Approved: 2/5/96
Date

MINUTES OF THE Senate Committee on Financial Institutions and Insurance.

The meeting was called to order by Chairperson Dick Bond at 9:00 a.m. on February 1, 1996 in Room 529-S of the Capitol.

All members were present.

Committee staff present: Dr. William Wolff, Legislative Research Department
Fred Carman, Revisor of Statutes
June Kossover, Committee Secretary

Conferees appearing before the committee: Insurance Commissioner Kathleen Sebelius
Jerry Slaughter, Kansas Medical Society
Tom Bell, Kansas Hospital Association
Cheryl Dillard, Healthnet
Bill Pitsenberger, Blue Cross/Blue Shield
Ann Koci, SRS
John Peterson, Kaiser Permanente

Others attending: See attached list

Senator Clark made a motion, seconded by Senator Emert, to approve the minutes of the meeting of January 31 as submitted. The motion carried.

The chairman announced that the subcommittee on SB 476 will hopefully meet on Tuesday afternoon, February 6. Richard Ryan of the Research Department has been requested to go to the Treasurer's office to review both the physical and fiscal arrangements for adaptability. Mr. Ryan will submit his report to the subcommittee.

The hearing was opened on **SB 477**, revising health management organization statutes and related matters. Kansas Insurance Commissioner Kathleen Sebelius explained that this legislation is a product of a health care advisory committee formed at her request. Ms. Sebelius outlined and briefly explained changes in law contained in this bill. She requested that the bill be amended to delete new section 15 and the definitions in section 6 relating to new section 15. (Attachment #1)

The chairman announced that this bill needs a considerable amount of work and will be assigned to a subcommittee for further review.

Jerry Slaughter, Kansas Medical Society, stated that his organization agreed with deleting section 15 and that other problem areas identified will be shared with the subcommittee and the staff of the Kansas Insurance Department. (Attachment #2)

Tom Bell, Kansas Hospital Association, testified that his organization also considered section 15 to be problematic. (Attachment #3

Cheryl Dillard, Healthnet, testified that although generally in support of **SB 477** and in agreement with Commissioner Sebelius' request to remove section 15, Healthnet would also request other changes in new section 14. (Attachment #4)

Bill Pitsenberger, Blue Cross/Blue Shield, stated that although in support of the bill as a whole, he is concerned with laws that apply to one kind of insurer and not another. (Attachment #5)

Ann Koci, Social and Rehabilitation Services, stated her strong support for this legislation with minor changes. (Attachment #6)

John Peterson, Kaiser Permanente, testified that his organization endorses this bill with the changes proposed by the Insurance Commissioner and requests that any language inconsistent with the NAIC model legislation be amended to comply with NAIC language. (Attachment #7)

There were no further conferees; the hearing was closed. The subcommittee appointed to further consider **SB 477** will consist of Senator Praeger (chair), Senator Clark and Senator Petty.

The committee adjourned at 9:50 a.m. The next meeting will be Monday, February 5, 1996.

SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: 2/1/96

NAME	REPRESENTING
JOHN FEDERICO	Pete McGill + Assoc
HARRY SPRING	HUMANA HEALTH CARE PLANS
Tom Wilder	Kansas Insurance Dept
Harlan Walton	Kansas Farm Bureau
Helen Norris	" " "
Alan Sollers	" " "
Kelly Kultala	KTLA
JUDY MAYO	SELF
Rich Guthrie	Health Midwest
HAROLD E. RIEGER	KAOM
Tom Bell	KHA
Cheryl Dillard	HealthNet
BOB ALDERSON	KPSC
PETER STERN	KPSC
HARRY SPRAGG	HUMANA
Brad Smoot	BCBS/KMHCA
Teresa Menaker	HIAA
Meg Henson	KMS
Charley Young	Via Christi

SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: _____

NAME	REPRESENTING
John Ensley	Medco
Barbara Belcher	Merck
Todd Lutz	Heartland Health, Inc.
Lori Callahan	KAMMCO
Ann Koci	SRS
Carol Ridgway	Ks Ins Dept / US Dept Labor
Gina Ackmes	Century Health Solutions

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

MEMORANDUM

To: Senate Financial Institutions
and Insurance Committee

From: Kathleen Sebelius, Commissioner
of Insurance

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

Date: February 1, 1996

Senate Bill 477, which was introduced at the request of the Kansas Insurance Department, makes a number of significant changes to the laws in Kansas which govern health maintenance organizations. As you are aware, the trend in medical care, both nationally and in this state, is toward managed care arrangements. The existing Kansas health maintenance organizations law was approved by the Legislature in 1974 and with a few minor exceptions, the statutes have not been amended since that time.

