Approved: 2/19/96
Date

MINUTES OF THE Senate Committee on Financial Institutions and Insurance.

The meeting was called to order by Chairperson Dick Bond at 9:10 a.m. on February 16, 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: Tad Kramar, Security Benefit Group of Companies
Tom Wilder, Kansas Insurance Department
William Sneed, Health Insurance Association of America
David Brenerman, UNUM Life Insurance Company
Morris Melloy, Transamerica Occidental Life Insurance Co.
Samuel Morgante, AMEX Life Assurance Company
Robert Glowacki, AEGON USA, Inc.
John Federico, Sterling House Corporation
John Grace, KAHSA

Others attending: See attached list

Senator Emert made a motion, seconded by Senator Steffes, to approve the minutes of the meeting of February 15 as submitted. The motion carried.

Tad Kramar, SBG, appeared before the committee to present the revisions to **SB 549**, concerning life insurance company investments in foreign jurisdictions and currencies. This bill was heard in committee on February 7 and was found to need several clarifying amendments. (Attachment #1) Mr. Kramar explained the changes contained in the balloon and Tom Wilder, Kansas Insurance Department, stated that they are in agreement with the amended language and requested passage of the bill as amended.

Senator Lee moved to amend **SB 549** as requested and recommend its passage. Senator Emert seconded the motion. The motion carried. Senator Hensley will carry this bill in the Senate.

The chair opened the hearing on **SB 656**, concerning long-term care insurance. William Sneed, HIAA, presented a history of the Kansas Insurance Department's regulations regarding long-term care and explained the problems encountered since the state moved from a "facility based" system to a "level of care " based system. (Attachment #2) Briefly, insurance companies cannot determine the level of care needed by assessing an insured's Activities of Daily Living (ADL's) skills because of the Insurance Department's interpretation of KAR 40-4-37 and 40-4-37d.

David Brenerman, UNUM Life Insurance Company, further explained what comprises ADL's, how they are assessed, and why they are better indicators of the level of care needed. Mr. Brenerman also advised that Kansas is the only state which does not allow the level of care needed to be determined by assessment of ADL's. (Attachment #3)

Senator Lee posed several questions regarding who assesses a person's ADL capacity and who then determines the appropriate level of care. Mr. Sneed agreed to prepare responses to Senator Lee's questions since committee time today would allow only for presentation of testimony and several of the conferees were from out of town.

Morris Melloy, Transamerica Occidental, explained how the NAIC developed the language relative to ADL's. (Attachment #4)

Samuel Morgante, AMEX Life Assurance Company, addressed the issue of how insurance benefits can be better utilized by accurately assessing and assigning the level of care needed. (Attachment #5)

Robert Glowacki, AEGON, stated that Kansas regulations do not allow for benefit eligibility criteria to be objective. (Attachment #6)

John Federico, representing Sterling House Corporation, proposed amending **SB 656** to raise the reimbursement "floor" and to change the criteria on page 5, lines 11-14, to establish a minimum level of functioning to the inability to perform no more than two activities of daily living. (Attachment #7)

John Grace, Kansas Association of Homes and Services for the Aging, voiced his organization's support for **SB 656**, stating that the use of ADL criteria for triggering long-term care insurance benefits appears to be the most reasonable way to determine appropriate placement and reimbursement. (Attachment #8)

Senator Praeger noted that this legislation appears to be consistent with the SRS/Department of Aging policy of screening all applicants to nursing homes to be sure those who do not need that level of care can be placed where they will benefit from other services.

The chairman requested that the principals involved in today's hearing meet with Mr. Wilder of the Kansas Insurance Department with a view to working out the problems foreseen with the passage of this bill.

Presenting written testimony were: Kathleen Sebelius, Kansas Insurance Commissioner (Attachment #9); Aid Association for Lutherans (Attachment #10); Bankers Life and Casualty Company (Attachment #11); and John Hancock Mutual Life Insurance Company (Attachment #12).

The committee adjourned at 10:00 a.m. The next meeting is scheduled for February 19, 1996.

SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: 2/16/96

NAME	REPRESENTING
Robert Glowacki	AEGON USA, Inc.
Morris Melloy	Transamerica Occidental Life
Robert Howe	John Hancock Mutual Life
Ray Nelson	Bankers Life & Casualty Co.
Lynn Boyd	Health Insurance Assoc. of America
Linda LeBeau	Lincoln National Life Insurance Co.
Eugene J. Volk	Bankers Life and Casualty Co.
David Brenerman	UNUM Life Insurance Co. of America
Kevin McFarland	Ks Homes & Services for Aging
Roger Trowbridge	KGC
Teresa Tiffenauer	HIAA
Sam Morgante	AMEX LIFE
Rich Hunecker	Ks Ins. Dept
Jake Rijsinger	KDOA
Kelly Kultala	KTLA
TAD KRAMAR	SECURITY BENEFIT
DAVID HANSON	KS INSUR ASSOCS.
Jim Woods	Security Benefit
Bill Sneed	HIAA

SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: 2/16/96

NAME	REPRESENTING
Wilma L Cole	Mennonite Fraternal Reg Comm.
DAVID BENZ	AID ASSOCIATION FOR LUTHERANS
Sharon Brosnan	AID ASSOC. FOR LUTHERANS
Bob Darnell	Aegon - USA

Session of 1996

SENATE BILL No. 549

By Committee on Financial Institutions and Insurance

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AN ACT concerning insurance; life insurance company investments in foreign jurisdictions and currencies; amending K.S.A. 40-2b04 and repealing the existing section.

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

Section 1. K.S.A. 40-2b04 is hereby amended to read as follows: 40-2b04. ~~Any life insurance company heretofore or hereafter organized under any law of this state may invest by loans or otherwise, with the direction or approval of a majority of its board of directors or authorized committee thereof, any of its funds, or any part thereof in bonds or other evidences of indebtedness issued, assumed or guaranteed by any foreign government, except as provided in K.S.A. 40-2b03, and amendments thereto, in an amount not to exceed 5% of its admitted assets as shown by the company's last annual report, as filed with the state commissioner of insurance or a more recent quarterly financial statement as filed with the commissioner, on a form prescribed by the national association of insurance commissioners, within 45 days following the end of the calendar quarter to which the interim statement pertains. The 5% limitation shall be in addition to any investments in foreign nations required by virtue of a company doing business in a foreign nation.~~ *(a) As used in this section:*

(1) "Business entity" means a sole proprietorship, corporation, limited liability company, association, partnership, joint-stock company, joint venture, mutual fund, trust, joint tenancy or other similar form of business organization, whether organized for-profit or not-for-profit.

(2) "Domestic jurisdiction" means the United States, Canada, and a state or political subdivision of the United States or Canada.

(3) "Foreign currency" means a currency other than that of the United States or Canada.

(4) "Foreign investment" means an investment in a foreign jurisdiction or in an asset domiciled in a foreign jurisdiction. An investment shall not be deemed to be foreign if the issuing business entity, qualified primary credit source or qualified guarantor is a domestic jurisdiction or a business entity domiciled in a domestic jurisdiction, unless:

(A) The issuing business entity is a shell business entity; and

(B) the investment is not assumed, accepted, guaranteed or insured

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Attachment #1

or otherwise backed by a domestic jurisdiction or a business entity, that is not a shell business entity, domiciled in a domestic jurisdiction.

(5) "Foreign jurisdiction" means a jurisdiction outside of the United States or Canada.

(6) "Qualified guarantor" means a guarantor against which an insurer has a direct claim for full and timely payment evidenced by a contractual right for which an enforcement action can be brought in a domestic jurisdiction.

(7) "Qualified primary credit source" means the credit source to which an insurer looks for payment as to an investment and against which an insurer has a direct claim for full and timely payment evidenced by a contractual right for which an enforcement action can be brought in a domestic jurisdiction.

(8) "Shell business entity" means a business entity having no economic substance except as a vehicle for owning interests in assets issued, owned or previously owned by a business entity domiciled in a foreign jurisdiction.

(b) Any life insurance company organized under any law of this state may ~~acquire~~ foreign investments of the same types as those that an insurer is permitted to acquire under K.S.A. 40-2b01, 40-2b02, 40-2b03, 40-2b05, 40-2b06, 40-2b07, 40-2b24, 40-2b26, 40-2b27 and 40-2b28 and K.S.A. 1995 Supp. 40-2b29, and amendments thereto, if:

(1) The aggregate amount of foreign investments then held by the insurer does not exceed 20% of its admitted assets; and

(2) the aggregate amount of foreign investments then held by the insurer in a single foreign jurisdiction does not exceed 10% of its admitted assets for jurisdictions that have a sovereign debt rating of SVO 1, or 3% of its admitted assets for all other jurisdictions.

(c) ~~An insurer may acquire~~ investments denominated in foreign currencies, whether or not they are foreign investments acquired under subsection (b), if:

(1) The aggregate amount of investments then held by the insurer denominated in foreign currencies does not exceed 10% of its admitted assets; and

(2) the aggregate amount of investments then held by the insurer denominated in the foreign currency of a single foreign jurisdiction does not exceed 10% of its admitted assets for jurisdictions that have a sovereign debt rating of SVO 1, or 3% of its admitted assets for all other jurisdictions.

(d) Notwithstanding the provisions of K.S.A. 40-2b13 and amendments thereto, the insurer's total foreign investments and investments denominated in foreign currencies shall not exceed the limitations set forth in subsections (b) and (c).

(9) "SVO" means the Securities Valuation Office of the National Association of Insurance Commissioners or any successor office established by the National Association of Insurance Commissioners.

invest, by loans or otherwise, with the direction or approval of a majority of its board of directors or authorized committee thereof, any of its funds, or any part thereof, in

Any life insurance company organized under any law of this state may invest, by loans or otherwise, with the direction or approval of a majority of its board of directors or authorized committee thereof, any of its funds, or any part thereof, in

of the same types as those that an insurer is permitted to acquire under K.S.A. 40-2b01, 40-2b02, 40-2b03, 40-2b05, 40-2b06, 40-2b07, 40-2b24, 40-2b26, 40-2b27 and 40-2b28 and K.S.A. 1995 Supp. 40-2b29, and amendments thereto, which are

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(e) The investment limitations in subsections (b) and (c) computed on the basis of an insurer's admitted assets shall relate to the amount ~~*required to be*~~ *shown on the insurer's last annual report as filed with the commissioner of insurance or a more recent quarterly financial statement as filed with the commissioner, on a form prescribed by the National Association of Insurance Commissioners, within 45 days following the end of the calendar quarter to which the interim statement pertains.* as

(f) Investments acquired under this section shall be aggregated with investments of the same types made under K.S.A. 40-2b01, 40-2b02, 40-2b03, 40-2b05, 40-2b06, 40-2b07, 40-2b24, 40-2b26, 40-2b27 and 40-2b28 and K.S.A. 1995 Supp. 40-2b29, and amendments thereto, and in a similar manner, for purposes of determining compliance with the limits, if any, contained in the other sections. b

Sec. 2. K.S.A. 40-2b04 is hereby repealed.

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

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MEMORANDUM

TO: The Honorable Dick Bond, Chairman
Senate Financial Institutions and Insurance Committee

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

DATE: February 16, 1996

RE: S.B. 656

Mr. Chairman, Members of the committee: my name is Bill Sneed and I am here today on behalf of the Health Insurance Association of America ("HIAA"). HIAA is a health insurance trade association consisting of more than 300 insurance companies that write more than 80% of the commercial health insurance in the United States today. Many of our member companies offer a variety of long-term care policies to Kansas consumers.

Today, the State of Kansas, as it relates to long-term care, has moved from a "facility based" system to a "level of care" based system. Unfortunately, the Kansas insurance code does not reflect this change. S.B. 656 is my client's proposal to incorporate a level of care system into the insurance code. Further, we would contend that failure to address this issue may jeopardize the hard work of many who over the last two years put in a tremendous amount of effort to get Kansas into the mainstream. Those efforts are reflected in S.B. 8, which was passed in 1995.

The impetus for our introduction of this legislation is threefold: it begins with the passage of S.B. 8 in 1995, and includes the Kansas Insurance Department regulations regarding long-term care, specifically K.A.R. 40-4-37 and 40-4-37d, and the Department's bulletin of February 2, 1996, regarding the regulations. In order to understand the purpose and scope of our legislation, it is essential to understand the history of long-term care insurance, S.B. 8, the resulting Department regulations, and the very recent Department bulletin regarding long-term care.

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Attachment #2

Long-Term Care 1985-1994

The history of long-term care and long-term care insurance dates back prior to 1985, but prior information is unnecessary since a review of the statutes from 1985 to 1994 will adequately explain the effect of S.B. 8.

In 1985, the legislature passed an amendment to K.S.A. 40-2,116 and statutorily defined "health facility." This law was passed to determine the contract rights between health facilities and mutual non-profit hospital service corporations (Blue Cross/Blue Shield). The importance of this statute will be evident in a moment.

In July, 1986, the Kansas Insurance Department established a Senior Advisory Committee and one of the subjects the group studied was long-term care insurance. The efforts of this group led to the introduction and successful passage of K.S.A. 40-2225, et seq., commonly referred to as the Long-Term Care Insurance Act. The Act is very short, and excluding some specific policy prohibitions, most provisions of a long-term care insurance policy were left up to rule and regulation. (K.S.A. 40-2228.)

After the Act went into effect on July 1, 1987, the Department began working on implementing the Act by issuing a regulation. During these discussions, the working group set about determining what would trigger the payment of benefits. The long-term care insurance industry proposed that the Department use Activities of Daily Living (ADLs) as the benefit payment criteria. ADLs are the "basic" activities of life. After extensive research, professionals in gerontology, not insurance, have determined that the inability to perform a certain number of these activities best determines the type and/or level of care a person needs. At that time, the use of ADLs was in its infancy, and the Department rejected the use of ADLs as benefit triggers. The Department's stated

position was that they feared use of ADLs would be more a method of denying claims rather than triggering benefits.

The Department also made the decision that admission into a certain type of facility would trigger benefits. Thus, the State of Kansas established a "facility based" system. To effectuate this system, the Department utilized the definition of "health facility" found in K.S.A. 40-2,116. Since the state only licensed skilled nursing homes, intermediate nursing care homes and intermediate personal care homes, the Department would only approve policies that paid benefits once an individual was admitted in one of those three types of facilities.

The Department unwittingly unleashed problems associated with a "facility based" system. The problem was and is that lower levels of care (at a lower cost) could not be realized and premiums for long-term care insurance products could not reflect this potential cost savings. Rates became artificially set since rates would have to be established reflecting the cost of the highest facility level. As a result, the insurance industry attempted to sell its products on a facility-defined basis. However, the health care system dramatically changed beginning in 1989, and as such, new "facilities" came on the scene.

To appropriately address these changes, during the 1991 legislative session, my client, along with others in the field, introduced H.B. 2420. This bill would have authorized ADLs and moved Kansas to a "level of care" system by removing the facility requirement. The Kansas Insurance Department opposed the bill, and at the urging of the House Committee, the Department agreed to re-establish the Senior Advisory Committee to review ADLs. With the agreement to study the issue, the House Committee took no action on H.B. 2420. During the remainder of 1991 and most of 1992, several meetings took place on the issue. During the 1992 session, and while the industry was still attempting to work with the Department, the legislature again changed K.S.A. 39-923 and created

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the terms "nursing facility" and "intermediate personal care homes," and again K.S.A. 40-2116 was amended to incorporate those changes.

After the 1992 session, the Department rejected industry's argument that Kansas needed to move to a "level of care" system. However, the Department did agree to allow ADLs for group long-term care products, since most of these products are sold nationwide and the vast majority of jurisdictions allowed ADLs. However, the Department did not decide on the above until September of 1992, after the 1992 legislative session.

By 1993, the new regulations were in place, and during 1993 and 1994 various long-term care filings were made with the Department. If the companies' definition of "facility" was broad enough, coverage in other facilities was sometimes allowed. In other instances they were not. However, during 1993 and 1994 the industry took little action on its policy filings due to two reasons. First, Kansas still limited the type of facility that could obtain a license. Secondly, the NAIC began working on model language that would put into place a level of care system. The current version was approved by the NAIC in March of 1995.

That all changed in 1995 when the legislature enacted S.B. 8. I will review S.B. 8 in a moment, but to bring this history full circle, once S.B. 8 went into effect the insurance industry once again began working with the Department on a new regulation. Once again, we urged the Department to move to a "level of care" based system. Once again, we urged the Department to look to the NAIC regulation and its use of ADLs. In fact, while we were working with the Department, myself and two of our member companies testified in front of the Health Care Reform Legislative Oversight Committee on September 21, 1995, and we intentionally withheld making a request that the Committee consider a bill like S.B. 656 inasmuch as we were trying to resolve the issue directly with the Department through its regulation.

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S.B. 8

S.B. 8 was the work product of the Long-Term Care Action Committee and the Special Committee on Public Health and Welfare which met in the 1995 interim. The committee's goal was to clarify and update Kansas law on regulation of residential facilities that served the elderly and disabled populations, who needed some assistance with the activities of daily living due to age or functional impairment, but who did not need a nursing home level of care. The committee received evidence that Kansas lagged behind most other states in the development of a range of residential settings to serve those who could not live independently because they required assistance with one or more activities of daily living (ADLs). The committee received evidence that as a result, in many areas of the state, individuals were forced to seek admission to a full-blown nursing facility because there were no alternatives. A more expansive description of the Committee's work is marked as attachment "A."

The Long-Term Care Action Committee recommended legislation to the 1995 legislature to create a definition of assisted living under the Adult Care Home Licensure Act, as well as create definitions for other levels of nursing care, and amend, streamline, or delete existing definitions. This legislation took the form of S.B. 8, which was introduced and heard in the Senate and House Public Health and Welfare committees.

