Approved: March 4 1998
Date

MINUTES OF THE Senate Committee on Financial Institutions and Insurance.

The meeting was called to order by Chairperson Don Steffes at 9:00 a.m. on February 23, 1998 in Room 529-S of the Capitol.

All members were present except: Senator David Corbin, Excused

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

Conferees appearing before the committee: Cindy Harrington, Golden Rule
Joe Holahan, Council for Affordable Health Insurance
Mike Doane, Kansas Association of Wheat Growers
David Gibbin, Tax Advantage Premium Insurance Agency
Chris Olson, Kansas Dairy Association
Tom Wilder, Kansas Insurance Department
Dr. Paul Wordlaw, physician, Olathe
Callie Jill Denton, Kansas Association of Health Plans

Others attending: See attached list

Senator Becker moved for the approval of the minutes of February 11, 16, 17, and 18 as presented. Motion was seconded by Senator Biggs. Motion carried.

Hearing on SB 575--Accident and sickness insurance policies, terms and provisions

Cindy Harrington, Golden Rule Insurance Company, Indianapolis, explained that the bill would allow affordable group insurance policies for association members to be evaluated and written based on the individual association member's need (Attachment 1). There would be restrictions to verify that such plans would be written only for valid and legitimate associations.

Joe Holahan, Council for Affordable Health Insurance, described the bill as one which would enable Kansans to acquire affordable health insurance through business, civic, farmer and other types of associations of which they are members (Attachment 2). By pooling their purchasing powers and entering health plans while still healthy, more individuals would be eligible for health insurance and enjoy guaranteed renewal if ill health does occur. The plan would allow risk underwriting and have exclusionary clauses. This is not self-insurance nor would it be risk rated. Most states allow non-employer association plans. The plan would not allow coverage of employees of the association member.

Mike Doane, Executive Vice-President of Kansas Wheat Growers Association, described the difficulty many farmers have in obtaining access to decent, affordable health insurance (Attachment 3). Their association members in Kansas are treated as if they were buying employer "group" coverage even if they have no employees, and have found themselves ineligible to take advantage of individual voluntary plans such as those offered in other states. Employer group plans have a balance of healthy and sick people but the voluntary plans must have underwriting capabilities in order to keep a balance of healthy and sick people in the group. With the adoption of the this bill, associations would be able to offer affordable health insurance as a benefit and offer options for additional coverage of such things as maternity.

David Gibben, Tax Advantaged Premium Insurance, Johnson County, related to the Committee the problems involved in sellingcomparable health plans in both Missouri and Kansas and the Kansas residents being charged $40 more than their Missouri counterparts (Attachment 4). This increasing price disparity of comprehensive major medical insurance premiums is difficult to understand and even more difficult to explain to Kansas customers.

Chris Wilson, president of Agricultural Resources and Communications, Inc., Wamego, reviewed her organization's experiences in trying to make group insurance available to the membership (Attachment 5). The problems have been affordability and benefits offered in such insurance plans. This bill would address the issue for many associations but not the larger ones. This problem could be solved by lowering the minimum number of members required in the bill.

Tom Wilder, Kansas Insurance Department, appeared in opposition due to the closed enrollment plans and the use of pre-existing conditions exclusions (Attachment 6). Pregnancy would be considered a pre-existing condition and the plans would have the right to not provide coverage. It would exempt association health plans from theese two listed provisions in Kansas group health insurance laws. There is also no lock-in on premium rates.

Callie Jill Denton, Kansas Association of Health Plans, said their organization opposes the bill because it creates a subclass of group health insurance due to there being no guaranteed issue during open enrollment, has limiting pre-existing condition exclusions, and prohibits certain rules for eligibility (Attachment 7).

The American Automobile Association presented written testimony (Attachment 8).

The hearing was closed.

Hearing on SB 662--Managed care amendment to Patient Protection Act

Dr. Paul Wardlaw, physician director of Olathe Medical Services, Inc., related the problems of associated with referral by primary care physicians for specialist care for patients (Attachment 9). Time elements, hiring of personnel just to deal with limited time referrals, and patient inconvenience due to constant re-referrals due to an on-going illness or condition wre listed as main concerns. He questioned the need for referrals for patients seeking acute non-emergency care through an urgent care center when such a referral is not needed in an emergency room setting. Insurance companies balk at receiving retroactive referrals for patients. He suggested that the cost of medical care is not in the physician-to-physician referral or the seeking of urgent medical care but in the procedures and case management aspects of care.