In May, 1995, I formed a Health Care Advisory Committee to provide input to the Insurance Department on a variety of health insurance issues. The group consisted of 25 members who were drawn from representatives of the insurance industry, managed care organizations, medical providers, private business, consumers and legislators. Senator Sandy Praeger and Representative Greta Goodwin served as members of the Advisory Committee. A full list of the members of the Health Care Advisory Committee is attached to my testimony. The group met eight times from May of last year through this January and the members discussed a number of topics related to health insurance. A considerable amount of time was spent reviewing the Kansas insurance laws which regulate managed health care.

Senate Bill 477 is a result of those discussions. It is designed to update the regulation of health maintenance organizations in Kansas. Most of the changes to the

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Attachment
#1

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statutes are derived from the Health Maintenance Organization Model Act developed by the National Association of Insurance Commissioners. There are also provisions in the bill taken from state insurance statutes and regulations in Missouri and Texas. The following is an outline of the provisions in 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.

(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. The new language which gives the Commissioner authority to establish additional informational requirements by rule and regulation is taken from existing statute (K.S.A. 40-3212) which allows the Kansas Insurance Department to establish regulations necessary to carry out the purposes of the HMO 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 actual monetary amounts of the deposit were omitted from the final bill draft prepared by the Revisor of Statutes and I have attached an amendment which shows where those amounts should be

inserted in the bill. 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. The language was taken from regulations recently approved by the Texas Insurance Department at the recommendation of Governor George Bush.

(11.) **Health Care Intermediary Contracts (New Section 15):** This new provision is based on regulations from the West Virginia Insurance Department. As will be explained later in my testimony, I request the Committee delete this Section from the bill.

(12.) **Holding Companies (Section 16):** 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.

As previously discussed, the Insurance Department suggests that several amendments be made to this bill. The amount of funds which HMOs must deposit with the Commissioner were left out of Section 11 starting on page 13. These deposit amounts are necessary and should be added to the bill as set out in the attached amendment.

There are also a number of changes which should be made to the bill concerning the new requirements for health care intermediary contracts between medical providers and HMOs. While the Insurance Department is concerned about its ability to regulate such agreements, it is clear that New Section 15 does not effectively address this issue. I suggest the Committee make the following changes to the bill to delete this provision from the legislation: (a) strike the definitions of "administrative health service contract" and "health service intermediary" from Section 6 of the bill starting on page 5; (b) delete

the words "health services intermediary" and "other" from Section 7, page 8, lines 34 and 35 so that it will only require HMOs to provide copies of form contracts which they use with their doctors and hospitals; and (c) strike all of New Section 15.

Senate Bill 477 will help modernize the way in which managed care is regulated in Kansas. There have been a number of changes in the operation of health maintenance organizations over the past 20 years and 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 ask the Committee to approve S.B. 477 with the amendments outlined in my testimony.

HH
2/1/96
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Kansas Insurance Department
Commissioner's Advisory Committee on Health Care
Kathleen Sebelius, Insurance Commissioner

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provider in the event of nonpayment by the health maintenance organization for any services which have been performed under contracts between such enrollees and the health maintenance organization. Further, any contract between a health maintenance organization and a provider shall provide that if the health maintenance organization fails to pay for covered health care services as set forth in the contract between the health maintenance organization and its enrollee, the enrollee or covered dependents shall not be liable to any provider for any amounts owed by the health maintenance organization. If there is no written contract between the health maintenance organization and the provider or if the written contract fails to include the above provision, the enrollee and dependents are not liable to any provider for any amounts owed by the health maintenance organization.

(c) No *group or individual certificate of coverage or* contract form or amendment to an approved *certificate of coverage or* contract form shall be issued unless it is filed with the commissioner. Such contract form or amendment shall become effective within 30 days of such filing unless the commissioner finds that such contract form or amendment does not comply with the requirements of this section.

