Classic Choice | FL | $7.00 | Jan 1990 to present |
| Time | 24 Karat | FL | no additional charge | |
| First National Life | Major Medical | FL | no separate charge | |
| Metropolitan Life | Major Medical | FL | no separate charge | |

EXHIBIT THRE

State of Kansas

Bill Graves Governor

**Department of Health and Environment**
James J. O'Connell, Secretary

Testimony presented to

House Committee on Financial Institutions and Insurance

by

The Kansas Department of Health and Environment

Senate Bill 36

The proposed Senate Bill 36 amends K.S.A. 40-2,102. This statute requires insurance policies to include coverage for newborn infants who are ill, injured, or born with a congenital defect or birth abnormality. By amending this particular statute, the proposal is intended to: (1) add immunization benefits to the coverage already required to be made available for newly born children; (2) specify that such coverage requirement will apply from birth to 36 months of age; (3) statutorily identify the primary vaccines and dosages to be covered; and (4) provide flexibility for additional vaccines and dosages that may be prescribed by the Secretary of Health and Environment.

First dollar vaccine coverage would provide additional vaccine accessibility by providing vaccine to children who are insured, without the parental concern of meeting a deductible/coinsurance or being referred to a local health department. This should encourage parents to get their children's immunizations from their children's private physicians and reduce the number of children going to local health departments.

A joint effort between the public and private sectors is necessary for Kansas to meet its Year 2000 Immunization goals. This bill provides for more opportunities to reach children with age appropriate immunizations.

The Kansas Department of Health and Environment supports SB 36.

Testimony presented by: Steven R. Potsic, M.D., M.P.H.
Director of Health
Kansas Department of Health and Environment
March 14, 1995

Financial Insts. & Ins.
Attachment 2
3-14-95

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March 14, 1995

To: House Financial Institutions and Insurance Committee

From: C. Wheelen, KMS Director of Public Affairs *Chip*

Subject: Senate Bill 36, as Amended by Senate Committee

The Kansas Medical Society supports the provisions of SB36 requiring first dollar coverage of early childhood immunizations. We believe it is one of the ways that we can improve rates of age appropriate immunization among Kansas children.

Physicians are increasingly aware that the cost of vaccine products creates a hardship for parents. Consequently, some physicians refer the parents to local public health clinics where they can have their children immunized at a much lower cost. This is possible because public health agencies are allowed to purchase vaccines at a significantly lower price than private physicians must pay. The physicians who refer the parents to local public health clinics do so in order to avoid health care expenditures. This interruption in the continuity of health care sometimes results in delayed immunization of the children.

Conversely, some parents take their children to public health departments for immunizations but do not take them to a physician for medical evaluation and other preventive services. This is also unfortunate because the opportunity for early detection of disease or a disabling condition may be lost. Under either scenario, it is the child who is at risk and could suffer long-term consequences.

We are somewhat disappointed that the bill requires coverage of immunizations only until the child reaches age three. We would prefer that the coverage be extended through age five in order to cover the cost of vaccines that are given in a series at periodic intervals. Attached to this statement is a copy of the immunizations recommended by the American Academy of Pediatrics. You will note that polio and diphtheria-tetanus-pertussis shots are recommended at age 4-6 years (prior to school attendance). We urge your favorable consideration of such an amendment.

We believe that passage of SB36 would make it possible for more children to be immunized at the physician's office or medical clinic in conjunction with other pediatric care. We think that this will increase the ratio of children who are immunized at appropriate ages. It is for these reasons that we request your favorable action. Thank you for considering our comments.

Financial I&I
Attachment 3
3-14-95

# Immunization Protects Children

Childhood immunization means protection against eight major diseases: polio, measles, mumps, rubella (German measles), whooping cough (pertussis), diphtheria, tetanus, and *Haemophilus influenzae* type b (Hib) infections. Is your child fully protected?

Check the table and ask your pediatrician if your child is up-to-date on vaccines. It could save a life or prevent disability. Measles, mumps, rubella, polio, pertussis, diphtheria, Haemophilus infections, and tetanus are not just harmless childhood illnesses. All of them can cripple or kill.

All are preventable. In order to be completely protected against diphtheria, tetanus, and pertussis, your child needs a shot of the combination diphtheria-tetanus-pertussis (DTP) vaccine at 2, 4, 6, and 15-18 months and a booster prior to school entry (4 - 6 years).

At 15 months your child should have a shot for measles, mumps, and rubella (MMR). A second MMR, primarily to boost measles and mumps immunity, should be given to children 11-12 years or older who have not had measles. In the event of measles outbreaks in the community, this MMR booster may be given on entry to kindergarten or at an earlier age.

Recommended by The American Academy of Pediatrics

| | DTP | Polio | TB Test | Measles | Mumps | Rubella | Hib — Conjugate** | Tetanus-Diphtheria |
|---|---|---|---|---|---|---|---|---|
| 2 months | ✓ | ✓ | | | | | ✓ | |
| 4 months | ✓ | ✓ | | | | | ✓ | |
| 6 months | ✓ | | | | | | ✓ | |
| 12-15 months | | | ✓ | | | | | |
| 15 months | | | | ✓ | ✓ | ✓ | ✓ | |
| 15-18 months | ✓ | ✓ | | | | | | |
| 4-6 years | ✓ | ✓ | | | | | | |
| 11-12 years* | | | | ✓ | ✓ | ✓ | | |
| 14-16 years | | | | | | | | ✓ |

*Except where public health authorities require otherwise.
**As of October 1990, only one HbCV (HbOC) has been approved for use in children younger than 15 months of age.

Children in high risk populations should be tested for tuberculosis in the first year. Hib conjugate (HbCV) vaccine is due at 2, 4, and 6 months with a booster at 15 months.** At 14-16 years a tetanus-diphtheria booster shot should be given.

If you don't have a pediatrician or family physician, call your local public health department. It usually has supplies of vaccine and may give shots free.

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3-2

*As Amended by Senate Committee*

Amendment requested by KS Medical Society

*Session of 1995*

# SENATE BILL No. 36

By Committee on Financial Institutions and Insurance

1-12

10 AN ACT relating to accident and health insurance; immunizations;
11 amending K.S.A. 40-2,102 and repealing the existing section.
12
13 *Be it enacted by the Legislature of the State of Kansas:*
14 Section 1. K.S.A. 40-2,102 is hereby amended to read as follows: 40-
15 2,102. (a) All individual and group health insurance policies providing
16 coverage on an expense incurred basis and individual and group service
17 or indemnity type contracts issued by a profit or nonprofit corporation
18 which provides coverage for a family member of the insured or subscriber
19 shall, as to such family members' coverage, also provide that the health
20 insurance benefits applicable for children shall be payable with respect
21 to a: (1) Newly born child of the insured or subscriber from the moment
22 of birth; (2) newly born child adopted by the insured or subscriber from
23 the moment of birth if a petition for adoption as provided in ~~section 10~~
24 *K.S.A. 59-2128 and amendments thereto* was filed within 31 days of the
25 birth of the child; or (3) child adopted by the insured or subscriber from
26 the date the petition for adoption as provided in ~~section 10~~ *K.S.A. 59-*
27 *2128 and amendments thereto* was filed.
28 The coverage for newly born children shall consist of: *(A)* Coverage of
29 injury or sickness including the necessary care and treatment of medically
30 diagnosed congenital defects and birth abnormalities*; and (B) routine and*
31 *necessary immunizations for all newly born children of the insured or*
32 *subscriber. For purposes of this subsection "routine and necessary im-*
33 *munizations" shall consist of at least three doses of vaccine against dipth-*
34 *eria, pertussis, tetanus, polio, Haemophilus B (Hib) and Hepatitis B; one*
35 *dose of vaccine against measles, mumps and rubella; and such other vac-*
36 *cines and dosages as may be prescribed by the secretary of health and*
37 *environment. The required benefits shall apply to immunizations admin-*
38 *istered to each newly born child from birth to* ~~*two years*~~ ~~**30**~~ ***months*** *of* — 72
39 *age and shall not be subject to any deductible, copayment or coinsurance*
40 *requirements.*
41 If payment of a specific premium or subscription fee is required to
42 provide coverage for a child, the policy or contract may require that no-
43 tification of birth of a newly born child or the filing of the petition for

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Topeka, KS 66603-3731
(913) 233-8638

**March 14, 1995**

**SB 36 Health Insurance Coverage for Childhood Immunizations, Birth-2 Years**

Chairperson Bryant and members of the House Financial Institutions and Insurance, my name is Mary Kopp MN, RN and I represent the Kansas State Nurses Association. I am here today as a proponent for Senate Bill 36.

I would like to preface my remarks by saying that the recommended amendments to K.S.A. 40-2, 102 lend support to basic Public Health Principles. Principles in disease prevention are based on ensuring safety and general well being of the community at large. By practicing immunization health principles the community is protected against contagious diseases such as measles and subsequent pain and suffering due to complications. For example, a typical hospitalization due to Measles complications averages $3,600.00. Other complications may include pneumonia or dehydration and in some cases encephalitis.

As you well know, Kansas 2 year olds are struggling to maintain a 50-60% overall immunization compliance rate depending on the county. Our goal is 90% by 1996. Children's immunization rates remain low, affected by one of the issues that brings us here today, COST. Cost and access continue to be barriers. Parental surveys indicate that cost remains a barrier in obtaining immunizations.

Immunization services across Kansas are delivered by a diverse array of public and private health care providers. At any one given time an individual can obtain immunizations from approximately 4 different providers. Those being private physician, federally qualified health centers, city or county health departments, and homeless shelters (Hunter clinic). In Kansas the public/private service delivery is split 35% private and 65% public sector.

This split of 35/65 private/public is particularly significant to the underinsured individuals. The ratio of public/private providers and the types of services they offer such as immunizations influence how these services are delivered or not, referred elsewhere or interrupted till later. This fragmentation is compounded with an ineffective recordkeeping system that fails to compile a complete health record and follow-up recall.

It is important that infants obtain age-appropriate immunizations. The immunization schedule is complex, there is no denying that. Legislation such as this will be one more positive step towards decreasing barriers such as cost.

b:leg95/yellow/sb36/la

**Kansas Insurance Department**
**Kathleen Sebelius, Commissioner**
420 SW 9th
Topeka, Kansas 66612-1678 (913) 296-3071

TO: House Financial Institutions and Insurance Committee

FROM: Richard G. Huncker
Accident and Health Supervisor

SUBJECT: Senate Bill 36 As Amended by Senate Committee

DATE: March 14, 1995

Senate Bill No. 36 as amended would amend K.S.A. Supp. 40-2,102(A), the accident and health insurance statute which requires coverage for newly born children.

The bill would add to the current accident and health insurance mandate, coverage for routine and necessary immunizations for all newly born children of the insured or subscriber. Coverage for immunizations applies to each newly born child from birth to 36 months of age and such coverage would not be subject to any deductible, copayment or coinsurance requirement.

The department believes that benefits derived from this bill would greatly outweigh any additional premium required by this mandate, if any.