Tom Wilder, Kansas Insurance Department, spoke in support of the bill which would clarify the situations under which insurance companies would be required to cover emergency room treatment and further define the situations where patients can have access to care from medical specialists (Attachment 10). The key provision to the bill is that it allows women to use an OB/GYN as their primary care physician.

Senator Karin Brownlee related personal family experiences in seeking acute care at an urgent care center and the difficulty due to lack of referral (Attachment 11). Urgent care referrals can take as long as three to five days. Chronic conditions should not require constant referrals from primary care physicians to specialists. She suggested that this referral be amended to one year due to frequent changes in health care insurance coverage.

Callie Denton, Kansas Health Care Plans, opposed the bill due to its two year specialty referrals not clinically indicated and the fact that the current law has not been in effect long enough to judge its success or failure (Attachment 12). Ms. Denton also opposed the section in which OB/GYN's could be considered primary care physicians whether they wanted that designation or not from a certain patient and the physician did not have to be part of the network. Costs would be increased if patients seek specialty care outside the networks without a referral.

The hearing was closed.

The meeting was adjourned at 10:00 a.m. The next meeting is scheduled for February 24, 1998.

SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: 2/23/98

NAME	REPRESENTING
Pat Morris	KAIA
Kevin Davis	Am. Family Ins.
Joe Holahan	Council for Affordable Health Insurance
Scott Knoer	KPIA
Bob Williams	Ks. Pharmacists Assoc.
STEVE KEARNEY	CIGNA
MaryEllen O'Brien Wright	Assis. Tech. for Kansans
Matt Goddard	HCBA
David Hanson	Ks Life Assn
Susan anderson	Heim + Weir
Tom Bell	KHA
Dean Reid	KSNA
Paul Wadkins	Okaw Medical Services
John Fredrico	Humana
Callie Dell Denton	KAHP
Tom Wilder	Kansas Insurance Dept
Steve Ashley	Ks Employers Health Care Comm

Testimony of Cindy Harrington
Golden Rule Insurance Company
Senate Committee on Financial Institutions and Insurance
Senate Bill 575
February 23, 1998

Mr. Chairman and members of the committee, my name is Cindy Harrington and I am pleased to appear before you today on behalf of Golden Rule Insurance Company in support of Senate Bill 575.

Over the past several years Kansas has enacted a number of changes in their group insurance laws. Those changes require guaranteed issue to all persons in a group and place limitations on any exclusions for preexisting conditions. Those restrictions apply both to employment-based groups, as well as to associations. We simply do not believe that those same rules can be applied to membership in an association, and still have affordable insurance available that can be offered by an association.

Senate Bill 575 would allow sales to association members to be evaluated and written based on the individual association member.

SB 575 includes a number of restrictions to assure that this would be allowed only for valid and legitimate associations. **We would urge your favorable consideration of SB 575.**

Senate F & I
Attachment 1
2/23/98

COUNCIL FOR AFFORDABLE HEALTH INSURANCE

TESTIMONY BEFORE THE
SENATE COMMITTEE ON FINANCIAL
INSTITUTIONS AND INSURANCE
HEARING ON SB 575
FEBRUARY 23, 1998

Good morning, Mr. Chairman and members of the Committee. My name is Joe Holahan. I am testifying today on behalf of the Council for Affordable Health Insurance (CAHI). Thank you for this opportunity to address the Committee.

CAHI is a national association of more than 200 health insurance companies, actuarial consulting firms, insurance agents and physicians. Many of CAHI's member companies provide individual and small employer insurance to Kansas citizens. Since its inception in 1992, CAHI has worked for and helped develop health insurance reforms at both the state and the federal level, including the Kassebaum/Kennedy health insurance reforms enacted by Congress in 1996.

