Approved: March 18, 1996
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 13, 1996 in Room 527S-of the Capitol.

All members were present except: Representative Tom Sawyer
Representative Phill Kline
Representative Brenda Landwehr
Representative Delbert Crabb

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

Conferees appearing before the committee: Tom Wilder, Kansas Insurance Department
Jerry Slaughter, Kansas Medical Society
Joe Furjanic, Kansas Chiropractor's Association
Brad Smoot, Kansas Managed Care Association
Gerald Grimaldi, Kaiser Permanente
Ann Koci, Adult Medical Services, SRS

Others attending: See attached list

Hearing on SB 603: Health insurance to cover certain conditions notwithstanding ERISA

Tom Wilder, Director of Government and Public Affairs for the Kansas Insurance Department, spoke on behalf of the legislation which would require the state employees health care plan to provide the same mental health benefits as are required by private health insurance (Attachment 1). This would mean they would have up to 30 days in-patient treatment each year. The benefit would be extended to state employees who are covered under the self-insured portion of the state health care plan. The self-insured contract is not subject to any of the state health insurance mandates which have been approved by the Kansas Legislature.

Hearing on SB 477: Revising health management organization statutes and related

Tom Wilder, representing the Kansas Insurance Department, explained that due to the need for updating regulations regarding health maintenance organizations, a Health Care Advisory Committee was established by the Commissioner to study all HMO issues (Attachment 2). With only minor changes the HMO statutes are the same as developed and passed in 1974 and definitely needed upgrading. Included in his testimony was an outline of each section changed, proposed amendments, and a list of all Advisory Committee members.

Jerry Slaughter, Kansas Medical Society, expressed concern about two sections of the bill (Attachment 3):

1. HMO's do not contract with "classes" or providers; they contract with individual providers. Sample contract should be adequate to provide to the department.

2. Terminated providers should still be paid for any continuing care he or she provides.

Joe Furjanic, Kansas Chiropractor's Association, expressed their eagerness to participate in HMO's and presented suggested amendments to the bill in balloon form (Attachment 4). There are currently two groups of chiropractors who are working in the managed care system in Wichita.

Brad Smoot, Kansas Managed Care Association, voiced support of the proposed legislation and asked that the bill remain in its present form as it came over from the Senate (Attachment 5). He was in favor of the KMS amendment which would call for the provision of sample contracts to the department.

Gerald Grimaldi, public affairs director for Kaiser Permanente in Kansas City, spoke in opposition to the proposed application of the insurance company holding company law to HMO's because the proposed application goes beyond the regulatory requirements which have been agreed upon by the NAIC (Attachment 6). All material transactions are currently reported to the Commissioner who has the authority to report any

material transactions. They would support the application of the holding company law dealing with mergers and acquisitions to HMO's.

Ann Koci, Commissioner of Adult and Medical Services of SRS, spoke in support of the legislation which will act to protect health care consumers throughout the state (Attachment 7).

Discussion and actions on SUB SB 529: Lapse of long-term care insurance policy, reinstatement

An amendment to include long-term care group policies or certificates in the legislation was proposed. This legislation would become effective July 1, 1996. It would be illegal to make such provisions retroactive on previously signed contracts.

Representative Welshimer moved to amend the bill as proposed. Motion was seconded by Representative Smith. Motion carried.

Representative Smith moved that the bill be passed as amended. The motion was seconded by Representative Samuelson. Motion carried.

Discussion and action on SB 573: Requiring minimum inpatient care coverage following birth of a child

Representative Samuelson moved for the adoption of a technical amendment to the bill. Motion was seconded by Representative Cox. Motion carried.

The Committee was reminded that the Senate had removed the language "attending physician" and it is unclear who signs the release order for the mother and child.

Representative Samuelson moved that the bill be passed as amended. Motion was seconded by Representative Graeber. Motion carried.

Discussion and action on SB 441: Uninsurable health care insurance plan, rate cap, tax credits

Representative Correll moved for the favorable passage of the bill. The motion was seconded by Representative Smith. Motion carried.

Discussion and action on SB 436: Closing hours for banks and trust companies

Representative Graeber moved that the language be stricken from the existing bill and replaced with the language of SB 2670 with a two year sunset amendment. Motion was seconded by Representative Landwehr.

Representative Humerickhouse issued a substitute motion which would retain the current language regarding banking hours and add the language of SB 2670 with no sunsetting amendment. Motion was seconded by Representative Dawson. A division and recorded vote was called for. There were 8 yes votes and 6 no votes.

Committee members were not totally in agreement with the motion and many voiced concern with the hasty action. A final decision does not have to be made for another year and by that time a more thorough study could be made via an interim committee. The bill this year is likely to be killed in the Senate and the "opt out" voters will lose out all together. The impetus of those members voting in favor of moving the bill out was that the continuation of the 30 mile rule which is detrimental to Kansas banks and tthe question of taxation needs to be debated on the floor.

Representative Graeber moved that the bill be passed out as amended. Motion was seconded by Representative Landwehr. Motion carried.

Representative Landwehr moved for the approval of the minutes of March 6 and 7. Motion was seconded by Representative Samuelson. Motion carried.

The meeting was adjourned at 5:05 p.m. The next meeting is scheduled for March 14, 1996.

HOUSE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE GUEST LIST

DATE: March 13, 1996

NAME	REPRESENTING
Tom Wilder	Kansas Insurance Dept
John Federico	Pete McGill + Assoc
Vanessa Hennan	HIAA
Mary Sprenc	Humana
Gerard Grimaldi	Kaiser Permanente
TAD KRAMER	SECURITY BENEFIT
Harold Riegle	Ks Osteopathic Assn
Joe Furjanic	KCA
Melissa Wangemann	Hein Elect & Weir
Chris Beal	Eli Lilly + Co.
Anne Koci	SRS
John Peterson	Kaiser Permanente
Mary Ellen Conlee	Health Affiliates Inc.
Lori Callahan	Kansmco
Mary Slaughter	KNS
Brad Smoot	KMHCA
David Hanson	Ks Insur Assocs

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

MEMORANDUM

To: House Financial Institutions and
Insurance Committee

From: Tom Wilder, Director of
Government and Public Affairs

Re: S.B. 603 (State Employees Health Care Plan/Benefits)

Date: March 13, 1996

I am appearing today in support of S.B. 603 which would require the state employees health care plan to provide the same mental health benefits as are required by private health insurance. The Kansas Insurance Code states that all health insurance policies sold in this state must provide coverage for up to 30 days in-patient treatment each year for alcoholism, drug abuse or nervous or mental conditions. Senate Bill 603 extends the requirements for mental health treatment benefits to state employees who are covered under the self-insured portion of the state health care plan.

The state employees health plan is negotiated by the Health Care Commission which is headed by the Secretary of Administration. The Commissioner of Insurance is one of the members of the Health Care Commission. There are three other Commissioners picked by the Governor. Most of the health care provided to state employees is through contracts with health insurance companies or health maintenance organizations. When the 1996 health care plan was prepared, the Health Care Commission decided to self-insure a portion of the contract. The self-insured contract is not subject to any of the state health insurance mandates which have been approved by the Kansas Legislature.