We urge the Committee to favorably consider passage of Senate Bill No. 36.

RGH:crah
1422

House FI&I
Attachment 5
3-14-95

Kansas Action for Children, Inc.

*Where Kansas Kids Count!*

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**Testimony to the**
**House Financial Institutions and Insurance Committee**
**by Sydney Hardman**
**Kansas Action for Children**
**March 14, 1995**

The newly released *1995 Kansas Kids Count Data Book,* which is a project of Kansas Action for Children, contains some good news about immunizations for young children.

The good news is that we are making progress in fully immunizing children by age 2 . Consider:

1990 - 51.7% of kindergartners fully immunized by age 2
1992 - 53% of kindergartners fully immunized by age 2
1993 - 57% of kindergartners fully immunized by age 2

This steady progress does not include the full impact of Operation Immunize, which we will begin to see in the *1996 Kansas Kids Count Data Book.*

We all want to continue the momentum Kansas has created toward reaching 90% of children fully immunized by age 2. Our state has already received national recognition for its efforts.

Amending K.S.A. 40-2, 102 in the manner proposed by SB 36 can bring the state another tool to improve our performance on immunizations. We strongly encourage the state to pass SB 36 and create another method to encourage all children to be fully immunized by age 2.

House FI&I
Attachment 6
3-16-95

LEGISLATIVE TESTIMONY

TO THE

# HOUSE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

# The Health Care Stabilization Fund
# and
# Senate Bill No. 46

March 14, 1995

Presentation By:

Bob Hayes, Executive Director
Health Care Stabilization Fund

Financial Insts. & Ins.
Attachment 7
3-14-95

*The Kansas*
*Health Care Stabilization Fund*

*Separation from the Kansas Insurance Department*
*Based on 1994 Legislation*

*Health Care Stabilization Fund* *3/14/95*

After careful review of the provisions of the 1994 legislation and the operational objective of the Health Care Stabilization Fund, the Fund's Board of Governors has determined the Fund should separate itself from the Insurance Department. We are currently proceeding with that objective, and Senate Bill No. 46, now before this Committee, will assist in completing this task. At the end of this presentation regarding the Health Care Stabilization Fund, we will discuss the provisions of Senate Bill No. 46 and respond to any questions the Committee may have regarding this bill.

## Overview of the Health Care Stabilization Fund

- *Established in 1976*
- *Resolved Medical Malpractice Insurance Market Problems*

*Health Care Stabilization Fund* *3/14/95*

The Health Care Stabilization Fund was created in 1976 because of the failure of the excess professional liability insurance markets for doctors, hospitals and other health care providers in Kansas. Approximately 15% of our Kansas doctors were unable to locate any excess professional liability insurance -- at any price. Hospitals and other health care providers were also confronted with a lack of excess insurance coverage. Even the new Hutchinson hospital facility, for example, was confronted with insurance availability problems. The extent of the excess insurance market failure extended throughout the state - in both urban areas and in rural settings.

## Fund is Actuarially Sound

- **Tillinghast Report**
  - Completed Spring 94
  - Estimated Positive Balance of $62 million
  - Estimated Liabilities of $124 million
- **Wakely Report**
  - Completed December of 1994
  - Estimated Positive Balance of $38 million
  - Estimated Liabilities of $148 million

*Based on a Projected June 30, 1994 Balance of $186 Million*

*Health Care Stabilization Fund* 3/14/95

Since 1991, the Fund has been determined not only to be actuarially sound but has acquired an estimated positive balance. The amount of the positive balance varies between the actuarial estimates of two independent actuarial firms. Tillinghast, the actuarial firm used by the Fund, has estimated the positive balance to be approximately $62 million. The estimated positive balance amount provided by Wakely & Associates, the actuarial firm selected by the Legislative Oversight Committee, was $38 million. While these two actuarial estimates may appear to be significantly different, both actuarial firms agree that, based on the Fund's projected June 30, 1994 balance of $186 million, the difference of $24 million between their estimates is not unreasonable or an indication that funding problems exist within the Fund itself.

Principle Source of the Positive Balance

- Re-evaluation of loss expectations originally projected for Fiscal Years 1989 through 1991

Health Care Stabilization Fund 3/14/95

Both actuarial firms indicate the source of the estimated positive balance of the Fund are the result of the current re-evaluation of the original loss estimates which were made in prior years; that is, the original loss expectations made in those prior years are not developing to the extent originally anticipated.

## Lower Fund Surcharge Rates

***Applying the Fund's Estimated Positive Balance Amounts:***

- *Fiscal Year 1993 Were Lowered By $4.4 Million or -16.8%*
- *Fiscal Year 1994 Were Lowered By $12.5 million or -41.7%*
- *Fiscal Year 1995 Were Lowered By $10 Million or -36%*

*Health Care Stabilization Fund* *3/14/95*

Because of the estimated positive balance of the Fund, it has been possible for the Fund surcharge to be set lower than the actuarially indicated surcharge rate for the latest three fiscal years. Furthermore, we are anticipating the continuation of the lower surcharge rates for the next fiscal year. Part of this objective is to reach a smaller estimated positive balance which will be maintained as a "cushion". The amount of a cushion was discussed in the last meeting of the Legislative Oversight Committee. During their meeting, it was agreed that a cushion of $20 million appeared to be reasonable. The amount of the cushion will be reviewed in greater detail when the Fund's Board of Governors receives the next actuarial report and sets the surcharge rates for Fiscal Year 1996.

The ability to utilize portions of the positive balance estimates to offset Fund surcharge rates is one of the benefits of maintaining the Health Care Stabilization Fund. If our health care providers were continuing to participate in the voluntary excess professional liability insurance markets, any "excess" premium payments made by Kansas providers would likely be used to pay for losses resulting from providers of states other than Kansas.

# Lower Fund Surcharge Rates

**FY 1993**

| Coverage Level | Indicated Rate | Levied Rate |
|---|---|---|
| $100/$300 | 44.2% | 40% |
| $300/$900 | 67.6% | 55% |
| $800/$2.4m | 103.1% | 85% |

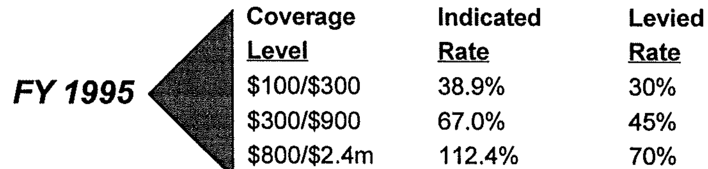
**FY 1994**

| Coverage Level | Indicated Rate | Levied Rate |
|---|---|---|
| $100/$300 | 41.5% | 30% |
| $300/$900 | 68.6% | 45% |
| $800/$2.4m | 111.1% | 70% |

*Health Care Stabilization Fund* //

Information on this page and on the next page reflect how high the Fund surcharge rates would have been if a portion of the Fund's estimated positive balance had not been available to offset the actuarially indicated surcharge rates.

# *Lower Fund Surcharge Rates*



***FY 1995***

| Coverage Level | Indicated Rate | Levied Rate |
|---|---|---|
| $100/$300 | 38.9% | 30% |
| $300/$900 | 67.0% | 45% |
| $800/$2.4m | 112.4% | 70% |

*Health Care Stabilization Fund* //

As indicated by the actuarially indicated surcharge rates, the actual annual loss potential of the Fund has been increasing in the most recent years.

We also wish to point out that while the Fund surcharge rates that have been levied have reduced health care provider professional liability insurance costs in the recent years, on an overall basis, the Kansas Medical Society believes that Kansas professional liability insurance rates are higher than most other states.

## *Other Benefits of the Fund*

- *Local Management*
- *Alleviate Insurance Market Dependence*
- *Provides a Residual Insurance Market*
- *Avoids Most Claims-Made Policy Problems*
- *Source of Information and Data*

*Health Care Stabilization Fund* *3/14/95*

Kansas health care providers receive other substantial benefits from the continuation of the Health Care Stabilization Fund. Other major benefits of the Fund are:

1. Local management of the Fund -- The Fund's Board of Governors is directly involved in the fiscal, organizational and administrative activities of the Fund. This includes all claim handling and provider defense activities.

2. Alleviates the dependence on national or foreign direct and reinsurance markets for the Fund's excess professional liability insurance coverage.

3. Provides a means to maintain a funded residual professional liability insurance market mechanism for the required basic professional liability insurance coverage.

4. Allows Kansas health care providers to avoid the basic professional liability claims-made tail coverage problems.

5. And finally, the Fund is a ready source of statistical information regarding the excess professional liability coverage it affords to Kansas health care providers.

## Samples of Fund Information

- December 31, 1994 Balance is: $186,880,661.32
- 7,500 to 8,000 Health Care Providers (21,000 providers since 1976)
- Paid Loss & Loss Expenses have been $222,677,822.82
- Average Loss Payment is $326,073.
- Total Cases 3,400

Health Care Stabilization Fund 3/14/95

From the existing records of the Fund, we can furnish the following information:

1. The December 31, 1994 balance of the Fund was: $186,880,661.32.

2. Between 7,500 and 8,000 health care providers are presently complying with the Fund. (On December 31, 1994 there were 7,429 providers listed in compliance; however, on any given date there are a number of providers who are in compliance but due to processing schedules of the industry and the Fund, their current compliance record has not been entered into the Fund's records.)

3. Since the inception of the Fund, about 21,000 health care providers have complied with the Fund -- either currently or at some time in the past.

4. Total paid losses and paid loss expenses of the Fund, as of the end of 1994, have been $222,677,822.82.

5. The FY1994 average loss payment from the Fund is $326,073.

6. The Fund has been notified of 3,400 cases. 3,016 have been closed and 384 are open.

## *Future Outlook of the Fund*

*To be maintained in a manner which will benefit not only the individual Kansas health care provider but also the Kansas health care delivery system.*

Health Care Stabilization Fund 3/14/95

This has been just a brief overview of the Kansas Health Care Stabilization Fund. In closing, it is important to again note that the Fund has experienced many difficulties throughout the years; however, at the present time and for the foreseeable future, those difficult times are part of the Fund's history. We are currently looking forward to maintaining the Fund in a manner which will benefit not only the health care providers but also the Kansas health care delivery system.

# Testimony on Senate Bill No. 46

This Senate Bill is intended to clean-up the remaining technical problems relating to the separation of the Health Care Stabilization Fund management activities from the Insurance Department that existed after the enactment of the 1994 legislation (House Bill No. 2730, Senate Bill No. 474 and Senate Bill No. 854).

Proposed revisions:

1. Line 32, Page 2 and Line 2, Page 3 - Insert the word "three".

   These changes require the professional societies or associations to submit a list of three Board of Governor nominees to the Commissioner. This small change should avoid any potential problem similar to the recent Workers Compensation Supreme Court Decision in the Sedlak v. Dick case.

2. Page 11 and page 12 -- Correct two technical areas.

   The first on page 11 deals with the required notice of basic coverage documentation to be in the manner and the form prescribed by the Board of Governors, not the Commissioner.