CAHI strongly supports Senate Bill 575, and we urge you to approve the bill. We believe SB 575 will greatly improve access to affordable health insurance for many Kansans by allowing them to obtain insurance through business, civic, farmer and other types of associations of which they are members. Association group insurance is an excellent way for individuals to pool their purchasing power to obtain more affordable insurance and better benefits than they otherwise could obtain on their own.

Right now, Kansas law effectively prevents insurance companies from offering non-employer, insurance coverage to associations located in the state. SB 575 would correct that problem. The bill also would conform the treatment of non-employer association plans to the way similar plans already are treated under Kansas law and to the way such coverage is treated by Kassebaum/Kennedy.

Attached to my testimony you will find a "Question & Answer" piece explaining SB 575 in greater detail and addressing some of the questions you may have. This concludes my prepared statement. I would be happy to answer any questions you may have at this time.

Senate I.D. & I
Attachment 2
2/23/98

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COUNCIL FOR AFFORDABLE HEALTH INSURANCE

KANSAS SB 575 Q&A

Q: Would SB 575 undermine Kansas's employer health insurance reforms?
A: No. SB 575 applies only to non-employer, individual coverage offered to the member of a valid association

SB 575 has no bearing on small employer or large employer coverage. The bill applies only to health plans offered to individuals who, under current Kansas law and Kassebaum/Kennedy, purchase individual, non-employer insurance. These individuals would simply be given the valuable benefit of being able to marshal their bargaining power through their association to negotiate better rates and better benefit packages than they otherwise would be able to find on their own.

Q: Would SB 575 allow associations to circumvent Kansas's mandated health insurance benefits?
A: No. The bill in no way changes the applicability of mandated benefit requirements to association health plans.

Q: What does SB 575 do and why?
A: SB 575 would conform the treatment of non-employer association health plans under Kansas law to the way Kassebaum/Kennedy treats such plans and the way that Kansas law treats other non-employer plans.

Kassebaum/Kennedy and current Kansas law both recognize that the requirements for employer-sponsored insurance plans are not suitable for the non-employer, "individual" health insurance market, where obtaining a mix of healthy along with not-as-healthy policyholders is more difficult to achieve. Individuals who purchase insurance for themselves in the individual market pay for it directly out-of-pocket and without the favorable tax treatment available to those who have employer-sponsored coverage. Because of these factors, healthier individuals tend to forego coverage unless they can obtain it a reasonable cost. Just as important, individuals control the timing of when they will purchase coverage. In contrast to this, employees who enter an employer-sponsored plan ordinarily must do so when they first become employed or during a limited enrollment period. Therefore, they don't have the ability to decline coverage until they are sick. In addition, it's a good bet that most persons who work full-time are in reasonably good health. All of these factors mean that employer-sponsored coverage tends to maintain a good balance of the healthy and not as healthy. Maintaining that balance is crucial to keeping insurance affordable, but circumstances in the individual market tend to work against it.

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For these reasons, Kassebaum/Kennedy and existing Kansas law permit individual coverage to be risk rated--meaning that a healthier person who applies for coverage pays less than someone who has a preexisting health condition. In this way, healthier individuals are encouraged to purchase and maintain coverage before they become ill, preserving the crucial mix of healthy and less healthy insureds. In addition, both Kassebaum/Kennedy and existing Kansas law permit an insurer to refuse an application for individual coverage if the applicant has a particularly high-risk preexisting medical condition. Individuals who are denied coverage because of a high-risk condition have guaranteed access to coverage through the state high-risk pool--the Kansas Health Insurance Association--where the cost of guaranteeing coverage is shared by all insurers in the individual and group insurance markets.

SB 575 would conform the treatment of an individual plan offered to a member of a valid association to these existing provisions of state and federal law. In addition, SB 575 would permit such plans to consider pregnancy as a preexisting condition and impose a preexisting condition exclusion for longer than three months, as is allowed for other non-employer plans under existing Kansas law and Kassebaum/Kennedy.

Q: How is SB 575 restricted to individual, non-employer coverage?

A: SB 575 clearly states that its provisions apply only to an insurance policy providing coverage to the member of a "valid association" and only if the policy "is not designed, administered or marketed as a plan for employers to provide coverage to two or more employees and does not provide coverage for employees of members of the association." (SB 575, page 8, lines 2-9).