House F.I. & I.
Attachment 1
March 13, 1996

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The Health Care Commission agreed to provide the same level of benefits to state employees under the self-insured contract as are found in the agreements with health insurers and managed care organizations. This coverage includes the mental health benefits found in K.S.A. 40-2,105. The provisions of S.B. 603 are important, however, because it will protect state employees in the future should the self-insured health plan not provide the same level of benefits as required by the mental health coverage mandate.

The Kansas Insurance Department asks the Committee to recommend S.B. 603 favorably for passage.

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

MEMORANDUM

To: House Financial Institutions
and Insurance Committee

From: Tom Wilder, Director of
Government and Public Affairs

Re: S.B. 477 (Health Maintenance Organizations)

Date: March 13, 1996

Senate Bill 477 was introduced at the request of the Kansas Insurance Department. The legislation makes a number of significant changes to the laws in this state which regulate the activities of health maintenance organizations. The trend in Kansas and nationally is toward managed care arrangements. The current Kansas health maintenance organizations statutes were approved by the Legislature in 1974 and, with a few minor exceptions, the statutes have not been amended in the last twenty years.

Last year Commissioner Sebelius formed a Health Care Advisory Committee to provide input to the Insurance Department on a variety of health insurance issues. The Advisory Committee is made up of 25 members who are drawn from representatives of the insurance industry, managed care organizations, medical providers, private business, consumers and legislators. Representative Greta Goodwin and Senator Sandy Praeger served as members of the Advisory Committee. A full membership list of the Health Care Advisory Committee is attached to my testimony.

The Advisory Committee held a number of meetings to discuss managed care issues. Senate Bill 477 is a result of their efforts. The provisions in the bill are based on

House FI&I
Attachment 2

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March 13, 1996

the discussions of the Health Care Advisory Committee and consultations between the Insurance Department and a number of interested parties including the Kansas Medical Society, Kansas Managed Care Association and others. Most of the changes to the law are taken from the Health Maintenance Organizations Model Law drafted by the National Association of Insurance Commissioners. In addition, a number of provisions from the Missouri Insurance Code were included in S.B. 477 since many of the managed care organizations which operate in Kansas also do business in that state.

The following is an outline of the key provisions of S.B. 477:

(1.) **Sale of Stock (Sections 1, 2 and 3):** The bill amends K.S.A. 40-204, 40-205 and 40-205a to add health maintenance organizations to the list of insurance entities which are required to apply to the Commissioner for the authority to sell stock.

(2.) **Licensing of Agents (Sections 4 and 5):** Individuals, corporations, associations and other entities which market health maintenance organization plans are added to the list of persons who must be licensed as health insurance agents. As a practical matter, many of the HMO plans which do business in Kansas are already have licensed agents because they also offer health insurance coverage through an indemnity insurer.

(3.) **Definitions (Section 6):** Most of the new definitions added to K.S.A. 40-3202 are taken from the NAIC Model Act. The definitions of "grievance", "individual practice association" and "medical group or staff model" come from the Missouri Insurance Code and regulations established by the Missouri Insurance Department. Other definitions were added at the suggestion of the Kansas Medical Society and Prudential Insurance Company.

(4.) **Certificate of Authority (Sections 7 and 8):** The new language added to K.S.A. 40-3203 and 40-3204 was taken from the NAIC Model Act. These two sections set out the information that must be provided to the Insurance Department in order for the Commissioner to approve an application for a Certificate of Authority to operate a health maintenance organization in Kansas.

(5.) **Certificate of Coverage (Section 9):** The provision gives enrollees in individual health care plans through an HMO a ten day period in which to cancel their coverage. This provision comes from the NAIC Model Law.

(6.) **Fidelity Bonds (Section 10):** The new bonding requirements added to K.S.A. 40-3225 come from the NAIC Model Act. The provision requires the HMO to maintain a fidelity bond for its employees, officers, directors and partners.

(7.) **Deposits (Section 11):** This Section sets out what funds must be deposited with the Commissioner in order for the HMO to do business in Kansas. The dollar aggregates

come from the Missouri Insurance Code. It was also decided to delete language from the current Kansas statute which allowed the Insurance Department to calculate the deposit requirements for health maintenance organizations based on the amount of the estimated uncovered expenditures of the HMO. The Financial Surveillance Division of the Kansas Insurance Department recommended a set dollar amount should be set out in the statute.

(8.) **Grievance Procedures (New Section 12):** This new provision, which states the procedures an HMO must use to handle enrollee grievances, is taken from regulations of the Missouri Insurance Department.

(9.) **Emergency Care Standards (New Section 13):** This Section was drafted based on Missouri Insurance Department rules.

(10.) **Transition of Care (New Section 14):** This Section sets out the responsibility of an HMO to assist the enrollee in finding a new medical provider in those cases where a provider is dropped from a network.

(11.) **Holding Companies (Section 15):** The existing statute (K.S.A. 40-3302) was amended to include health maintenance organizations in the list of insurance entities which are regulated under the insurance holding company laws of this state.

These new provisions will update the regulation of managed care organizations in Kansas and they mirror changes which have been made or are under consideration by a number of other states.

There are two amendments which the Insurance Department would ask the Committee to consider:

(a.) Rules and Regulations - The bill as originally drafted allowed the Insurance Commissioner to adopt regulations to establish what additional information must be provided to enrollees by their Health Maintenance Organizations in the Certificate of Coverage. The rule and regulation authority, which appears on page 13, lines 20 and 21, was deleted by the Senate Committee. The Department asks that this provision be included in the bill.

(b.) Continuity of Care - The bill includes a provision (Section 14) on page 18 which requires managed care organizations to have a mechanism to help enrollees when one of a medical provider is dropped from the network used by the health maintenance organization. The Senate deleted language which would have also required the managed care organization to keep an enrollee with a provider who is dropped from the network for a period of up to 90 days in cases where it is medically necessary to keep that same provider. The Department believes the language which was removed by the Senate provides an important protection to members of a health maintenance organization and it

should be put back into the bill. I have attached a balloon which would amend the bill to reinstate this provision in a slightly different form.

Senate Bill 477 will help modernize the way in which managed care is regulated in Kansas. There have been a number of changes over the past 20 years in the business operations of health maintenance organizations in this state. Our statutes have not kept pace with these changes. The legislation will provide a new framework for the Kansas Insurance Department to oversee this growing health care market. I would ask the Committee to approve S.B. 477 with the amendments outlined in my testimony.

Kansas Insurance Department
Commissioner's Advisory Committee on Health Care
Kathleen Sebelius, Insurance Commissioner

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rollee to receive authorization prior to receiving the emergency medical service. The enrollee must notify the health maintenance organization of receipt of medical services for emergency conditions within 24 hours or as soon after that as is reasonably possible. Nothing shall require the health maintenance organization to authorize payment for any services provided during that 24 hour period, regardless of medical necessity, if those services do not otherwise constitute benefits under the certificate of coverage approved by the commissioner.