S.B. 8 was designed to provide choice for those in need of long-term care resulting from functional disabilities arising from aging or handicapping conditions by allowing the provision or coordination of a range of services in different types of residential settings rather than requiring these individuals to more to another type of facility as needs change. This was the significant change in policy proposed by the legislation: if an individual's needs were being met in an assisted living

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facility, it would not be necessary for them to move to a higher-level nursing facility, even if the individual was receiving care that meets traditional definitions of "skilled care."

S.B. 8, in its final form, included the following general changes:

- redefined the term "adult care home" in K.S.A. 1994 Supp. 39-923 to include new categories of residential care including "assisted living facility," "residential health care facility," "home plus," and "adult day care"
- deleted categories of "intermediate personal care home" and "one-to-five-bed home"
- added new definition of nursing facility for mental health, though not representing a new category of long-term care
- added requirement of skilled nursing to definition of mental health nursing facility

A number of entities were involved in the process of moving S.B. 8 through the legislative process, including Kansans for Improvement of Nursing Homes, Inc. ("KINH"), Kansas Association of Homes and Services for the Aging ("KAHSA"), Kansas Department of Health and Environment ("KDHE"), Kansas Health Care Association ("KHCA"), the Kansas Department on Aging, and others. Perhaps the most important element that was addressed by these entities is that by moving to a level of care system, costs could be reduced, and the new population of older Kansans could be better served.

K.A.R. 40-4-37 and 40-4-37d

Once S.B. 8 was signed into law, the Kansas Insurance Department was charged with developing regulations to implement the new definitional levels of long-term care.

Beginning in May of 1995 and continuing to date, my client and several member companies have met with the Kansas Insurance Department to discuss the proposed regulation. We urged the

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Department to re-evaluate the position on ADLs in the individual market and to provide a mechanism for the payment of benefits to be matched to the level of care a person is receiving. On December 1, 1995, a public hearing was held regarding the proposed regulations. Formally and on the record, my client and several member companies again urged the Department to consider the above issues. On January 25, 1996, K.A.R. 40-4-37 and K.A.R. 40-4-37d were published in the *Kansas Register* with an effective date of February 9, 1996. (Attachment "B.")

Insurance Department Bulletin

The Kansas Insurance Department issued a bulletin (1996-2), dated February 2, 1996, which gave notice of the long-term care regulations drafted in response to S.B. 8. (Attachment "C.") The Department stated that the regulations were crafted for the limited purpose of bringing the regulations into conformity with current Kansas law regarding adult care home licensing requirements. The Department declined to address any other regulatory aspect of long-term care, stating instead that the Department would study further issues in 1996.

The most shocking aspect of the bulletin was the statement that companies which provide benefits for any sort of intermediate care must pay the same level of benefits to the recipients of such care, regardless of whether care occurs in an assisted living facility, traditional nursing home facility, or any other variation. Any policy provision not conforming to this equal-pay policy will be considered discriminatory and in violation of the insurer's unfair trade practices act. Companies were charged with submitting necessary policy form amendments to the Department and administering the provisions of any in-force policy in accordance with the dictates of the bulletin. Companies were expected to comply by February 9, 1996, seven days after the bulletin was issued and only two or three days after the bulletin would have arrived in the mail. Since the publication

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of the regulation, we have been meeting with members of the Insurance Department in an attempt to answer our concerns that have been raised by the Department's bulletin.

S.B. 656

The intent of S.B. 656 is to utilize current state law and add NAIC language that would allow "level of care" standards. The following is a breakdown of the proposed amendments and additions to current law.

1. Section 1 is an amendment to K.S.A. 40-2,116, a definitional statute. Subsections (a), (c), (d), (g), (h), (i), (o) and (p) are NAIC definitions.

The next change is to the current definition of "health facility" (new section (j), page 2, lines 8-14) and eliminates the incorporation by reference of K.S.A. 39-923.

Subsections (b), (k) and (m) are the current definition of the allowable facilities found in K.S.A. 39-923, except that the phrase "by choice" has been eliminated. Having that phrase in the licensing laws may be appropriate, but when determining insurance coverage, such phrase is unnecessary and eliminates the possibility of self-referral.

2. Section 2 amends K.S.A. 40-2228. The first change is found on page 3, lines 12-14. This will allow the Commissioner to establish policies that utilize activities of daily living or cognitive impairment to determine the payment of benefits.

The next change is found on page 5, lines 3-8, in new subsection (i). This will allow policies to pay benefits based upon levels of care given at the different facilities. The language includes the protection that no policy will pay at less than 50% of benefits in a nursing facility. Further, all benefits and rates are subject to Insurance Department approval. Finally, the criteria for ADLs is added by the new language found on page 5, lines 9-42, in new subsections (j)-(m). This is NAIC

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language.

Conclusion

The industry's dilemma is quite simple. Without S.B. 656, (1) we will have to price our product so that regardless of what type of care a person is receiving, it will be at a benefit level at the highest level of treatment; or (2) cease writing this business or write this business as a Kansas-only book of business; or (3) retain the status quo and wait to see if the Insurance Department changes course on this issue.

It is our position that alternatives #1 or #2 go against the intent of S.B. 8, cripple the advent of appropriate care at lower costs, and will dry up the availability of long-term care insurance products. In regard to alternative #3, we have several member companies that will individually address that issue. Therefore, we urge the Committee to act favorably on S.B. 656.

Respectfully submitted,

William W. Sneed

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SPECIAL COMMITTEE ON PUBLIC HEALTH AND WELFARE*

COMMITTEE MEETINGS

The Special Committee on Public Health and Welfare met on September 29-30, 1994, to consider issues related to the Board of Healing Arts and the practice of chiropractic as defined in the Kansas Healing Arts Act. Additionally, the Special Committee met on November 30, 1994, to hear conferees on the concepts of assisted living and the appropriate level of state oversight of such residential services.

Minutes of the meetings are on file with the Division of Legislative Administrative Services. Staff memoranda are available in the Legislative Research Department and in the Office of the Revisor of Statutes.

BACKGROUND

The Kansas Healing Arts Act and Chiropractic Issues

The request for an interim study on the Board of Healing Arts came from the Chair of the Senate Committee on Public Health and Welfare who asked that an interim committee consider the following:

- whether the statutory scope of practice of each category of licensee under the Kansas Healing Arts Act is consistent with contemporary education and training received by the professions;
- whether the structure and composition of the Board of Healing Arts is appropriate for the functions performed by the Board and its agency personnel;
- whether the various allied professions regulated by the Board are compatible with the principal responsibilities of the Board; and
- whether any legislation is needed to better define the licensed scope of practice of each category of licensee as well as statutory changes needed to improve the Board's ability to perform its functions.

The second part of the assigned study was requested by the Kansas Chiropractic Association as a result of discussion of those professionals who are qualified to perform child health assessments pursuant to the provisions of 1994 S.B. 520. The latter was enacted in a form that authorizes only those persons who may be providers under the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) component of the Medicaid program to conduct the child health assessments, that is, persons licensed to practice medicine and surgery, persons acting under the direction of a person licensed to practice medicine and surgery, or a licensed nurse who has completed the Department of Health and Environment

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* S.B. 8 and H.B. 2004 accompany this report.

training and certification. Concurrent with passage of S.B. 520, there was discussion of referring the subject of the scope of practice of chiropractors to an interim study so that "misunderstandings about the profession can be cleared up which will enable the legislature to make health care decisions for Kansas citizens in a knowledgeable way."

Assisted Living

The second study assigned to the Special Committee on Public Health and Welfare was requested by a representative of Sterling House Corporation which constructs and manages "assisted living facilities" in Kansas. The request for a study asked that an interim study be conducted on what, if any, regulation and oversight is needed for "assisted living facilities." The request for a study specified that it include the development and implementation of a licensure category for assisted living, including:

- service delivery standards that support individual resident dignity, independence, individuality, privacy, choice, and decision making in a home-like environment;
- environmental standards that support resident dignity, independence, individuality, privacy, choice, and decision-making in a homelike environment;
- staffing standards that support independence and a home-like setting while maintaining residency costs for tenants or funding agents; and
- emphasis on the individual facility's ability to provide or coordinate needed support services.

COMMITTEE ACTIVITY

The Kansas Healing Arts Act and Chiropractic Issues

The Executive Director of the Kansas Chiropractic Association; the President of the Association; the President of the National College of Chiropractic; a faculty member of the Logan College of Chiropractic; a chiropractor who currently practices in California; and two chiropractors who practice in Kansas were selected as conferees by the Association to educate the Committee as to the art, science, and philosophy of chiropractic. Staff presented the results of research on the chiropractic regulatory acts of the other states and on the structure of the boards that regulate practitioners of chiropractic in other states.

In terms of the review of the Board of Healing Arts, the Committee heard from the Executive Director of the Board; from three members of the Board, including the President, Vice-President, and a member who had just completed a term on the Board; the Vice-President of the Federation of State Medical Boards of the United States; and representatives of the Kansas Medical Society and the Kansas Association of Osteopathic Medicine.

A faculty member of the University of Kansas School of Medicine addressed the Committee on medical education and outlined the overall medical school curriculum.

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Development of State Regulation. The Committee learned of the progression of regulation of practitioners of the healing arts, beginning with the first regulation of the practice of medicine by the State of Kansas in 1901 and of the practice of osteopathy and chiropractic in 1913. Each of the early acts created a separate board to license and oversee the practice of one specific branch of the healing arts. Generally, the early acts "grandfathered" existing practitioners and imposed what would today be considered minimum educational requirements on new practitioners. Passage of an examination and registration with the county clerk allowed allopathic and osteopathic physicians to practice, while chiropractors recorded their licenses with the county recorder of deeds. In 1937, as part of a newly enacted basic sciences act, the Legislature defined the "healing arts" as practitioners of medicine, osteopathy, and chiropractic and required applicants for the practice of the healing arts to pass a basic science examination administered by the State Board of Education.

In 1957, the Legislature repealed the earlier individual laws applying to the licensing of doctors of medicine (M.D.s), to osteopathic physicians (D.O.s), and to chiropractors (D.C.s) and in their place created the Board of Healing Arts and the Kansas Healing Arts Act. The new law defined each of the three professions and extended representation on the regulatory board to each. As the bill making these changes proceeded through the legislative process, the definition of the practice of medicine and surgery and the practice of osteopathy remained relatively unchanged; however, the definition of the practice of chiropractic was significantly broadened in the late hours of the legislative session. Specifically, the definition was expanded from "Persons who adjust by hand any displaced tissue of any kind or nature" to substantially the current definition "(1) Persons who examine, analyze and diagnose the human living body, and its diseases by the use of any physical, thermal or manual method and use the X-ray diagnosis and analysis taught in any recognized chiropractic school; and (2) persons who adjust any misplaced tissue of any kind, or nature, manipulate, or treat the human body by manual, mechanical, electrical or natural methods or by the use of physical means, physiotherapy (including light, heat, water or exercise), or by the use of foods, food concentrates, or food extract, or who apply first aid and hygiene, but chiropractors are expressly prohibited from prescribing or administering to any person medicine or drugs in materia medica or from performing any surgery, as hereinabove stated or from practicing obstetrics." The bill with the expanded definition of chiropractic passed and became law on July 1, 1957, at which time the three previously existing boards were abolished.

Almost annually since 1965, the Kansas Healing Arts Act has been amended. In 1969, among other things, legislation abolished the Board of Basic Science Examiners and transferred its function to the Board of Healing Arts, amended the term "illness" in the definition of the practice of medicine and surgery to include "physical or mental" illness, and made changes in the structure and operation of the Board. In 1975 the size of the Board was increased from 11 to 12 with the addition of a public member and, in the next year the Board offices were moved from Kansas City to Topeka. Extensive amendments were made in 1976 reflecting the work of an interim special committee which had taken an extensive look at the Kansas Healing Arts Act as well as several other health care provider regulatory acts. Changes involved continuing education, renewal fees, temporary permits and licenses, grounds for revocations and suspensions of licenses, criminal penalties, and placing Board employees in the unclassified civil service. Other bills enacted in 1976 to address the medical malpractice insurance crisis required licensees of the Board, as a condition of practicing in Kansas, to participate in the Health Care Stabilization Fund, a fund from which excess insurance coverage is provided to contributing health care providers. Further, the Insurance Commissioner was required to report certain actions on the part of licensees to the Board for investigation.

The involvement of the Board in malpractice issues continued and was extended by the Legislature's focus on tort reform and the solvency of the Health Care Stabilization Fund in the mid-1980s. In 1983, the Board received authorization to hire its own counsel, and a year later the position of disciplinary

counsel was established. In that same year, 1984, a review committee was created to hear matters the disciplinary counsel determined to have merit. In 1986, the Board was expanded to 15 members through the addition of two more public members. In 1987, the management structure of the Board was changed to shift responsibilities for daily operations to an executive director hired by the Board, subject to Senate confirmation. An administrative assistant position also was created to assist the director, and all Board employees were placed under the supervision of the executive director.

Currently, the Board of Healing Arts regulates the practice of medical doctors, osteopaths, and chiropractors -- all licensees in the healing arts. In addition, the Board maintains a register of physicians' assistants, registers physical therapists, occupational therapists, and respiratory therapists, and certifies physical therapist and occupational therapy assistants. While podiatrists are licensed under statutes separate from the Kansas Healing Arts Act, enforcement of the Kansas Podiatry Act also is the responsibility of the Board of Healing Arts.

Chiropractic Issues. From 1913 through the reform legislation of 1957, chiropractors were licensed by a separate Board of Chiropractic Examiners, a board composed of one ordained minister, one school teacher, and three practicing chiropractors of integrity and ability who were residents of the state. The scope of practice authorized a chiropractor to "adjust by hand any displaced tissue of any kind or nature" but did not include authority to "prescribe for or administer to any person any medicine or drugs now or hereafter included in materia medica, perform any minor surgery, only as hereinbefore stated, nor obstetrics."

The 1957 legislation creating the Board of Healing Arts and requiring passage of a basic science test apparently was the work product of the Kansas Medical Society and Kansas Osteopathic Association after two years of combined study aimed at resolving past differences between the professional groups. As news stories of the hearings on the bill disclose, the chiropractic profession opposed the bill introduced at the request of the other two professions. In testimony before the House Committee on Hygiene and Public Health, chiropractors argued against the basic science examination as a requirement for licensure, noting they did not study the basic sciences in the same light as the medical doctor. In the expressed opinion of some chiropractors appearing before the Legislature, the intent of the bill was to do away with chiropractors in Kansas through a new alliance between the medical doctors and osteopaths.

In the Committee of the Whole debate on the bills, Representative Eldred Brown of Kansas City attempted unsuccessfully to have chiropractors removed from the 1957 bill. Failing in the attempt, Representative Brown was able to persuade the House to amend the scope of practice of chiropractic into substantially the form it appears in the Kansas statutes today. Representative Brown explained his amendment to be nothing more than allowing chiropractors to do what they had been doing. Reviewing the 1957 enactment from the perspective of 1994, it would appear the Kansas definition is fairly uniform with other state definitions of chiropractic in that it focuses on manipulation and excludes the use of drugs, surgery, and obstetrics. The Kansas act may be more specific than those of other states in that it specifies the use of heat and X-rays in the scope of practice of a Kansas-licensed chiropractor.

Apparently many of the differences separating persons licensed to practice medicine and surgery (doctors of medicine and doctors of osteopathic medicine) from chiropractors continue in the 1990s. Conferees appearing before the Special Committee discussed the most recent example of chiropractors being excluded from the mainstream of health care delivery by organized medicine (*Wilk v. AMA*) and the lingering prejudice in the health care marketplace nearly ten years after the decision in that case in which the American Medical Association was permanently enjoined from "restricting, regulating or impeding or aiding and abetting others from restricting, regulating, or impeding the freedom of any AMA members or any

institution or hospital to make an individual decision as to whether or not that AMA member, institution, or hospital shall professionally associate with chiropractors, chiropractic students, or chiropractic institutions."

Chiropractors and chiropractic educators appearing before the Special Committee indicated their desire to educate the members of the Special Committee in an effort to remove the greatest barrier to chiropractic -- ignorance, or a simple lack of knowledge of the profession. Conferees appeared in strong support of the philosophy of chiropractic as a treatment modality utilizing no drugs and no surgery. Their story of chiropractic was one of increasing professionalism, education, and training that qualify them to play an integral part in the future of health care.

While those appearing before the Special Committee made it clear their purpose in the interim was not to seek changes in the scope of practice of chiropractic in Kansas, they did want legislators to know that consumers should have access to the provider of their choice, *i.e.*, chiropractors should not be discriminated against; that current insurance equality laws should be enforced; that chiropractors should be granted hospital privileges; that injured workers should have freedom of choice in workers' compensation cases; that the chiropractic role in Medicaid should be expanded; and that the practice of manipulation should be restricted by law only to those who are trained licensees of the Board of Healing Arts.

The Board of Healing Arts. The Executive Director of the Board explained the last ten years have been years of great change for the Board. The workload of the Board has increased significantly: the size of the staff more than doubled; the grounds for and the number of disciplinary actions have increased; impaired provider programs have had some mitigating impact on the number of disciplinary cases brought to the Board; the governing structure of the Board has changed with the creation of the position of an executive director; and continued financial support by the Legislature has allowed the Board office to be computerized thereby increasing its ability to track both licensing and disciplinary functions.