SB 575 also creates stringent requirements for an association to qualify as a "valid association". The bill states that a "valid association" is limited to one which:

"(i) Has been in active existence for at least five years;
"(ii) has been organized and maintained in good faith for purposes other than that of obtaining insurance;
"(iii) has a minimum of 500 members;
"(iv) does not condition membership on health status;
"(v) has a constitution, charter or bylaws which provide for regular meetings, at least annually, to further the purposes of the members;
(vi) collects dues and solicits contributions from members;
(vii) provides members with voting privileges and representation on the governing board and committees."

(SB 575, page 8, lines 12-21).

2-3

KANSAS ASSOCIATION of WHEAT GROWERS

P.O. Box 1266 • Manhattan, KS 66505-1266 • (785) 587-0007 • FAX (785) 587-0003

KANSAS ASSOCIATION OF WHEAT GROWERS

Testimony Before the

Senate Committee on Financial Institutions and Insurance

Hearing on S. 575

February 23, 1998

Good Morning Mr. Chairman and members of the Committee. Thank you for this opportunity to testify in support of Senate Bill 575. My name is Michael Doane, and I am the Executive Vice-President of the Kansas Association of Wheat Growers (KAWG).

About the KAWG Program

Historically, the Kansas Association of Wheat Growers has made association group insurance available to our member farmers. This insurance is our own association plan specifically designed to meet our members' needs. Since 1985, we have obtained our insurance plan through a larger, multi-state group, the Grain Growers Membership and Insurance Trust.

Our insurance program is managed by our trust's board of directors, which includes farmer representatives from each of our participating state and national associations. We have an independent, professional trust administrator, and we buy the insurance from a large company that operates in most states.

Nationally, the Grain Growers health insurance program includes over 6,500 members and their families. Out of this 6,500, nearly 900 are members of the Kansas Association of Wheat Growers. The Grain Growers program has 16 state and national participating associations.

Senate F & D
Attachment 3
2/23/98

I want to emphasize that the insurance plan we obtain for our members is particularly important to us because farmers historically have had difficulty in obtaining access to decent, affordable health insurance.

I also want to emphasize that a vast majority of our members don't have employees. What we're talking about here is our insurance for members who either don't have employees or who don't buy insurance for employees.

Current Law

As we understand it, current Kansas law treats single association members who don't have employees as if they were buying employer "group" coverage. This has made it impossible for us to find insurance for these members.

With employer group coverage, insurance companies get compulsory inclusion of healthy employees in the group. This gives employer groups a balance of healthy and sick people. But with voluntary insurance like ours, and without employees, our insurance company has made it clear that they need underwriting to keep a balance of healthy and sick people in our group. Of course, once a member and his family are in our association insurance program, if they get sick, they are guaranteed the right to stay.

Our Trust's Board of Directors thinks our insurer's position is reasonable and consistent with what we would hear from other insurance companies.

Effects of Current Law on our Members

The only insurance we're still able to get for our new members is for the small percentage of them that purchase insurance for their employees. As I explained, that's a type of "group" insurance that we can still obtain without having rates for our members go through the roof.

S 575

S 575 would allow us to again offer non-employer health insurance as a benefit of association membership, without the affordability problems caused by the current law. We would also be able to have normal maternity coverage available as an option to our members who are planning families and at a reasonable price.

We urge you to approve S 575. The bill will allow Kansas farmers to obtain good, affordable health insurance - something we know our members desperately need.

February 22, 1998

To the Senate Financial Institution and Insurance Committee

My name is David Gibbin and I am a partner in a small insurance agency called Tax Advantage Premium Insurance Agency in the Northeast corner of Johnson County, Kansas. The firm is licensed in both Missouri and Kansas and we enjoy active sales in both states.

Health Insurance

Tax savings

for the intelligent

business owner

I am here today to advise the committee from a "real world" perspective regarding the selling of health insurance policies to consumers in Kansas. Specifically, I would like to confine my comments to the increasing price disparity of comprehensive major medical insurance premiums between my home state and Missouri.