   The change on page 12 relates to documentation of professional liability coverage for those providers whose Fund coverage has been terminated from Fund coverage.

3. Revisions set forth in Section 3, pages 12 through 14, relate to the administration of the availability plan for the required basic professional liability insurance coverage. These revisions are intended to leave the principle regulatory authority with the Commissioner but to provide a means for the Fund's Board of Governors to review any plan submitted and make specific recommendations to the Commissioner. The Commissioner would then be required to approve or disapprove those plans consistent with the Board of Governor's recommendations.

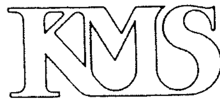
4. Section 4, pages 14 to 17. The existing provisions of K.S.A. 40-3414 regarding self-insurance authorization are presently under the Commissioner's authority. Revisions set forth in this bill change self-insurance authorization for the basic professional liability coverage to be the responsibility of the Board of Governors rather than the Commissioner's.

5. The remaining changes set forth in Sections 5 and 6 appear to correct technical oversights which were omitted from the 1994 legislation.

   Section 5 relates to reporting requirements for providers suspected to be in violation of the Fund law.

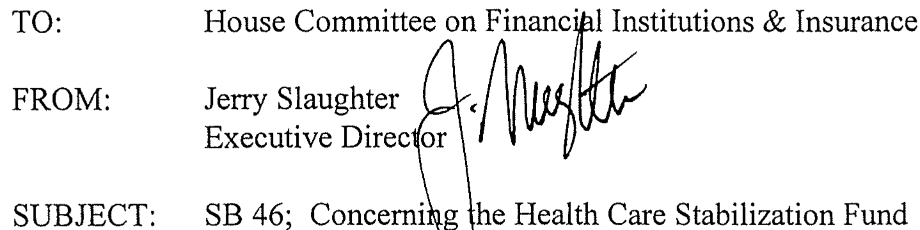
   Section 6 provides for the reporting of medical malpractice claim information to the Board of Governors, not the Commissioner.

We will be pleased to respond to any questions regarding these proposed revisions.



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

March 14, 1995



TO: House Committee on Financial Institutions & Insurance

FROM: Jerry Slaughter
Executive Director

SUBJECT: SB 46; Concerning the Health Care Stabilization Fund

The Kansas Medical Society appreciates the opportunity to appear today in support of SB 46, which makes technical changes to the Health Care Provider Insurance Availability Act. The amendments contained in SB 46 are designed to complete the transfer of responsibility for operating the HCSF from the Commissioner of Insurance to the Fund's Board of Governor's. This process was initiated be last year's legislature, and this bill merely cleans up some of the details that were overlooked.

Established in 1976 to provide professional liability insurance coverage to health care providers, the Fund has operated successfully throughout almost two decades of often stormy and volatile market conditions. There are no state tax dollars in the Fund. It is entirely supported by premiums (surcharges) paid by physicians, hospitals and other health care providers. At January 31, 1995, the Fund had a balance of $192 million, and was in very sound financial shape. During its existence, the Fund has paid out almost $200 million in settlements and judgments.

The Fund is embarking on a new path this year, as last year the Legislature enacted legislations to transfer its operations from the Insurance Commissioner's jurisdiction to its own Board of Governors, a move we support. The bill before you today helps complete that transition, and we urge your support. Thank you for the opportunity to offer these comments.

FI&I
Attachment 8
March 14, 1995

# KaMMCO

## KANSAS MEDICAL MUTUAL INSURANCE COMPANY

TO: House Financial Institutions and Insurance Committee

FROM: Lori Callahan, General Counsel

RE: S.B. 46

DATE: March 14, 1995

The Kansas Medical Mutual Insurance Company, KaMMCO, is a Kansas domestic physician-owned, professional liability insurance company formed by the Kansas Medical Society. KaMMCO currently insures over 1,000 Kansas physicians and is the largest insurer of physicians in the state. KaMMCO is also the servicing carrier for the statutorily created Kansas Health Care Provider Insurance Availability Plan, a joint underwriting association for Kansas health care providers.

KaMMCO supports S.B. 46. In 1994 legislation was enacted which made the Kansas Health Care Stabilization Fund independent of the Kansas Insurance Department. This was done to reflect the autonomy of the Fund, which is solely supported by Kansas health care providers, and receives no state funds. This was the first major reconsideration of the Fund since its creation in the 1970's. In so doing, there were minor technical issues which were not addressed, but have become apparent since the Fund became independent January 1, 1995. These technical matters are consistent with and necessary for the full enactment of the 1994 legislation. Accordingly, KaMMCO urges this committee to vote this bill favorable for passage.

House FI&I
Attachment 9
March 14, 1995

*Endorsed by the Kansas Medical Society*

623 W. TENTH ST.-STE. 200 • TOPEKA, KANSAS 66612
913-232-2224 / 800-232-2259 / 913-232-4704 (FAX)

**Kansas Insurance Department**
Kathleen Sebelius, Commissioner
420 SW 9th
Topeka, Kansas 66612-1678 (913) 296-3071

TO: House Financial Institutions and Insurance Committee

FROM: Richard G. Huncker
Accident and Health Supervisor

SUBJECT: Senate Bill 126 As Amended by Senate Committee of the Whole

DATE: March 14, 1995

Senate Bill No. 126 as amended would amend K.S.A. Supp. 40-2209(A). This bill is a coverage enhancement that would permit certain individuals, under specific circumstance, to enroll in group sickness and accident plans providing hospital, medical or surgical expense benefits after the end of an open enrollment period without being required to provide evidence of insurability.

The proposed late enrollee amendments (a thru c) are identical to those permitted in the Kansas Small Employer Group Insurance law, K.S.A. 1994 Supp. 40-2209d(q).

There should be minimal or no premium adjustments as a result of the passage of this bill.

We urge the Committee to favorably consider passage of Senate Bill No. 126.

RGH:crah
1423

FII
Attachment 10
3-14-95

# M E M O R A N D U M

TO: The Honorable Bill Bryant, Chairman
House Financial Institutions and Insurance Committee

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

DATE: March 14, 1995

RE: S.B. 126

---

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 300 insurance companies that write over 80% of the health insurance in the United States today. Please accept this memorandum as our testimony in regard to S.B. 126. S.B. 126 is an amendment to the group sickness and accident insurance laws within the State of Kansas. The proposed amendment would expand the ability of an insured to gain access to group insurance from outside of that individual's enrollment period.

Certainly, we recognize that this is a public policy decision that the legislature must make. We recognize that on balance you must look at the types of criteria an individual must meet in order to gain access to health insurance. However, we believe it is equally important that the legislature recognize that on the other side of the equation is the issue that some "gatekeeping" mechanism is necessary in all forms of insurance to protect the total insured population from adverse selection. Any time you lessen the requirements for access, those gatekeeping provisions become less effective and more susceptible to adverse selection.



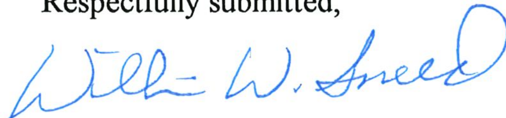
House FI&I
Attachment 11
3-14-95

Certainly, several of the items listed in the amendment are being proposed because of an action not within the control of the insurer. However, in the original proposal on page two, lines three through five, the amendment would have allowed an individual to switch coverages if such coverages were provided in a "cafeteria" arrangement.

A cafeteria plan is generally recognized as an insured looking at several options and composing an insurance program best suited for his or her needs. By allowing an individual to move freely through the cafeteria plans and not during the time of enrollment, an individual could procure a high deductible, bare-bones policy and, prior to a known event, switch over to a low dollar deductible, high benefit package in order to cover a specific (and anticipated) event. My client was opposed to this section, and the Senate Committee agreed.

As we have stated, we recognize that it is a public policy decision on the access criteria used in insurance programs. We certainly realize that that must be balanced in the totality of any program. However, we must urge the Committee to move cautiously when loosening access criteria, and in particular, we strongly urge that the Senate Committee action, deleting new subsection (2), be maintained.

Respectfully submitted,



William W. Sneed



GEHRT & ROBERTS, CHARTERED
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Topeka, Kansas 66604-0306
(913) 273-7722
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Department of Social and Rehabilitation Services
Child Support Enforcement Program

House Financial Institutions & Insurance Committee
March 14, 1995

**Senate Bill 126**
Related to health insurance

Mr. Chairman and members of the committee, thank you for the opportunity to testify on behalf of Secretary Schalansky today concerning Senate Bill 126.

One of the primary responsibilities of the SRS Child Support Enforcement Program is to help children by obtaining health insurance coverage. As many of you are aware, CSE's duties concerning medical coverage were greatly expanded by the Congress in the Omnibus Budget Reconciliation Act of 1993 (OBRA '93). The main thrust of the 1993 law was to ensure access to group health coverage for children not living with the covered parent.

If the covered parent is ordered to enroll the child in a group plan, OBRA requires that the parent be able to enroll the child "without regard to any enrollment season restrictions." A copy of the OBRA text is attached for reference (Attachment A). We are concerned that the current wording on page 2, lines 10 and 11, creates a new enrollment season restriction by limiting such enrollments to the first 31 days following entry of the medical support order.

Enrollment season restrictions have an important function in limiting a plan's administrative costs and in preserving a plan's actuarial soundness. Unless the mandate in OBRA '93 is changed, however, we believe that the proposed limitation on enrollment puts Kansas at serious risk of being out of compliance with state plan requirements for Title XIX (Medicaid).

If Kansas' Title XIX state plan were found out of compliance, Kansas could be subjected to suspension of all Title XIX funding with an ultimate penalty of $250 million per year. If, instead, federal regulators applied a statistical disallowance of funding for children not enrolled because of the 31-day limitation, the sanction could still be expected to exceed $350,000 per year.

On a practical note, medical support orders are only entered or modified two or three times throughout a child's minority. Many of CSE's obligated parents change jobs much more frequently, forcing us to play "catch up" with them. In our experience, locating a new employer rarely coincides with the employer's open enrollment period. Under these conditions, even the 31-day grace period would not help prevent expenditure of medicaid funds for the child.

For these reasons, we urge the committee to consider the attached amendment to SB 126 (Attachment B). Thank you for your continued interest in the needs and well-being of children.