(c) If the participating provider is responsible for seeking prior authorization from the health maintenance organization before receiving payment for the treatment of emergency medical conditions and the enrollee is eligible at the time when covered services are provided, then the enrollee will not be held financially responsible for payment for covered services if the prior authorization for emergency medical services has not been sought and received, other than for what the enrollee would otherwise be responsible, such as copayments and deductibles.

(d) All disputes between an enrollee and a health maintenance organization arising under the provisions of this section shall be resolved by means of the grievance procedures established by the health maintenance organization.

New Sec. 14. A health maintenance organization shall establish reasonable procedures for assuring a transition of enrollees to physicians or health care providers and for continuity of treatment, including providing immediate notice to the enrollee and making available to the enrollee a current listing of preferred providers, in the event ~~of a plan termination or termination of the participation of a provider with the plan. Each contract between a health maintenance organization and a physician or health care provider must provide that in the event of plan termination, or termination of the participation of a provider with the plan, such action shall not release the physician or health care provider from the generally recognized obligation to treat the enrollee and cooperate in arranging for appropriate referrals or release the obligation of the health maintenance organization to reimburse the enrollee at the same preferred provider rate for a period of up to 90 days if, at the time of plan or provider termination, the enrollee has special circumstances such as a disability, life threatening or complex illness or is in the third trimester of pregnancy and is receiving treatment in accordance with the dictates of medical prudence.~~ *a provider's participation in the plan is terminated for any reason,* ~~*If the plan authorizes the terminated provider to continue treating the enrollee, the plan shall have an obligation to pay the terminated provider at the previously contracted rate for such services and the enrollee will not be liable for any amounts owed for medical care other than any deductibles, coinsurance or co-pay-*~~

The plan shall include provisions for the continuation of care to enrollees for a period up to 90 days by a provider who is terminated from a network in those cases where the continuation of such care is medically necessary and in accordance with the dictates of medical prudence and where the enrollee has special circumstances such as a disability, a life threatening illness or is in the third trimester of pregnancy. The provisions for the continuation of care shall include guarantees that the enrollee will not be liable to the provider for any amounts owed for medical care other than any deductibles or co-paymet amounts specified in the certificate of coverage or other contract between the enrollee and the health maintenance organization.

~~*ment amounts specified in the certificate of coverage or other contract between the enrollee and the health maintenance organization.*~~

~~New Sec. 15.~~ ~~A health maintenance organization may not enter into an administrative health service contract with a health service intermediary unless the contract is in writing, is filed with the commissioner, is accompanied by an opinion by a qualified independent actuary which states that the entering of the contract by the health maintenance organization is financially sound, and the contract contains provisions which:~~

~~(1) Require the health service intermediary to provide the health maintenance organization and the commissioner, with a regular written financial reports, at least quarterly, that state the assets of the health service intermediary and identify in the aggregate all payments made or owed to its providers in sufficient detail for the health maintenance organization and the commissioner to determine if the payments are being made in a timely manner and which identify in the aggregate the reasonably estimated incurred but not reported health care costs;~~

~~(2) require the health maintenance organization to monitor the financial reports required by the health service intermediary under this subsection;~~

~~(3) permit the health maintenance organization and the commissioner, both singularly and jointly, upon reasonable prior notice, to audit, inspect and copy the books, records and other evidence of the operations of the health service intermediary which are, in the discretion of the health maintenance organization or the commissioner, relevant to the obligations of the intermediary under the administrative health service contract for the purpose of determining the intermediary's compliance with all requirements legally mandated by statute, rules and regulations or the administrative health service contract subject to any confidentiality requirements imposed by state or federal law;~~

~~(4) any additional information which the commissioner may require by rules and regulations.~~

~~As used in this section, the term "financially sound" means that according to presently accepted actuarial standards of practice, consistently applied and fairly stated, that the respective considerations to the parties under the contract, including, but not limited to, reserves, the investment earnings on such considerations, the considerations anticipated to be received and retained by the parties under the contract, and related actuarial values, make adequate provision for the anticipated cash flows required by the contractual obligations and related expenses of the parties.~~

Sec. ~~16~~ *15*. K.S.A. 40-3302 is hereby amended to read as follows: 40-3302. As used in this act, unless the context otherwise requires:

(a) "Affiliate" of, or person "affiliated" with, a specific person, means

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March 13, 1996

TO: House Committee on Financial Institutions and Insurance

FROM: Jerry Slaughter
Executive Director

SUBJECT: SB 477; amendments to the HMO law

The Kansas Medical Society appreciates the opportunity to appear today on SB 477, which would substantially amend the law governing HMOs. In addition to increasing the capital and solvency requirements and adding new language relating to the rights of subscribers, the bill includes new definitions of terms which are introduced into the HMO act. We are grateful to Commissioner Sebelius and her staff for taking the time to consider our suggestions and concerns about various provisions throughout this process.

In general, we support the intent of this legislation, which is to assure that risk bearing entities in the new health care marketplace are adequately capitalized and regulated in order to protect the public. We believe that any organization which intends to bear risk should be prudently capitalized and re-insured against large losses and the unpredictability of normal operating business cycles.

We do have a couple of remaining questions about two sections of the bill. The first is on page 9, lines 1-6, and it deals with making copies of certain contracts available to the department. We do not oppose the intent of the provision, but we would like clarification that it does not deal with individual employment contracts or individualized contracts with various health care providers. Technically, HMOs do not contract with *classes* of providers; they contract with individual providers. Since there may be many different contracts held by an HMO within a class of providers, it would seem to us that a *sample* contract would be sufficient. We have attached suggested amendments to reflect our concern.

The second concern deals with New Section 14, page 18. We understand the Insurance Commissioner is going to offer an amendment to this section. The intent of the amendment, as we understand it, is to assure that in the event a provider is terminated from an HMO while the patient still needs the provider's continuing care, that such care will be available at no cost to the patient. It further allows the HMO to assign another provider in cases where it is appropriate to do so. We have no problem with that concept, but we are concerned that the Commissioner's amendment does not provide that a provider so terminated would still be paid for any continuing care he or she provides. The current version of the bill deals with that issue we believe, but we would not object to the Insurance Commissioner's amendment if similar language is added. We have attached a balloon with our suggested addition to the Insurance Commissioner's amendment.

With the exception of those items mentioned above, we feel the bill can be supported. Thank you for considering our comments.