I am lucky in that I can sell my products in both Kansas and Missouri. Why? Because it gives me the unique perspective of witnessing two different markets at work. Both states are lucky in that their insurance departments provide their citizens with many approved plan options to choose from. There are also many different quality insurance companies licensed in both states conducting business. The companies themselves view the marketplace correctly in that they don't offer a "one size fits all" approach, instead they tailor their products to reflect the diverse nature of the customer base. However, it has come to my attention that our Kansas plans (and this is where I make my home) suffer from one major deficiency, favorable premium cost comparison with respect to health plans in general.

My partner and I run a service organization and not strictly a sales organization. You can understand the real anguish we suffer, with close to 15 years in the business between the two of us, over the fact that we sit down with a Kansas customer, less than one mile from the our state line, and are frequently forced to offer that individual or family, a plan that cost sometimes as much as $40 more per month (that's $480 per year) than the same Missouri plan. This just doesn't happen once in awhile, it happens regularly. Inequalities are a part of life, but I can assure you that there is no practical reason for this when the companies involved enjoy the same national ratings by oversight organizations, offer similar benefit configurations and provide generally the same level of customer service.

I don't typically remind my customers of this, though sometimes they do ask about the difference in price for their policy and the one a friend described to them that they use; Needless to say, that friend usually lives in Missouri. I have never come before a committee such as this to describe this problem, but if there is one small chance that this testimony will alleviate a difficult situation, and the difficulty is not just experienced by me, but by my customers, this visit has been worth it and I will gladly make many more.

Thank you for your time and attention.

Sincerely,

David A. Gibbin

Senate Fin'l
Attachment 4
2/23/98

Tax Advantaged Premium Insurance
2112 West 50th Terrace
Westwood Hills, KS 66205
PHONE 913 262 5316 Toll Free 888-848-8385
FAX 913 432 3483
email DAGibbin@compuserve.com

ARC Agricultural Resources & Communications, Inc.
4210 Wam-Teau Drive, Wamego, Kansas 66547, 913-456-9705

STATEMENT OF
AGRICULTURAL RESOURCES & COMMUNICATIONS, INC.
TO THE
SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE
SENATOR DON STEFFES, CHAIR
REGARDING S.B. 575
FEBRUARY 23, 1998

Mr. Chairman and Members of the Committee, I am Chris Wilson, President of Agricultural Resources and Communications, Inc., located at Wamego, Kansas. Our company is involved in providing management and other services for agricultural associations and in the development and sale of curriculum materials for secondary and postsecondary agricultural classrooms. We are in support of S.B. 575.

We currently provide management services for KS Dairy Association (KDA), KS Dairy Commission (KDC), KS Agricultural Aviation Association (KAAA), KS Seed Industry Association (KSIA), and KS Holstein Association (KHA). In addition, we provide communications and administrative services for other organizations, such as KS Sheep Association (KSA) and American Agri-Women (AAW). The membership of these organizations is primarily family farms and small agribusinesses. None of these organizations currently have a group insurance program, but we are very interested in being able to provide such member services through these associations. KSIA had a group plan a few years ago, but it was dropped because of lack of participation due to the cost. The KSIA Board of Directors has been working over the past year to provide additional member services, particularly in the area of group purchasing, and is in the process of negotiating for an insurance provider. KDA has talked with a number of insurance providers but so far we have been unable to come up with a plan attractive to our membership.

We think S.B. 575 could provide an alternative that would give our associations greater

Senate FI&I
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choice and help to enable us to provide a group insurance program. Unfortunately, the bill as written would not include KSIA and KAAA, which have memberships of approximately 200 and 300, respectively. So, we would appreciate your consideration of lowering the minimum number of members required on page 8, line 15 of the bill.

The lack of affordable health care insurance options is something we hear a lot from the individual members of the associations we work with, and we appreciate your consideration of this legislation that could help these associations provide greater service and more affordable health care insurance to their members.