Respectfully submitted,

Jamie L. Corkhill
Policy Counsel
Child Support Enforcement
296-3237

FI&I
Attachment 12
3-14-95

(P.L. 103-66)
signed 8/10/93



*SEC. 13623. MEDICAL CHILD SUPPORT.*

*(a) STATE PLAN REQUIREMENT.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—*

*(1) by striking "and" at the end of paragraph (54);*

*(2) in the paragraph (55) inserted by section 4602(a)(3) of OBRA–1990, by striking the period at the end and inserting a semicolon;*

*(3) by redesignating the paragraph (55) inserted by section 4604(b)(3) of OBRA–1990 as paragraph (56), by transferring and inserting it after the paragraph (55) inserted by section 4602(a)(3) of such Act, and by striking the period at the end and inserting a semicolon;*

*(4) by placing paragraphs (57) and (58), inserted by section 4751(a)(1)(C) of OBRA–1990, immediately after paragraph (56), as redesignated by paragraph (3);*

*(5) in the paragraph (58) inserted by section 4751(a)(1)(C) of OBRA–1990, by striking the period at the end and inserting a semicolon;*

*(6) by redesignating the paragraph (58) inserted by section 4752(c)(1)(C) of OBRA–1990 as paragraph (59) and by transferring and inserting it after the paragraph (58) inserted by section 4751(a)(1)(C) of such Act, and by striking the period at the end and inserting "; and"; and*

*(7) by inserting after paragraph (59) the following new paragraph:*

*"(60) provide that the State agency shall provide assurances satisfactory to the Secretary that the State has in effect the laws relating to medical child support required under section 1908.".*

*(b) MEDICAL CHILD SUPPORT LAWS.—Title XIX (42 U.S.C. 1936 et seq.) is amended by inserting after section 1907 the following new section:*

*"REQUIRED LAWS RELATING TO MEDICAL CHILD SUPPORT*

*"SEC. 1908. (a) IN GENERAL.—The laws relating to medical child support, which a State is required to have in effect under section 1902(a)(60), are as follows:*

*"(1) A law that prohibits an insurer from denying enrollment of a child under the health coverage of the child's parent on the ground that—*

*"(A) the child was born out of wedlock,*

Attachment "A"

"(B) the child is not claimed as a dependent on the parent's Federal income tax return, or

"(C) the child does not reside with the parent or in the insurer's service area.

"(2) In any case in which a parent is required by a court or administrative order to provide health coverage for a child and the parent is eligible for family health coverage through an insurer, a law that requires such insurer—

"(A) to permit such parent to enroll under such family coverage any such child who is otherwise eligible for such coverage (without regard to any enrollment season restrictions);

"(B) if such a parent is enrolled but fails to make application to obtain coverage of such child, to enroll such child under such family coverage upon application by the child's other parent or by the State agency administering the program under this title or part D of title IV; and

"(C) not to disenroll (or eliminate coverage of) such a child unless the insurer is provided satisfactory written evidence that—

"(i) such court or administrative order is no longer in effect, or

"(ii) the child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the effective date of such disenrollment.

"(3) In any case in which a parent is required by a court or administrative order to provide health coverage for a child and the parent is eligible for family health coverage through an employer doing business in the State, a law that requires such employer—

"(A) to permit such parent to enroll under such family coverage any such child who is otherwise eligible for such coverage (without regard to any enrollment season restrictions);

"(B) if such a parent is enrolled but fails to make application to obtain coverage of such child, to enroll such child under such family coverage upon application by the child's other parent or by the State agency administering the program under this title or part D of title IV; and

"(C) not to disenroll (or eliminate coverage of) any such child unless—

"(i) the employer is provided satisfactory written evidence that—

"(I) such court or administrative order is no longer in effect, or

"(II) the child is or will be enrolled in comparable health coverage which will take effect not later than the effective date of such disenrollment, or

"(ii) the employer has eliminated family health coverage for all of its employees; and

"(D) to withhold from such employee's compensation the employee's share (if any) of premiums for health coverage (except that the amount so withheld may not exceed the maximum amount permitted to be withheld under section 303(b) of the Consumer Credit Protection Act), and to pay such share of premiums to the insurer, except that the Secretary may provide by regulation for appropriate circumstances under which an employer may withhold less than such employee's share of such premiums.

"(4) A law that prohibits an insurer from imposing requirements on a State agency, which has been assigned the rights of an individual eligible for medical assistance under this title and covered for health benefits from the insurer, that are different from requirements applicable to an agent or assignee of any other individual so covered.

"(5) A law that requires an insurer, in any case in which a child has health coverage through the insurer of a noncustodial parent—

"(A) to provide such information to the custodial parent as may be necessary for the child to obtain benefits through such coverage;

"(B) to permit the custodial parent (or provider, with the custodial parent's approval) to submit claims for covered services without the approval of the noncustodial parent; and

"(C) to make payment on claims submitted in accordance with subparagraph (B) directly to such custodial parent, the provider, or the State agency.

"(6) A law that permits the State agency under this title to garnish the wages, salary, or other employment income of, and requires withholding amounts from State tax refunds to, any person who—

"(A) is required by court or administrative order to provide coverage of the costs of health services to a child who is eligible for medical assistance under this title,

"(B) has received payment from a third party for the costs of such services to such child, but

"(C) has not used such payments to reimburse, as appropriate, either the other parent or guardian of such child or the provider of such services;

to the extent necessary to reimburse the State agency for expenditures for such costs under its plan under this title, but any claims for current or past-due child support shall take priority over any such claims for the costs of such services.

"(b) DEFINITION.—For purposes of this section, the term 'insurer' includes a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, a health maintenance organization, and an entity offering a service benefit plan.".

(c) EFFECTIVE DATE.—(1) Except as provided in paragraph (2), the amendments made by this section apply to calendar quarters beginning on or after April 1, 1994, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) In the case of a State plan under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the preceding sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

# SENATE BILL No. 126

By Financial Institutions and Insurance

1-26

12 AN ACT concerning accident and sickness insurance; late enrollees;
13 amending K.S.A. 1994 Supp. 40-2209 and repealing the existing
14 section.
15
16 *Be it enacted by the Legislature of the State of Kansas:*
17 Section 1. K.S.A. 1994 Supp. 40-2209 is hereby amended to read as
18 follows: 40-2209. (A) Group sickness and accident insurance is declared
19 to be that form of sickness and accident insurance covering groups of
20 persons, with or without one or more members of their families or one
21 or more dependents. Except at the option of the employee or member
22 and except employees or members enrolling in a group policy after the
23 close of an open enrollment opportunity, no individual employee or mem-
24 ber of an insured group and no individual dependent or family member
25 may be excluded from eligibility or coverage under a policy providing
26 hospital, medical or surgical expense benefits both with respect to policies
27 issued or renewed within this state and with respect to policies issued or
28 renewed outside this state covering persons residing in this state. For
29 purposes of this section, an open enrollment opportunity shall be deemed
30 to be a period no less favorable than a period beginning on the employee's
31 or member's date of initial eligibility and ending 31 days thereafter. *An*
32 *eligible employee, member or dependent who requests enrollment follow-*
33 *ing the open enrollment opportunity shall be considered a late enrollee.*
34 *However, an eligible employee, member or dependent shall not be consid-*
35 *ered a late enrollee if:*
36 *(1) The individual:*
37 *(a) Was covered under another group policy which provided hospital,*
38 *medical or surgical expense benefits at the time the individual was eligible*
39 *to enroll;*
40 *(b) states, at the time of the open enrollment period, that coverage*
41 *under another group policy which provided hospital, medical or surgical*
42 *expense benefits was the reason for declining enrollment;*
43 *(c) has lost coverage under another group policy providing hospital,*

Attachment "B"

12-6

1 *medical or surgical expense benefits as a result of the termination of em-*
2 *ployment, the termination of the other policy's coverage, death of a spouse*
3 *or divorce; and*
4 *(d) requests enrollment within 31 days after the termination of cov-*
5 *erage under the other policy;* **or**
6 ~~(2) the individual is employed by an employer who offers multiple~~
7 ~~health benefit plans and the individual elects a different health benefit~~
8 ~~plan during an open enrollment period; or~~
9 ~~(3)~~ *(2) a court has ordered coverage to be provided for a spouse or*
10 *minor child under a covered employee's or member's policy* ~~and request~~
11 ~~for enrollment is made within 31 days after issuance of such court order~~. — delete
12 No group policy providing hospital, medical or surgical expense benefits
13 issued or renewed within this state or issued or renewed outside this state
14 covering residents within this state shall limit or exclude benefits for spe-
15 cific conditions existing at or prior to the effective date of coverage there-
16 under. Such policy may impose a waiting period, not to exceed 90 days
17 for benefits for conditions, including related conditions, for which diag-
18 nosis, treatment or advice was sought or received in the 90 days prior to
19 the effective date of coverage. Such policy shall waive such a waiting
20 period to the extent the employee or member or individual dependent
21 or family member was covered by a group or individual sickness and
22 accident policy, coverage under section 607(1) of the employees retire-
23 ment income act of 1974 (ERISA), a group specified in K.S.A. 40-2222
24 and amendments thereto or a group subject to K.S.A. 12-2616 *et seq*. and
25 amendments thereto which provided hospital, medical and surgical ex-
26 pense benefits within 31 days prior to the effective date of coverage with
27 no gap in coverage. Any group policy may impose participation require-
28 ments, define full-time employees or members and otherwise be designed
29 for the group as a whole through negotiations between the group sponsor
30 and the insurer to the extent such design is not contrary to or inconsistent
31 with this act and may be issued to such group upon the following basis:
32 ~~(1)~~ ~~*(4)*~~ *[(3)]* Under a policy issued to an employer or trustees of a
33 fund established by an employer, who is the policyholder, insuring at least
34 three employees of such employer, for the benefit of persons other than
35 the employer. The term "employees" shall include the officers, managers,
36 employees and retired employees of the employer, the partners, if the
37 employer is a partnership, the proprietor, if the employer is an individual
38 proprietorship, the officers, managers and employees and retired em-
39 ployees of subsidiary or affiliated corporations of a corporation employer,
40 and the individual proprietors, partners, employees and retired employ-
41 ees of individuals and firms, the business of which and of the insured
42 employer is under common control through stock ownership contract, or
43 otherwise. The policy may provide that the term "employees" may include

12-87

(remaining pages omitted)

Section 2. K.S.A. 1994 Supp. 40-2209d is hereby amended read as follows:

12-8

40-2209d. As used in this act:

(a) "Actuarial certification" means a written statement by a member of the American academy of actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of K.S.A. 40-2209h *and amendments thereto*, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(b) "Approved service area" means a geographical area, as approved by the commissioner to transact insurance in this state, within which the carrier is authorized to provide coverage.

(c) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business, by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

(d) "Basic small employer health care plan" means a health benefit plan developed by the board pursuant to K.S.A. 40-2209k *and amendments thereto*.

(e) "Board" means the board of directors of the program.

(f) "Carrier" or "small employer carrier" means any insurance company, nonprofit medical and hospital service corporation, nonprofit optometric, dental, and pharmacy service corporations, municipal group-funded pool, fraternal benefit society or health maintenance organization, as these terms are defined by the Kansas Statutes Annotated, that offers health benefit plans covering eligible employees of one or more small employers in this state.

(g) "Case characteristics" means, with respect to a small employer, the geographic area in which the employees reside; the age and sex of the individual employees and their dependents; the appropriate industry classification as determined by the carrier, and the number of employees and dependents and such other objective criteria as may be approved family composition by the commissioner. "Case characteristics" shall not include claim experience, health status and duration of coverage since issue.

(h) "Class of business" means all or a separate grouping of small employers established pursuant to K.S.A. 40-2209g *and amendments thereto*.