(d) Every contract shall include a clear and understandable description of the health maintenance organization's method for resolving enrollee grievances.

(e) The provisions of subsections (A), (B) and (C) of K.S.A. 40-2209 and 40-2215 and amendments thereto shall apply to all contracts issued under this section, and the provisions of such sections shall apply to health maintenance organizations.

Sec. 10. K.S.A. 40-3225 is hereby amended to read as follows: 40-3225. *(a)* Any director, officer or partner of a health maintenance organization who receives, collects, disburses or invests funds in connection with the activities of such organization shall be responsible for such funds in a fiduciary relationship to the health maintenance organization.

(b) A health maintenance organization shall maintain in force a fidelity bond or fidelity insurance on such employees and officers, directors and partners in the amount not less than $250,000 for each health maintenance organization or a maximum of $5,000,000 in aggregate maintained on behalf of health maintenance organizations owned by a common parent corporation, or such sum as may be prescribed by the commissioner.

Sec. 11. K.S.A. 40-3227 is hereby amended to read as follows: 40-3227. (a) Unless otherwise provided below, each health maintenance organization doing business in this state shall deposit with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities or any combination of these

in the amount of $150,000 for a medical group or staff model health maintenance organization or $300,000 for an individual practice association.

or other measures, *for the benefit of all of the enrollees of the health maintenance organization,* ~~that are acceptable in the amount set forth in this section for the payment of uncovered expenditures.~~

~~(b) The amount for an organization that is beginning operation shall be the greater of: (1) Five percent of its estimated expenditures for health care services for its first year of operation; or~~

~~(2) twice its estimated average monthly uncovered expenditures for its first year of operation; or~~

~~(3) $25,000.~~

~~At the beginning of each succeeding year, unless not applicable, the health maintenance organization shall deposit with the organization or trustee, cash, securities or any combination of these or other measures acceptable to the commissioner, in an amount equal to 4% of its estimated annual uncovered expenditures for that year.~~

~~(c) Unless not applicable, an organization that is in operation on the effective date of this act shall make a deposit equal to the larger of: (1) One percent of the preceding 12 months' uncovered expenditures; or~~

~~(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.

~~(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.

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(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 act has been deposited with the commissioner or an organization or trustee acceptable to the department of insurance of its state of domicile for the benefit of Kansas enrollees.

(f) All income from deposits shall belong to the depositing organization and shall be paid to it as it becomes available. A health maintenance organization that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities or any combination of these or other measures of equal amount and value. Any securities shall be approved by the commissioner before being substituted.

~~(g) In any year in which an annual deposit is not required of an organization, at the organization's request the commissioner shall reduce the required, previously accumulated deposit by $100,000 for each $250,000 of net worth in excess of the amount that allows the organization not to make the annual deposit. If the amount of net worth no longer supports a reduction of its required deposit, the organization shall immediately redeposit $100,000 for each $250,000 of reduction in net worth, provided that its total deposit shall not exceed the maximum required under this section.~~

(g) All health maintenance organizations doing business in this state shall maintain insurance from an insurance company in an amount and form as may be required by the commissioner for the satisfaction of any liabilities of the health maintenance organization or the costs of liquidation in the event of an insolvency.

New Sec. 12. A health maintenance organization shall provide in its certificate of coverage the procedures for resolving enrollee grievances.

KANSAS MEDICAL SOCIETY
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February 1, 1996

TO: Senate Financial Institutions and Insurance Committee

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 deposit requirements and adding new language relating to the rights of subscribers, the proposed bill brings previously unregulated risk bearing entities under the purview of the Insurance Commissioner. We are grateful to Commissioner Sebelius and her staff for taking the time to discuss this legislation with us prior to the hearing, and we are committed to offering constructive suggestions as we continue our analysis of the bill.

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 support that concept, but hope that the final regulatory framework is not so confining as to stifle innovative approaches to delivering health services in the new environment. Specifically, we hope that groups of physicians, and other providers, can still organize themselves into local or regional delivery networks that have the ability to bear some risk, without having to meet regulatory requirements that only larger institutional entities with substantial administrative resources can handle. Having said that, we do believe that any organization which intends to bear risk should be prudently capitalized and re-insured against large losses and normal operating business cycles.