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

MEMORANDUM

To: Senate Financial Institutions
and Insurance Committee

From: Tom Wilder

Re: Senate Bill 575 (Association Health Policies)

Date: February 23, 1998

I am appearing today in opposition to S.B. 575 which exempts health policies sold through an association from the open enrollment requirements of the Kansas health insurance laws and from the limitations which our statutes place on the use of preexisting condition exclusions. These two provisions provide important protections for Kansas consumers.

"Open enrollment" is the annual opportunity provided to all individuals who are eligible to join a group health policy to apply for coverage. Kansas law states that all group policies shall have a 31 day open enrollment period each year. Senate Bill 575 removes this requirement for certain types of association policies. (1) Open enrollment periods make it possible for someone to apply for coverage under an association health plan in cases where they have lost other health insurance, for example, because they lose a job or through the death of or divorce from a spouse who provided health insurance.

The legislation also allows association health plans to (2) exclude preexisting medical conditions from coverage. Our current large group health insurance laws limit the use of preexisting condition exclusions to medical conditions which occur 90 prior to health coverage for up to 90 days after the start of the policy. Presumably, this bill would allow an association to exclude any medical condition which happened at any time in an individual's lifetime for the entire period the policy is in force.

Senate F.I.&I.
Attachment 6
2/23/98

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Senate Bill 575 also removes the provision in our law which prohibits a group policy from excluding coverage for pregnancy as a preexisting medical condition. This change gives association health plans the absolute right to not provide coverage for pregnancies. Maternity benefits are an important part of health insurance coverage for many individuals and it should not be excluded from a health policy.

Senate Bill 575 is bad public policy because it would exempt association health plans from two provisions in our group health insurance laws which are important to consumers - the open enrollment requirements and the limits placed on the use of preexisting condition exclusions. I would ask that you not approve this legislation.

6-2

Kansas Association of Health Plans

Testimony before the
Senate Financial Institutions and Insurance Committee
The Honorable Don Steffes, Chairman
Hearings on SB 575
February 23, 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 opposes SB 575 because it creates a subclass of group health insurance. Federally, the Health Insurance Portability and Accountability Act of 1997 (HIPAA) set minimum standards for group health insurance policies. Such standards include requiring guaranteed issue during open enrollment, limiting preexisting condition exclusions, and prohibiting certain rules for eligibility.

SB 575 exempts policies issued by an association to its members from the requirements of HIPAA. By allowing policies of insurance issued by an association to be excluded the purposes of HIPAA are defeated, i.e. to require minimum standards for group health insurance policies. In addition, consumers could be harmed if they are not aware that their association's health insurance is not subject to what has become the industry norm for group health insurance.

Overall, SB 575 is not consumer-friendly and the Kansas Association of Health Plans urges you to oppose it.

Respectfully,

Callie J Denton

Callie Jill Denton
Executive Director

Senate FI&I
Attachment 7
2/23/98

AAA Kansas

Member Services
Travel Agency
Insurance Agency
Financial Services

3545 S.W. 6th St
PO Box 1129
Topeka, Kansas 66601-1129
785/233-0222
800/365-5222

February 17, 1998

Senate Committee on Financial Institutions and Insurance
Kansas State House
Topeka, KS 66612

Dear Mr. Chairman and Members of the Committee:

I am pleased to offer our support of SB 575. AAA has over 180,000 members in Kansas. In addition to providing travel and auto-related services to these members, we also operate an insurance agency. Through this agency, we offer members a full line of insurance services, including disability and long term care insurance.

SB 575 would create additional options for health insurance offerings for our members. Current group association health insurance falls under the same rules established for employment-based insurance – the practical effect of which is to lessen or eliminate the availability of health insurance offerings by association groups.

SB 575 would give us, and our members, an additional option and we would urge your favorable consideration.

Thank you for your time.

Sincerely,

Mitch Fuqua

Mitch Fuqua
Vice President, Marketing & Service Quality

Senate FI&I
Attachment 8
2/23/98

Senate Financial Institution and Insurance Committee

February 23, 1998

Amendment to Managed Care Act

By Paul D. Wardlaw, M.D.