Members of the Board spoke positively of their experiences on the Board. Board members did not recommend changing the Board function or size, but there was recognition that those ancillary providers regulated by the Board want representation. Further, as health care reform proceeds, other demands may be made on the Board that will require changes. The Executive Director described some of the issues the Board is facing in the future as the potential for persons not licensed in Kansas to treat Kansas residents through telemedicine; how to deal with unlicensed individuals who have carved out a niche in health care; the potential for federal legislation that would restrict the state's authority to restrict the practice of any class of health care professionals beyond restrictions arising from their skill and training; the development and increasing use of practice parameters; and erosion in the confidentiality associated with peer review activities.

Persons Licensed to Practice Medicine and Surgery. The Kansas Medical Society raised two issues for legislative consideration. The first would add a definition of the "practice of medicine and surgery" to the Kansas Healing Arts Act. Such a definition would address a perceived vagueness in the current law. The second would create a separate licensing agency for persons licensed to practice medicine and surgery -- medical doctors and osteopaths. This change, according to the conferee, would return the licensing and supervision of such professionals to the status of regulation in place through the first half of this century, namely regulation by peers.

The Kansas Association of Osteopathic Medicine chose to address only one issue with the Special Committee, the composition of the Board of Healing Arts. The Association supported the concept of the Board representing professions rather than numbers of practitioners. As such, the current structure of the Board is cost effective as opposed to funding and staffing separate boards, and its composition

provides a check and balance. The comments of past and current Board members and the remarks of the House Governmental Organization Committee on the sunset review of the Board were offered as testimony in favor of retaining the present composition of the Board of Healing Arts.

Assisted Living

The Secretaries of Aging and Social and Rehabilitation Services; representatives of the Sterling House Corporation, the Department of Health and Environment, the Kansas Association of Homes and Services for the Aging, the American Association of Retired Persons, Kansans for the Improvement of Nursing Homes, the Kansas State Nurses Association, and the State Board of Nursing; the administrator of a home health agency; and the administrator of a county hospital shared their views on the need for legislative action to clarify and update the Kansas laws on the regulation of residential facilities that serve elderly and disabled individuals who need some assistance with the activities of daily living due to age or functional impairment, but who do not need a nursing facility (skilled or intermediate adult care home) level of care. In addition, a resident of Oberlin who was present at the meeting was invited to address the Special Committee on her experiences in trying to develop the first assisted living facility in her area.

Residential Care in Kansas. The Committee was told Kansas lags behind many other states in the development of a range of residential settings to serve those individuals who are not able to live independently or to remain in their own homes because they require assistance with one or more activities of daily living such as bathing, dressing, cooking, or the taking of medications due to physical or cognitive impairment. As a result, in many areas of the state individuals must seek admission to a nursing facility because there are no alternative residential facilities and remaining in their own home is not feasible. Partly as a result of the failure to develop alternative residential settings, Kansas had the seventh highest rate of institutionalization of persons over the age of 85 in the nation in 1992; the highest number of licensed nursing facility beds per 1,000 population age 65 and over; and approximately 7 percent of elderly Kansans reside in a nursing facility compared to the national average of 5 percent.

A subcommittee of the Long Term Care Action Committee identified the following types of residential settings that serve as alternatives to nursing facilities for the frail elderly and physically disabled in Kansas, along with the number of such facilities licensed or registered in 1993.

- Intermediate Personal Care Homes licensed by the Department of Health and Environment -- 43;
- One-to-Five Bed Homes licensed by the Department of Health and Environment -- 24;
- Adult Family Homes (adult foster care) registered by Social and Rehabilitation Services -- 72; and
- Residential Care for the Physically Handicapped licensed by Social and Rehabilitation Services -- 19.

The facilities listed above totaled just 1,576 beds compared to 29,745 licensed beds in nursing facilities and long-term care units of hospitals. Intermediate personal care homes and one-to-five bed homes are licensed under the Adult Care Home Licensure Act as are nursing facilities. One-to-five bed homes may represent

different levels of care depending on the qualifications of the operator. At the present time those residential settings that are most likely to represent assisted living are licensed as intermediate personal care homes, although some may be licensed by Social and Rehabilitation Services as residential care for the physically handicapped.

Defining Assisted Living. There is no one specific, universal definition of assisted living in Kansas or nationwide at this time. However, the Secretary of Aging suggested some common elements that make up the usual view of assisted living. The term usually refers to an environment, a living facility, or a place. The term has the connotation of independence, *i.e.*, a place with lockable doors in which all of the events of daily life can be accomplished within the living area and which offers around-the-clock supervision and services on an as-needed or on-call basis. Coupled with the concept of a living environment is a package of services available to residents to help them to meet the needs of daily life, ranging from transportation to assistance in getting in and out of bed or toileting. Assisted living varies from the usual apartment complex because of the supportive services that are available.

The representative of Sterling House Corporation described the philosophy underlying assisted living as a residential dwelling model of care that supports each resident's privacy, independence, dignity, choices, individuality, and ability to age in place. Further, assisted living, according to the conferee, is a model of care that assumes residents should have the freedom to choose the type and amount of services and care they will receive as well as some control over the level of risks accompanying those services. Assisted living, according to the conferee, represents a shift in long-term care thinking and approaches since long-term care has traditionally adopted a medical patient care model in which the individual is given a prescriptive regime of care to follow. The services typically provided in assisted living fall into four categories: Hotel type services such as meals, housekeeping, transportation, etc.; personal care such as assistance in walking, transferring from bed to chair, bathing, and other services necessitated by functional disability; routine nursing services; and special care such as service coordination, monitoring the plan of care and changes in care needs, and providing for access to specialty providers and behavioral management.

The Long Term Care Action Committee has proposed the following definition of assisted living as set out in 1994 H.B. 3049:

> "Assisted living facility means any place or facility caring for three or more individuals not related within the third degree of relationship to the administrator, operator or owner by blood or marriage and who, due to functional impairments, need personal care and may need supervised nursing care to compensate for activities of daily living limitations and in which the place or facility includes apartments for residents and provides or coordinates a range of services available 24 hours a day, seven days a week for the support of resident independence."

The definition proposed by the Long Term Care Action Committee would be added to the Adult Care Home Licensure Act as a new level of residential care.

The representative of the Department of Health and Environment noted that assisted living has become the operative term for what Kansas has called personal care, pursuant to the statutory definition thereof. Services typically provided in assisted living include meals, activities, and personal grooming that do not require the services of a licensed nurse. Supervision of self-administered medications is also

provided. The physical design standards required by current regulations are intended to provide a home-like setting.

It was emphasized that assisted living is not intended to be a replacement for nursing facilities and should not be viewed as such. It is based on a different philosophy of long-term care and seen as a part of a continuum of services and long-term care options.

Issues in Assisted Living. Individuals who met with the Committee raised a number of issues related to the current regulation of assisted living in Kansas, including issues arising from the Kansas Nurse Practice Act and interpretation of that act.

The conferees were virtually unanimous in stating a definition of assisted living needs to be developed and that such definition needs to clearly delineate the components that make up assisted living and differentiate it from other types of residential care. There appeared to be agreement the current use of the category known as intermediate personal care under the Adult Care Home Licensure Act is not totally satisfactory, nor is the category of residential care for the physically handicapped licensed by Social and Rehabilitation Services.

Conferees raised issues relating to nurse delegation and the necessity of allowing nurses to delegate acts that fall within the scope of nursing to nonnursing personnel if assisted living is to be viable and affordable. It was suggested there has been some confusion on the part of providers, some nurses, and state agency personnel as to the specific requirements of nurse delegation, including the authority of the individual licensed nurse to determine what tasks can be delegated and to whom. It was stated the various state agencies are not interpreting the existing statutory authority with the latitude intended by the Legislature nor are the interpretations consistent. Representatives of the Board of Nursing contended inappropriate delegation is occurring. The Committee learned the Board had taken disciplinary action against several licensed nurses because, in the judgement of the Board, the nurses had engaged in inappropriate delegation of acts that constitute nursing. One conferee recommended the "careful expansion of nurse delegation in assisted living."

A majority of those who met with the Committee stressed the need for flexibility in the regulation of assisted living, and virtually all recommended that such facilities not be "over-regulated" in order to encourage the development of additional assisted living facilities and to allow different models of assisted living.

An issue raised by the Long Term Care Action Committee is that of consolidating all licensing of long-term care facilities, except those designated as mental health and mental retardation services, under one agency. The recommendation of the Long Term Care Action Committee is that legislation be enacted that transfers licensure of two types of facilities now licensed or registered by Social and Rehabilitation Services to the Department of Health and Environment.

The Committee was told there are several financial barriers to the development of assisted living facilities. One is the lack of third party reimbursement for assisted living, particularly under Medicaid. The Committee was told several states have been creative in finding ways to reimburse a part of the cost of assisted living under the Medicaid program. Another barrier is the difficulty of securing development capital because lending institutions are concerned about the lack of a "track record" for such facilities.

There were discussions of the cost of assisted living and whether such facilities would contribute to the state expenditure for long-term care services. There appeared to be agreement the development of additional assisted living facilities could, in the long run, reduce the growth in expenditures for nursing facilities and lead to a reduction in the number of nursing facility beds in the state. The Committee was cautioned the state must be careful, as assisted living is expanded, the long-term care system is not simply expanded, along with an expansion in total costs. Some discussion needs to take place regarding the control of costs at the other end of the spectrum -- the nursing facility. It is important to make sure, as assisted living and other residential care options are developed, that empty nursing facility beds are not filled. The Secretary of Social and Rehabilitation Services presented additional information on long-term care costs, where large state expenditures occur currently, and the potential for growth in costs if community alternatives to nursing facilities are not developed.

Long Term Care Action Committee Recommendations. The Long Term Care Action Committee, which is now made up of representatives of the Departments on Aging, Health and Environment, Social and Rehabilitation Services, Commerce and Housing, and Education and the University of Kansas School of Social Welfare, is recommending legislation to the 1995 Legislature that would, among other things, create a definition of assisted living under the Adult Care Home Licensure Act. The legislation would also create new definitions of "residential health care facility," "home plus," "adult day care," "nursing facility for mental health," and "intermediate care facility for the mentally retarded." The proposed legislation creates other definitions of terms used in the categories of care that would be added to the act; deletes references to intermediate personal care homes and one-to-five bed homes; and amends and streamlines existing definitions relating to levels of nursing care. The proposed legislation is identical to H.B. 3049 introduced late in the 1994 Session at the request of the Long Term Care Action Committee, but not worked due to time constraints. A companion bill would amend the act under which adult care home administrators are licensed to provide that assisted living facilities and residential health facilities under a specified size are not included in the definition of adult care home under that act. The latter has the effect of allowing the smaller residential facilities to operate without having to employ a licensed adult care home administrator.

CONCLUSIONS AND RECOMMENDATIONS

The Kansas Healing Arts Act and Chiropractic Issues

The Special Committee on Public Health and Welfare expresses its appreciation to the Kansas Chiropractic Association for providing local, state, and national representatives of the chiropractic profession as conferees. Appreciation is extended to the staff of the Board of Healing Arts for bringing a national perspective to the study of board structure through a representative of the Federation of State Medical Boards of the United States.

After lengthy discussion, the Special Committee makes no recommendation regarding the scope of practice of chiropractors. However, the Committee approved for introduction a bill that would amend K.S.A. 1993 Supp. 72-5214, as amended by 1994 Senate Bill No. 520, to authorize chiropractors to conduct child health assessments for certain students enrolling in Kansas schools for the first time. Further, the Committee recommends chiropractors be included in the Medicaid managed care project currently being developed by the Department of Social and Rehabilitation Services. The Committee makes no recommendations relating to other issues involving the Board or licensees in the healing arts.

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Assisted Living

The Special Committee on Public Health and Welfare, after discussion of the issues and recommendations brought to the Committee by the individuals who educated the members and responded thoughtfully and completely to the questions posed by members, has concluded legislation should be introduced to define a level of care to be known as assisted living. The Committee concurs with the recommendations of a number of conferees that the regulation of such facilities should be sufficient to protect the residents, but should not result in overregulation. The Committee is pleased the very state agencies that play a regulatory role in long-term care and that advocate for the elderly have taken a public position agreeing that regulation should be done with the safety of residents as a primary concern, but with as little regulatory oversight as will accomplish that end. In light of the agreement of those agencies that comprise the Long Term Care Action Committee and the agreement of a number of the other conferees, the Special Committee concluded a bill substantially in the form of that proposed in 1994 and again for introduction in the 1995 Session by the Long Term Care Action Committee should be drafted and introduced as a Committee bill.

The Special Committee on Pubic Health and Welfare has drafted a bill that would amend several of the statutes under which adult care homes are licensed and regulated to create the new definitions proposed by the Long Term Care Action Committee, including a definition of assisted living, and including the other amendments proposed in 1994 H.B. 3049. The Committee bill incorporates amendments to several additional statutes that were identified during drafting of the bill in order to conform with the substantive amendments noted earlier. In addition, the Committee bill incorporates the amendments to the act under which adult care home administrators are licensed in the bill rather than in a separate bill.

The Special Committee on Public Health and Welfare recommends the appropriate committees of the 1995 Legislature give careful consideration to the bill introduced by the Committee and the enactment of legislation in substantially the form of the Committee bill.

State of Kansas

Law Enforcement Training Commission

Notice of Meeting

The Kansas Law Enforcement Training Commission will meet at 10 a.m. Wednesday, January 31 at the Kansas Bureau of Investigation Headquarters, 1620 S.W. Tyler, Topeka. The meeting is open to the public.

Tino Monaldo
Chairperson

Doc. No. 017208

State of Kansas

Kansas Insurance Department

Permanent Administrative Regulations

Article 4.—ACCIDENT AND HEALTH INSURANCE

40-4-17. Accident and health insurance companies; record of loss experience required; form adopted by the national association of insurance commissioners; filing date. (a) Each insurance company transacting accident and health insurance business in the state of Kansas shall maintain a record of country-wide loss experience for each policy form. The record shall be maintained on a "premium earned" and "losses incurred" basis or, optionally, on a "premium received" and "losses paid" basis.

(b) The insurance company shall maintain loss experience on each policy form currently issued and on any policy form not currently issued from which the renewal premiums represent five percent or more of the total premiums received.

(c) The insurance company shall record loss experience on total group business written. The insurance company need not maintain separation of loss experience on individual group policies.

(d) The insurance company shall report experience on the form adopted by the national association of insurance commissioners, as of 1994, which is hereby adopted by reference, and shall file the form not later than May 1 of each year. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-2215(C)(1); effective Jan. 1, 1966; amended May 1, 1979; amended May 1, 1986; amended Feb. 9, 1996.)

40-4-37. Long-term care insurance; application; definitions. (a) These regulations shall apply to individual or group long-term care insurance policies, subscriber contracts, endorsements and riders delivered or issued for delivery in this state by the following:

(1) Insurance companies;

(2) fraternal benefit societies;

(3) nonprofit hospital and medical service corporations; and

(4) health maintenance organizations.

(b) A policy, rider or endorsement shall not be advertised, described, solicited or issued for delivery in this state as long-term care insurance unless it conforms to the requirements of these regulations.

(c) As used in these regulations, these terms shall have the following meanings:

(1) "Long-term care insurance," "group long-term care insurance," "commissioner," "applicant," "certificate" and "policy" shall have the meanings set forth in K.S.A. 1991 Supp. 40-2227.

(2) "Medicare" means programs established by the "Health Insurance for the Aged Act," Title XVIII of the social security amendments of 1965, as then constituted or later amended.

(3) "Nursing facility" means a home, residence or institution, other than a hospital, which is primarily engaged in providing nursing care and related services on an inpatient basis under a license issued by the appropriate licensing agency. It may be a freestanding facility including the following:

(A) nursing facility;

(B) skilled nursing home;

(C) intermediate nursing care home;

(D) assisted living facility; or

(E) residential health care facility.

Any definition of a nursing facililty shall adhere to the above definition unless otherwise approved by the commissioner of insurance.

(4) No insurance carrier shall define "mental or nervous disorder" more restrictively than the following:

(A) neurosis;

(B) psychoneurosis;

(C) psychopathy;

(D) psychosis; or

(E) any mental or emotional disease or disorder. However, no policy, contract or rider shall exclude or limit benefits on the basis of organic brain disease, including alzheimer's disease or senile dementia.

(5) The insurer may define "nurse" so that the description is restricted to a certain type of nurse, whether a registered graduate professional nurse, a licensed practical nurse, or a licensed vocational nurse. If the words "nurse," "trained nurse" or "registered nurse" are used without specific instruction, then the insurer shall recognize the services of any individual who qualified under this terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

(6) The insurer may include the words "duly qualified physician" or "duly licensed physician" in its definition of "physician." An insurer using these terms shall recognize and accept, to the extent of its obligation under the contract, all providers of medical care and treatment when these services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

(7) "Sickness" includes the following: an illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a waiting period which will not exceed 30 days from the effective date of the coverage of the insured person. The definition may be further modified to exclude illnesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

(8) "Guaranteed renewable" means the following: (continued)

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(A) The insured may continue the long-term care insurance in force by the timely payment of premiums; and

(B) the insurer shall not unilaterally make any change in any provision of the policy or rider while the insurance is in force and shall not decline to renew the policy. However, the insurer may revise the rates on a class basis.

(9) "Noncancellable" means the insured may continue the long-term care insurance in force by timely paying premiums during which period the insurer shall not unilaterally make any change in any provision of the insurance or in the premium rate.

(10) "Lapse" means termination of a policy due to the policyholder's failure to pay the premium within the time required.

(d) K.A.R. 40-4-37a, 40-4-37f and 40-4-37i shall not apply to group long-term care insurance policies issued to an employer-employee group. (Authorized by K.S.A. 40-103, K.S.A. 40-2228; implementing K.S.A. 40-2228; effective, T-89-9, March 18, 1988; effective Sept. 12, 1988; amended Jan. 6, 1992; amended Jan. 4, 1993; amended Feb. 9, 1996.)