House FI&I
Attachment 3
March 13, 1996

(4) a copy of any contract or agreement made or to be made between the health maintenance organization and any health services intermediary or any other class of providers and a copy of any contract made or agreement made or to be made between third party administrators, marketing consultants or persons listed in subsection (3) and the health maintenance organization;

~~(4)~~ *(5)* a statement generally describing the organization, its enrollment process, its operation, its quality assurance mechanism, its internal grievance procedures, the methods it proposes to use to offer its enrollees an opportunity to participate in matters of policy and operation, the geographic area or areas to be served, the location and hours of operation of the facilities at which health care services will be regularly available to enrollees in the case of staff and group practices, the type and specialty of health care personnel and the number of personnel in each specialty category engaged to provide health care services in the case of staff and group practices, and a records system providing documentation of utilization rates for enrollees. In cases other than staff and group practices, the organization shall provide a list of names, addresses and telephone numbers of providers by specialty;

~~(5)~~ *(6)* copies of all contract forms the organization proposes to offer enrollees together with a table of rates to be charged;

~~(6)~~ *(7)* the following statements of the fiscal soundness of the organization:

(A) Descriptions of financing arrangements for operational deficits and for developmental costs if operational one year or less;

(B) a copy of the most recent unaudited financial statements of the health maintenance organization;

(C) financial projections using an accrual accounting system with generally accepted accounting principles for a minimum of three years from the anticipated date of certification and on a monthly basis from the date of certification through one year. If the health maintenance organization is expected to incur a deficit, projections shall be made for each deficit year and for one year thereafter. Financial projections shall include:

(i) Monthly statements of revenue and expense for the first year on a gross dollar as well as per-member-per-month basis, with quarters consistent with standard calendar year quarters;

(ii) quarterly statements of revenue and expense for each subsequent year;

(iii) a quarterly balance sheet; and

(iv) statement and justification of assumptions;

~~(7)~~ *(8)* a description of the procedure to be utilized by a health maintenance organization to provide for:

(A) Offering enrollees an opportunity to participate in matters of pol-

sample or representative

,excluding individual employment contracts or agreements,

rollee to receive authorization prior to receiving the emergency medical service. The enrollee must notify the health maintenance organization of receipt of medical services for emergency conditions within 24 hours or as soon after that as is reasonably possible. Nothing shall require the health maintenance organization to authorize payment for any services provided during that 24 hour period, regardless of medical necessity, if those services do not otherwise constitute benefits under the certificate of coverage approved by the commissioner.

(c) If the participating provider is responsible for seeking prior authorization from the health maintenance organization before receiving payment for the treatment of emergency medical conditions and the enrollee is eligible at the time when covered services are provided, then the enrollee will not be held financially responsible for payment for covered services if the prior authorization for emergency medical services has not been sought and received, other than for what the enrollee would otherwise be responsible, such as copayments and deductibles.

(d) All disputes between an enrollee and a health maintenance organization arising under the provisions of this section shall be resolved by means of the grievance procedures established by the health maintenance organization.

New Sec. 14. A health maintenance organization shall establish reasonable procedures for assuring a transition of enrollees to physicians or health care providers and for continuity of treatment, including providing immediate notice to the enrollee and making available to the enrollee a current listing of preferred providers, in the event of a plan termination or termination of the participation of a provider with the plan. Each contract between a health maintenance organization and a physician or health care provider must provide that in the event of plan termination, or termination of the participation of a provider with the plan, such action shall not release the physician or health care provider from the generally recognized obligation to treat the enrollee and cooperate in arranging for appropriate referrals or release the obligation of the health maintenance organization to reimburse the enrollee at the same preferred provider rate for a period of up to 90 days if, at the time of plan or provider termination, the enrollee has special circumstances such as a disability, life threatening or complex illness or is in the third trimester of pregnancy and is receiving treatment in accordance with the dictates of medical prudence, *a provider's participation in the plan is terminated for any reason.* ~~*If the plan authorizes the terminated provider to continue treating the enrollee, the plan shall have an obligation to pay the terminated provider at the previously contracted rate for such services and the enrollee will not be liable for any amounts owed for medical care other than any deductibles, coinsurance or co-pay-*~~

The plan shall include provisions for the continuation of care to enrollees for a period up to 90 days by a provider who is terminated from a network in those cases where the continuation of such care is medically necessary and in accordance with the dictates of medical prudence and where the enrollee has special circumstances such as a disability, a life threatening illness or is in the third trimester of pregnancy. The provisions for the continuation of care shall include guarantees that the enrollee will not be liable to the provider for any amounts owed for medical care other than any deductibles or co-payment amounts specified in the certificate of coverage or other contract between the enrollee and the health maintenance organization. **In the event the terminated provider is authorized to continue treating the enrollee pursuant to this subsection, the health maintenance organization shall have an obligation to pay the terminated provider at the previously contracted rate for services provided to the enrollee.**

~~ment amounts specified in the certificate of coverage or other contract between the enrollee and the health maintenance organization.~~

New Sec. ~~15.~~ A health maintenance organization may not enter into an administrative health service contract with a health service intermediary unless the contract is in writing, is filed with the commissioner, is accompanied by an opinion by a qualified independent actuary which states that the entering of the contract by the health maintenance organization is financially sound, and the contract contains provisions which:

~~(1)~~ Require the health service intermediary to provide the health maintenance organization and the commissioner, with a regular written financial reports, at least quarterly, that state the assets of the health service intermediary and identify in the aggregate all payments made or owed to its providers in sufficient detail for the health maintenance organization and the commissioner to determine if the payments are being made in a timely manner and which identify in the aggregate the reasonably estimated incurred but not reported health care costs;

~~(2)~~ require the health maintenance organization to monitor the financial reports required by the health service intermediary under this subsection;

~~(3)~~ permit the health maintenance organization and the commissioner, both singularly and jointly, upon reasonable prior notice, to audit, inspect and copy the books, records and other evidence of the operations of the health service intermediary which are, in the discretion of the health maintenance organization or the commissioner, relevant to the obligations of the intermediary under the administrative health service contract for the purpose of determining the intermediary's compliance with all requirements legally mandated by statute, rules and regulations or the administrative health service contract subject to any confidentiality requirements imposed by state or federal law;

~~(4)~~ any additional information which the commissioner may require by rules and regulations.

As used in this section, the term "financially sound" means that according to presently accepted actuarial standards of practice, consistently applied and fairly stated, that the respective considerations to the parties under the contract, including, but not limited to, reserves, the investment earnings on such considerations, the considerations anticipated to be received and retained by the parties under the contract, and related actuarial values, make adequate provision for the anticipated cash flows required by the contractual obligations and related expenses of the parties.

Sec. ~~16~~ *15*. K.S.A. 40-3302 is hereby amended to read as follows: 40-3302. As used in this act, unless the context otherwise requires:

(a) "Affiliate" of, or person "affiliated" with, a specific person, means

3-4

Kansas
Chiropractic
Association

Before the
House Financial Institutions
and Insurance Committee

March 13, 1996

Testimony of

Joseph Furjanic
Executive Director
Kansas Chiropractic Association

Testimony of SB 477

Mister Chairman and members of the committee, I appreciate the opportunity to speak regarding SB 477.

I have prepared some amendments to the bill which are attached.

House FI&I
Attachment 4
March 13, 1996

1334 S. TOPEKA BLVD. • TOPEKA, KANSAS 66612-1878 • (913) 233-0697 • FAX (913) 233-1833

necessary to verify the information contained in the application.

