Approved: 3-18-98
Date

MINUTES OF THE HOUSE COMMITTEE ON INSURANCE.

The meeting was called to order by Chairperson Dennis Wilson at 1:32 p.m. on March 11, 1998 in Room 527-S of the State Capitol.

All members were present except: Representative Broderick Henderson, excused
Representative Jim Garner, excused
Representative Robert Krehbiel

Committee staff present: Bill Wolff, Legislative Research Department
Robert Nugent, Revisor of Statutes
Beth James, Committee Secretary

Conferees appearing before the committee: Jerry Slaughter, Kansas Medical Society
Tom Wilder, Kansas Insurance Department
Thomas L Bell, Kansas Hospital Association

Others attending: See attached list

The meeting was called to order at 1:32 p.m. by Chairperson Dennis Wilson. The first order of the meeting was **SB 423.**

SB 423: Employees of the health care stabilization fund.

The Chairperson called Jerry Slaughter to the podium. (Attachment #1). Mr. Slaughter said that when the legislature separated the Health Care Stabilization Fund from the Insurance Department they did not address who would be responsible for setting the salaries for unclassified positions. This bill does that. Mr. Slaughter requested that the committee pass the bill favorably.

There were no other conferees. The Chairperson closed the hearing on this bill.

The next topic was **SB 439.**

SB 439: Medicare provider organization, regulations and creation.

The Chairperson called Tom Wilder to the podium. (Attachment #2). Mr. Wilder said that **SB 439** was introduced at the requested of the Insurance Department to allow them the authority to regulate provider sponsored organizations. Provider sponsored organizations contract to furnish health insurance coverage to Medicare beneficiaries. These "PSO's" are made up of doctors and hospitals who offer their services directly to the public. In the past these PSO's used an insurance company as an intermediary to bear the risk. Now the PSO will deal directly with the Medicare enrollees on a risk bearing basis. They will no longer require a "go between." Under our current law we recognize two types of entitles to engage in health insurance. This bill would set up a third category called a Medicare provider organization. Mr. Wilder then "walked" the committee through the bill. There were no questions.

The Chairperson called Tom Bell to the podium. (Attachment #3). Mr. Bell said that it is generally doctors and hospitals that will be forming these PSO's. Although he thinks the feds anticipate that there could be some other types of health care providers who would be involved in forming a Medicare provider organization. He went through the principles on page two that he thought were important. He then had the committee look at the time line that followed his written testimony. He said they feel this bill does a good job of trying to comply with what the federal law requires but also gives the state the flexibility it needs to regulate these entities.

The Chairperson asked the committee to please read the written testimony that was submitted by Callie Jill Denton, Executive Director of the Kansas Association of Health Plans. (Attachment #4).

Seeing that there were no other conferees on **SB 439** the Chairperson closed the hearing.

Chairperson Wilson asked the committee members to turn their attention back to **SB 423**, and if they would like to work it would entertain a motion on the bill. Representative Tomlinson made a motion to pass out **SB423** favorably and because it is of a non-controversial nature to put it on the consent calendar. The motion was seconded by Representative Kirk. There was no discussion. The committee voted to pass the bill out favorably and put in on the consent calendar.

The Chairperson asked if anyone had any further business. There was none. The meeting was adjourned at 1:57 p.m.

HOUSE INSURANCE COMMITTEE GUEST LIST

DATE: 3-11-98

NAME	REPRESENTING
Amy Campbell	Ks State Optom. Society
Callie Hill Denton	KAHP
SHANE STREMMING	Intern for Rep. Campbell
Janelle White	Budget
Kerry SLAUGHTER	KMS
Tom Wilder	Kansas Insurance Dept
Dave Hanson	Ks Insur Assns
Rich Guthrie	Health Midwest
Steve Ashley	Ks Health Care Coun
Bob HAYES	HCSE
ZARINA SHOCKLEY-SPARLING	HUMANA
Kristin VanVoorst	Humana
Meg Draper	KMS
T B Wilder	U.S. Chamber
Mrs Douglas Ann Wilson	
Ralph B. Wilson	

KANSAS MEDICAL SOCIETY

March 11, 1998

TO: House Insurance Committee

FROM: Jerry Slaughter
Executive Director

SUBJECT: SB 423; concerning certain employees of the Health Care Stabilization Fund

The Kansas Medical Society appreciates the opportunity to appear today in support of SB 423.