40-4-37d. Long-term care insurance; benefits; medical condition; activities of daily living; definitions; requirements. (a) A long-term care policy may require a recommendation by a physician that the services are necessary due to illness, injury, or functional impairment but shall not condition benefits on medical necessity.

(b)(1) In addition to or in lieu of a recommendation by a physician as described in section (a) of this regulation, group long-term care insurance policies covering employees, dependents and retirees of a single employer may include provisions which condition the payment of benefits on an assessment of the insured's ability to perform activities of daily living or cognitive impairment.

(2) As used in this section, activities of daily living consist of the following defined activities and performance criteria:

(A) "Bathing" means the ability to get into and out of the tub or shower, turn on the water, get the soap or other cleansing product, and bathe the entire body including back and feet. A person is dependent if the person cannot bathe in a bathtub or shower without the assistance of another person or is able to participate only minimally, such as washing face and hands only.

(B) "Dressing" means the ability to get clothes from closets or drawers and put them on or take them off, including undergarments and outer-garments, as well as fasteners and braces, if worn. Dressing includes the ability to fasten one's shoes. A person is dependent if the person can dress only with the assistance of another person or is able to participate only minimally, such as putting on outer-garments only.

(C) "Eating" means the ability to bring food to the mouth or hold a glass to the mouth, and chew and swallow food. A person is dependent if the person is fed by hand, is being fed intravenously or through a feeding tube, is unable to bring food to the mouth or is unable to chew and swallow the food.

(D) "Maintaining continence" means the ability to maintain control of urination or bowel movement. A person is dependent if the person loses bladder control three times per week or more, loses bowel control two times per week or more, or needs assistance in maintaining a catheter or colostomy bag.

(E) "Toileting" means the ability to get to and from the toilet, onto and off the toilet, clean oneself after elimination, and adjust clothes after toileting. A person is dependent if the person needs help with one or more of these tasks, maintaining balance, or caring for a catheter or colostomy bag.

(F) "Transferring from bed to chair" means the ability to get into or out of bed or a chair. A person is dependent if the person is unable to get into or out of bed or a chair without human assistance.

(G) "Mobility" means the ability to walk or move from one place to another. A person is dependent if the person requires assistance or supervision from another person to safely walk or if the person needs to be wheeled from one place to another.

(3) "Cognitive impairment" means a deficiency in the ability to think, perceive, reason, remember or otherwise routinely display an ability to take care of oneself without the ongoing assistance of or supervision by another person.

(4) Any determination of impairment shall not be more restrictive than requiring either a deficiency in the ability to perform three of the activities of daily living or the presence of cognitive impairment.

(5) Only properly credentialed, experienced, trained professionals, such as physicians, registered nurses or licensed specialist social workers shall perform assessments of activities of daily living and cognitive impairment.

(6) Group long-term care insurance policies which condition the payment of benefits on an assessment of the insured's ability to perform activities of daily living or cognitive impairment shall include a clear and understandable description of the method for resolving insured grievances. (Authorized by K.S.A. 40-103, 40-2228; implementing K.S.A. 40-2228; effective, T-40-9-25-92, Sept. 25, 1992; effective Feb. 8, 1993; amended Feb. 9, 1996.)

Article 5.—CREDIT INSURANCE

40-5-109. Same; experience reports. Each insurer doing consumer credit insurance business in this state shall annually file with the insurance department a report of credit life and credit accident and health business written on a calendar year basis. This report shall utilize the credit insurance supplement-annual statement blank promulgated by the national association of insurance commissioners June 1985. The filing shall be made each year not later than the filing date stated on the most recently adopted "NAIC Credit Insurance Experience Exhibit Form of 1985," which is hereby adopted by reference. (Authorized by K.S.A. 40-103, 16a-4-112; implementing K.S.A. 16a-4-203; effective Jan. 1, 1974; amended May 1, 1979; amended May 1, 1986; amended May 1, 1988; amended Feb. 9, 1996.)

Kathleen Sebelius
Commissioner of Insurance

Doc. No. 017209

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ATTACHMENT C

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

Bulletin 1996-2

TO: All companies with policy and/or certificate forms approved to market Long-Term Care Insurance

FROM: Kathleen Sebelius
Commissioner of Insurance KS

SUBJECT: Revision to Regulation KAR 40-4-37 et seq

DATE: February 2, 1996

The purpose of this Bulletin is to advise you of revisions to KAR 40-4-37 et seq resulting from the passage of 1995 Kansas Senate Bill No. 8, as codified in KSA 1995 Supp. 39-923 et seq which became effective July 1, 1995. Attached for your information is a copy of KAR 40-4-37 et seq as amended which will become effective on February 9, 1996.

These revisions to our long term care regulations have been limited to those necessary to bring such regulations into conformance with current Kansas adult care home licensing requirements. A study to determine whether additional provisions will be made to our Long Term Care Regulations will occur in 1996. This will include, in part, a review of the NAIC Model Long Term Care Regulations by the Insurance Commissioner's senior citizen advisory committee.

Senate Bill No. 8 is the work product of a number of different long-term care advocates and providers. The reason for this legislation was to allow long-term care residents to receive a range of services in one location rather than requiring them to move from one facility to another, as their needs change.

Senate Bill No. 8 changed the Kansas Department of Health and Environment (KDHE) statutes which define nursing facilities and the levels of care they provide. Our long term care insurance regulation, KAR 40-4-37(c)(3) has been revised to maintain consistency with this state's licensing laws for nursing facilities. Prior to Senate Bill 8, the definition of nursing facility, as stated in KAR 40-4-37(c)(3), included a personal/custodial nursing home licensed as an intermediate personal care home as defined by KDHE statute KSA 39-923(a)(4). This bill removed this level of nursing home and replaced it with assisted living and residential health care facilities. In order to address this change, KAR 40-4-37(c)(3) has also been amended to replace the term intermediate personal care home with the two new facility definitions, assisted living facility and residential health care facility.

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Companies with currently approved policies which provide benefits for confinement in intermediate personal care homes will be expected to pay the same level of benefits regardless of whether care is in an assisted living facility, residential health care facility, or a traditional nursing home health care facility. Any policy provision which does not adhere to this benefit requirement should be interpreted or construed as unfairly discriminatory pursuant to KSA 1994 Supp. 40-2404(7)(b). Insurers providing benefits for confinements in assisted living/residential health care facilities will be allowed, as in the past, the contractual right to require a physician's recommendation as to the necessity of the confinement. In discussions we have had with officials of KDHE, it is our understanding that intermediate personal care homes currently licensed will be relicensed as either an assisted living facility or a residential care facility upon their next licensing renewal.

Our records reflect that almost all long-term insurance policies approved by the department since January 1, 1988 provide coverage for confinements in intermediate personal care homes at the same benefit level as provided for confinements in traditional nursing homes. With regard to new long term care policy form submissions, policy forms will not be allowed to differentiate benefit amounts based on facility licensure. In essence, this means that companies must provide benefits at the same level for confinements in skilled, intermediate, assisted living or residential health care facilities.

In reviewing Senate Bill No. 8, the department noted that the revised definitions of nursing facility and nursing care replaced the word "infirmed" with the phrase "functional impairment." In this regard, KAR 40-4-37d has also been amended to reflect this change.

As a result of changes to KAR 40-4-37 et seq companies will need to submit for approval any necessary or appropriate amendments to be sent to existing policyholders. However, you will be expected to administer the provisions of any in force policies and certificates in accordance with the revisions outlined above. Companies should submit filings immediately in order to allow this department sufficient time for review. We wish to emphasize that it is each company's responsibility to have forms in compliance with this new regulation if they wish to issue long-term care policies on or after February 9, 1996.

Your acknowledgment of receipt and understanding of this Bulletin is expected within 30 days. It will be necessary to include in your response the steps your company will take to comply with this bulletin and K.A.R. 40-4-37, et seq. However, if your company no longer issues long-term care policies in Kansas, please so indicate in your acknowledgment of this Bulletin. If you have any questions regarding your company's compliance, please direct all inquiries and your acknowledgment to the Accident and Health Division of this department.

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KANSAS INSURANCE DEPARTMENT

Proposed Revisions to K.A.R. 40-4-37

40-4-37 Long-term care insurance; ~~scope;~~ application; definitions.

(a) These regulations shall apply to individual or group long-term care insurance policies, subscriber contracts, endorsements and riders delivered or issued for delivery in this state by the following:

(1) Insurance companies;

(2) fraternal benefit societies;

(3) nonprofit hospital and medical service corporations; and

(4) health maintenance organizations.

(b) A policy, rider or endorsement shall not be advertised, described, solicited or issued for delivery in this state as long-term care insurance unless it conforms to the requirements of these regulations.

(c) As used in these regulations, these terms shall have the following meanings:

(1) "Long-term care insurance," "group long-term care insurance," "commissioner," "applicant," "certificate" and "policy" shall have the meanings set forth in K.S.A. 1991 Supp. 40-2227.

(2) "Medicare" means programs established by the "Health Insurance for the Aged Act," Title XVIII of the social security amendments of 1965, as then constituted or later amended.

(3) "Nursing facility" means a home, residence or institution, other than a hospital, which is primarily engaged in providing nursing care and related services on an inpatient basis under a license issued by the appropriate licensing agency. It may be a freestanding facility ~~or place;~~ including the following:

(A) nursing facility~~;~~;

(B) skilled nursing home~~,~~;

(C) intermediate nursing care home~~,~~; ~~intermediate--personal care home, or a one to five bed adult care home~~.

(D) assisted living facility~~,~~; or

(E) residential health care facility~~,~~ .

~~It may also be a distinct part of a facility, including a ward, wing, unit or swing bed of a hospital or other institution.~~ Any definition of a nursing facility shall adhere to the above definition unless otherwise approved by the commissioner of insurance.

(4) No insurance carrier shall define "mental or nervous disorder" ~~shall not be defined~~ more restrictively than ~~including~~ the following:

(A) neurosis~~,~~;

(B) psychoneurosis~~,~~;

(C) psychopathy~~,~~;

(D) psychosis~~,~~; or

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(E) any mental or emotional disease or disorder. However, no policy, contract or rider shall exclude or limit benefits on the basis of organic brain disease, including alzheimer's disease or senile dementia.

(5) The insurer may define "nurse" ~~may be defined~~ so that the description ~~of a nurse~~ is restricted to a certain type of nurse, whether a registered graduate professional nurse, a licensed practical nurse, or a licensed vocational nurse. If the words "nurse," "trained nurse" or "registered nurse" are used without specific instruction, then the insurer shall recognize the services of any individual who qualified

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under this terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

(6) ~~"Physician" may be defined by including the words "duly qualified physician" or "duly licensed physician."~~ The insurer may include the words "duly qualified physician" or "duly licensed phsycian" in its definition of "physician." An insurer using these terms shall recognize and accept, to the extent of its obligation under the contract, all providers of medical care and treatment when these services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

(7) "Sickness" ~~shall not be defined more restrictively than~~ includes the following: ~~"Sickness" means~~ an illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a waiting period which will not exceed 30 days from the effective date of the coverage of the insured person. The definition may be further modified to exclude illnesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

~~(8) "Skilled nursing care," "intermediate nursing care," and "personal/custodial care" shall not be defined more restrictively than the definitions set forth in K.S.A. 39-923 for skilled nursing care, supervised nursing care, and simple nursing personal care, respectively.~~

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~~(9)~~ (8) "Guaranteed renewable" means the following:

(A) The insured ~~has--the--right--to~~ may continue the long-term care insurance in force by the timely payment of premiums; and

(B) the insurer ~~has---no---unilateral---right---to~~ shall not unilaterally make any change in any provision of the policy or rider while the insurance is in force and ~~cannot~~ shall not decline to renew the policy. However, ~~rates--may--be--revised--by--the--insurer~~ the insurer may revise the rates on a class basis.

~~(10)~~ (9) "Noncancellable" means the insured ~~has--the---right to~~ may continue the long-term care insurance in force by ~~the~~ timely ~~payment---of~~ paying premiums during which period the insurer ~~has--no--right--to~~ shall not unilaterally make any change in any provision of the insurance or in the premium rate.

~~(11)~~ (10) "Lapse" means termination of a policy due to the policyholder's failure ~~by--the---policyholder~~ to pay the premium within the time required.

(d) K.A.R. 40-4-37a, 40-4-37f and 40-4-37i shall not apply to group long-term care insurance policies issued to an employer-employee group. (Authorized by K.S.A. 40-103, K.S.A. 40-2228; implementing K.S.A. 40-2228; effective T-89-9, March 18, 1988; effective September 12, 1988; amended Jan. 6, 1992; amended Jan. 4, 1993; amended P-_____).

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By GE 9/12/95 Asst.

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UNUM®

Testimony by UNUM Life Insurance Company of America
On Senate Bill 656
An Act Concerning Long Term Care

I am David Brenerman, Director of Government Relations at UNUM Life Insurance Company of America. I am responsible for directing UNUM's legislative/regulatory activities on long term care (LTC) insurance. I am also Chairman of the HIAA Long Term Care Committee.

As brief background about my company, UNUM has been headquartered in Portland, Maine for over 140 years and has field offices throughout the country, including a sales office in Overland Park, Kansas. UNUM is the leading provider of Long Term Disability Income insurance in the nation. We are also the LTC insurance market leader in cases sold to employers and to retirement communities. UNUM is also among the top 15 insurers in the individual LTC market.

Introduction:
The Kansas Insurance Department has failed to take responsible action on two issues affecting long term care (LTC) insurance. This failure has the following results on the LTC insurance market in this state:

1.) The requirements for LTC insurance are seriously out-of-step with regulations we see throughout the rest of the nation.

2.) Policies are more expensive here than in most other states; this makes LTC insurance less accessible to the public. If LTC insurance is less accessible, more consumers will end up on Medicaid.

3.) Benefits we provide elsewhere we have not provided in this state, to the detriment of the consumer.

SB 656 addresses very serious concerns we have with recent policies of the Department.

1. Definition of Nursing Facility
The Department is requiring insurers to pay across the board the same LTC insurance benefits regardless of the cost or amount of care being provided. For instance, the Department is requiring insurers to pay the same amount for care in an assisted living facility or residential care facility as we pay for care in a nursing home. However, care in an assisted living facility is less expensive, less skilled, and less comprehensive than care provided in a nursing home. But the Department says the benefits must be the same. To use an analogy, the Department is basically saying that we have to pay for a Cadillac even though the consumer is buying a Ford Escort. The Department's requirement flies in the face of current insurance industry practice of paying more benefits for comprehensive, higher quality, and higher intensity nursing care in a traditional nursing home then we pay for folks who do not need to be in a nursing home and who choose a less expensive alternative such as assisted living or residential care. The Department's rule requires us to overinsure our policyholders, resulting in higher premiums for consumers.

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Paying the same benefits for different levels of care will raise premiums approximately 10-15%. The Department will tell you that its rule changes nothing, that insurers are already paying the same benefits regardless of the level and expense of care. This is not true. Although my company pays for assisted living at 60% of the nursing home benefit in all other states, we do not offer coverage for assisted living in Kansas. In order to comply with this new rule, we will have to adjust our rates. This will have an adverse effect on consumers.

Finally, on this issue, we question a Department policy that insurers cover assisted living at nursing home levels, when it is our understanding that the State's own Medicaid program does not even cover assisted living at all.

2. <u>Benefit Triggers:</u>

How states define the triggering event for an insured to receive benefits is a primary issue for LTC insurance. It was 5 years ago that I appeared before a House Insurance hearing here in Kansas to testify in support of legislation that would have permitted insurers to use Activities of Daily Living/cognitive impairment triggers rather than the outdated and unfair physician certification system required in Kansas. At that hearing, a former Deputy Commissioner told the legislative committee the Department could handle this issue administratively, and the committee allowed the Department to do so. However, five years later, little has happened except promises to address the issue.

Upon a request from a major employer in this state, the Department did take one step forward a couple of years ago by permitting ADLs as a benefit trigger for employer groups; we believe now is the time for the State of Kansas to allow the use of ADL/cognitive triggers in all LTC policies.

This is particularly an appropriate time in light of the fact that the National Association of Insurance Commissioners (NAIC) has recently moved forward with a Benefit Triggers Model Regulation. After a number of months of study and analysis, the NAIC developed ADL/cognitive definitions and requirements that balance current industry practices with accepted definitions in the medical rehabilitation field

Given the current state of LTC insurance policies and the recent adoption of an NAIC benefit triggers model regulation, we urge this committee to adopt SB 656 to apply for all LTC policies for the following reasons:

* ADL/cognitive triggers provide a more consistent and objective measure of disability and equate better to an individual's true need for long term care services than does an arbitrary physician certification. Insurers use ADLs in every state in the nation, except Kansas.

* Insurers use the Katz scale of 6 ADLs as the basis for designing their policy benefits. The Katz ADL scale is based on the foremost medical study for measuring disability and need for long term care services.

* The current physician certification requirements of Kansas law do not work well for LTC insurance for the following reasons:

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- ✓ Physicians are not often trained in determining functional or cognitive loss as they relate to a person's need for specific long term care services. Other practitioners are better suited for this, therefore it is not reasonable that the physician be the sole opinion upon which benefit decisions are rendered.

- ✓ A physician certification is fraught with potential for fraud and abuse. Without adequate understanding of the insured's ability to function independently, some physicians may falsely or incorrectly certify a patient's disability or recommend services that may not be appropriate. An example: One MD places a person in a nursing home because the family cannot care for him/her and that is the path of least resistance. The person may not need long term care, but only has difficulty getting groceries, etc.