Thank you for the opportunity to testify in support of this legislation. I come to you as a family physician who has practiced in Olathe for the past twelve years and has participated in a wide variety of Health Maintenance Organizations and other managed care products. Currently, I practice part-time and serve as the physician director of Olathe Medical Services, Inc., a forty-five provider primary care group serving southern Johnson County and Miami County through fifteen clinics. Additionally, from 1992 to 1995 I served as a part-time Health Maintenance Organization Medical Director for a national insurance company that had a small Kansas City Health Maintenance Organization. Therefore, I have some understanding of both sides of the issues raised by this proposed legislation.

Under the gatekeeper type of Health Maintenance Organization the primary care physician must seek the approval of the insurance company before referring the patient for other specialist care. The following steps must take place.

1. You as a patient present to me a your primary care provider.
2. I determine that you need additional care by another specialist.
3. I then instruct one of the referral secretaries to prepare the referral – that may involve filling out a form or making a phone call or perhaps or both. The amount of time involved in this activity can amount to a full-time

Senate FI&I
Attachment 9
2/23/98

employee for every four-to-five doctors both as seen in our organization and reported in data of the Medical Group Management Association. That is significant additional cost in time of the physician, dollars spent and patient convenience.

This legislation would help relieve some of that burden by allowing us as primary care providers to determine that a patient needs ongoing care by the other specialist and then granting them a referral that is good for longer than sixty to ninety days or only a set number of visits. It is redundant for me to continue to have to instruct my referral secretaries to make a referral for a patient whose problem is clearly ongoing and beyond the scope of my usual clinical practice.

This would seem to be beneficial also to the insurance company with less time spent by the authorization personnel repeating the authorization process every sixty to ninety days.

Another aspect of this proposed legislation is that a person may seek acute non-emergency care without referral. I understand that to refer to care given for an acute but not life-threatening illness. This care might be rendered in an urgent care center or an emergency room. The use of co-pay differentials seems to be a more efficient way to encourage the appropriate use of urgent care centers and emergency rooms. Patients will call and discuss the need for that kind of visit with their primary care provider if there is adequate financial incentive. Referrals should not be needed in these cases. It is my opinion that acute care is seldom denied by primary care providers excepting in a few very obvious cases. Why should the referral process be involved here?

My experience suggests that the worrisome cost of medical care is not in the physician-to-physician referral or the seeking of urgent medical care but in the procedures and case management aspects of our care.

Finally, let me encourage you to consider increased support of measures such as this that protect the right of the patient to make choices in their care; and do not impede the ability of the physician to make the best clinical decisions for his/her patients by encumbering him/her with unnecessary processes.

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

MEMORANDUM

To: Senate Financial Institutions
and Insurance Committee

From: Tom Wilder

Re: Senate Bill 662 (Patient Protection Act)

Date: February 23, 1998

I am appearing today in support of Senate Bill 662 which strengthens the provisions of the Patient Protection Act which was approved by the Kansas Legislature last year. First, the legislation would clarify the situations under which insurance companies would be required to cover emergency room treatment. In addition, the bill further defines the situations where patients can have access to care from medical specialists.

Under current law, an insurance policy must pay for emergency room treatments if the attending provided records symptoms that indicate there is the possibility of a serious impairment of the body. The bill adds to this standard the fact that there could be a "painful" impairment of bodily functions which would require coverage by the health insurer.

The bill also provides that health insurers who require insureds to use a specific doctor must make an alternative medical provider available to provide treatment in cases where that doctor is unavailable.

The key provision of S.B. 662 allows women to use an obstetrician/gynecologist as their primary care physician. There are at least 20 states as of last year which either require managed care plans to allow women to use their Ob-Gyn as a primary care physician or allow direct access to these providers for pregnancy and gynecological care.

Senate FI & I
Attachment 10

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2/23/98

It gives women the opportunity to obtain regular access to their Ob-Gyn without having to first get the approval of another doctor.

I believe Senate Bill 662 improves the language of the Patient Protection Act which was placed into law last session. I would ask that you approve the bill favorably.