We understand that one of the sections of the bill which raised the most questions for us, section 15, may be deleted for now, pending more study. We support eliminating it for now, until its impact can be more fully examined. There are several new definitions in section 6, some of which we need to study more closely. We hope to have specific comments to the Commissioner, and this committee, on that section within a few days.

With the exception of looking closer at those items mentioned above, we feel much of the bill can be supported. We will continue to work with the Commissioner's staff to improve our understanding of the impact of the bill, and try to have any suggestions for amendments to your committee by early next week. Thank you for considering our comments.

Senate FI+I
2/1/96
Attachment # 2

KANSAS HOSPITAL ASSOCIATION

Donald A. Wilson
President

TO: Senate Committee on Financial Institutions and Insurance

FROM: Kansas Hospital Association

RE: Senate Bill 477

DATE: February 1, 1996

The Kansas Hospital Association appreciates the opportunity to comment regarding the provisions of Senate Bill 477. This bill makes many revisions to the Kansas law governing health maintenance organizations.

Most of Senate Bill 477 is the product of a series of meetings and discussions of a task force established by the Insurance Commissioner. The Kansas Hospital Association recognizes these efforts of the Insurance Commissioner and her staff to bring forth a workable proposal. We are concerned, however, that one section of the bill does not meet this goal.

Section 15 of Senate Bill 477 (page 17) states that an HMO may not enter into an "administrative health services contract" with a "health services intermediary" unless several requirements are met. Simply stated, a health care provider or group of providers may not enter into an agreement with an HMO to provide services on a capitated payment basis unless:

1) an independent actuary certifies the contract as financially sound;
2) the provider or provider group files quarterly financial reports with the HMO and the Insurance Commissioner;
3) the provider or provider group agrees to audits by the HMO and Insurance Commissioner; and
4) the provider or provider group submits other information required by the Insurance Commissioner.

We think there are several reasons why Section 15 of Senate Bill 477 should be removed. First, the requirement of an independent actuarial report regarding the soundness of the contract could work against some Kansas hospitals. Numerous small and rural facilities in Kansas are already facing financial hardship and could find themselves locked out of the

Senate FI&I
2/1/96
Attachment #3

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managed care marketplace by this provision. Second, we think the attempt to regulate health care providers who contract with HMOs is misplaced. The HMO itself must meet certain solvency and financial requirements designed to protect the subscriber. Although the financial condition of the provider is relevant to the contract, it is the HMO that bears the ultimate financial risk. Finally, the broad definition of "health services intermediary" and "administrative health service contract" make the potential reach of Section 15 much longer than what might be anticipated, placing a burden not only on health care providers but also the Insurance Commissioner's office.

Thank you for your consideration of our comments.

/cdc

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2/1/96
3-2

HEALTHNET

To: Senate Committee on Financial Institutions and Insurance

From: Cheryl Dillard, Public Affairs Director

Date: February 1, 1996

Re: Senate Bill 477 - Health Maintenance Organizations

Mr. Chairman, members of the Committee, thank you for the opportunity to appear before you today to express the general support of the managed care industry for an amended version of SB 477, consistent with changes in the bill that we understand will be requested by Commissioner Sebelius and that we will raise today. This is a comprehensive bill and we would encourage the Committee to consider a very full discussion of many of the provisions.

It was my pleasure to serve on the Commissioner's Health Care Committee as a representative of the Kansas Managed Care Association. The Health Care Committee endorsed an update in several provisions of the Kansas HMO law, originally enacted in 1976. The managed care industry supports these updates in the areas like grievance procedures, quality assurance and fiscal soundness, as the new language represents the way managed care plans are already operating in Kansas. I would call the Committee's attention to the fact that HMO's are required by Kansas law to obtain, on an every three year basis, an independent review of their quality management programs. The independent review organizations report their findings to the Commissioner who has the authority to discipline a plan who fails to meet the criteria established by the Department.

The managed care industry has always supported this consumer protection and others contained in the 1976 law. We welcome the updates because we believe that we have and should continue to have a tested record for quality assurance, customer satisfaction and cost-effectiveness.

Some provisions in SB 477 are new and not part of the original law. We would make suggestions which we think would strengthen the bill. In New Section 14, page 17, we recommend deleting everything after the first sentence which ends with the word "plan" in line 25. This change would require us under the law to put in place a plan in the event that providers are terminated from the network, but would not specify the details of such a plan.