- ✓ Physicians need to be part of a team of health care providers determining the disability level of the insured. The ADL scale allows all providers to use the same consistent measure of disability.

* An additional consideration for the Legislature in permitting ADLs is the current attempt in Congress to clarify the tax treatment of long term care insurance benefits and premiums. Congress and the President are discussing whether LTC policies should receive similar tax treatment as accident and sickness policies receive.

  The LTC tax provisions that may be included in a final budget agreement define a "qualified" long term care policy as requiring a standard no less restrictive than 6 ADLs. Kansas ADL regulations would not meet the Congressional tax favored treatment for individuals purchasing long term care policies. It is important that the state of Kansas encourage the development of the private long term care market to alleviate its Medicaid burden by assuring that individuals and employers who purchase these polices are not unfairly taxed. Adopting SB 656 would help the state meet the ADL requirements of this tax bill . I should point out that Senator Dole was the prime Senate sponsor of the tax clarification provisions.

The Department will say that it intends to address ADL issues, but for over 5 years, it has not. It will also say that ADLs will keep people who need long term care from getting benefits. That is far from the truth. As I mentioned earlier, ADLs are the most objective and fair method for determining an individual's need for long term care. ADLs are used throughout the rehabilitation field and are commonly used in nursing homes to determine need for care.

Thank you for considering my comments.

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TRANSAMERICA
LIFE COMPANIES

Transamerica Occidental Life Insurance Company
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February 16, 1996

The Honorable Richard L. Bond
Chairperson
Financial Institutions and Insurance
State of Kansas Statehouse
300 SW 10th Avenue
Topeka, KS 66612-1504

RE: Senate Bill 656 - Activities of Daily Living

Dear Senator Bond:

Transamerica Occidental Life Insurance Company is pleased to have the opportunity to provide some background regarding the development of SB 656. The material we are presenting relates to those provisions of SB 656 that establish standards for the determination of benefits under long-term care insurance policies.

SB 656 contains provisions that will allow insurers to determine benefits on the basis of a person's deficiency with defined activities of daily living (ADLs). The legislation also includes provisions that require benefits to be paid when a person is cognitively impaired. The inclusion of these provisions in the Kansas regulatory requirements for long-term care insurance will improve the ability of consumers to understand the benefits they purchase and facilitate comparison of this very valuable insurance coverage. Currently, we are not permitted to use this simple, easy to understand methodology for determining nursing home benefits in individual LTC insurance polices in the state of Kansas.

Senate Bill 646 is based largely on recent activity by the National Association of Insurance Commissioners (NAIC). Prior to joining Transamerica Occidental Life Insurance Company, I was a Health Analyst for the NAIC responsible for NAIC activities affecting the senior insurance market. The NAIC is an association comprised of the chief insurance regulatory official in each state and four U.S. territories. One stated goal of the NAIC is to develop model laws and procedures for states to consider in an effort to develop uniform provisions and procedures where uniform regulatory standards are appropriate. In August 1994, the NAIC charged its Senior Issues Task Force to develop regulatory standards for benefit triggers in long-term care insurance policies. The NAIC solicits input and participation from a wide variety of

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interested parties including insurers, consumers and consumer organizations, federal and state regulatory agencies and other persons with expertise in the matters under discussion. The full NAIC membership adopted the work of this Task Force in September 1995.

The NAIC started this process with the goal of facilitating consumer understanding of LTC insurance policies the benefit provisions. For over a year, the NAIC received active participation from trained physicians, registered nurses and other persons with expertise in senior issues. The NAIC reviewed existing state laws and regulations already in place that specified requirements for the use of ADLs in long-term care insurance policies. The NAIC used a Kansas Regulation (KAR 40-4-37d) as the starting point for their deliberations. This Kansas regulation allows the use of ADLs in group long-term care insurance policies for nursing home confinement benefits, but prevents the use in the individual market.

The development of ADLs dates back several years and is often times attributed to the research of Sidney Katz, MD. Dr. Katz and several colleagues recognized the need to establish improved measures of function for those concerned with increasing problems of the aged and chronically ill and developed ADLs. The NAIC improved on this valuable research by incorporating the ideals and methods for measuring functional losses outlined by the Dr. Katz and his colleagues by coming up with terms that are simplified for ease in understanding. In addition to defining the ADLs, the NAIC established minimum criteria for the level of assistance a person would need in order to qualify for benefits.

The inclusion of ADLs in the Kansas regulatory requirements for long-term care insurance policies establishes:

1. Clear definitions of ADLs (Bathing, Continence, Dressing, Eating, Toileting, and Transferring).

2. A clear definition of cognitive impairment.

3. Limits (no more than 3 of 6) on the number of ADLs that a person must need assistance with in order to receive benefits.

4. Flexibility for insurers to add additional ADLs in policies and or in the number of ADLs deficiencies required to receive benefits (e.g., 1 of 6, 2 of 6 or 3 of 7).

5. Clear disclosure requirements to facilitate consumer understanding of their coverage.

6. A clear maximum deficiency level that can not be more stringent than requiring the need for hands-on assistance in performing the ADLs with flexibility for companies to allow other forms of deficiency measures such as stand-by assistance.

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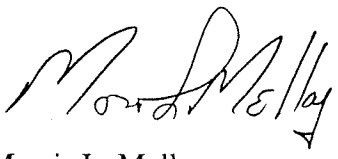
This legislation is a well-balanced approach that allows for innovation in the developing long-term care insurance market yet recognizes the importance of increasing understanding and comparison of this coverage. Congress is working on legislation that will provide tax clarification on long-term care policies and certain tax benefits for the purchase of this coverage. The legislation under consideration will require the use of ADLs in long-term care polices in order for them to receive favorable tax consideration. The bills under discussion use the same ADLs included in SB 656.

Senate Bill 646 provides several meaningful changes to the current regulatory requirements in Kansas on long-term care (LTC) insurance. Most importantly, this legislation will increase and facilitate consumer understanding of LTC insurance and comparison of coverage's available by allowing companies to use "activities of daily living" (ADLs) for the benefit determination.

I would be happy to assist you further with any questions or concerns that you may have on this legislation. I can be reached at (816)246-6121.

Sincerely:



Morris L. Melloy
Compliance and Policy Analyst

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February 16, 1996

Testimony of

AMEX Life Assurance Company

Samuel Morgante

Senate Bill 656

Kansas Long Term Care

Insurance Legislation

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Attachment #5

My name is Sam Morgante and I appreciate the opportunity to address this Committee on behalf of AMEX Life Assurance Company ("AMEX"). AMEX Life has been an industry leader for two decades in developing affordable and comprehensive long term care (LTC) insurance policies for an aging population concerned about the growing costs of long term care. AMEX Life is represented on the Board of Directors of the Health Insurance Association of America's (HIAA) and its Long Term Care Insurance Committee. AMEX Life has also been active as a founding member of the Coalition for Long Term Care Financing. AMEX Life currently has over 5,700 Kansas residents as long term care policyholders and over six million dollars in inforce long term care insurance premium. We also support about 600 resident agents in the State of Kansas. AMEX Life maintains LTC career sales offices in Overland Park and Wichita.

At AMEX Life, I am Director of Product Development and Government Relations. I personally serve on the HIAA Long Term Care Legislative and Regulatory Subcommittee and have provided assistance with numerous state initiatives in the area of Long Term Care Insurance. Currently, I also serve on the Board of the New York State Partnership for Long Term Care.

Today, I would like to touch on two issues here in the State of Kansas which are of significant concern to AMEX Life and to the overall LTC insurance industry. These are: 1) The definitions of facilities where LTC insurance policies can be utilized; and 2) The "trigger" mechanism necessary to access long term care insurance benefits. Both of these issues arise out of insurance regulations which have been proposed by the Kansas Insurance Department.

Facility Definitions

As a result of 1995's adoption of a Kansas Health Department proposal that defined long term care facilities in Kansas (Senate Bill 8), the Kansas Insurance Department has chosen to

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promulgate in regulation an overly broad definition of "Nursing Facilities". These definitions may make sense from a state "health" perspective in regulating these types of facilities. Senate Bill 8 removed intermediate personal care homes from these definitions and replaced them with assisted living facilities and residential health care facilities. However, the proposed insurance regulations would treat distinctly different types of facilities under a common definition. They would require LTC insurance policies to provide benefits in each type of facility and also require benefit payment at exactly the same level for differing facilities.

In 1991, AMEX Life Assurance Company pioneered the concept of providing LTC benefits for confinement in assisted living facilities ("ALF's"). Beginning at that time, this benefit was included as an additional facility benefit under a provision separate from our Nursing Home benefit. Benefit payment was priced and intended to be payable at a level of 60% of the Nursing Home benefit. Daily charges for such facilities are lower than those at nursing homes. We were and continue to be concerned about the potential for over-billing by and over-payment to providers which is why we set a payment level near where we believed actual costs to be. The policies paid a fixed daily dollar level depending upon what a client purchased.

In 1991, AMEX sought approval to offer this benefit here in Kansas and was denied the opportunity to do so, being told that no such facilities existed in this State. Since 1991, the state of the art in long term care facilities and in LTC insurance policies has continued to evolve rapidly.

Today, the Assisted Living Facility Association of America (ALFAA) defines assisted living as a special combination of housing, supportive services, personalized assistance and health care that responds to the individual needs of those who need help with activities of daily living ("ADL's") and instrumental activities of daily living, but who do not need 24 hour skilled medical care.

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By 1994, under a new product filing, AMEX Life was granted approval by the Kansas Insurance Department to offer an ALF benefit payable at a level of 80% of the amount payable for nursing home stays. Again, this was based on the fact that daily charges at ALF's are lower than those for nursing homes. Nationally, the current practice in policies sold today for AMEX Life, as well as many other insurers, is to pay a lower level of payment, 60% or 80% being typical, of the daily dollar maximum, because the level of care provided (usually at a custodial or intermediate level) in an ALF is less intensive than that in a nursing home and the charges to an in-patient resident consequently are lower. Inforce policies nationally and the AMEX product currently available for sale in Kansas, along with those of other insurers are currently priced with these assumptions.

As promulgated by the Department of Insurance, the new regulations require retroactively that existing, inforce, policies must provide equal benefit payments in any facility, which include assisted living and residential health care facilities as defined by the regulations. This means that under policies issued in 1988 or 1990 stays in ALF's would be covered and would be payable at 100% of the daily benefit limit. AMEX Life would be forced to pay for benefits which we were once denied the opportunity to even price for and sell in this state. And, we would have to pay this benefit for policies issued even before these facilities existed.

The likely results of such unprecedented action would be excessive payments to providers, increased utilization, and consequently rate increases for existing policyholders.

Benefit Triggers

The National Association of Insurance Commissioners ("NAIC") has recently adopted a "Model" provision for Benefit Triggers. This was adopted after a process which included significant due diligence and input from industry experts and consumer activists alike. The Model maintains that the most appropriate criteria for benefit eligibility is the use of Activities of Daily Living (ADL's) and Cognitive Impairment.

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The NAIC provision adopts a six ADL model based on the extensive research of Dr. Sidney Katz and includes: Bathing, Dressing, Toileting, Transferring, Continence, and Eating. The proposed use of "Mobility" as a 7th ADL in Kansas regulations is unnecessary in that its definition is embedded in the definition of the other ADL's. We strongly urge the adoption of this provision in lieu of the existing provision in the regulations. AMEX Life currently sells LTC policies in all fifty states and with a mobile senior population, the benefits of these policies are portable. We would prefer the consistent use of benefit triggers wherever a policyholder needs to access policy benefits.

In addition, the current debate on Federal tax clarification for LTC insurance policies specifically addressees this issue and defines a "qualified plan" as one that contains a standard no less restrictive than 6 ADL's. Residents of Kansas might not have access to the same favorable tax status of long term care insurance should this federal legislation become law. Kansas Senator Robert Dole has been a strong supporter of this legislation.

The Kansas regulations also call for a physician to certify that services are necessary due to functional impairments or that need exists for nursing care to assist or the perform ADL's. In today's medical practice, personal physicians often are not involved in the assessment of ADL's. In fact, research suggest that while individuals may want their physicians to assess their functional performance and emotional well being as part of medical care this rarely happens (see attached report). There are health care professionals such as nurses, social workers, care managers and actual providers of long term care services, whose training specifically includes experience in arranging and managing long term care services. Therefore, we recommend that Kansas regulations reflect this reality and allow other health care professionals the right to make these assessments. Kansas regulations currently afford group carriers this option. We recommend that Individual policies be permitted the same option.

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With the several changes to the Kansas LTC insurance marketplace we offer in Senate Bill 636, this state can make some steps in the direction permitting the private insurance industry to offer competitively priced long term care insurance products. Thank you for the opportunity to speak here today.

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Physicians' Assessment of Functional Health Status and Well-being

The Patient's Perspective

Edward L. Schor, MD; Debra J. Lerner, PhD; Sue Malspeis, SM

Background: Ascribing quality to medical care rests in part on the expectation of physician behavior and the content of care. The adoption of functional outcomes of care as legitimate measures of quality will require greater attention to patient-provided assessments of health and add new dimensions to medical practice and quality assessment.

Methods: We conducted a cross-sectional, national population survey of adults to obtain estimates of the frequency with which physicians reportedly inquire about patients' functional health status and emotional well-being, patients' attitudes about such assessments, and the perceived use of data thus obtained in the therapeutic process.

Results: The majority of physicians rarely or never ask about the extent to which patients' health limits their ability to perform everyday activities (64.7% to 78.7%); neither do they inquire about limitations imposed by emotional problems (71.4% to 84.4%). Physicians are more likely to make such inquiries in the presence of chronic illness or diminished health status, or with older patients, although such assessments remain the exception to usual practice and a large portion of functional impairment is undiscovered. More than 60% of respondents want their physicians to assess their functional health status and well-being.

Conclusions: While individuals want their physicians to assess their functional performance and emotional well-being as a part of medical care, by their reports this occurs infrequently. The content of care may be less comprehensive than physicians believe to be the case.

(*Arch Intern Med. 1995;155:309-314*)

ENHANCING OR maintaining a person's ability to function physically, emotionally, and socially is an important goal of medical care.[1-4] Functional health outcomes are especially important in the care of the elderly and chronically ill.[5-7] To address these aspects of their patients' health, physicians must collect information about functional capabilities and base their management, in part, on these findings.

While comprehensive care of this sort has its advocates, there are substantial barriers to its adoption. Neither the organization of care nor reimbursement for care encourage cognitive services or broadly defined comprehensive care.[8] Brief, standardized paper-and-pencil measures of functional health status are available but have not been widely used outside of research settings.

In the absence of a familiar technology to assess functional aspects of patients' health, physicians are less likely to fully evaluate their patients' health-related quality of life. Without a complete picture of their patients' health status, physicians risk developing incomplete management plans and are limited in their ability to fully assess the effectiveness of the care they provide. Additionally, patients are apt to be less satisfied with their care if their expectations that their physicians take account of their functional abilities are unmet. The movement toward universal managed care is likely to aggravate these problems if comprehensive care is curtailed through interrupting continuity of care and further restricting the professional time and resources available to patients. This study provides a benchmark of the current practice of functional health status assessment by clinicians, using data from health care consumers.

From The Health Institute, New England Medical Center, Boston, Mass.

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MATERIALS AND METHODS

DATA COLLECTION

A nationwide population-based survey of functional health status and well-being was conducted by the National Opinion Research Center, University of Chicago (Ill), between October 15 and December 22, 1990. The survey sampled 2909 heads of households, adults aged 18 years or older, drawn from a stratified, multistage area probability sample of households in the continental United States. Because functional health status is known to decline with advancing age, an additional sample of 342 people aged 65 years or older was drawn from within the sampled households.

In all, 3251 persons were sampled, most (80%) of whom were assigned to a mail administration group and 20% of whom were assigned to a telephone administration group. (One objective of the study was to compare telephone and mail survey costs.)[9] Identical information was collected from both groups. In total, 2030 subjects responded to a mail survey of which 361 completed the survey by telephone (response rate, 79.2%), and 444 responded to a survey that was exclusively by telephone (response rate, 68.8%), yielding a final sample of 2474 respondents (response rate, 77.1%). The entire final sample was used for this analysis.

MEASURES

Respondents first completed a measure of health status, the 36-item Short Form of the Health Status Questionnaire (SF-36).[10-12] This is a brief, valid, and reliable instrument that has been extensively used in survey and clinical research and is being used in practice settings. Having just completed this measure, respondents thus were familiar with the information obtained by an assessment of functioning and well-being. They were then asked to report on three aspects of their medical care. The first was the frequency with which their physician assessed two dimensions of their health status: (1) functional performance (ie, the patient's ability to carry out everyday physical activities, role responsibilities, and social activities), and (2) emotional well-being (ie, their state of mental health as well as its impact on their ability to carry out role responsibilities and social activities) (see **Table 1** for questionnaire items). The second was whether they believed that their physician considered their functional performance and emotional well-being in formulating management plans, even when specific questions were not explicitly asked. Finally, they were asked about their own attitudes toward physician inquiries regarding these aspects of their health. This series of questions was preceded by several other questions asking about their usual source of medical care, the interval since last seeing a physician, and their satisfaction with their medical care.