STATE OF KANSAS

KARIN BROWNLEE
SENATOR, 23RD DISTRICT
JOHNSON & MIAMI COUNTIES
1232 S. LINDENWOOD DR
OLATHE, KANSAS 66062
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Testimony on SB662 before

Senate Financial Institutions and Insurance

February 23, 1998

One of the primary characteristics of HMO health insurance seems to be the use of a primary care physician (PCP), also known as a gate keeper for the patients care. I might suggest this concept be called "gate blocker" or the "mother may I" system. Although the use of the PCP is very helpful, there are times that this concept causes access to healthcare to become burdensome both for the patient and the doctor. The purpose of SB662 is to relieve some of this burden.

My motivation for proposing these changes is prompted partly by experiences my family has had and by conversations with doctors and/or their office staff. Ideally, patients should be more involved in their healthcare. The gatekeeper system to some extent takes some decisionmaking out of the hands of the patient and puts them more at the mercy of the insurance company. My personal experience is that of having a relationship with a specialist for about eighteen years yet having to go back to my PCP (whom I have had for about six years) to get permission to continue to obtain care from the specialist. The other area of frustration is getting a referral for a walk-in health center visit for acute care. We have found some of these situations to be burdensome both to us as the patients and the doctor and his staff.

There are several situations where a patient may have a chronic condition which will require the utilization of specialists for years if not for the remainder of the patient's life. I advocate with this bill that pursuing their medical care should be simplified by not re-requesting referrals on a frequent basis. Written in the bill is the proposal that a referral be valid for two years. In talking to healthcare professionals, I realize this may need to be amended to one year because of the frequent changes in health insurance coverage.

Finally, the bill includes allowing an OB/GYN to also be considered as a PCP. My intent is that such specialists be a part of the insured's network. I would be open to additional language if necessary to clarify this.

Thank you for this opportunity to express my views on this important subject. I would appreciate your thoughtful consideration.

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Kansas Association of Health Plans

Testimony before the
Senate Financial Institutions and Insurance Committee
The Honorable Don Steffes, Chairman
Hearings on SB 662
February 23, 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 opposes SB 662. First, the bill amends K.S.A. 1997 Supp. 40-4607 (b) by requiring that referrals for specialist care be effective for two years. KAHP opposes this amendment for several reasons. First, requiring referrals for specialty care to be effective for two years is not feasible administratively. Most plans' claims systems are set up to correspond with one-year contracts and are not prospective beyond the current contract year. If referrals were required to be effective for two years, plans' current claims systems would not be able to reconcile the referrals with insureds leaving the plan or changing policies.

In addition to being difficult to administrate, two year specialty referrals are not clinically indicated. Rather, plans want to encourage chronically ill patients to include their primary care physician in treatment plans whenever possible. The amendment in SB 662 would interfere with a primary care physicians's ability to effectively manage the care of their patients.

Finally, as you will recall K.S.A. 1997 Supp. 40-4607 (b) became effective on July 1, 1997. KAHP does not support amendments to this very new law in order to see its full impact.

KAHP is also in opposition of New Section 3 of the bill that permits female insureds to designate their OB/GYN as their primary care physician. Most plans currently cover an annual visit to an OB/GYN without a referral. However, obstetrics/gynecology is specialty care. OB/GYN providers are credentialed differently and are paid differently from primary care physicians. By allowing OB/GYNs to serve as primary care physicians, the distinction is blurred. Such a change would be difficult to reconcile by most plans.

In addition, there is no language limiting female patients to OB/GYN providers within the plans' networks. Allowing patients to seek specialty care outside of the networks without a referral will substantially increase costs. A survey released January 21, 1998 by the Kaiser-Harvard Program on the Public and Health/Social Policy found that 82% of those

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questioned favored a law allowing women to designate their OB/GYN as their primary care physician. However, when the same people were asked if they still favored the law if it might result in an increase in insurance premiums, only 58% still supported it; only 51% supported the law if it might result in government getting too involved; and only 48% supported the law if it might result in employers dropping coverage. Clearly, consumers want additional benefits but not if they might result in higher insurance costs, more regulation, or possibly the loss of employer-sponsored insurance.

A final consideration is that the bill does not allow OB/GYN providers to opt out of being named a primary care physician. Some OB/GYNs may not want to provide primary care.

The Kansas Association of Health Plans requests that SB 662 be reported adversely.

Respectfully,

Callie J Denton

Callie Jill Denton
Executive Director