The bill makes only one change in the law which governs the HCSF. When the legislature separated the Fund from the Insurance Commissioner's office a few years ago, the responsibility for setting salaries for unclassified positions was inadvertently not addressed. As a result, there has been confusion as to whether the Governor, the Insurance Commissioner or the Fund Board of Governors was responsible for these functions.

After discussions during the interim involving Senator Bond (who has been a member of the Health Care Stabilization Fund Oversight Committee since its inception) , the Budget Office, the Governor's office, the Fund and others, it was determined that the best approach would be to clarify that the Fund had the responsibility, in the same manner as other unattached agencies of state government do. The Oversight Committee subsequently discussed the matter and requested introduction of SB 423. The bill makes it clear that the Fund Board of Governors, which is appointed by the Insurance Commissioner, is responsible for setting salaries for its unclassified employees, subject, of course, to legislative appropriations. Classified employees of the Fund are covered in the same manner as classified employees in all other agencies.

This bill merely corrects an earlier oversight, and should not be controversial. We encourage you to pass the bill favorably. We would be happy to answer any questions you might have. Thank you for your consideration.

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House Insurance
Attachment #1 3-11-98

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

MEMORANDUM

To: House Insurance Committee

From: Tom Wilder

Re: Senate Bill 439 (Medicare Provider Sponsored Organizations)

Date: March 11, 1998

Senate Bill 439 provides the Insurance Department with the authority to regulate provider sponsored organizations ("PSOs") which contract to furnish health insurance coverage to Medicare beneficiaries. Last fall, Congress approved the Balanced Budget Act which established new "Medicare+Choice" Plans offered through health maintenance organizations, health insurance carriers and provider sponsored groups. Provider sponsored organizations include doctors and hospitals and these groups are permitted to offer their services directly to the Medicare enrollees on a risk bearing basis without using an insurer as an intermediary.

The new federal law assumes provider sponsored organizations will obtain a state license before they are permitted to offer Medicare+Choice services. However, the state licensing requirements can be waived in the following cases:

- If a state fails to act on the license application within 90 days.
- If the state denies the application for a license because it imposes licensing requirements that are not applied to similar organizations.
- If a state applies solvency requirements that are different from federal solvency standards for Medicare PSOs. The federal solvency rules are in the final process of development by the Department of Health and Human Services.

House Insurance
Attachment #2-1
3-11-98

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Currently, Kansas law does not allow provider sponsored groups to offer health insurance coverage unless the organization is licensed either as an accident and health insurance company or as a health maintenance organization ("HMO"). Senate Bill 439 adds a new category of licensed entity under the Kansas Health Maintenance Organizations Act for "Medicare Provider Organizations." The legislation gives the Insurance Department the ability to license Medicare PSOs and to impose on these provider groups a number of the same requirements that are applied to HMOs which operate in Kansas.

Senate Bill places Medicare PSOs under the jurisdiction of the Kansas Department of Insurance. The following changes are made to the Kansas health maintenance organization statutes:

Section 1. (Definitions) - A new definition of a "Medicare Provider Organization" is added to the law. These are provider sponsored groups which are authorized to offer Medicare+Choice Plans as defined in the Balanced Budget Act of 1997. The term Medicare Provider Organization is also added to several of the other definitions in the law where appropriate.

Section 2. (Certificates of Authority) - This section outlines the information which must be provided to the Insurance Commissioner as part of an application for a certificate of authority to operate in the state. The requirements for Medicare PSOs will be the same as those applied to Health Maintenance Organizations. Unlike HMOs, however, Medicare provider groups will not be required to set up procedures to enrollees to participate in the management of the organization. In addition, the new law allows the Commissioner to waive any of the statutory application requirements in cases where the PSO has complied with licensing standards set by regulatory agencies of other states or of the federal government.

Section 3. (Licensing Approvals) - The Commissioner must approve a completed application for a Certificate of Authority within 60 days or inform the applicant of any additional information which will be required to process the application. The law is also amended to allow the Commissioner to establish, by rule and regulation, solvency standards for Medicare PSOs. Any solvency standards set by the state must follow the

federal guidelines which are still being developed by the Department of Health and Human Services.

Section 4. (Denials of License Applications) - The Commissioner must notify a Medicare provider group if there is reasonable cause to deny, suspend or revoke a license. The provider sponsored organizations has 15 days to request a hearing to contest the action taken by the Commissioner.

Section 5. (Powers) - The provision sets out the powers granted to a Medicare Provider Organization.