(d) (1) Agents licensed pursuant to subsection (b) shall advise the commissioner of any officers, directors, partners or employees who are licensed as individual insurance agents and are not disclosed at the time application is made for a license within 30 working days of their affiliation with the licensee. Failure to provide the commissioner with such information shall subject the licensee to a monetary penalty of $10 per day for each working day the required information is late subject to a maximum of $50 per person per licensing year.

(2) Officers, directors, partners or employees disclosed at the time of the original application or reported thereafter whose affiliation with the licensee is terminated shall be reported to the commissioner within 30 days of the effective date of termination. Failure to report such termination shall subject the licensee to the penalty prescribed in paragraph (1) of this subsection.

Sec. 6. K.S.A. 40-3202 is hereby amended to read as follows: 40-3202. As used in this act:

~~(a) "Administrative health service contract" means an agreement between a health maintenance organization and a health service intermediary or between health service intermediaries in which:~~

~~(1) The intermediary accepts payments, including payments on a capitated, fixed per capita, fixed aggregate sum or percentage of premium basis, from the health maintenance organization for one or more health care services to be rendered by providers to enrollees of a health maintenance organization, where the intermediary assumes financial risk for payments to providers, and~~

~~(2) the intermediary contracts with providers to render one or more health care services to enrollees of a health maintenance organization.~~

~~(a)~~ ~~(b)~~ *(a) "Commissioner" means the commissioner of insurance of the state of Kansas.*

~~(b)~~ ~~(c)~~ *(b)* "Basic health care services" means but is not limited to ~~usual physician, hospitalization, laboratory, x-ray, emergency and preventive services and out-of-area coverage.~~ the usual emergency and preventative services provided by providers, hospitalization, laboratory, x-ray, and out-of-area coverage.

~~(d)~~ *(c) "Capitated basis" means a fixed per member per month payment or percentage of premium payment wherein the provider assumes ~~the full~~ risk for the cost of contracted services without regard to the type, value or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities.*

~~(e)~~ *(d) "Certificate of coverage" means a statement of the essential features and services of the health maintenance organization coverage which is given to the subscriber by the health maintenance organization or by the group contract holder.*

delete

periodic rate basis;

(3) provides ~~physician~~ services directly through ~~physicians~~ who are either employees or partners of such organization or under arrangements with a ~~physician~~ or any group of ~~physicians~~ or under arrangements as an independent contractor with a ~~physician~~ or any group of ~~physicians~~;

(4) is responsible for the availability, accessibility and quality of the health care services provided or made available.

~~(o) "Health service intermediary" or "intermediary" means a physician, hospital, physician hospital organization, independent provider organization, independent provider network or other entity or person that arranges for one or more health care services to be rendered by providers to enrollees of a health maintenance organization. The term does not include a health maintenance organization.~~

~~(p)~~ *(o) "Individual contract" means a contract for health care services issued to and covering an individual. The individual contract may include dependents of the subscriber.*

~~(q)~~ *(p) "Individual practice association" means a partnership, corporation, association or other legal entity which delivers or arranges for the delivery of basic health care services and which has entered into a services arrangement with persons who are licensed to practice medicine, ~~osteopathy~~ **and surgery**, dentistry, chiropractic, pharmacy, podiatry, optometry or any other health profession ~~and a majority of whom are licensed to practice medicine or osteopathy and surgery~~. Such an arrangement shall provide:*

(1) That such persons shall provide their professional services in accordance with a compensation arrangement established by the entity; and

(2) to the extent feasible for the sharing by such persons of medical and other records, equipment, and professional, technical and administrative staff.

~~(r)~~ *(q) "Medical group" or "staff model" means a partnership, association or other group:*

*(1) Which is composed of health professionals licensed to practice medicine ~~or osteopathy~~ **and surgery** and of such other licensed health professionals, including but not limited to dentists, chiropractors, pharmacists, optometrists and podiatrists as are necessary for the provision of health services for which the group is responsible;*

~~(2) a majority of the members of which are licensed to practice medicine or osteopathy and surgery; and~~

~~(3)~~ *the members of which: (A) As their principal professional activity over 50% individually and as a group responsibility are engaged in the coordinated practice of their profession for a health maintenance organization; (B) pool their income and distribute it among themselves according to a prearranged salary or drawing account or other plan, or are*

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health care

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salaried employees of the health maintenance organization; (C) share medical and other records and substantial portions of major equipment and of professional, technical and administrative staff; and (D) establish an arrangement whereby the enrollee's enrollment status is not known to the member of the group who provides health services to the enrollee.

(r) "Net worth" means the excess of assets over liabilities as determined by the commissioner from the latest annual report filed pursuant to K.S.A. 40-3220 and amendments thereto.

~~(g)~~ *(s)* "Person" means any natural or artificial person including but not limited to individuals, partnerships, associations, trusts or corporations.

~~*(t) "Physician" means a person licensed to practice medicine and surgery under the healing arts act.*~~ delete

~~(h)~~ ~~*(t)*~~ ~~*(u)*~~ (t) "Provider" means any physician, hospital or other person which is licensed or otherwise authorized in this state to furnish health care services.

~~(i)~~ ~~*(u)*~~ ~~*(v)*~~ (u) "Uncovered expenditures" means the costs of health care services that are covered by a health maintenance organization for which an enrollee would also be liable in the event of the organization's insolvency as determined by the commissioner from the latest annual statement filed pursuant to K.S.A. 40-3220 and amendments thereto.

~~(j)~~ ~~(v)~~ ~~"Net worth" means the excess of assets over liabilities as determined by the commissioner from the latest annual report filed pursuant to K.S.A. 40-3220 and amendments thereto.~~

Sec. 7. K.S.A. 40-3203 is hereby amended to read as follows: 40-3203. (a) Except as otherwise provided by this act, it shall be unlawful for any person to provide health care services in the manner prescribed in subsection ~~(f)~~ *(n)* of K.S.A. 40-3202 and amendments thereto without first obtaining a certificate of authority from the commissioner.

(b) Applications for a certificate of authority shall be made in the form required by the commissioner and shall be verified by an officer or authorized representative of the applicant and shall set forth or be accompanied by:

(1) A copy of the basic organizational documents of the applicant such as articles of incorporation, partnership agreements, trust agreements or other applicable documents;

(2) a copy of the bylaws, regulations or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) a list of the names, addresses ~~and~~, official capacity with the organization ~~of~~ *and biographical information for* all *of* the persons who are to be responsible for the conduct of its affairs, including all members of the governing body, the officers and directors in the case of a corporation and the partners or members in the case of a partnership or corporation;

4-4

therefor, or that payment of the fees required by K.S.A. 40-3213 *and amendments thereto* has not been made or that ~~he~~ *the commissioner* is not satisfied with the sufficiency of the information supplied pursuant to the provisions of K.S.A. 40-3203 *and amendments thereto* or that the organization has failed to demonstrate its ability to assure that health care services will be provided.