The questionnaire also elicited data on demographics, chronic health problems, and experience with medical care. The SF-36 questionnaire assesses health status and well-being in eight domains: physical functioning, role limitations due to physical health problems, pain, general health perceptions, vitality, social functioning, role limitations due to emotional problems, and mental health. A high score is consistent with better health (maximum, 100). Scores on all of the health scales were dichotomized at the 25th percentile into high and low groups, the latter being relatively more functionally impaired. The mental health subscale was dichotomized at a score of 52, which is indicative of mental health disorders.[13]

STATISTICAL ANALYSIS

Data were analyzed for the total sample and for subgroups using subgroup stratification variables. Subgroup comparisons of assessment frequency and assessment attitudes used the χ^2 test statistic. To simplify the presentation, the five original frequency response categories (always, mostly, sometimes, rarely, never) were collapsed into three categories (always/mostly, sometimes, rarely/never). Data aggregation methods did not affect results.

For the analyses of assessment frequency using Pearson correlation coefficient r, scores from the three individual questionnaire items included in the functional performance scales were combined to create a single, continuous variable. Items for the emotional well-being scales were similarly aggregated. If two or more responses were missing, then the summary variable was treated as missing. If all three of the questions were answered "rarely or never," then the variable was coded as "low" (=1). When all responses were "most or every" visit, the variable was coded as "high" (=3). Other response combinations were labeled "mixed" (=2).

The results presented in this article have been weighted to reflect the demographic characteristics of the general US population including age by sex, race, and geographic region.

RESULTS

PHYSICIAN ASSESSMENT OF FUNCTIONAL PERFORMANCE AND EMOTIONAL WELL-BEING

Demographic data from the respondents appear in **Table 2**. Most respondents (64% to 84.4%) reported that their physicians rarely or never ask about functional performance or emotional well-being (**Table 3**). However, many respondents believed that their physicians are aware of and concerned about their functional performance and emotional well-being even though they do not inquire directly about these issues. Of the 59.8% who consistently said their physical functioning was rarely or never assessed, more than one third (36.8%) nonetheless reported that their physicians take their usual daily activities into account when providing advice; similarly, more than a quarter (27.7%) of those who reported that their physician rarely or never assessed their emotional status (67.5%) believed that their physician considered their emotional health when advising them.

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Table 1. Functional Performance and Emotional Well-being Assessment

When you visit a doctor, how often does the doctor ask whether—(response choices: every visit, most visits, some visits, rarely, never)
- Your health limits your ability to perform everyday physical activities (such as walking, climbing stairs, or lifting objects)?
- Your physical health limits you in carrying out your regular daily responsibilities (such as work, housework, or child care)?
- Your physical health interferes with your usual social activities with family and friends?
- You are feeling sad, depressed, or anxious?
- Emotional problems limit you in carrying out your regular daily responsibilities (such as work, housework, or child care)?
- Emotional problems interfere with your usual social activities with family and friends?

ASSESSMENT AND RESPONDENT CHARACTERISTICS

Table 4 compares the perceptions of physician behavior by members of the different sample subgroups. The subgroup comparisons generally yield the same trend noted for the total sample, ie, most of the respondents reported that their physicians rarely or never ask about their functional performance or emotional well-being, and that physicians are less likely to inquire about the limitations that physical or emotional health problems have on the patient's social activities.

Both older respondents (≥65 years) and chronically ill respondents reported being asked about the effects of their physical health on their ability to carry out their physical activities and their daily role responsibilities more often than did younger not chronically ill respondents. However, chronic illness did not affect the low rate of inquiry about the social consequences of physical health.

Respondents offered similar reports about their physicians' assessment of emotional well-being. The chronically ill and older subgroups reported higher rates of assessment, but the majority of them reported that their emotional well-being is rarely assessed. For example, about two thirds of the chronically ill (66.3%) and the older respondents (70.5%) reported that they are rarely or never asked if they feel sad, depressed, or anxious.

Scores derived from the eight SF-36 questionnaire subscales were used to classify respondents according to their levels of physical and emotional functioning. For brevity, Table 4 displays data from only three representative subscales of the SF-36 questionnaire. In general, the reported frequency of physicians' inquiries differs in relation to patients' health status. For example, reported rates of physicians' assessment of functional performance are significantly higher among those respondents with low scores on physical function. Analyses using other subscales of physical health (ie, bodily pain and role function impaired by physical problems) yielded similar results and significance ($P \leq .001$). Nevertheless, the proportion of functionally impaired respondents who are mostly or always asked about their functional performance never exceeds 30%.

Table 2. Weighted Population Demographics

Category	Percent
Gender	
Male	52.3
Female	47.7
Age, y	
<65	84.3
≥65	15.7
Race	
White	82.4
Black	10.5
Hispanic/Latino	4.1
Asian	1.1
Other	1.9
Marital status	
Married	61.1
Never married	21.3
Divorced	8.3
Separated	2.1
Widowed	7.1
Education completed, y	
<12	17.2
12	34.0
>12	48.8

Patients with diminished mental health reported that their physicians are more likely to inquire about the functional consequences of their emotional problems than are patients with better mental health, although the rates of inquiry for both are low (5.5% to 16.9%). In contrast, patients' mental health status does not appear to influence the rates with which physicians inquire about the functional consequences of physical limitations. Physicians were reported to inquire about the effects of physical health on their patients' ability to carry out daily activities about equally among the psychologically impaired and unimpaired as measured by the general mental health subscale of the SF-36 questionnaire.

The frequency with which individuals with more negative perceptions of their own health reported being asked about their emotional well-being was not significantly greater than for those who viewed their health more positively. There is an association between some other patient characteristics and their reports of being asked by their physician about their functional performance and well-being, respectively: recently hospitalized (r=.13/.02, $P \leq .001$/not significant), satisfied with medical care (r=.19/.20, $P \leq .001$), and health improved due to medical care (r=.20/.20, $P \leq .001$).

CONSUMER RECEPTIVITY TO FUNCTIONAL PERFORMANCE AND EMOTIONAL WELL-BEING ASSESSMENT

Most respondents wanted their physicians to inquire about their functional performance (63.3%) and emotional well-being (61.9%), and more than half were willing to fill out a questionnaire concerning these aspects of health, 61.4% and 56.0%, respectively. The chronically ill respondents younger than 65 years were more receptive than

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Table 3. Patient Reported Frequency of Physician Assessment of Functional Performance and Emotional Well-Being

	Asks if Physical Health Limits			Asks About Emotional Health		
	Physical Activity	Daily Responsibilities	Social Activities	Sad, Depressed, or Anxious	Limits Daily Responsibilities	Limits Social Activities
Always/mostly	19.1	16.1	10.2	12.8	7.5	6.0
Sometimes	16.3	15.2	11.1	15.8	12.1	9.7
Rarely/never	64.7	68.7	78.7	71.4	80.5	84.4

* Total sample, n=2474.

other respondents to being asked about functional performance ($P \leq .001$). Older age was a more powerful influence on respondents' preference than was chronic illness status; the older chronically ill individuals (≥65 years) did not respond differently from those without a chronic health problem. Although younger respondents were more receptive than those in the older group to the assessment of emotional well-being ($P \leq .001$), age was not associated with receptivity to functional performance assessment.

In general, receptivity to physician assessment of functional performance and well-being differed, but not significantly, by the physical health status of the respondent. However, respondents scoring lower on the mental health subscale were more willing than their emotionally healthier counterparts to provide data concerning emotional well-being directly to physicians (88.8% vs 78.2%, $P \leq .001$) or indirectly via the survey form (78.6% vs 72.3%, $P \leq .05$).

COMMENT

There are two major findings from our study. First, according to patients' reports, the explicit assessment of functional health status and emotional well-being by physicians does not seem to be a routine part of medical care. Most individuals, including the majority of the chronically ill, aged, and functionally impaired reported that these aspects of their health are infrequently assessed. Other high-risk groups that might warrant and benefit from special attention to their functional performance and emotional health are being missed. For example, people reporting pain, poor vitality, or negative general health perceptions, all of whom might be signaling a state of diminished emotional well-being, by their report are not singled out for more intensive exploration of their emotional or physical health status. The presentation of physical complaints by patients experiencing emotional distress is a well-documented process, and failure to address the underlying problem can perpetuate a pattern of inappropriate use of medical services.[14-16] Further, this study documents the tendency of physicians to neglect exploration of psychological and social domains of health.[17,18] This omission is an important obstacle to performing a comprehensive health assessment and to adequately meeting patients' needs.

An unexpected finding was that while some respondents reported that their physicians do not ask them about either their functional performance (37%) or their emotional well-being (28%), they believe that this information finds its way into the physician's clinical decision making and therapeutic recommendations. Patients were more likely to report this apparent discrepancy when they had a regular source of care and when they had seen a physician recently. Some physicians may argue that within the context of an ongoing physician-patient relationship, they are indeed able to accurately assess patients' functional performance and emotional well-being without explicitly asking about those issues. However, there is evidence that physicians tend to be unaware of patients' functional and emotional status.[19,20] It is possible that in their need to view their care as comprehensive and of high quality, patients imbue the relationship with their physician with characteristics that may not be present. If physicians are knowledgeable about these aspects of health status, as a consequence of an ongoing relationship with their patients, one might expect more than 37% of the patients to recognize this characteristic of their care.

Our second major finding stands in contrast to the first and speaks to the issue of the public's unmet demand for comprehensive care. From the consumers' point of view, health care should include the assessment of their functional capabilities and their state of emotional well-being. At least 61% to 70% of adults would like their medical care to include functional health status assessment (in the form of being asked about physical functioning, emotional well-being, or both). Patient preference for comprehensive health care is evident both in their reported desire for functional health status assessment and in their belief that even in the absence of formal assessment, their functional performance and emotional well-being are still factored into the health care recommendations made by their physicians. This receptivity is relatively uniform across all segments of the adult population. By not assessing these aspects of their patients' health, physicians limit their ability to fully appreciate the degree of their patients' functional impairment and to provide therapeutic advice within the context most relevant to the patient, ie, their daily life roles and responsibilities.

Our results must be viewed in the context of the limitations inherent to a survey of retrospective assessments by patients of their physicians' behavior. Many physicians might take umbrage with our findings and argue that patients cannot validly report on what transpires during the course of a medical encounter. However, patients' perceptions, regardless of their accuracy, are likely to influence their health behaviors. In addition, while physicians may claim to assess their patients' functioning and well-being, albeit indirectly, our empirical evidence at-

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Table 4. Reported Frequency: Percent of Physician Assessment of Functional Performance and Emotional Well-being Subgroups*

Subgroups	Physician Asks If Physical Health Limits			Physician Asks About Emotional Problems		
	Physical Activity	Daily Responsibilities	Social Activities	Sad, Depressed, or Anxious	Limits Daily Responsibilities	Limits Social Activities
Chronically ill (n=873)						
Always/mostly	24.1†	18.4†	10.0 NS	15.9†	9.7‡	7.3§
Sometimes	21.1	18.2	13.1	17.8	13.8	11.5
Rarely/never	54.7	63.4	75.9	66.3	76.6	81.2
Not chronically ill (n=1583)						
Always/mostly	17.0	15.1	9.9	11.5	6.6	5.4
Sometimes	14.2	14.0	10.3	15.0	11.4	8.8
Rarely/never	68.8	70.9	79.9	73.5	82.0	85.7
Age, y ≥65 (n=706)						
Always/mostly	28.0†	22.1†	14.3‡	15.3 NS	9.3 NS	7.1 NS
Sometimes	20.6	18.4	13.6	14.2	10.9	9.3
Rarely/never	51.4	59.6	72.1	70.5	79.8	83.6
Age, y <65 (n=1757)						
Always/mostly	17.4	15.0	9.4	12.3	7.2	5.8
Sometimes	15.5	14.7	10.7	16.1	12.3	9.7
Rarely/never	67.2	70.4	79.9	71.6	80.6	84.5
Physical function						
Score ≤70 (n=648)						
Always/mostly	28.9†	22.6†	14.5†	19.0†	9.9†	7.8†
Sometimes	22.6	20.1	16.6	17.0	15.7	13.6
Rarely/never	48.5	57.3	68.9	64.1	74.5	78.7
Score >70 (n=1799)						
Always/mostly	16.5	14.5	9.1	11.1	6.9	5.5
Sometimes	14.6	13.9	9.7	15.6	11.1	8.8
Rarely/never	68.9	71.6	81.2	73.4	82.0	85.7
General health perceptions						
Score ≤57 (n=1833)						
Sometimes	21.4	18.8	14.5	19.2	13.7	12.5
Rarely/never	53.3	61.8	74.2	65.7	77.4	81.3
Always/mostly	24.3†	19.4†	11.2‡	15.1‡	8.9 NS	6.2§
Score >57 (n=1833)						
Always/mostly	17.5	15.3	10.0	12.2	7.2	5.9
Sometimes	14.9	14.2	10.1	14.9	11.6	8.9
Rarely/never	67.7	70.5	79.9	73.0	81.2	85.2
Mental health						
Score ≤52 (n=359)						
Always/mostly	19.7§	14.6 NS	11.5 NS	16.9†	12.0†	8.8†
Sometimes	20.7	18.8	13.1	20.8	14.8	15.8
Rarely/never	59.7	66.7	75.5	62.3	73.1	75.7
Score >52 (n=2115)						
Always/mostly	19.0	16.4	10.0	12.1	6.8	5.5
Sometimes	15.6	14.6	10.8	5.0	11.6	8.7
Rarely/never	65.5	69.0	79.2	72.9	81.5	85.8

*NS indicates not significant.
†P ≤.001.
‡.001 < P≤.01.
§.01 < P≤.05.

tests otherwise. A number of findings lend credence to the study's main conclusions. For example, our results indicate that both receptivity to assessment of functional health status and emotional well-being and receipt of this aspect of comprehensive care are associated with having an established physician-patient relationship and satisfaction with care. The causal direction of this relationship cannot be established from our data. Such assessment may encourage patients to maintain relationships with their physicians and may also contribute to their satisfaction with medical care or vice versa; both explanations may be operative. These results confirm the generally acknowledged importance of continuity of care.

Focusing on functional outcomes of care represents somewhat of a conceptual shift and creates a pragmatic challenge for medical practitioners. Unlike many of the other proposals for changes in medical care that are mainly technical or administrative in nature, the diffusion of health status assessment into patient care rests, in part, on assumptions about the meaning of health, the significance of certain health indicators to the patient, and the legitimate scope of concern and responsibility of medical professionals and the health care system. There is little documented experience concerning effective treatment options for the functionally and/or psychologically impaired patient within the context of general medi-

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cal practice. In times of professional concern about reimbursement for cognitive services and pressures for productivity, it may be difficult to convince physicians to adopt a working definition of health that requires more time and additional skills to provide high quality care. Routine assessment of patients' functional health status and emotional well-being may provide a mechanism to meet this challenge. The results of standardized assessment of patients' functional outcomes can direct reimbursement systems to reward quality and value. Placed in that light, this study provides a baseline against which changes in the quality and content of medical care can be measured.

Accepted for publication May 13, 1994.

This work has been supported by the New England Medical Center, Boston, Mass, under the auspices of a grant from The Henry J. Kaiser Family Foundation, Menlo Park, Calif.

We express our appreciation to Alvin R. Tarlov, MD, M. Teresa Celada, MA, Colleen A. McHorney, PhD, and Constance L. Kelley.

Reprints not available.

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AEGON Insurance Group

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February 14, 1996

The Honorable Richard L. Bond
Chairperson
Financial Institutions and Insurance
State of Kansas Statehouse
300 SW 10th Avenue
Topeka, Kansas 66612-1504

Re: Senate Bill 656

Dear Senator Bond:

AEGON, through it's Long-Term Care Division, is one the largest writers of individual long-term care insurance. We began writing long-term care insurance in 1988 and over the last several years we have watched the market and our market share grow.

Kansas is one of our largest states for current production. Kansas ranks fourth in our total long-term care production, accounting for over 6.5% of our 1995 business. Inforce premiums reflect almost the same figures: Kansas ranks sixth in total inforce premiums, accounting for 5% of our total premiums. At year end 1995, we had well over $7 million of long-term care premiums inforce in Kansas alone, insuring over 7,000 residents of Kansas.

AEGON's Concern With Current Insurance Regulations.

We have three primary concerns with the current Kansas Insurance Regulations. Senate Bill 656 addresses two of those concerns, and with a small change to Senate Bill 656 our third concern could be addressed also. Our concerns with Senate Bill 656 are as follows:

1. ***Kansas Insurance Regulations Mandate Insurers To Cover Assisted Living and Residential Care.*** Please understand that AEGON does cover assisted living and residential care in all states. However, we cover these types of facilities in an ***optional*** Home Health and Community Care rider. Our rational is as follows:

   - The utilization of assisted living is both unknown and expensive. The expense is generally not due to the daily charge, but rather the number of people that will use an assisted living

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facility. Many of these facilities are apartment like, including private baths and kitchen facilities, making the facility look like a retirement apartment. Clearly insurers cannot insure the cost of someone's apartment, or better said, insurers cannot provide an insurance policy that pays for a retirees rent or housing costs.

- The utilization of assisted living is unknown and will drive the premiums of long-term care policies much higher. For every person that is in a nursing home there are at least 3 people in the community that have the same level of disability. *If just one of those three people decide to go to an assisted living facility an insurer's claim costs will automatically double.* This means that the average annual premium of $1,000 could be increased to $2,000 by adding assisted living to a long-term care insurance policy.

- Assisted living facilities are developing at an ever increasing rate. The January issue of *Integrated Senior Care* indicates that the assisted living industry is even being noticed on Wall Street. At least six companies **(Sterling House, Emeritus, ARV Assisted Living, Just Like Home, Regent, and Assisted Living Inc.)** went public in 1995 with several more offerings expected in the first half of 1996. While this is not bad, assisted living facilities must be able to fill the beds in order to be profitable. The utilization of assisted living as described above is an unknown, however, we do know that more and more people will utilize assisted living facilities, ultimately driving the premiums for long-term care insurance upward.