Section 6. (Certificates of Coverage) - The statute outlines information which must be included in certificates of coverage issued to Medicare enrollees. The requirements may be waived if cases where there are similar rules imposed by the Department of Health and Human Services for Medicare contracts. The section also requires that contracts between Medicare PSOs and any providers include a "hold harmless" provision so that the patient is not billed for any additional amounts above what is required in their policy.

Section 7. (Contracting Requirements) - The provision allows Medicare Provider Organizations to offer services based on capitated payment arrangements.

Section 8 (Examinations) - The Commissioner is authorized to examine the business operations and financial status of Medicare PSOs at least once every three years. In addition, provider groups must have an on-site quality of care assessment every three years. The section permits the Commissioner to accept examination reports issued by other state or federal agencies.

Section 9. (Licensing Fees) - The provision sets the fees for license applications and for the filing of annual reports. Medicare Provider Organizations are exempted from premium taxes.

Section 10 (State Law Exemptions) - The section provides that Medicare PSOs are not subject to any of the other provisions of the Insurance Code.

Section 11 (Rules and Regulations) - The amendment repeals the requirement that the Insurance Department publish a separate volume of all of the regulations concerning Health Maintenance Organizations.

Section 12 (Federal Exemption) - This section allows Medicare Provider Organizations to comply with any federal contracting requirements even if they conflict with state law.

Section 13 (Financial Reporting) - Medicare PSOs are required to file annual financial reports with the Insurance Department.

Section 14. (Responsibility of Officers and Directors) - The section provides that the officers and directors of a Medicare PSO are personally liable for violations of the act.

Section 15 (Fiduciary Responsibilities) - Officers, directors and partners of Medicare Provider Organizations who have the responsibility for investing funds are considered to have a fiduciary relationship with the provider group. However, Medicare PSOs are not subject to the same bonding requirements as applied to health maintenance organizations.

Senate Bill 439 will give the Commissioner the tools necessary to license and regulate the operations of provider groups which offer Medicare+Choice Plans. State regulation of Medicare PSOs was anticipated by the Balanced Budget Act. I would ask that you approve S.B. 439 as amended.

KANSAS HOSPITAL ASSOCIATION

Memorandum

Donald A. Wilson
President

TO: House Insurance Committee

FROM: Kansas Hospital Association
Thomas L. Bell, Senior Vice President/Legal Counsel

RE: Senate Bill 439

DATE: March 11, 1998

The Kansas Hospital Association appreciates the opportunity to comment regarding the provisions of Senate Bill 439. This bill would provide a mechanism to license "Medicare provider organizations" in Kansas.

BACKGROUND

The introduction of SB 439 is largely a result of congressional passage of the federal Balanced Budget Act of 1997. One part of the Balanced Budget Act involved the enactment of the *Medicare+Choice* program. Under this new program, Medicare beneficiaries would be able to choose to receive benefits throughout the original Medicare fee-for-service program or through *Medicare+Choice plans,* which include Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), Medical Savings Accounts, or Provider-Sponsored Organizations (PSO). The goal of the *Medicare+Choice* program was to give Medicare beneficiaries more choice of health plans, while moving the program toward a managed care model.

Obviously, the Balanced Budget Act establishes a substantial amount of new federal law relating to the Medicare program. In some circumstances, however, the intent is that the new federal law works in conjunction with state laws. For example, the law requires that in order for a PSO to participate in *the Medicare+Choice* program, it must first seek licensure by the state in which it intends to operate. In essence, SB 439 attempts to provide a process for such state licensure to take place.

A Provider-Sponsored Organization under the Balanced Budget Act and a Medicare Provider Organization under SB 439 is the same thing. The federal law defines a PSO as a public or private entity established by health care providers, which provide a substantial proportion of health care items and services directly through affiliated providers who share, directly or indirectly, substantial financial risk. In other words, the health care providers are the plan.

House Insurance
Attachment # 3
3-11-98

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If a PSO wants to be a part of the *Medicare+Choice,* program, it must first seek state licensure. In general, if state licensure requirements are inconsistent with the federal law governing this program, a PSO can seek a federal waiver to participate in *Medicare+Choice.* The Balanced Budget Act specifically directs the Secretary of the Department of Health and Human Services to develop regulations providing solvency standards for PSOs, with a target date of publication by April 1, 1998. By June 1, 1998, the Secretary must establish regulations regarding all other standards for *Medicare+Choice* organizations. These federal standards will preempt any inconsistent state law or regulation. As such, a state discussing the licensing of PSOs, or Medicare Provider Organizations, as SB 439 calls them, must be sensitive to the requirements contained in the federal law.