(b) The commissioner shall, within 60 days after the receipt of a completed application and any prescribed fees, issue a certificate of authority to any person filing such application if the commissioner finds that:

(1) The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy and possess good reputations;

(2) any deficiencies identified by the commissioner in the application have been corrected;

(3) the health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise except to the extent of reasonable requirements for copayments and/or deductibles; and

(4) the health maintenance organization is in compliance with K.S.A. 40-3227 and amendments thereto.

Sec. 9. K.S.A. 40-3209 is hereby amended to read as follows: 40-3209. (a) All forms of *group and individual certificates of coverage and* contracts issued by the organization to enrollees or other marketing documents purporting to describe the organization's health care services shall contain as a minimum:

(1) A complete description of the health care services and other benefits to which the enrollee is entitled;

(2) the locations of all facilities, the hours of operation and the services which are provided in each facility in the case of ~~*independent*~~ ***individual*** *practice associations or medical* staff and group practices, and, in all other cases, a list of providers by specialty with a list of addresses and telephone numbers;

(3) the financial responsibilities of the enrollee and the amount of any deductible, copayment or coinsurance required;

(4) all exclusions and limitations on services or any other benefits to be provided including any deductible or copayment feature and all restrictions relating to pre-existing conditions;

(5) all criteria by which an enrollee may be disenrolled or denied reenrollment;

(6) service priorities in case of epidemic, or other emergency conditions affecting demand for ~~medical~~ health care services;

(7) a provision that an enrollee or a covered dependent of an enrollee whose coverage under a health maintenance organization group contract has been terminated for any reason but who remains in the service area

and who has been continuously covered by the health maintenance organization for at least three months shall be entitled to obtain a converted contract or have such coverage continued under the group contract for a period of six months following which such enrollee or dependent shall be entitled to obtain a converted contract in accordance with the provisions of this section. The converted contract shall provide coverage at least equal to the conversion coverage options generally available from insurers or mutual nonprofit hospital and ~~medical~~ service corporations in the service area at the applicable premium cost. The group enrollee or enrollees shall be solely responsible for paying the premiums for the alternative coverage. The frequency of premium payment shall be the frequency customarily required by the health maintenance organization, mutual nonprofit hospital and ~~medical~~ service corporation or insurer for the policy form and plan selected, except that the insurer, mutual nonprofit hospital and ~~medical~~ service corporation or health maintenance organization shall require premium payments at least quarterly. The coverage shall be available to all enrollees of any group without medical underwriting. The requirement imposed by this subsection shall not apply to a contract which provides benefits for specific diseases or for accidental injuries only, nor shall it apply to any employee or member or such employee's or member's covered dependents when:

(A) Such person was terminated for cause as permitted by the group contract approved by the commissioner;

(B) any discontinued group coverage was replaced by similar group coverage within 31 days; or

(C) the employee or member is or could be covered by any other insured or noninsured arrangement which provides expense incurred hospital, surgical ~~or~~ medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination. Written application for the converted contract shall be made and the first premium paid not later than 31 days after termination of the group coverage or receipt of notice of conversion rights from the health maintenance organization, whichever is later, and shall become effective the day following the termination of coverage under the group contract. The health maintenance organization shall give the employee or member and such employee's or member's covered dependents reasonable notice of the right to convert at least once within 30 days of termination of coverage under the group contract. The group contract and certificates may include provisions necessary to identify or obtain identification of persons and notification of events that would activate the notice requirements and conversion rights created by this section but such requirements and rights shall not be invalidated by failure of persons other than the employee or member entitled to conversion to comply with any such provisions. In

provider

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or other provider

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~~(2) until April 1, 1980, $10,000. On and after April 1, 1980, organizations making deposits under this paragraph shall increase the amount of such deposit by an amount of not less than $1,500 per year until the deposit totals $25,000.~~

~~In the second year, if applicable, the amount of the additional deposit shall be equal to 2% of its estimated annual uncovered expenditures. In the third year, if applicable, the additional deposit shall be equal to 3% of its estimated annual uncovered expenditures for that year. In the fourth year and subsequent years, if applicable, the additional deposit shall be equal to 4% of its estimated annual uncovered expenditures for each year. Each year's estimate, after the first year of operation, shall reasonably reflect the prior year's operating experience and delivery arrangements.~~

~~(d)~~ *(b)* The commissioner may waive any of the deposit requirements set forth in ~~subsections (b) and (c)~~ *subsection (a)* whenever satisfied that: (1) The organization has sufficient net worth and an adequate history of generating net income to assure its financial viability for the next year; or (2) the organization's performance and obligations are guaranteed by an organization with sufficient net worth and an adequate history of generating net income; or (3) the assets of the organization or its contracts with insurers, hospital or ~~medical~~ service corporations, governments or other organizations are reasonably sufficient to assure the performance of its obligations.

provider

~~(e)~~ *(c)* When an organization has achieved a net worth not including land, buildings and equipment of at least $1,000,000 or has achieved a net worth including land, buildings and equipment of at least $5,000,000, the annual deposit requirement shall not apply.

(d) If the organization has a guaranteeing organization which has been in operation for at least five years and has a net worth not including land, buildings and equipment of at least $1,000,000 or which has been in operation for at least 10 years and has a net worth including land, buildings and equipment of at least $5,000,000, the annual deposit requirement shall not apply. If the guaranteeing organization is sponsoring more than one organization, the net worth requirement shall be increased by a multiple equal to the number of such organizations. This requirement to maintain a deposit in excess of the deposit required of an accident and health insurer shall not apply during any time that the guaranteeing organization maintains for each organization it sponsors a net worth at least equal to the capital and surplus requirements set forth in article 11 of chapter 40 of the Kansas Statutes Annotated for an accident and health insurer.

(e) The deposit requirements imposed by this act shall not apply to health maintenance organizations not organized under the laws of this state to the extent an amount equal to or exceeding that required by this

certificate of coverage the procedures for resolving enrollee grievances. At a minimum, the certificate of coverage shall include the following provisions:

(a) The definition of a grievance;

(b) how, where and to whom the enrollee should file such enrollee's grievance; and

(c) that upon receiving notification of a grievance related for payment of a bill for ~~medical~~ services, the health maintenance organization shall:

(1) Acknowledge receipt of the grievance in writing within 10 working days unless it is resolved within that period of time;