- Everyone will not need nor will everyone want to utilize an assisted living facility. Today, Kansas Insurance Regulations allow residents to elect coverage for home health and community care on an optional basis. Kansas Insurance Regulations recognize that home health care is expensive and that not everyone needs or wants an optional home health care rider. Industry statistics show that about 66% of the long-term care buyers purchase a policy with home health care benefits.

  Many residents have family members that can and will provide assistance instead of allowing a home health care agency to come into the home. Requiring everyone to purchase a home health care rider does not make sense and the same reasoning applies to assisted living and residential care; consumers should have the freedom and ability to purchase coverage that most reflects their needs and personal situation. Mandating benefits that will not be used is both expensive and senseless

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for a product that can help the state of Kansas offset the ballooning Medicaid budget.

- Medicaid does not cover assisted living for good reason. Due to Medicaid's fear that utilization will be extremely high, the cost of covering assisted living would be prohibitive. Insurers and more importantly, consumers are affected by this same reasoning in the private insurance market.

Our Recommendation. We would suggest Kansas allow assisted living and residential care be covered on an optional basis, allowing the residents of Kansas to elect the benefits that most closely reflect their personal and family situations.

2. ***Kansas Insurance Regulations Do Not Allow For Benefit Levels to Vary For Different Facilities.*** Senate Bill 656 corrects this problem and we are very much in support of the wording in Senate Bill 656. Our reasons are as follows:

- Assisted Living is generally less costly than nursing home care. National statistics show that assisted living charges are about 60-80% of a nursing home charge. Of course some assisted living facilities can charge less or even more than a nursing home, depending upon the individual facility, services provided, etc. However, the concept of an assisted living facility is to provide fewer services, less hands-on help, at a lower cost.

- Over insuring against the assisted living risk will occur. Consumers will be mandated by law to purchase more coverage than is actually necessary, therefore, premiums will be higher and the consumer may receive no actual increase in benefits. This is a waste of valuable premium dollars considering that most purchasers of long-term care insurance are retired.

3. ***Kansas Insurance Regulations Do Not Allow For Benefit Eligibility Criteria To Be Objective.*** Senate Bill 656 corrects this major flaw in the current Kansas Insurance Regulations and we are in full support of the wording in the bill. Our reasons are as follows:

- Current Kansas Insurance Regulations require nursing home benefits to be paid on a physician's recommendation alone. The problem can best described by two actual examples.

  Example. The insured was confined to an assisted living facility with a diagnosis of Alzheimer's Disease. Clearly this is a payable

claim and the insurer began the claim process. Within 30 days, another claim, this time on the husband of the insured, was submitted. The husband was not disabled in <u>any</u> of the activities of daily living, nor did the husband have Alzheimer's Disease. The physician had the husband admitted because the husband was lonely, and did not want to cook for himself. With a $100 per day benefit this claim amounts to $36,500 per year. Clearly loneliness or the desire to have someone else do the cooking is not insurable at any price.

Example. During the summer our claim department received a call from an assisted living facility. The facility wanted to verify benefits for a particular insured. When asked if the insured was already confined to the facility, the facility responded that the insured was not confined, but rather was making "plans for the winter months". Clearly, long-term care insurance policies cannot pay for apartment living that is more for convenience than for assistance with the activities of daily living or the debilitating effects of Alzheimer's Disease.

Under current Kansas regulations these two claims are payable, if and only if the insured's physician recommends confinement in an assisted living or residential care facility. No other state requires this, and we are not aware of another state that does not allow the use of the activities of daily living or a cognitive impairment as the sole trigger for accessing long-term care benefits.

- When combined with the current Kansas Insurance Regulation that mandates assisted living and residential care coverage, the use of the physician recommendation benefit trigger allows providers and insureds to abuse and select against insurers and insurance contracts. Ultimately this will lead to the rate increases that the insurance industry is trying to avoid.

- AEGON's claim experience in Kansas is worse than expected, that is, our premiums are too low to support the level of claims that we are experiencing. One other state, North Dakota, has a similar definition of nursing homes, and as you might expect, our experience in North Dakota is similarly bad.

  Our experience in North Dakota indicates that claims are 50% higher than expected. In Kansas, that same figure is 29%. However, AEGON has been writing business in North Dakota longer and we fully expect that without a change in Kansas Insurance Regulations our experience in Kansas will mimic our

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experience in North Dakota. In fact, there is a very good chance that our Kansas experience will be significantly worse since we are unable to use Activities of Daily Living or Cognitive Impairment as a benefit trigger as we are allowed to do in North Dakota.

Finally, our actuarial staff has three claim experience files. One file is for our entire block of business. The two other files are labeled for two specific states; one is for North Dakota, the other is for Kansas. We continue to monitor the business in Kansas, and continually see deterioration in that block.

In conclusion, it is clear that our nation will not have any new government programs that will pay for the increased nursing home and home health care utilization that will continually grow as our population ages. Medicare spending for home health care was $2 billion in 1988, $10 billion in 1993 and, 1999 is projected to exceed $22 billion. Most of this growth *is not due to medical inflation,* but rather it is due to increased utilization. While not everyone can afford to purchase a private long-term care insurance policy, a substantial number of those over 65 can afford to purchase a long-term care policy. It is our feeling, supported by several studies, that 35-45% of those over the age of 65 can in fact afford to purchase the long-term care coverage that is available today. However, if the cost of coverage is increased or if coverage is not available the number of those that can afford coverage is severely reduced. If the State of Kansas is going to rely on the private insurance market to help offset the increasingly high cost of long-term care services Senate Bill 656 with our recommended changes must be enacted.

We are at your service. If you require further information or documentation, please call me at (800) 553-7600.

Best regards,

Robert P. Glowacki, FLMI, CLU
Vice President Government Relations
Long-Term Care Division

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PETE McGILL & ASSOCIATES INC.

GOVERNMENT AFFAIRS & PUBLIC RELATIONS

300 WEST EIGHTH • THIRD FLOOR • TOPEKA, KANSAS 66603-3912 • 913·233·4512 • FAX 913·233·2206

Testimony In Support of SB 656

John J. Federico

Submitted On Behalf of The Sterling House Corporation

Senate Financial Institutions & Insurance

February 16, 1996

My name is John Federico of Pete McGill & Associates and I appear here today on behalf of the Sterling House Corporation in general support of SB 656. Sterling House is the leading provider of assisted living in the Midwest. In Kansas, there are currently 19 Sterling House Assisted Living Facilities and they are proud of the reputation they have established in this constantly developing market.

Sterling House believes that assisted living represents a new and exciting alternative to traditional long-term care options and feel that it truly enhances the quality of life for those they serve. Because they are committed to quality, they believe that the assisted living industry should be regulated to a degree capable of monitoring quality among providers while still allowing freedom of variety and continued creativity and innovation.

Sterling House supports the intent to establish and maintain long-term care insurance in Kansas. They feel that it will provide increased access to those in need of services, while also removing some of the financial burden of long-term care cost from the taxpayers and the State. However,...Sterling House is concerned about the impact that certain language found in SB 656 may have on the industry as a whole and the residents it serves.

I respectfully direct your attention to Section 2(i), on page 5, lines 5 through 7. It states that services provided in the assisted living or residential health care

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setting, be reimbursed at a rate of 50% of that paid in the nursing home setting. Sterling House believes that this sets the "floor" unnecessarily low and that payors, basing reimbursement on the **setting** rather than the **service**, would use this rate as a guide. Currently, assisted living residences and nursing homes provide many of the same services, including skilled nursing care. Therefore, long-term care insurance expenditures might be more efficiently paid based on the consumers **need** for the utilization of covered services, rather than the **housing option** the individual may choose.

Their next concern is in regard to Section 2(j), page 5, lines 11 through 14. This section is devoted to establishing a minimum level of functional limitation prior to accessing insurance payment. The benchmark as defined here is; "a deficiency in the ability to perform not more than **three** activities of daily living or the presence of cognitive impairment." Sterling House feels that the following language would more accurately reflect the needs of the consumer;.... "the **inability** to perform not more than **two** activities of daily living or the presence of a cognitive impairment." Although the National average of those residing in assisted living facilities shows that they need assistance with three ADL's, Sterling House feels there are legitimate reasons why it should be two rather than three. Thus, if the current language remains, it is their opinion that assistance would be denied to many policyholders in need of services, or those unable to care for themselves in their own home.

In summary, the Sterling House Corporation is conceptually supportive of SB 656, but urges you to consider what we feel are reasonable, yet important changes. Thank you for your time and I will be happy to respond to any questions.

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KAHSA
KANSAS ASSOCIATION OF
HOMES AND SERVICES FOR THE AGING

MEMORANDUM

TO: Senator Dick Bond, Chair, and Members of the Senate Financial Institutions and Insurance Committee

FROM: John R. Grace, President/CEO

RE: Senate Bill 656

DATE: February 15, 1996

==========

Thank you, Mr. Chairman, and members of the Committee.

The Kansas Association of Homes and Services for the Aging is a not-for-profit association which represents over 150 not-for-profit retirement, nursing, and community service providers throughout Kansas.

We support Senate Bill 656.

Senate Bill 8, which was passed into law during the 1995 Legislative Session, redefined adult care homes, and provided for a number of new licensure categories, including assisted living and residential health care. SRS has designed a new reimbursement program in which providers will be reimbursed at varying rates based upon the needs of Medicaid recipients. Thus, the provider of assisted living services will be reimbursed at a lower rate than the nursing facility rate.

Private long-term care insurance benefits, based upon the level of care needed by consumers, should result in a lower priced product that will be more affordable and, therefore, more attractive to Kansas consumers. It is reasonable to expect that more Kansans will purchase long-term care insurance. In this way, Senate Bill 656 can serve as a catalyst for the shift from reliance on public to private reimbursement for long-term care services.

In addition, we believe that the use of the Activities of Daily Living (ADL) criteria for triggering the long-term care insurance benefit would be consistent with the functional screening that will be a part of determining appropriate reimbursement for Medicaid recipients. This criteria appears to be the most reasonable way to determine appropriate placement and reimbursement.

Thank you for this opportunity. I'd be glad to answer any questions.

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700 SW HARRISON, SUITE 1106
TOPEKA, KANSAS 66603-3759
913-233-7443
FAX: 913-233-9471

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. 656 (Long Term Care Insurance)

Date: February 16, 1996

I would like to thank the Committee for the opportunity to testify in opposition to Senate Bill 656. This legislation makes significant changes to the standards currently in Kansas law for the sale of long term care policies. While there may be ideas presented in the bill which could be incorporated into our law, the provisions set out in S.B. 656 merit careful study. Any consideration of these changes should include input from those consumers who purchase and rely on coverage from long term care insurance policies.

I think it is important to understand the history of the marketing of long term care insurance in Kansas. The Kansas Long Term Care Act (K.S.A. 40-2225 et seq.) was passed by the Legislature in 1988 at a time when there was a problem with the availability of long term care insurance products in this state. In addition, the Act was designed to address a significant number of consumer complaints received by the Department each year from purchasers of long term care insurance who found that they were unfairly denied coverage from the insurer.

Since the passage of the Act in 1988 the long term care market in Kansas has improved. In 1988 only 7 companies sold long term care insurance in this state. Today approximately 60 insurers are in the market. In 1994 there were over 70,000 Kansans

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420 SW 9th Street
Topeka, Kansas 66612-1678
913 296-3071
Fax 913 296-2283
Consumer Assistance Hotline
1 800 432-2484 (Toll Free)

covered by long term care policies and the companies who sold those policies paid over $104 million in premiums.

Last year the Kansas Legislature approved S.B. 8 which was introduced at the request of the Kansas Department of Health and Environment. That legislation changed the definitions of the types of nursing homes which could operate in this state. I have attached a chart to my testimony which shows the types of homes licensed by KDHE before and after the passage of S.B. 8. Because of the new definitions, the Insurance Department recently approved changes to its long term care regulations to include the updated terms.

I understand that this bill is in part in response to our new regulations. There some long term care insurers who have expressed concerns about the application of our rules to policies which they market in Kansas. I have told companies that the Department will work with them to work out any problems they might have. You should be aware that my staff will be meeting today at 10:30 with many of the same insurance conferees who are testifying today to discuss the impact of the new regulations.

I have also made it very clear to those companies which sell long term care insurance that the Insurance Department will undertake a comprehensive review of our long term care statutes and regulations. The industry has been aware since last fall that I will form a "Seniors Task Force" to examine a number of insurance issues of concern to senior citizens in Kansans. I plan to appoint this group within the next 30 days. I have also repeatedly told the industry that the first issue which will be addressed by the Seniors Task Force is a discussion of our long term care laws. I am frankly disappointed that the insurance industry apparently does not believe the Department is sincere in its intention to review many of the same issues presented in S.B. 656.

As I indicated, the provisions in Senate Bill 656 can have serious ramifications for those Kansans who have purchased coverage through a long term care policy. I want to briefly touch on two of those concerns:

(1.) Benefit Triggers: The legislation allows insurers to condition the benefits in a policy based on whether the insured meets tests designed to determine whether they can function under "activities of daily living" or "ADLs." Kansas currently permits the use

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of ADLs in group long term care policies. The Department has in the past been reluctant to approve the use of activities of daily living for individual policies. The plain fact is that ADLs are a means used by insurers to deny coverage to an insured. An individual purchaser of a long term care policy does not have the same power to negotiate with an insurer if there is a coverage dispute than does a group policy holder such as a large employer.

The state had a lot of problems in the 1980s with companies routinely denying coverage under a long term care policy. I want to make certain if we extend the use of ADLs to the individual market that consumers are protected. The proper use of activities of daily living is to assess the needs of the nursing home resident. I do not want them to just be another means for the insurer to deny coverage to an otherwise eligible insured.

(2.) Benefit Differentials: Section 2 of the bill starting on page 5, line 5 allows insurers to pay up to 50% less in benefits to insureds who are confined to "assisted living facilities" or "residential health care facilities." The industry argues that the care provided at these types of nursing homes are at a lower level than care provided in other types of facilities and therefore they should be not pay as much for those services.

However, one of my concerns is that we currently allow the sale of policies in Kansas where insurers agree to pay 100% of the cost of at an intermediate personal care home. Under S.B. 8 those nursing homes will can now be licensed as an "assisted living facility" or a "residential care home." I do not want insureds who purchased a policy with the belief that they would receive 100% benefits now forced to accept up to 50% less in coverage just because the type of license held by the nursing home changes. While there may be reasons why our regulations should be changed to permit new policies to pay lesser benefits for assisted living arrangements, the policies already in force should keep the same level of benefits outlined in the policy.

I also believe there should be strict disclosure standards for policies which are designed to pay a lesser level of benefits for assisted living. The consumer needs a clear understanding that they may not receive full coverage from their long term care policy--and this is information they need to know before they have to access those benefits.

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Senate Bill 656 changes the rules of the game for purchasers of long term care insurance. I am willing, as I have often stated in the past, to review issues such as the expanded use of benefit triggers in individual policies. I think however the consumers in this state deserve a careful review of any changes in how the long term care insurance market is regulated in this state. The consideration of any changes to our laws on long term care insurance should include the views of consumers. I would strongly urge this Committee to reject S.B. 656.

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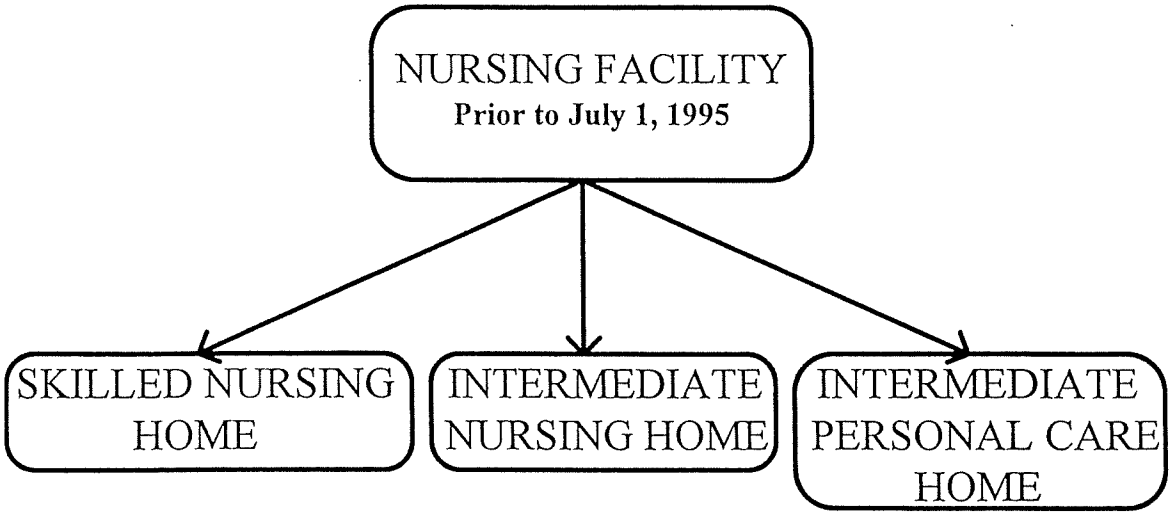
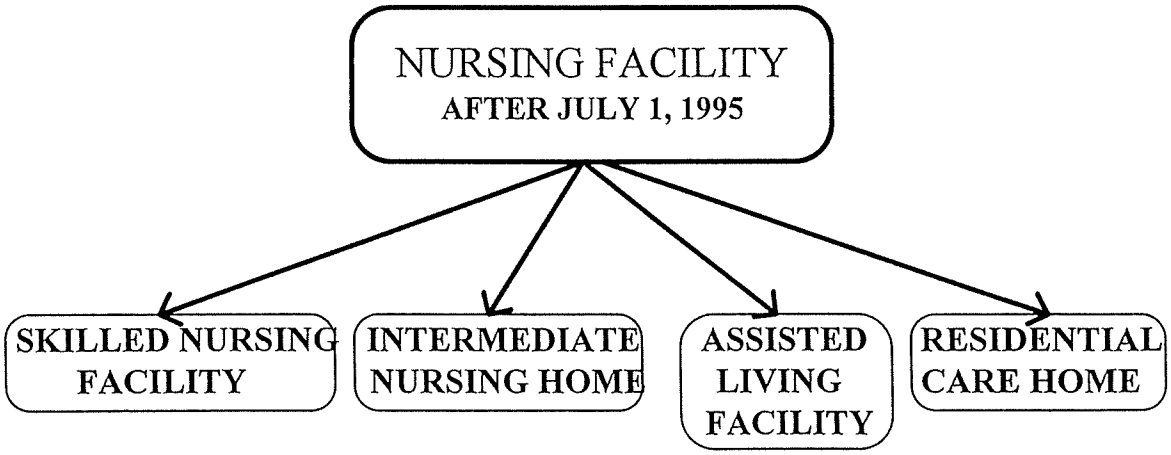
LONG TERM CARE FACILITIES



AFTER
IMPLEMENTATION OF 1995 SENATE BILL NO. 8 ON JULY 1, 1995



The above shows a nursing facility licensed as an Intermediate Personal Care Home. The enactment of 1995 SB No. 8 replaced this category with the new categories of

1.) Assisted Living Facility, and
2.) Residential Care Home.