KHA PRINCIPLES

- The Kansas Hospital Association recognizes the direction of the federal Balanced Budget Act that states should develop a licensure process for *Medicare+Choice,* PSOs or Medicare Provider Organizations.
- In developing such a process, the Legislature should make its first priority the protection of consumers in situations where a particular entity is accepting insurance risk. This is true whether that entity is a PSO, an HMO or a traditional insurer.
- At the same time, state legislatures should encourage the development of PSOs. These organizations are provider-driven, putting clinical decisions in the hands of those most capable of balancing efficiency and patient care.
- The State of Kansas should avoid creating an additional layer of regulation on Medicare Provider Organizations that is inconsistent with federal law and regulations. That potential exists with Senate Bill 439 because at this point it is unclear what those federal standards will ultimately include.
- KHA is supportive of the Insurance Commissioner's efforts to develop a comprehensive law regulating different kinds of risk-bearing entities, presumably to be presented to the Legislature next session. Such a statute will provide the Commissioner the flexibility she needs to regulate each type of organization.

CONCLUSION

The Secretary of HHS is supposed to develop regulations governing Medicare PSO solvency by April 1. Other non-solvency regulations are to be published by June 1. At this point in time, we do not know what those federal regulations will say. In order to avoid two sets of potentially conflicting standards, SB 439 should recognize the controlling authority of these undeveloped federal regulations.

Thank you for your consideration of our comments.

Attachment

PSO TIMELINE AS OF DECEMBER 1, 1997

December, 1997	HCFA to publish Medicare+Choice/PSO timeline, including date after which it will no longer accept risk contract applications
January 1, 1998	The Negotiated Rulemaking Committee for PSO Insolvency Standards must report to HHS Secretary regarding its progress.
January 1, 1998	HCFA to require Medicare risk contractors to submit data regarding inpatient services for periods beginning on or after July 1, 1997.
January 1, 1998	HCFA begins assessment on all contractors of information user fee.
January – February, 1998	HCFA to issue interim final rule providing PSO definition. PSOs can apply for minimum enrollment waivers for 1998.
March, 1, 1998	The Negotiated Rulemaking Committee for PSO Insolvency Standards must issue its report.
March 1, 1998	JCFA to announce Medicare+Choice payment rates for 1999.
April 1, 1998	HCFA to publish PSO financial solvency standards.
May 1, 1998	All Medicare+Choice plans (including PSOs) must submit adjusted community rate ("ACR") proposals for basic and supplemental benefits, the plans premium, description of cost sharing, actuarial value of cost sharing, and description of any additional benefits.
June 1, 1998	HCFA to publish "Mega-Reg", which is all Medicare+Choice standards other than solvency.

Date of Publication of Mega-Reg	HCFA stops entering into new Medicare risk contracts.
November, 1998	HCFA signs all new Medicare+Choice contracts, including PSO contracts.
November, 1998	HHS conducts an educational and publicity campaign to inform beneficiaries about Medicare+Choice contracts, including PSOs.
January 1, 1999	Start date of Medicare+Choice contracts, including PSOs.
January 1, 1999	50/50 enrollment composition rule repealed.
January 1, 1999	Secretary has authority to grant 3 year waivers from minimum enrollment rules.

Kansas Association of Health Plans

Testimony before the
House Insurance Committee
The Honorable Dennis Wilson, Chairman
Hearings on SB 439
March 12, 1998

The Kansas Association of Health Plans (KAHP) is a nonprofit corporation dedicated to providing the public information on managed care health plans. Members of the KAHP are Kansas licensed health maintenance organizations, preferred provider organizations, and others who support managed care. KAHP members serve over 200,000 Kansans.

The Kansas Association of Health Plans supports authorizing the Commissioner of Insurance to license Medicare provider-sponsored organizations (PSOs) pursuant to federal law. In addition, KAHP supports parallel federal and state solvency standards for Medicare PSOs.

KAHP also supports prohibiting Medicare PSOs from serving non-Medicare patients. Such appears to be the intent of SB 439 but if not KAHP would encourage that issue to be specifically addressed and clarified.

Respectfully,

Callie J Denton

Callie Jill Denton
Executive Director

House Insurance
Attachment #4
3-11-98