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

(j) "Department" means the insurance department.

(k) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health benefits plan covering such employee and the dependent eligibility standards established by the board.

(l) "Eligible employee" means an employee who works on a full-time basis, with a normal work week of 30 or more hours, and includes a sole proprietor, a partner of a partnership or an independent contractor, provided such sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer but does not include an employee who works on a part-time, temporary or substitute basis.

(m) "Financially impaired" means a member which, after the effective date of this act, is not insolvent but is:

(1) Deemed by the commissioner to be in a hazardous financial condition pursuant to K.S.A. 40-222d and amendments thereto; or

(2) placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(n) "Health benefit plan" means any hospital or medical expense policy, health, hospital or medical service corporation contract, and a plan provided by a municipal group-funded pool, or a health maintenance organization contract offered by an employer or any certificate issued under any such policies, contracts or plans. "Health benefit plan" does not include policies or certificates covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, specified disease, vision care, coverage issued as a supplement to liability insurance, insurance arising out of a workers compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable

with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(o) "Index rate" means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(p) "Initial enrollment period" means the period of time specified in the health benefit plan during which an individual is first eligible to enroll in a small employer health benefit plan. Such period shall be no less favorable than a period beginning on the employee's or member's date of initial eligibility and ending 31 days thereafter.

12-9

§2(2)

1-21-10

(q) "Late enrollee" means an eligible employee or dependent who requests enrollment in a small employer's health benefit plan following the initial enrollment period provided under the terms of the first plan for which such employee or dependent was eligible through such small employer, however an eligible employee or dependent shall not be considered a late enrollee if:

(1) the individual:

(A) Was covered under another employer-provided health benefit plan at the time the individual was eligible to enroll;

(B) states, at the time of the initial eligibility, that coverage under another employer health benefit plan was the reason for declining enrollment;

(C) has lost coverage under another employer health benefit plan as a result of the termination of employment, the termination of the other plan's coverage, death of a spouse, or divorce; and

(D) requests enrollment within 31 days after the termination of coverage under another employer health benefit plan; or

(2) the individual is employed by an employer who offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period; or

(3) a court has ordered coverage to be provided for a spouse or minor child under a covered employee's plan ~~and request for enrollment is made within 31 days after issuance of such court order~~. — delete

(r) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or which could have been charged or offered, by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(s) "Plan of operation" means the articles, bylaws and operating rules of the program adopted by the board pursuant to K.S.A. 40-2209l *and amendments thereto*.

(t) "Preexisting conditions provision" means a policy provision which excludes or limits coverage for charges or expenses incurred during a specified period not to exceed ~~one year~~ *90 days* following the insured's effective date of coverage as to a condition or related conditions for which diagnosis, treatment or advice was sought or received in the six months immediately preceding the effective date of coverage.

(u) "Premium" means moneys paid by a small employer or eligible employees or both as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

(v) "Program" means the Kansas small employer health reinsurance program, established under K.S.A. 40-2209l *and amendments thereto*.

§2(3)

(w) "Rating period" means the calendar period for which pre-ium rates established by a small employer carrier are assumed to e in effect but any period of less than one year shall be considered as a full year.

(x) "SEHC plan" means the Kansas small employer health care plan which shall be a health benefit plan for small employers established by the board in accordance with K.S.A. 40-2209k *and amendments thereto*.

(y) "Service waiting period" means a period of time after full-time employment begins before an employee is first eligible to enroll in any applicable health benefit plan offered by the small employer.

(z) "Small employer" means any person, firm, corporation, partnership or association eligible for group sickness and accident insurance pursuant to subsection (A) of K.S.A. 40-2209 and amendments thereto actively engaged in business whose total employed work force consisted of, on at least ~~50 percent~~ *50%* of its working days during the preceding year, no more than ~~25~~ *50* eligible employees, the majority of whom were employed within the state. In determining the number of eligible employees, companies which are affiliated companies or which are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer. Except as otherwise specifically provided, provisions of this act which apply to a small employer which has a health benefit plan shall continue to apply until the plan anniversary following the date the employer no longer meets the requirements of this definition.

(aa) "Standard small employer health care plan" means a basic SEHC plan with specified benefit enhancements and such deductible and coinsurance provisions as may be developed by the board pursuant to K.S.A. 40-2209k *and amendments thereto*.

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

§2(4)

# CHILD SUPPORT ENFORCEMENT PROGRAM (CSE)

In 1975 the Congress enacted Title IV-D of the Social Security Act to counter the ballooning tax burden of public assistance for children left unsupported by one or both parents, and to improve the lives of the one in five children living in poverty. Federal law requires each state to establish an effective statewide child support program: (1) to improve the quality of life for children; (2) to reduce the costs for Aid to Families with Dependent Children (AFDC), foster care, and medical assistance; (3) to help families become independent of public assistance; and (4) to return the responsibility of supporting children to parents whenever possible.

The Kansas CSE Program is a joint federal, state, and county operation which must satisfy numerous specific federal requirements concerning all phases of operation. CSE must provide a full range of support services, from establishing orders through modifying and enforcing them, in two basic types of cases:

1) Public Assistance (PA) - When a child's custodian applies for public assistance, the family's child and medical support rights are assigned to the State. If CSE collects support in an AFDC case, the first $50 of current support is passed on directly to the family. The rest, and any collection of past due support, is used to reimburse the state and federal governments for the public assistance provided to the child's family. All support collections in excess of the claim for reimbursement go to the family.

2) Non-PA - As required by federal law, the same child and medical support services are available to anyone, regardless of income, who applies for support enforcement services. The idea is to prevent the need for public assistance by insuring reliable support payments, and also to provide equal treatment for all children. It is important to note that approximately 60% of Non-PA cases have received AFDC in the past.

By operating a program in compliance with federal requirements, Kansas qualifies for three types of federal IV-D funding:

1) Kansas is entitled to keep 41% of support collected to reimburse AFDC expenses;
2) Kansas is reimbursed for 66% of eligible IV-D administrative costs; and
3) Kansas earns incentives, ranging from 6 to 10% of support collections. The incentive for Non-PA work is limited to 115% of the PA incentive.

By using available funding mechanisms, the Kansas CSE Program has always been a cost effective, revenue producing program.

The Department of Social and Rehabilitation Services (SRS) is the designated Title IV-D agency for the State of Kansas. The current CSE caseload consists of approximately 120,000 IV-D cases serving at least a quarter million individuals.

SRS provides IV-D services in all areas of the state through 487 full time and 26 part time staff and through contracts with several county and district attorneys; the Office of Judicial Administration, for the services of 17 district court trustees; and private contractors, such as collection agencies, credit bureaus, and process servers.

Over the past eight years Kansas IV-D collections have grown by 460%, from $20 million in

FY87 to over $92 million in FY94. Kansas has been recognized as one of the top ten states nationally in terms of percentage increases in collections. Enactment of beneficial state legislation, enhancement of program and legal staff, and implementation of the KAECSES computer system were major factors in this impressive growth. In FY94 alone, over $27 million in public assistance grants were reimbursed due to IV-D actions.

Cost avoidance, another fiscal benefit, results when CSE's monthly support collections exceed the AFDC grant and trigger closure of the AFDC case. To reduce the family's risk of returning to AFDC dependence, CSE services automatically continue. IV-D collection efforts during FY94 resulted in the closure of over 4000 AFDC cases.

The Title IV-D program also establishes thousands of medical support (health insurance) orders each year and shares health insurance information with the Medicaid Program. This allows medicaid costs to be billed to the responsible insurer, instead of to taxpayers.

Paternity establishment plays a vital role in SRS' mission by enhancing the child's financial and social resources and by allowing recovery of state-paid birth expenses. Paternity establishment and educational outreach also positively affect the teen pregnancy problem by highlighting parental responsibility. Many children benefit each year from having their parentage clearly established, giving them access to cash and medical support as well as to family medical information and potential inheritance or other rights. In FY94 CSE established paternity for nearly 8000 children, up from 835 in FY87.

Initiatives currently being pursued include:

- **Enhanced computerization** -- establishing a federally certified, statewide child support computer system by October 1, 1995.

- **Privatization** -- using private sector resources whenever appropriate functions can be performed more efficiently or effectively through a contractual arrangement.

- **Implementation of Welfare Reform** -- expanding CSE services for recipients of medical, food stamps, or child care assistance to help them achieve financial independence.

- **Implementation of cost-recovery fee** -- establishing a modest cost recovery fee in non public assistance cases, including incoming interstate cases, to insure compliance with federal requirements.

- **In-hospital paternity establishment** -- encouraging hospitals to seek voluntary acknowledgements of paternity at the time of birth for children born out of wedlock.

- **Medical support enforcement** -- requiring absent parents to actually provide coverage for their children when group insurance coverage is available at an affordable cost.

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# Kansas Insurance Department

**Kathleen Sebelius, Commissioner**
420 SW 9th Street
Topeka, Kansas 66612-1678 (913) 296-3071

TO: House Committee on Financial Institutions and Insurance

FROM: Patrick Mulvihill, Assistant Chief Examiner
Kansas Insurance Department

RE: SB 125 (Investment in Money Market Mutual Funds)

DATE: March 14, 1995

Under current law, an insurance company may invest in money market mutual funds. The statutes limit aggregate investment by an insurance company in common stocks and money market mutual funds to 25% of the total assets of the company unless the money market fund has the following types of investments in its portfolio: (a) District of Columbia, territorial, municipal, state or federal bonds or notes; (b) Canadian municipal, provincial or governmental obligations; (c) certain foreign government obligations; or (d) corporate securities or notes.

In addition, insurers are permitted to invest their funds in repurchase agreements. A repurchase agreement is a short term investment contract where an entity such as a bank agrees to sell an asset (typically securities, bonds or notes) and to also repurchase that asset at the expiration of the agreement. The types of repurchase agreements which insurance companies can invest in must be secured by either government or corporate obligations, as referred to in (a) through (d) above.

The purpose of S.B. 125 is to allow insurance companies to invest in money market mutual funds which in turn invest in repurchase agreements. Since insurers can directly invest in repurchase agreements, it is logical to allow them to place their moneys in money market mutual funds which invest in repurchase agreements.

House FI&I
Attachment 13
3-14-95

# MEMORANDUM

TO: The Honorable Bill Bryant, Chairman
House Financial Institutions and Insurance Committee

FROM: William W. Sneed, Legislative Counsel
American Investors Life Insurance Company

DATE: March 14, 1995

RE: S.B. 125

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Mr. Chairman, Members of the Committee: My name is Bill Sneed and I represent American Investors Life Insurance Company. American Investors is a wholly-owned subsidiary of AmVestors Financial Corporation. American Investors is an insurance company predominantly active in the annuity business and is a domestic insurer within the State of Kansas.