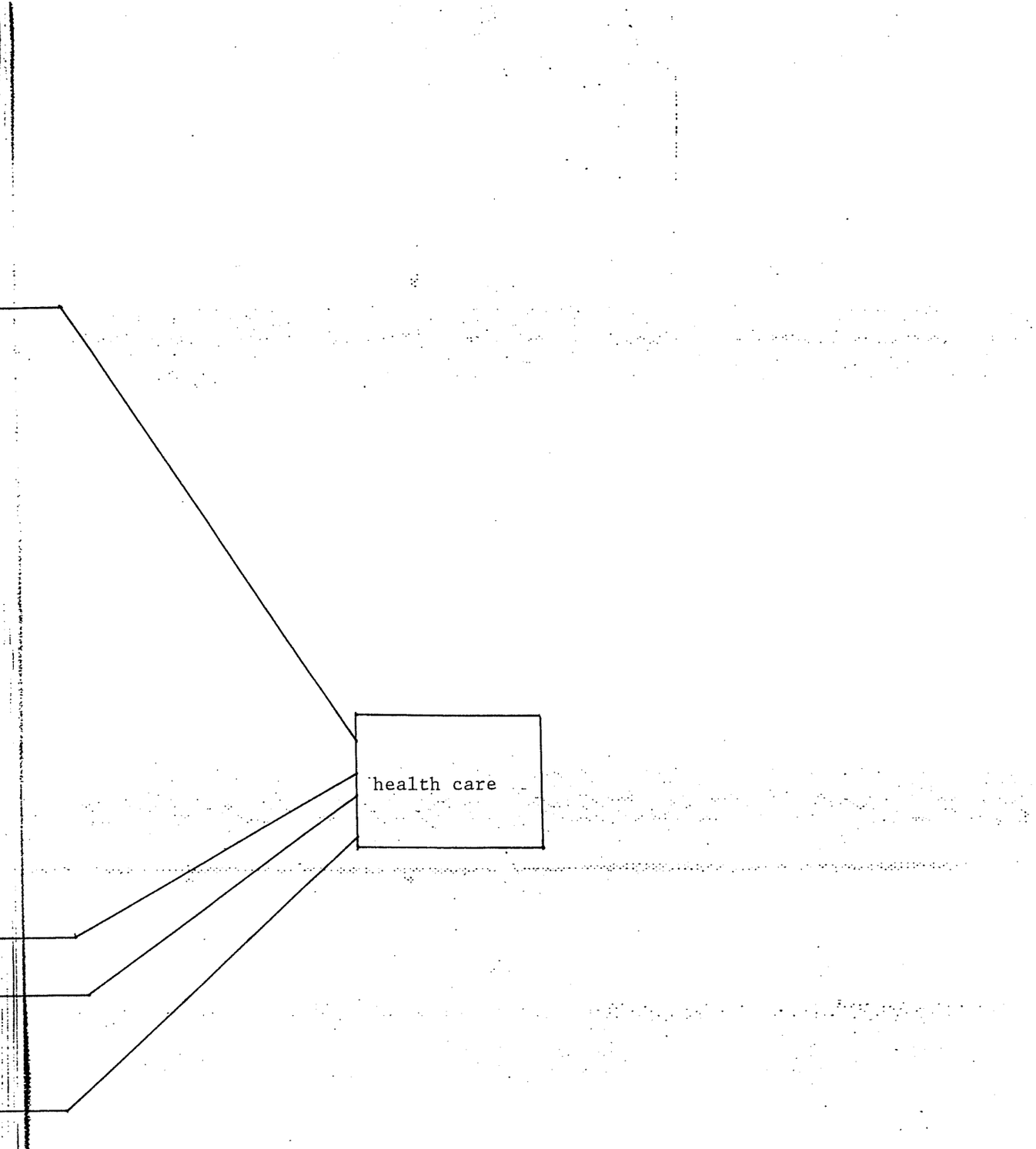
(2) conduct a complete investigation of the grievance within 20 working days after receipt of a grievance, unless the investigation cannot be completed within this period of time. If the investigation cannot be completed within 20 working days after receipt of a grievance, the enrollee shall be notified in writing within 30 working days time, and every 30 working days after that, until the investigation is completed. The notice shall state the reasons for which additional time is needed for the investigation;

(3) have within five working days after the investigation is completed, someone not involved in the circumstances giving rise to the grievance or its investigation decide upon the appropriate resolution of the grievance and notify the enrollee in writing of the decision of the health maintenance organization regarding the grievance and of any right to appeal. The notice shall explain the resolution of the grievance and any right to appeal. The notice shall explain the resolution of the grievance in terms which are clear and specific; and

(4) notify, if the health maintenance organization has established a grievance advisory panel, the enrollee of the enrollee's right to request the grievance advisory panel to review the decision of the health maintenance organization. This notice shall indicate that the grievance advisory panel is not obligated to conduct the review. This provision shall also state how, where and when the enrollee should make such enrollee's request for this review.

New Sec. 13. (a) A health maintenance organization that requires prior authorization before making payment for the treatment of ~~medical~~ emergency conditions, as defined by the health maintenance organization, shall provide enrollees with a toll-free telephone number answered 24 hours per day, seven days a week. At least one person with ~~medical~~ training who is authorized to determine whether an emergency condition exists shall be available 24 hours per day, seven days a week to make these determinations.

(b) A health maintenance organization shall not base its denial of payment for emergency ~~medical~~ services solely on the failure of the en-



a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

(b) "Commissioner of insurance" means the commissioner of insurance, the commissioner's deputies, or the insurance department, as appropriate.

(c) "Control" including the terms "controlling," "controlled by" and "under common control with", means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 10% or more of the voting securities of any other person. This presumption may be rebutted only for registration purposes pursuant to K.S.A. 40-3305 and amendments thereto by a showing made in the manner provided by subsection (i) of K.S.A. 40-3305 and amendments thereto, that control does not exist in fact. The commissioner of insurance may determine, after a hearing in accordance with the provisions of the Kansas administrative procedure act, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(d) "Insurance holding company system" means two or more affiliated persons, one or more of which is an insurer.

(e) "Insurer" means any corporation, company, association, society, fraternal benefit society, *health maintenance organization*, mutual nonprofit hospital service corporation, nonprofit medical service corporation, nonprofit dental service corporation, nonprofit optometric service corporation, reciprocal exchange, person or partnership writing contracts of insurance, indemnity or suretyship in this state upon any type of risk or loss except lodges, societies, persons or associations transacting business pursuant to the provisions of K.S.A. 40-202 and amendments thereto.

non-profit chiropractic service corporation

(f) "Person" means an individual, corporation, a partnership, an association, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing acting in concert.

(g) "Securityholder" of a specified person means one who owns any security of such person, including common stock, preferred stock, debt obligations, and any other security convertible into or evidencing the right to acquire any of the foregoing.

(h) "Subsidiary" of a specified person means an affiliate controlled by such person directly, or indirectly, through one or more intermediaries.

4-9

rollee to receive authorization prior to receiving the emergency ~~medical~~ service. The enrollee must notify the health maintenance organization of receipt of ~~medical~~ services for emergency conditions within 24 hours or as soon after that as is reasonably possible. Nothing shall require the health maintenance organization to authorize payment for any services provided during that 24 hour period, regardless of medical necessity, if those services do not otherwise constitute benefits under the certificate of coverage approved by the commissioner.

(c) If the participating provider is responsible for seeking prior authorization from the health maintenance organization before receiving payment for the treatment of emergency ~~medical~~ conditions and the enrollee is eligible at the time when covered services are provided, then the enrollee will not be held financially responsible for payment for covered services if the prior authorization for emergency ~~medical~~ services has not been sought and received, other than for what the enrollee would otherwise be responsible, such as copayments and deductibles.