In Section 16, pages 18 and 19, health maintenance organizations are added to the holding company requirements. The NAIC model in this area only includes HMO's under the sections regulating mergers and acquisitions. We would request that the Committee follow the NAIC model.

Mr. Chairman, I would be pleased to answer questions.

Senate FI&I
2/1/96
Attachment #4

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TESTIMONY OF
BLUE CROSS AND BLUE SHIELD OF KANSAS ON
S. B. 477

SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE
FEBRUARY 1, 1996

I am Bill Pitsenberger, Vice-President and General Counsel of Blue Cross and Blue Shield of Kansas, a domestic health insurance company which provides coverage to more than 700,000 Kansans directly, and covers almost 30,000 more through its affiliated health maintenance organizations.

I had the pleasure of serving as a member of Commissioner Sebelius's task force which gave rise to S.B. 477.

We support S.B. 477 as a whole, but I wanted particularly to address those elements of the Bill which would apply to HMOs some of the same regulatory provisions which today apply to insurance companies.

Under S.B. 477, the sale of stock in an HMO would be subject to the same oversight by the commissioner as the sale of stock in an insurance company (Sections 1-3); persons who sell HMO coverage would have to be licensed as agents (Sections 4 and 5); and the acquisition of control of an HMO by a new party, as well as certain intracorporate and shareholder transactions, such as the declaration of an extraordinary dividend, bulk reinsurance transactions, and other actions, would be subject to the same oversight as such actions in relation to an insurance company.

I am not going to tell you why we think those kinds of things are good public policy; obviously, the legislature thought they provided important protections to Kansans or it would not have enacted them for insurance companies. Instead, I am going to point out that HMOs are viewed by consumers as not different than insurance companies. Under the state employee program, and in many other programs, employees can choose between traditional programs and HMOs; to them, they are interchangeable. They don't know that the people selling these programs may not be licensed agents, or that the HMO they are enrolling in may have changed ownership three times in the last two years.

It seems to us that if these laws are good laws, they ought to apply to all kinds of health care financing mechanisms. If they aren't good laws, they should be done away with. But there is no rational basis for the laws to apply to one kind of insurer but not to another.

Of course, we also support the other elements of S.B. 477, and encourage its passage.

Senate 7/81
2/1/96
Attachment #5

Kansas Department of Social and Rehabilitation Services
Rochelle Chronister, Secretary

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

February 1, 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. It was developed with the input of a working group represented by industry and the Kansas Insurance Department, and it represents a compromise among all parties.

SRS is pleased with many of the provisions in SB 477, particularly those that require HMOs to be subject to the same laws and requirements as other insurance companies. SRS strongly 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 insurance.
- Requiring swift resolution of grievances.

We are concerned with several issues related to SB 477:

•First, HMO financial reserve account requirements were omitted from the original bill. We support modifications to Section 11(a) correcting the omission of specific dollar amounts for reserve account requirements.

•Secondly, Section 11(e) allows for reciprocity with other state insurance departments. However, it leaves purchasers of health care, like SRS, in a position of weakness, because reserve accounts are in other states, and we are unable to access those funds in the event of insolvency. Such arrangements should be approved only in circumstances when there is a written agreement between the Kansas Insurance Department and the reciprocal insurance department, **and** when the HMO is determined to have deposited reserves appropriate to cover losses in both Kansas and the reciprocal state. Allowing for reciprocity without these additional provisions defeats the purpose of reserve accounts.

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•Third, Section 11(g), which relates to new requirements for insolvency insurance, is vague. The following types of insurance should be explicitly required:

- •insolvency insurance.
- •stop-loss insurance.
- •insurance policies against bodily injury, burglary, robbery or theft.

•Finally, SRS believes there is a need for tougher financial standards for HMOs than those currently outlined in this bill. The Health Care Financing Administration suggests the following of all Medicaid managed care plans:

•The plan should maintain a positive net worth.
•The plan should have readily available financial resources to cover any operating deficits incurred to the point "break-even" is reached.
•The plan should have sufficient cash and adequate liquidity set aside (i.e. restricted) and accessible to the Kansas Insurance Department to meet obligations as they become due.