S.B. 125 would be an amendment to K.S.A. 40-2b24, which is a part of the investment code for life insurance companies. The amendment as proposed by the Kansas Insurance Department would allow the investment in money market mutual funds not being subject to the limitations found in K.S.A. 40-2b21. Simply, this amendment would allow life insurance companies to invest in money market mutual funds that invest the funds in repurchase agreements. Such an investment would be authorized so long as the money market mutual fund met the definition of "qualified investment" as set out in other portions of the investment code. This proposed amendment would clarify the current statute on such investments and would maintain with insurance companies the ability to invest funds in an area that has generally been accepted for insurance company investments. Finally, such investments would still have to meet the investment code criteria, and such, the Insurance Department would still retain oversight of the totality of the investments.



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Thus, on behalf of my client, we support S.B. 125 and respectfully request your favorable consideration.

Respectfully submitted,

William W. Sneed



5601 S.W. Barrington Court South
P.O. Box 4306
Topeka, Kansas 66604-0306
(913) 273-7722
(913) 273-8560

# MEMORANDUM

TO: The Honorable Bill Bryant, Chairman
House Financial Institutions and Insurance Committee

FROM: William W. Sneed, Legislative Counsel
American Investors Life Insurance Company

DATE: March 14, 1995

RE: S.B. 345

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Mr. Chairman, Members of the Committee: My name is Bill Sneed and I represent American Investors Life Insurance Company. American Investors is a wholly-owned subsidiary of AmVestors Financial Corporation. American Investors is an insurance company predominantly active in the annuity business and is a domestic insurer within the State of Kansas.

S.B. 345 is an amendment to K.S.A. 40-2b25. You will note that the bill strikes all current language found in K.S.A. 40-2b25 and replaces it with all new language. As I will explain later in my testimony, it was determined to be more straightforward to insert all new language. If we were to strike and insert new language throughout the current statute it would become rather confusing, and it is our belief that those activities currently allowed under K.S.A. 40-2b25 will continue to be allowed, along with some additional investment authority.

The purpose of this bill is to insert the latest language developed by the National Association of Insurance Commissioners ("NAIC") Model Investment Code on this particular subject. Currently, the Model Investment Code is being redrafted by the NAIC. The provisions that deal directly with S.B. 345 have been agreed upon, but other areas of the Investment Code have not been concluded, and it is anticipated that the earliest the entire model bill will be



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sometime toward the end of 1995. We believe that the authority granted under S.B. 345 is needed by Kansas insurers, and as such, we are requesting that this particular provision of the model legislation be enacted at this time.

In a nutshell, this proposal will allow any domestic life insurance company to invest, subject to review by the Kansas Insurance Department and statutory restrictions, in financial instruments which provide hedging transactions and certain income generation transactions. In essence, this bill allows an insurance company to invest in financial instruments which provide safeguards from interest rate volatility.

My client provides interest-sensitive insurance products to its customers. These products provide an interest rate which must be closely matched to the interest my client receives on its investments. Until recently, the economy has found itself in a downward trend on interest rates. As such, the need for this type of investment has not been of great urgency. However, we now find ourselves with an interest rate upswing, and it is because of that upswing that my client wishes to invest in these types of products so as to minimize its risk from substantial increases and/or decreases in interest rates.

I have attached illustrations which go through the various types of financial instruments that would be allowed under this Act. Suffice to say we believe these illustrations demonstrate that the investment in these financial instruments provides a type of "insurance" for the insurance company, and as such, creates protection for our consumers, the policyholders.

Obviously, investing in these types of securities takes a specialized investment manager. To that end, the model law requires that the insurance company must be able to


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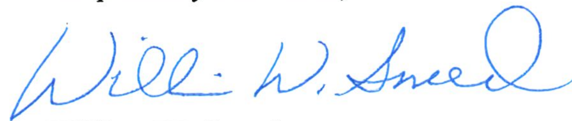
demonstrate to the Commissioner of Insurance the intended characteristics of the financial instrument, along with the ongoing effectiveness of the investment.

Additionally, subsection (c) of the bill limits the amount a domestic insurance company may invest of its portfolio in these types of investments. Thus, you will have ongoing review by the Insurance Department of these investments prior to and during the course of holding the investments, along with the overall cap that is instituted in S.B. 345.

Again, we appreciate the Committee's allowing us to present testimony as a proponent of this bill. We believe the proposal provides greater flexibility to its domestic insurance companies, and at the same time, creates additional safeguards for various investments that insurance companies may make that may be interest-sensitive.

Thank you very much, and we respectfully request your favorable treatment of S.B. 345.

Respectfully submitted,



William W. Sneed

**GEHRT & ROBERTS, CHARTERED**
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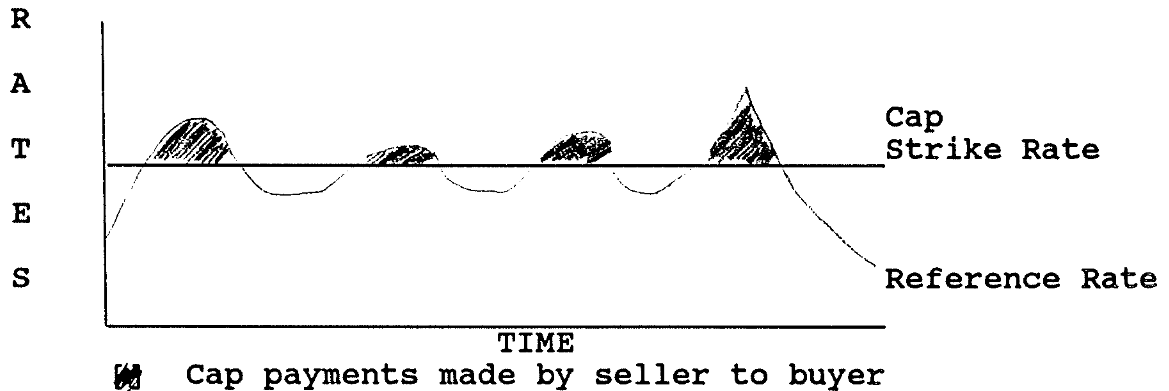
# CAPS

Definition- A Cap is an agreement between a seller (writer) and a buyer (holder), obliging the seller to make payments to the buyer, for each reset period that the reference rate exceeds the strike rate. Payments are determined by taking the notional amount times the difference between the reference rate and the strike rate. Cap payments cannot go negative.

Use: Caps are interest rate hedges that protect the holder during periods of rising interest rates by providing increasing income as rates increase above the Cap strike rate.

## RANDOM RATE MODEL

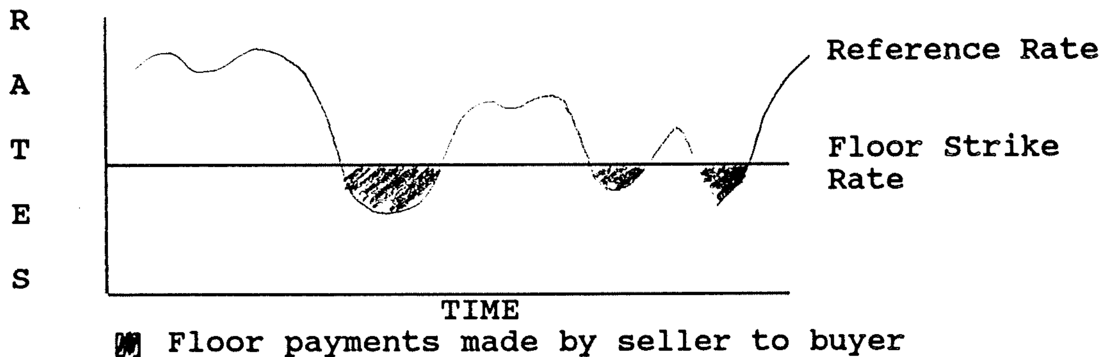


FLOORS

Definition- A Floor is an agreement between a seller (writer) and a buyer (holder), obliging the seller to make payments to the buyer, for each reset period that the strike rate exceeds the reference rate. Payments are determined by taking the notional amount times the difference between the strike rate and the reference rate. Floor payments cannot go negative.

Use: Floors are interest rate hedges that protect the holder during periods of falling interest rates by providing <u>increasing income</u> as <u>rates decrease</u> beneath the Floor strike rate.

RANDOM RATE MODEL



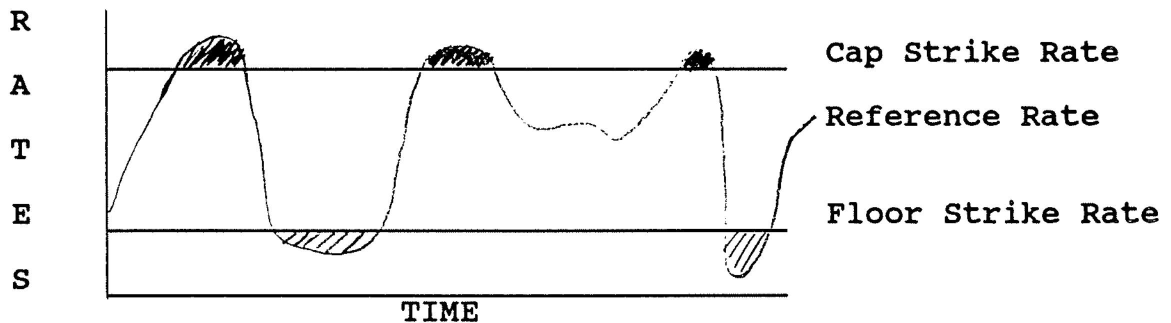

Floor payments made by seller to buyer

# COLLAR

Definition- A Collar is an agreement between a seller (writer) and a buyer (holder), obliging the seller to make payments to the buyer for each reset period in which the reference rate exceeds the Cap strike rate, and the buyer to make payments to the seller each reset period the Floor strike rate exceeds the reference rate. The holder of a Collar is a buyer of a Cap and a seller of a Floor.

Use: Collars are interest rate hedges which provide increasing income as rates rise, and decreasing income as rates fall. When the reference rate is between the Cap strike rate and the Floor strike rate, income is unchanged.

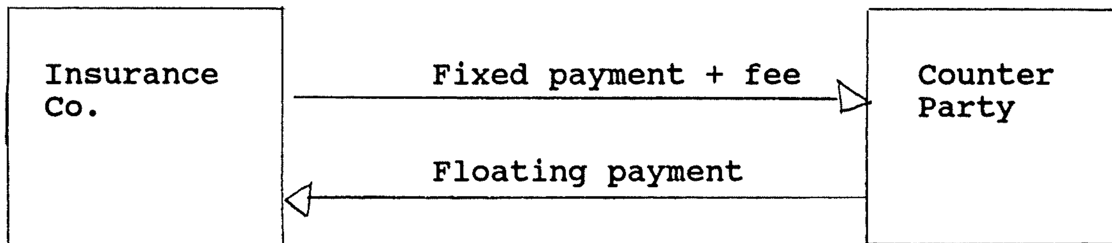
## RANDOM RATE MODEL



## SWAPS

Definition- An interest rate Swap is an agreement between two parties in which the parties exchange coupons or interest payments based on a notional amount. Most interest rate Swaps involve the exchange of fixed coupon payments for floating coupon payments. However, floating-to-floating interest rate Swaps are not unusual. The following illustration assumes a fixed-to-floating Swap.