(d) All disputes between an enrollee and a health maintenance organization arising under the provisions of this section shall be resolved by means of the grievance procedures established by the health maintenance organization.

New Sec. 14. A health maintenance organization shall establish reasonable procedures for assuring a transition of enrollees to ~~physicians or~~ health care providers and for continuity of treatment, including providing immediate notice to the enrollee and making available to the enrollee a current listing of preferred providers, in the event ~~of a plan termination or termination of the participation of a provider with the plan. Each contract between a health maintenance organization and a physician or health care provider must provide that in the event of plan termination, or termination of the participation of a provider with the plan, such action shall not release the physician or health care provider from the generally recognized obligation to treat the enrollee and cooperate in arranging for appropriate referrals or release the obligation of the health maintenance organization to reimburse the enrollee at the same preferred provider rate for a period of up to 90 days if, at the time of plan or provider termination, the enrollee has special circumstances such as a disability, life threatening or complex illness or is in the third trimester of pregnancy and is receiving treatment in accordance with the dictates of medical prudence.~~ ***a provider's participation in the plan is terminated for any reason. If the plan authorizes the terminated provider to continue treating the enrollee, the plan shall have an obligation to pay the terminated provider at the previously contracted rate for such services and the enrollee will not be liable for any amounts owed for*** ~~***medical***~~ ***care other than any deductibles, coinsurance or co-pay-***

health care

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health care

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MANAGED HEALTH CARE

ASSOCIATION

Statement of Brad Smoot, Legislative Counsel
Kansas Managed Health Care Association
Before the House Financial Institutions and Insurance Committee
Regarding 1996 Senate Bill 477
March 13, 1996

I am Brad Smoot, Legislative Counsel for the Kansas Managed Health Care Association. We are pleased to have an opportunity to comment on 1996 Senate Bill 477. The Kansas Managed Health Care Association wishes to acknowledge the hard work of the Kansas Insurance Department and the Commissioner's Health Care Task Force in crafting this rewrite of Kansas HMO laws. This bill will improve Kansas HMO laws to the benefit of insureds and managed care plans.

Our Association supports S 477 as amended by the Senate. Should this Committee desire further amendment of the bill, we can support the amendments proposed by the Kansas Medical Society regarding Section 14 and the other provisions relating to the filing of provider contracts (see Section 7). We understand that both amendments have been accepted by the Kansas Insurance Department.

The Association cannot accept the reinsertion of lines 20-21, page 13, as proposed by the KID. We agree with the Senate that this grant of regulatory authority to the Insurance Department is overly broad. And although we have not had a chance to review the amendments proposed by the chiropractors association, we are concerned that they may do violence to numerous sections of the bill and that their ramifications have not been discussed. We would be forced to oppose such changes at this stage in the process.

Finally, the KMHCA has taken no position on the amendments proposed by Kaiser Permanente.

Thank you for the opportunity to comment on S 477 and we urge the committee to act favorably on this measure.

House F I & I
attachment 5
March 13, 1996

KAISER PERMANENTE

Thank you, Mr. Chairman. I am Gerard Grimaldi, public affairs director for Kaiser Permanente. Kaiser Permanente is a group model HMO which serves nearly 50,000 members in the greater Kansas City area.

We oppose the application of the insurance company holding company law to HMOs for a number of reasons. As a group model HMO, we would point out that this proposed application goes beyond the regulatory requirements which have been agreed upon by the NAIC. As a direct provider of health care, not an indemnity insurer nor part of an insurance holding company, Kaiser Permanente is unique in this regard. We don't buy speculative office buildings, shopping centers or make foreign investments. We provide health care to our members.

Kaiser Permanente believes the application of the Insurance Holding Company law to HMOs is unnecessary and would impose a highly regulatory and overly burdensome requirement on HMOs. We feel that we already report all material transactions to the Commissioner and that the Commissioner has the authority to require reporting any material transactions. The NAIC Model HMO Act does not apply the entire holding company law to HMOs, and for HMOs that operate in more than one state uniformity among state laws is important for compliance purposes. As has been pointed out, we would support application of the holding company law dealing with mergers and acquisitions to HMOs - such as limited application of the holding company law is consistent with the NAIC Model HMO Act.

Thus, our concern is not necessarily with specific provisions of the holding company law, but in line with our interest in uniformity of state HMO acts and the desire to avoid unnecessary administrative and regulatory burdens which can only add to health care costs. If the Commissioner believes that there are transactions which pose a significant risk to the public and to an HMO's enrollees which currently are not reported to the Department, we would support a limited application of the holding company law to such transactions.

As such, we support the attached amendment. Thank you, Mr. Chairman and members of the committee.

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

House FI&I
Attachment 6
March 13, 1996

PROPOSED AMENDMENT FOR S.B. 477, AS AMENDED BY SENATE COMMITTEE

On page 19, strike out existing Section 15 and insert the following:

New Section 15. No person may make a tender for or a request or invitation for tenders of, or enter into an agreement to exchange securities for or acquire in the open market or otherwise, any voting security of a health maintenance organization or enter into any other agreement if, after the consummation thereof, that person would, directly or indirectly (or by conversion or by exercise of any right to acquire) be in control of the health maintenance organization, and no person may enter into an agreement to merge or consolidate with or otherwise to acquire control of a health maintenance organization, unless, at the time any offer, request or invitation is made or any agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the person has filed with the commissioner and has sent to the health maintenance organization, information required by K.S.A. 40-3304(b)(1), (2), (3), (4), (5), and (12) and the offer, request, invitation, agreement or acquisition has been approved by the commissioner. Approval by the commissioner shall be governed by K.S.A. 40-3304(d)(1) and (2).

TOTAL P.03

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Kansas Department of Social and Rehabilitation Services
Rochelle Chronister, Secretary

House Committee on Financial Institutions and Insurance
Testimony on SB No. 477
Pertaining to Health Maintenance Organization (HMO) Reform

March 13, 1996

Mr. Chairman and members of the committee, I am Ann Koci, Commissioner of Adult and Medical Services. Thank you for the opportunity to testify on behalf of Secretary Chronister today concerning Senate Bill 477. This bill is a long-awaited health maintenance organization (HMO) reform bill that overhauls the original HMO legislation written in the 1970s.

SRS is pleased with the provisions in SB 477, particularly those that require HMOs to be subject to the same laws and requirements as other insurance companies. SRS supports the new provisions to the Kansas Insurance Department's legislation that are currently in the SRS HMO contracts, including:

- Additional information may be requested in licensure submission.
- Requiring fidelity bonds for HMO staff.
- Requiring insolvency planning.
- Requiring swift resolution of grievances.

SRS supports SB 477. It represents an important and meaningful reform which is supported by the industry as well as the Kansas Insurance Department and which will act to protect health care consumers throughout the state.

3-11-96

Attachment 7
March 13, 1996