SRS strongly believes that this bill should be passed without "any willing provider" language included. Inclusion of "any willing provider" language will limit HMOs' ability to determine which providers are qualified to participate in their networks, thereby threatening the quality of care delivered to HMO enrollees.

However, SRS strongly supports SB 477. Even without the suggested changes discussed above, 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.

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KAISER PERMANENTE

January 31, 1996

Hon. Richard L. Bond
Chair, Financial Institutions and Insurance
Room 128-S.
Topeka, KS 66612

Dear Senator Bond:

I am writing to express the concerns of the Kaiser Permanente Medical Care Program ("Kaiser Permanente") with certain portions of S.B. 477. As you know, Kaiser Permanente is a prepaid group practice HMO that provides or arranges health care to more than 47,000 members in the greater Kansas City area. In general, we fully support the goal of Commissioner Sebelius to strengthen and improve the Kansas HMO Act. Representatives of Kaiser Permanente also participate actively in the work of the NAIC, and we have supported efforts over the years to improve the NAIC's Model HMO act ("NAIC Model"). All of the concerns we have with S.B. 477 involve areas where the proposed changes in the Kansas statutes are substantially at odds with comparable provisions in the NAIC Model. Both because of the substantive concerns expressed below and because we think it is important to support the goal of the NAIC to encourage uniformity among state laws, we hope that the bill will be amended to more closely follow the NAIC Model.

Kaiser Permanente supports the changes in Section 9 which are consistent with the NAIC Model. However, we would point out that Subsection (a)(10) is not in the NAIC model and we do not support this proposed change.

Because of our participation in the meetings of the Commissioner's Advisory Committee on Health Care, we recognize the Commissioner's concern with insolvency protection measures. However, the proposed subsection(g) of Section 11 would, in effect, require that HMOs purchase coverage from entities that may be direct competitors of HMOs. This proposed section is not in the NAIC Model. However, the NAIC Model contains other insolvency protection measures that offer significant consumer protections without requiring HMOs to purchase coverage from a competitor. Kaiser Permanente would support implementation of the NAIC's uncovered insolvency deposit language (NAIC Model Section 14).

In regards to the proposed Section 14 of Senate Bill 477, Kaiser Permanente would point out that these provisions are not currently contained in the NAIC Model. We support the intent of the first sentence, but note that the section as currently proposed would require an HMO to continue to reimburse a provider who no longer has a relationship with an HMO, even if the termination resulted from problems with quality.

Commissioner Sebelius indicated at this week's meeting of the Commissioner's Advisory Committee on Health Care that her department may propose some further changes in the

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proposed Section 15, and we await the opportunity to review these. If the intent is to have a remedy should an HMO become insolvent, we would suggest adoption of the NAIC Model provision (Section 13D) that requires that contracts between HMOs and providers contain "hold harmless" clauses that protect enrollees from unpaid bills of providers if they are not paid by an insolvent HMO. Such requirements protect enrollees while imposing fiscal responsibility on contracting providers, which seems to be the goal of this section.

The proposed Section 16 of Senate Bill 477 would apply the entire insurance holding company system law to HMOs. The NAIC Model (section 30) applies to HMOs only the sections of the holding company law dealing with mergers and acquisitions. Most states closely follow the NAIC Model Act and do not apply the holding company laws to HMOs. As the Commissioner already receives substantial reporting of material changes in our operations, application of the Holding Company Law would impose new and possible expensive regulatory burdens on HMOs, especially HMOs such as Kaiser Permanente that are not part of any insurance holding company system. For a multi-state HMO such as Kaiser Permanente, it is very helpful for states to follow the NAIC Model laws, and we fully support the NAIC approach in this area.

Again, as we noted initially, all of these concerns involve areas where S.B. 477 would depart from the NAIC Model. As the only HMO in the state of Kansas to receive Full Accreditation Status from the National Committee for Quality Assurance, Kaiser Permanente is committed to provide the highest quality health care to our members. We recognize and support the role of Commissioner Sebelius and the legislature in these matters. At the same time, we hope that the Kansas HMO Act can be amended to more fully reflect the work that has gone into the NAIC Model HMO Act over the years.

Thank you for your consideration of our views, and please let me know if you have any questions with any of the issues raised herein.

Sincerely,

Gerard J. Grimaldi
Public Affairs Director

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