### SWAP DIAGRAM




Use: Swaps are used to convert fixed rate assets into floating rate assets. This would typically be done when a company has floating rate liabilities. They may also be used to convert floating rate assets into fixed rate assets.

**Kansas Insurance Department**
**Kathleen Sebelius, Commissioner**
420 SW 9th Street
Topeka, Kansas 66612-1678 (913) 296-3071

TO: House Committee on Financial Institutions and Insurance

FROM: Don Gaskill, Chief Examiner
Kansas Department of Insurance

RE: S.B. 345 (Investment in Futures Contracts)

DATE: March 14, 1995

The Kansas Department of Insurance supports Senate Bill 345 which provides life insurance companies with more flexibility in managing their investment portfolio. The legislation would replace the existing statute (K.S.A. 40-2b25) which allows life insurance companies to invest in financial futures contracts as part of a hedging transaction tied to a specific asset or group of assets. Senate Bill 345 would permit life insurance companies to invest in additional types of financial futures contracts.

The Department of Insurance does believe, however, that the bill should be amended to provide additional limitations on the ability of life insurance companies to invest in these financial instruments. Paragraph (c) (1) of S.B. 345 sets limits investments in options, caps, floors and warrants which are not specifically attached to any other security or investment to 7.5% of a company's admitted assets. The Department believes the limitation on these types of financial futures contacts should be 110% of the excess of the insurance company's capital and surplus over the statutory minimum capital and surplus requirements. This change would provide additional safeguards on the investment by a life insurance company in financial futures contracts which are not tied to a specific asset. A copy of a proposed amendment is attached to this testimony.

In addition, the Department of Insurance would request that subsection (d) of the current law (K.S.A. 40-2b25) be retained. That subsection requires insurers to set up documented policies and procedures and record keeping systems for the investment in financial futures contracts prior to engaging in such transactions. With these two changes, the Department of Insurance supports the favorable passage of S.B. 345.

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3-14-95

Proposed amendment to S.B. 345

**Amendment language in bold type.**

(c) A life insurance company may enter into financial instrument transactions for the purpose of hedging except that the transaction shall not cause any of the following limits to be exceeded:

(1) The aggregate statement value of options, caps, floors and warrants not attached to any other security or investment purchase in hedging transactions may not exceed ~~7.5% of the life insurance company's admitted assets~~ **110% of the excess of such insurer's capital and surplus as shown on the company's last annual or quarterly report filed with the commissioner of insurance over the minimum requirements of a new stock or mutual company to qualify for a certificate of authority to write the kind of insurance which the insurer is authorized to write;**

*Session of 1995*

# SENATE BILL No. 345

By Committee on Ways and Means

2-20

AN ACT concerning insurance; life insurance company investments; financial futures contracts; amending K.S.A. 40-2b25 and repealing the existing section.

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

Section 1. K.S.A. 40-2b25 is hereby amended to read as follows: 40-2b25. ~~(a) Any life insurance company organized under any law of this state shall not enter into financial futures contracts except as part of a hedging transaction. The use of financial futures contracts for hedging purposes must be authorized by the insurer's board of directors.~~

~~(b) As used in this section:~~

~~(1) "Commodity futures trading commission" means the federal regulatory agency charged and empowered under the commodity futures trading commission act of 1974 (7 U.S.C. 1 et seq.) with regulation of the exchanges, or any other agency of the federal government which succeeds to or shares such power.~~

~~(2) "Deferred gains or losses" means the amounts of unrecognized increase and decrease in the value of financial futures contracts related to uncompleted hedging transactions. These deferred amounts may, in some cases, result from terminated financial futures contracts.~~

~~(3) "Exchange-traded" means traded on an exchange designated as a contract market regulated by the commodity futures trading commission.~~

~~(4) "Financial futures contract" means an exchange-traded agreement to make or take delivery of, or to make a cash settlement in lieu thereof, a specified amount of financial instruments on a specified date or period of time, under terms and conditions regulated by the commodity futures trading commission.~~

~~(5) "Financial instrument" means a security, currency or index of a group of securities or currencies authorized or permitted under law.~~

~~(6) "Hedge" means a positioning of a hedged item with one [illegible]e hedging transactions.~~

~~(7) "Hedged item" means a company asset or liability, group or company assets or liabilities, or assets or liabilities or groups of assets or liabilities reasonably expected to be acquired or incurred by the company~~

16-3

~~in the normal course of business. Such assets or liabilities must bear price or interest rate risk.~~

~~(8) "Hedging transaction" means the opening or closing, as such transaction may be adjusted from time to time, of one or more financial futures contracts which can reasonably be expected to minimize or reduce the price or interest rate risk of the hedged item.~~

~~(9) "Margin" includes initial and maintenance margins and means any type of deposit or settlement made or required to be made with a futures commission merchant, clearinghouse or safekeeping agent to ensure performance of the terms of the financial futures contract.~~

~~(c) An insurer shall not have initial or maintenance margins outstanding of more than 10% of the excess of such insurer's capital and surplus over the minimum requirements of a new stock or mutual company to qualify for a certificate of authority to write the kind of insurance which the insurer is authorized to write.~~

~~(d) Prior to engaging in transactions in financial futures contracts, an insurer shall develop and adequately document policies and procedures regarding investment strategies and objectives, recordkeeping needs and reporting matters. Such policies and procedures shall address authorized investments, investment limitations, authorization and approval procedures, accounting and reporting procedures and controls and shall provide for review of activity in financial futures contracts by the insurer's board of directors or such board's designee.~~

~~Recordkeeping systems must be sufficiently detailed to permit internal auditors and insurance department examiners to determine whether operating personnel have acted in accordance with established policies and procedures, as provided in this act. Insurer records must identify for each hedging transaction the related financial futures contracts and the hedged items. Transactions in financial futures must be evidenced by a trade confirmation or other evidence of ownership issued to the insurer by an entity authorized to do so as provided in subsection (b)(3).~~

~~(e) Gains and losses from hedged transactions may be deferred for hedged items carried at amortized cost. Until a hedge is terminated, deferred gains and losses are contra-assets and contra-liabilities, respectively. After the hedge is terminated, deferred gains and losses shall be included in the amortized cost of the hedged item. If the hedged item is no longer anticipated to be acquired or incurred, the hedge must be terminated and the deferred gain or loss from the hedging transactions must be recognized currently. Allocation of gains or losses to the hedged item shall be recognized in a systematic and rational method, as set forth in accounting procedures required in subsection (d). For assets and liabilities carried at market value, gains or losses on open hedging transactions shall be recognized currently.~~



*(a) Any life insurance company heretofore or hereafter organized under any law of this state may use financial instruments under this section to engage in hedging transactions and certain income generation transactions or as these terms may be further defined in regulations promulgated by the commissioner. The life insurance company shall be able to demonstrate to the commissioner the intended hedging characteristics and the ongoing effectiveness of the financial instrument transaction or combination of the transactions through cash flow testing or other appropriate analysis.*

*(b) As used in this section:*

*(1) "Cap" means an agreement obligating the seller to make payments to the buyer, each payment based on the amount by which a reference price or level or the performance or value of one or more underlying interest exceeds a predetermined number, sometimes called the strike rate or price.*

*(2) "Collar" means an agreement to receive payments as the buyer of an option, cap or floor and to make payments as the seller of a different option, cap or floor.*

*(3) (A) "Financial instrument" means an agreement, option, instrument or any series or combination thereof:*

*(i) To make or take delivery of, or assume or relinquish, a specified amount of one or more underlying interests, or to make a cash settlement in lieu thereof; or*

*(ii) which has a price, performance, value or cash flow based primarily upon the actual or expected price, level, performance, value or cash flow of one or more underlying interests.*

*(B) Financial instruments include options, warrants, caps, floors, collars, swaps, forwards, future and any other agreements, options or instruments substantially similar thereto, or any series or combination thereof.*

*(4) "Financial instrument transaction" means a transaction involving the use of one or more financial instruments.*

*(5) "Floor" means an agreement obligating the seller to make payments to the buyer in which each payment is based on the amount that a predetermined number, sometimes called the floor rate or price, exceeds a reference price, level, performance or value of one or more underlying interests.*

*(6) "Forward" means an agreement (other than a future) to make or take delivery of, or effect a cash settlement based on the actual or expe price, level, performance or value of one or more underlying interest.*

*(7) "Future" means an agreement traded on a qualified exchange, to make or take delivery of, or effect a cash settlement based on the actual or expected price, level, performance or value of one or more underlying*

~~in the normal course of business. Such assets or liabilities must bear price or interest rate risk.~~

~~(8) "Hedging transaction" means the opening or closing, as such transaction may be adjusted from time to time, of one or more financial futures contracts which can reasonably be expected to minimize or reduce the price or interest rate risk of the hedged item.~~

~~(9) "Margin" includes initial and maintenance margins and means any type of deposit or settlement made or required to be made with a futures commission merchant, clearinghouse or safekeeping agent to ensure performance of the terms of the financial futures contract.~~

~~(c) An insurer shall not have initial or maintenance margins outstanding of more than 10% of the excess of such insurer's capital and surplus over the minimum requirements of a new stock or mutual company to qualify for a certificate of authority to write the kind of insurance which the insurer is authorized to write.~~

~~(d) Prior to engaging in transactions in financial futures contracts, an insurer shall develop and adequately document policies and procedures regarding investment strategies and objectives, recordkeeping needs and reporting matters. Such policies and procedures shall address authorized investments, investment limitations, authorization and approval procedures, accounting and reporting procedures and controls and shall provide for review of activity in financial futures contracts by the insurer's board of directors or such board's designee.~~

~~Recordkeeping systems must be sufficiently detailed to permit internal auditors and insurance department examiners to determine whether operating personnel have acted in accordance with established policies and procedures, as provided in this act. Insurer records must identify for each hedging transaction the related financial futures contracts and the hedged items. Transactions in financial futures must be evidenced by a trade confirmation or other evidence of ownership issued to the insurer by an entity authorized to do so as provided in subsection (b)(3).~~

~~(e) Gains and losses from hedged transactions may be deferred for hedged items carried at amortized cost. Until a hedge is terminated, deferred gains and losses are contra-assets and contra-liabilities, respectively. After the hedge is terminated, deferred gains and losses shall be included in the amortized cost of the hedged item. If the hedged item is no longer anticipated to be acquired or incurred, the hedge must be terminated and the deferred gain or loss from the hedging transactions must be recognized currently. Allocation of gains or losses to the hedged item shall be recognized in a systematic and rational method, as set forth in accounting procedures required in subsection (d). For assets and liabilities carried at market value, gains or losses on open hedging transactions shall be recognized currently.~~



*(a) Any life insurance company heretofore or hereafter organized under any law of this state may use financial instruments under this section to engage in hedging transactions and certain income generation transactions or as these terms may be further defined in regulations promulgated by the commissioner. The life insurance company shall be able to demonstrate to the commissioner the intended hedging characteristics and the ongoing effectiveness of the financial instrument transaction or combination of the transactions through cash flow testing or other appropriate analysis.*