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Aid Association for Lutherans
4321 N. Ballard Road
Appleton, WI 54919-0001

February 16, 1996

The Honorable Dick Bond, Chairman
Senate Financial Institutions and Insurance Committee

RE: Senate Bill 656

Chairman Bond and Committee Members:

AAL has sold LTC insurance since 1988 and currently has over 37,000 certificates in force in the U.S. Ninety percent of our certificates cover assisted living facilities and 98 percent use activities of daily living in the determination of claim eligibility. We have 940 certificates in force in the state of Kansas representing over $725,000 in annual premium. AAL has 38 agents whose primary state of business is Kansas and a number of others licensed in state who primarily operate in a border state.

Senate Bill 656 addresses two important issues directly affecting the affordability of long-term care insurance -- benefit eligibility and benefit payment levels. The benefit payment process can be viewed simply as a two-step process. First, is the insured eligible for claim payment? Second, if the insured is eligible, what benefit amount should be paid?

To determine benefit eligibility a series of benefit triggers is used. Benefit triggers are used by insurance carriers in an attempt to control antiselection and over-utilization by answering the question, "When is it appropriate to pay for care received by an insured?"

In all states except Kansas, AAL uses activities of daily living (ADLs) and a cognitive assessment. Activities of daily living include bathing, dressing, toileting, transferring (to and from a chair or bed), eating, and continence. As the ability to perform these activities declines, the need for assistance and care increases. The cognitive impairment trigger is designed for cases where the insured's physical condition is fine but due to memory or reasoning problems external care is advisable. An example of a cognitive impairment would be Alzheimer's Disease. The trigger is set so that when the insured is assumed to need care the contract will pay for that care.

As I mentioned earlier, we use ADLs for 98 percent of our business. The only place where we are not permitted to use ADLs is in Kansas. In Kansas our premiums are 17% higher on average than across the rest of the country. Our claims experience has not matured to the point where we can determine whether this adjustment is appropriate. It may be too low or it may be too high. We know that most people do not want to enter a nursing home but the same stigma is not as prevalent for more residential-type settings such as assisted living. We felt an adjustment was

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necessary to reflect the additional risk.

The U.S. Congress is currently working on standards for long-term care policies. Premiums on contracts meeting these standards will be tax-deductible. Among the standards is a requirement that benefit eligibility be conditioned on the impairment of ADLs or the presence of a cognitive impairment. If Kansas fails to allow these benefit triggers, policies sold in this state will not be tax-deductible. This effectively increases the cost of the insurance for Kansas citizens and reduces the likelihood of some people insuring themselves against this risk.

Once eligibility is determined, the appropriate benefit must be paid. This is normally based on the type and level of care provided and the setting in which the care is provided. AAL currently pays three different levels for three different types of care. The first is nursing home care; the second, alternate care facility (which includes assisted living facilities) care; and the third, home care. Each of the payment levels reflects the differing cost of providing that type of care. Nursing home is the most continuous, intense, and costly type of long-term care. Assisted living is less intense, deals with less impaired patients, and is less costly. Home care costs can vary greatly depending on the type of care and the qualifications of the caregiver but generally run a bit less than nursing home care.

The cost of assisted living varies greatly among facilities. A 1994 Vermont study put the range at $850 to $3,000 per month. In Oregon, probably the state with the most advanced assisted living network in the country, the average cost per day in an assisted living facility was $56 in 1993. This was 62% of the average daily nursing home rate of $90.

Pricing assisted living benefits can be tricky. There are undoubtedly people who would enter nursing homes if their policies did not cover assisted living but choose assisted living since it is covered. There are also cases where people will enter assisted living facilities because they are covered when they would have remained in their home in the absence of insurance. Thus, adding coverage for assisted living and similar facilities causes the substitution of this care for nursing home care but also creates additional claims.

Based on our pricing assumptions, paying assisted living claims at 60% (a rate comparable to the average from the Oregon study) increases the premiums for an insured age 62 less than 1%. The additional claims incurred with the additional coverage are offset mostly by the lower daily rate. However, when assisted living facilities are covered at 100%, this offset is no longer present. Rates need to increase about 14% (at age 62) to cover the extra facilities.

Allowing insurance carriers to vary the benefit levels to reflect the difference in cost helps avoid over-insurance problems and keeps the premium levels down. This keeps the coverage meaningful and affordable. Sensible benefit triggers and varying benefit levels result in affordable insurance which means that private long-term care insurance can be a viable long-term care option. The expansion of a long-term care insurance market that provides meaningful benefits at a reasonable cost can reduce the strain placed on Medicaid to cover the long-term care needs of the state's population. If insurers are not able to design products with reasonable cost controls they are forced to price policies above the reach of many consumers. The uninsured

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population is then forced to use Medicaid as a safety net.

Thank you for the opportunity to present this information.

Sincerely,

David R. Benz, FSA, MAAA
Director and Associate Actuary

Sharon Brosnan
Legislative and Regulatory Compliance Consultant

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BANKERS *LIFE AND CASUALTY COMPANY*
222 Merchandise Mart Plaza • Chicago, IL 60654-2001
(312) 396-6000

February 16, 1996

The Honorable Richard L. Bond
Chairperson
Financial Institutions and Insurance
State of Kansas Statehouse
300 SW 10th Avenue
Topeka, KS 66612-1504

RE: Senate Bill 656

Dear Senator Bond:

Bankers Life and Casualty Company would like to offer written testimony regarding Senate Bill 656.

As a matter of background, Bankers Life and Casualty is one of the largest Long Term Care insurance carriers in the country. Today, in the state of Kansas alone, we have approximately 140 agents licensed to sell LTC insurance and 6,600 LTC policies/insureds inforce. Kansas represents roughly 5% of our company's inforce Long Term Care business. In addition, in 1995 Kansas residents received over $2.3 million in benefit payments under their LTC insurance coverage.

Bankers Life and Casualty Company would like to convey its support of Senate Bill 656. (Please note item #2 which follows for a suggested modification.) This Senate Bill contains changes to the current Long Term Care laws which we view as very important to the future availability of reasonably affordable, high quality, Long Term Care insurance protection for the residents of Kansas.

We believe that Senate Bill 656 addresses two important issues:

1. Benefit Eligibility Criteria for Long Term Care Insurance

   We support the items included in Senate Bill 656 that address the benefit eligibility criteria for Long Term Care insurance products.

   Among the key items included in Senate Bill 656 is the addition of definitions for "Activities of Daily Living" (often called ADLs). The Bill defines 6 particular ADLs, ("bathing", "continence", "dressing", "eating", "toileting", and "transferring"), and allows insurance policies to trigger the payment of benefits based upon a determination of the insured's ability to perform these ADLs and on cognitive impairment.

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Specifically, the Bill states that: "Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three (3) of the activities of daily living or the presence of cognitive impairment".

This addition of Activities of Daily Living, along with the above stated benefit eligibility criteria is completely consistent with recent changes made to the NAIC's Long Term Care Model Regulation as well the LTC Regulations of all other states. The definition of ADLs and their use as a trigger for benefits, have become an important tool in developing objective, measurable criteria for triggering LTC insurance benefits. Having an objective benefit determination criteria helps insureds to know exactly when their benefits are payable.

2. Lower Levels of Benefits (Specifically Assisted Living and Residential Health Care Facilities)

Another important item in Senate Bill 656 is the allowance for Long Term Care benefits received in an Assisted Living Facility or a Residential Health Care Facility to be paid at a lower benefit level, not to be less than 50% of the benefit payable for services provided in a traditional Nursing Facility.

We support this provision, however we would urge that Senate Bill 656 be modified to allow benefits received in Assisted Living or Residential Health Care Facilities to be covered on an **optional** basis in Long Term Care insurance products.

We view this change as consistent with the treatment of other lower levels of care such as Home Health Care and other community based services. These benefits are offered as a separate option, for an additional premium.

This directly impacts the affordability of LTC insurance in the state of Kansas. Current regulations in the state of Kansas require LTC insurance to cover all care provided in these lower level facilities, (Assisted Living Facility or a Residential Health Care Facility), up to the full benefit amount payable for traditional nursing facilities.

It is important to note that Nursing Home insurance policy prices are generally based upon government data and company experience which has been for confinements in traditional nursing home facilities only. The inclusion of additional lower level facilities into insurance policies cannot come without consideration for increasing premium rates. Many insurers today will provide coverage in these lower level settings, if the stay in this setting is in lieu of a stay in a traditional nursing home. This is done via an "Alternate Care" provision in many LTC insurance products, and allows insured individuals to receive the most appropriate level of care in the most appropriate and cost-effective setting. This alternate setting must be agreed to by the insurer, the insured, and the insured's doctor. "Alternate Care" benefits are often payable up to an amount less than the full nursing home benefit.

Because these Alternate Care, (or lower level), benefits are paid in lieu of a nursing home stay, companies can provide this benefit for little or no additional premium.

However, current Kansas regulations require LTC insurance to provide benefits in Assisted Living or Residential Health Care Facilities regardless of whether or not a stay in a

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traditional nursing facility would have been needed. In addition, benefits in these lower level facilities must be paid at the full amount of traditional nursing facilities. These current requirements are likely to cause increases to future premium rates which need to be charged for LTC insurance in the state of Kansas. Higher prices would have an adverse effect on the ability of Kansas residents to protect themselves from the potential risk of long term care expenses.

In conclusion, allowing the lower level coverage provided for in Assisted Living or Residential Health Care Facilities to be included with Home Health Care benefits as an optional benefit will preserve the insureds ability to purchase the type of insurance protection best suited for their individual needs. The insured can choose to purchase complete comprehensive Long Term Care insurance which provides for all levels of care, or a more limited, but more affordable plan which provides for care in nursing facilities.

Thank you for your consideration of our testimony on this matter.

Sincerely,

Susan Morisato

Susan Morisato, F.S.A., M.A.A.A.
Vice President & Health Product Actuary

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Comments Relating to Kansas SB 656

John Hancock Mutual Life Insurance Company
Boston Massachusetts
February 16, 1996

We appreciate the opportunity to offer our comments relative to SB 656 which repeals certain changes that have recently been contained in amendments to Kansas Administrative Rules. We enthusiastically support the provisions of SB 656, which proposes changes to K.S.A. 1995 Supp. 40-2116 and K.S.A. 40.2228, and has the effect of changing provisions contained in K.A.R. 40-4-37

John Hancock Mutual Life Insurance Company is the leading carrier in the employer group long-term care insurance market, with about 120,000 certificates in force. Our employer group policies cover about 2000 Kansans employed by companies such as Southwestern Bell Corporation, Ford Motor Company, General Motors Corporation, State Farm Insurance, US West and Westinghouse. We are also a major insurer in the individual long-term care market with over 59,000 policies in force. We are a leader in product design and innovation. Our policies and certificates have been applauded by consumer groups and customers for meeting the long-term care needs of the public in a consistent and creditable manner. We are a founding member of The Coalition for Long-Term Care Financing, and serve on the Health Insurance Association of America (HIAA) Long-Term Care Committee.

John Hancock welcomes responsible regulation. We feel that our interests and those of consumers are best served by regulation that fosters the sale of quality products by reputable carriers. John Hancock supports the use of the NAIC Long-Term Care Insurance Model Act and Regulation, with certain exceptions, as the basis for responsible state regulation.

Our comments will focus on areas within the regulations which are changed by the provisions of SB 656.

Changes to K.A.R. 40-4-37 revise the definition of nursing facility to include assisted living and residential health care facilities. While our employer group policies typically cover assisted living facilities, the definition that we use for such facilities focuses specifically on residential care provided for persons with dementia, to include Alzheimer's disease. The definition that we use for Nursing Home differs substantially, focusing on providing all levels of care (skilled nursing, intermediate nursing and custodial care) to individuals.

Because there is a significant difference in the types and levels of care provided in these facilities, our policies reimburse their respective costs on a differing basis. Nursing homes, which provide a higher and more comprehensive level of care, are reimbursed at a correspondingly higher level than assisted living facilities, which provide a less intensive, lower level of care. Care provided in assisted living facilities cannot be regarded as a substitute for the care provided in a nursing home. The ultimate reduction in the cost of policies that are written in this manner allows a greater number of consumers access to long-term care insurance.

The changes to Section 40-4-37 preclude insurers from reimbursing differing facilities at appropriately different levels. The amended regulation eliminates an insurers ability to

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differentiate, and causes an increase in premium cost to the consumer. In addition, Kansas Insurance Department Bulletin 1996-2 specifically requires that currently approved policies which provide benefits for confinement in the newly defined assisted living and residential care facilities may no longer differentiate as to the level at which facilities are paid.

In this case, a Kansas state agency has imposed a change upon existing contractual agreements between individual policyholders and insurers. This action, put forth in the Insurance Department Bulletin, raises two issues which cause us significant concern. A question of impairment of contract exists where the insurer's contractual obligation to price in an manner adequate to cover a specified level of risk is compromised by a state imposed revision of that level of risk. In addition, having previously priced for a lower level of risk than that required by revision to state regulatory language, the insurer must re-price the policy, and increase premium cost to Kansans.

We have discussed our concerns with the Department, recommending that the regulation allow that assisted living facilities be reimbursed at some reduced level in order to reflect the differing level of care provided. Specifically, we recommended that long-term care policies reimburse these facilities at a minimum of 50% of the daily maximum benefit, while nursing homes be reimbursed at 100% of the daily maximum benefit. The Bulletin changes the manner in which policies would reimburse assisted living facilities. Provisions contained in SB 656 Section 2 (i) would allow insurers to continue to reimburse at appropriately differentiated levels, according to the level of care provided.

Amendments to K.A.R. section 40-4-37d allowed benefit trigger provisions in employer group long-term care insurance policies to follow a standard similar to that used in both the NAIC Long-Term Care Insurance Model Regulation, and in currently proposed federal legislation relating to long-term care insurance tax and standards. Notable differences exist which have caused there to be inconsistencies between coverage available in Kansas and coverage available in most other jurisdictions. This is a particular concern for carriers such as John Hancock, that frequently deliver certificates in multiple states under one employer group policy.

In addition, the definitions of ADLs contained in Section 40-4-37d as they relate to the level of disability necessary to trigger benefit status, are not consistent. Some of the definitions require that assistance from another person be necessary to trigger benefit status, while other definitions are unclear on this issue.

The NAIC has recently adopted an ADL trigger which employs a three of six standard, with a separate cognitive trigger provision. Kansas regulation includes mobility in addition to the six ADLs used by the NAIC. The NAIC has based its benefit trigger standard on the advice of academics, consumer advocates, regulators and insurance carriers. The ADL approach was developed by Dr. Sidney Katz, a nationally recognized authority on functional impairment, and is the method most commonly used by major long-term care insurance carriers. We have recommended, in discussions with the Insurance Department, that section 40-4-37d reflect the NAIC benefit trigger standard in its entirety.

SB 656 Section 2 (j)-(n) would cause the NAIC benefit trigger standard to be used in long-term care policies sold to residents of Kansas. These provisions would alleviate the inconsistencies between coverage available to Kansas and coverage available in nearly all other jurisdictions.

Individual long-term care policies, as well as other non-employer group policies are currently subject to a physician certification standard under the benefit trigger provisions of Kansas

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regulation. It has been our experience that the physician is but one part of an integrated health care team. It is often the actual providers of care (nurses, home health care providers, social workers, etc.) that provide the most valuable and complete information regarding the need for care. As the NAIC discussions in this area suggest, experts agree that the ADL/cognitive impairment trigger is an appropriate measuring tool for benefit eligibility. Kansas was one of the first states to recognize this fact and implemented this in the employer group market. We urge you to adopt this same framework to the individual and non-employer group market by supporting the important changes which are contained in SB 656.

We thank you for allowing us the opportunity to comment on Kansas SB 656. We enthusiastically support the changes to regulatory language which will result from enactment of this legislation We will be happy to provide you with additional information if necessary.

Sincerely,

David S. Martin
Director
Contracts and Legislation
Group Long-Term Care

Marie K. Roche
Director of Compliance
Retail Long-Term Care

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