*(b) As used in this section:*

*(1) "Cap" means an agreement obligating the seller to make payments to the buyer, each payment based on the amount by which a reference price or level or the performance or value of one or more underlying interest exceeds a predetermined number, sometimes called the strike rate or price.*

*(2) "Collar" means an agreement to receive payments as the buyer of an option, cap or floor and to make payments as the seller of a different option, cap or floor.*

*(3) (A) "Financial instrument" means an agreement, option, instrument or any series or combination thereof:*

*(i) To make or take delivery of, or assume or relinquish, a specified amount of one or more underlying interests, or to make a cash settlement in lieu thereof; or*

*(ii) which has a price, performance, value or cash flow based primarily upon the actual or expected price, level, performance, value or cash flow of one or more underlying interests.*

*(B) Financial instruments include options, warrants, caps, floors, collars, swaps, forwards, future and any other agreements, options or instruments substantially similar thereto, or any series or combination thereof.*

*(4) "Financial instrument transaction" means a transaction involving the use of one or more financial instruments.*

*(5) "Floor" means an agreement obligating the seller to make payments to the buyer in which each payment is based on the amount that a predetermined number, sometimes called the floor rate or price, exceeds a reference price, level, performance or value of one or more underlying interests.*

*(6) "Forward" means an agreement (other than a future) to mal take delivery of, or effect a cash settlement based on the actual or expec. price, level, performance or value of one or more underlying interests.*

*(7) "Future" means an agreement traded on a qualified exchange, to make or take delivery of, or effect a cash settlement based on the actual*

interests.

(8) "Hedging transaction" means a financial instrument transaction which is entered into and maintained to reduce:

(A) The risk of a change in the value, yield, price, cash flow or quantity of assets or liabilities which the insurer has acquired or incurred or anticipates acquiring or incurring; or

(B) the currency exchange-rate risk or the degree of exposure as to assets or liabilities which an insurer has acquired or incurred or anticipates acquiring or incurring.

(9) "Income generation transaction" means a financial instrument transaction involving the writing of covered call options which is intended to generate income or enhance return.

(10) "Option" means an agreement giving the buyer the right to buy or receive, sell or deliver, enter into, extend or terminate, or effect a cash settlement based on the actual or expected price, level, performance or value of one or more underlying interests.

(11) "Potential exposure" means:

(A) As to a futures position, the amount of the initial margin required for that position; or

(B) as to swaps, collars and forwards, .5% times the notional amount times the square root of the remaining years to maturity.

(12) "Swap" means an agreement to exchange for net payments at one or more times based on the actual or expected price, level, performance or value of one or more underlying interests.

**(13) "Underlying interest" means the assets, other interests, or a combination thereof, underlying a financial instrument, such as any one or more securities, currencies, rates, indices, commodities or financial instruments.**

~~(13)~~ (14) "Warrants" means an option to purchase or sell the underlying securities or investments at a given price and time or at a series of prices and times outlined in the warrant agreement. Warrants may be issued alone or in connection with the sale of other securities, as part of a merger or recapitalization agreement, or to facilitate divestiture of the securities of another corporation.

(c) A life insurance company may enter into financial instrument transactions for the purpose of hedging except that the transaction shall not cause any of the following limits to be exceeded:

(1) The aggregate statement value of options, caps, floors and warrants not attached to any other security or investment purchase in hedging transactions may not exceed ~~7.5% of the life insurance company's admitted assets~~ **110% of the excess of such insurer's capital and surplus as shown on the company's last annual or quarterly report filed with the commissioner of insurance over the minimum requirements of a new stock or mutual company to qualify for a certificate of authority to write the kind of insurance which the insurer is authorized to write;**



(2) the aggregate statement value of options, caps and floors written in hedging transactions may not exceed 3% of the life insurance company's admitted assets; and

(3) the aggregate potential exposure of collars, swaps, forwards and futures used in hedging transactions may not exceed 5% of the life insurance company's admitted assets.

(d) A life insurance company may enter into the following types of income generation transactions if:

(1) Selling covered call options on non-callable fixed income securities or financial instruments based on fixed income securities, but the aggregate statement value of assets subject to call during the complete term of the call options sold, plus the face value of fixed income securities underlying any financial instrument subject to call, may not exceed 10% of the life insurance company's admitted assets; and

(2) selling covered call options on equity securities, if the life insurance company holds in its portfolio the equity securities subject to call during the complete term of the call option sold.

(e) Upon request of the life insurance company, the commissioner may approve additional transactions involving the use of financial instruments in excess of the limits of subsection (c) or for other risk management purposes, excluding replication transactions, pursuant to regulations promulgated by the commissioner.

(f) For the purposes of this section, the value or amount of an investment acquired or held under this section, unless otherwise specified in this code, shall be the value at which assets of an insurer are required to be reported for statutory accounting purposes as determined in accordance with procedures prescribed in published accounting and valuation standards of the national association of insurance commissioners (NAIC), including the purposes and procedures of the securities valuation office, the valuation of securities manual, the accounting practices and procedures manual, the annual statement instructions or any successor valuation procedures officially adopted by the NAIC.

(g) Prior to engaging in transactions in financial instruments, an insurer shall develop and adequately document policies and procedures regarding investment strategies and objectives, recordkeeping needs and reporting matters. Such policies and procedures shall address authorized investments, investment limitations, authorization and approval procedures, accounting and reporting procedures and controls and shall provide for review of activity in financial instruments by the insurer's board of directors

1 **or such board's designee.**
2 **Recordkeeping systems must be sufficiently detailed to permit**
3 **internal auditors and insurance department examiners to deter-**
4 **mine whether operating personnel have acted in accordance with**
5 **established policies and procedures, as provided in this section.**
6 **Insurer records must identify for each transaction the related fi-**
7 **nancial instruments contracts.**
8 Sec. 2. K.S.A. 40-2b25 is hereby repealed.
9 Sec. 3. This act shall take effect and be in force from and after its
10 publication in the statute book.

*SESSION OF 1995*

## SUPPLEMENTAL NOTE ON SENATE BILL NO. 345

As Amended by Senate Committee on
Financial Institutions and Insurance

### Brief*

S.B. 345, as amended, would amend K.S.A. 40-2b25 concerning the authorized investments of life insurance companies. The bill would strike all of the existing statute and incorporate the latest language developed by the National Association of Commissioners and agreed to but not yet formally presented as part of a redraft of its Model Investment Code.

Any Kansas life insurance company would be allowed to use designated financial instruments to engage in hedging transactions and certain income generation transactions. To do so, the company must be able to demonstrate to the Insurance Commissioner the intended hedging characteristics and the effectiveness of the financial instrument transaction or combination of transactions through cash flow testing or other appropriate analysis.

"Financial instrument" would be defined as an agreement, option, instrument, or any series or combination thereof: to make or take delivery of, or assume or relinquish, a specified amount of one or more underlying interests, or to make a cash settlement in lieu thereof; or which has a price, performance, value or cash flow based primarily upon the actual or expected price, level, performance, value or cash flow of one or more underlying interests. "Underlying interests" would be defined as the assets, other interests, or a combination underlying a financial instrument, such as any one or more securities, currencies, rates, indices, commodities, or financial instruments.

"Financial instruments" would be defined to include options, warrants, caps, floors, collars, swaps, forwards, future, and any other substantially similar agreements, options, or instruments, or any series or combination of instruments. (Most of the instruments listed are defined individually in the bill.)

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* Supplemental Notes are prepared by the Legislative Research Department and do not express legislative intent.

0013330.01/wgw

The Senate Committee amendment adds a definition for "Underlying interest" which inadvertently had been left out of the original bill; reduces the percentage of the insurer's capital and surplus that may be invested in hedging transactions from 7.5 percent of admitted assets to 110 percent of the excess of capital and surplus over the minimum requirements for a new insurance company to meet in order to write the same business in Kansas; and reinstates from the old law provisions requiring insurers to develop and adequately document policies and procedures regarding investment strategies and objectives, record-keeping needs and reporting matters.

## Background

S.B. 345 was recommended by American Investors Life Insurance Company and supported by the Security Benefit Group of Companies. Representatives of the companies explained that the proposal will allow any domestic life insurance company to invest, subject to review by the Insurance Department, in financial instruments which provide hedging transactions and certain income generation transactions. The bill would specifically authorize investments to assist companies in reducing and managing risk and in matching their liabilities with the assets they have invested.

The Insurance Commissioner supported the bill with the Senate Committee amendments.

The Security Benefit Group of Companies

Security Benefit Life Insurance Company
Security Benefit Group, Inc.
Security Distributors, Inc.
Security Management Company

700 Harrison St.
Topeka, Kansas 66636-0001
(913) 295-3000


March 14, 1995

Subj: Senate Bill 345
Life Insurance Company Investments
Financial Futures, etc.

Dear Chairman and Committee Members:

The Security Benefit Group of Companies is a diversified financial services organization offering life insurance, mutual funds, annuities and retirement plans. The parent company, Security Benefit Life Insurance Company, has been in business over 100 years. The Security Benefit Group of Companies has over $4 billion in assets under management and employs approximately 550 Kansans. We support Senate Bill 345.

Senate Bill 345 would specifically authorize life insurance companies to invest assets in financial instruments such as options, financial futures and swaps. Currently, K.S.A. 40-2b25 allows insurance companies to invest in financial futures. Although Senate Bill 345 proposes to repeal K.S.A. 40-2b25, it would allow life insurers to continue to invest in financial futures, plus grant additional authority to invest in other financial instruments.

Senate Bill 345 will assist life insurance companies in reducing and managing risk. Due to customer sophistication and demand, the products issued by life insurance companies are becoming more complex. These products often entail the crediting of a current competitive rate of interest and provide the customer with significant flexibility. Life insurers must carefully match their liabilities with the assets they have invested. This is called asset/liability management.

Insurers analyze and project their potential liabilities, and then structure their investment portfolio accordingly. Senate Bill 345 will provide a valuable tool in structuring our portfolio of assets to match our liabilities.

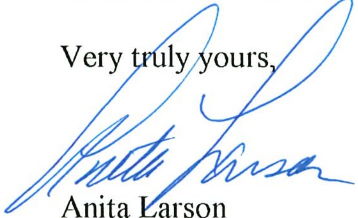
Senate Bill 345 is substantially similar to the Model Investment Law being considered by the National Association of Insurance Commissioners. Although the Model Investment Law has not been adopted, it reflects the recognition of the industry and regulators that investments in financial instruments are useful and necessary tools.

We support Senate Bill 345 because it allows insurers to diversify and "hedge" or reduce their risks, especially interest rate risk. We urge you to act favorably on Senate Bill 345.

House FI&I
Attachment 17
3-14-95

Thank you for your time and consideration. I would be happy to address your questions and concerns.

Very truly yours,



Anita Larson
Assistant Counsel
Security Benefit Group, Inc.