Approved: April 1, 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 March 19, 1998 in Room 529-S of the Capitol.

All members were present except: Senator Sandy Praeger, Excused
Senator Karin Brownlee, Excused

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

Conferees appearing before the committee: Tom Wilder, Kansas Insurance Department
Brad Smoot, Blue Cross/Blue Shield
Dave Hanson, Domestic Insurance Companies

Others attending: See attached list

Hearing on HB 2636--Clarification of reinsurance statute to comply with NAIC model
Tom Wilder, Kansas Insurance Department, requested approval of this proposed legislation which would delete the reference to policyholders in the statute which allows insurance companies, which are authorized to do business in Kansas, to reinsure risks with insurance carriers that are not licensed in the state under certain conditions (Attachment 1). This is patterned after the current NAIC model.

Senator Becker moved to amend **SB 409-providing coverage for prostate cancer screening** into **HB 2636** (Attachment 2). This would apply to any state employee's state health insurance policy. The bill passed the Senate 39-0 and is in a House committee at this time.

An additional amendment presented by the industry included language excluding the proposed mandate from medicare supplemental policies and long-term care policies (Attachment 3).

Senator Feleciano moved to accept both of the proposed amendments. Motion was seconded by Senator Becker. Motion carried.

Senator Becker moved to report the bill favorably as amended. Motion was seconded by Senator Feleciano. Motion carried.

Dr. Wolff reported that the ten to twelve insurance mandates which have been proposed in the Kansas Legislature this year are also appearing in other state legislatures. Major issues in all states have been diabetes, mental health parity, and reconstructive breast surgery. Maryland is creating a special commission to study such mandates. Dr. Wolff suggested that if such mandates were put in an interim committee, agenda items should include who the mandate covers and who is omitted, as well as addressing the problem of uniformity.

Brad Smoot, Blue Cross/Blue Shield, expressed concern for the need of all mandates and that probably individually they could each stand alone (Attachment 4). He thanked the Committee for breaking down the issue into: (1) body parts; (2) provider mandates; and (3) access mandates. He included articles supporting his statement that mandates raise the cost of insurance thus causing fewer persons to be insured through either employers dropping coverage or the employee dropping family coverage. Many employers are shifting to self-insurance because they do not pay premium taxes. Higher deductibles are also occurring in health insurance coverage. Blue Cross/Blue Shield has signed up more employees but it is losing numbers because of a lack of dependent coverage. They are losing people who added to the "good health" base.

Dave Hanson, representing the domestic insurance companies, recommended the interim study address consistency and uniformity in application as well as develop a definition for major medical.

Written testimony from Callie Jill Denton, Kansas Association of Health Plans was received (Attachment 5).

The Committee adjourned at 10:00 a.m. The next meeting is scheduled for March 23, 1998.

SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: 3-19-98

NAME	REPRESENTING
Callie Hill Denton	KAHP
David Hanson	Ks Life Insur Assn
Linda McCoursey	KS Insurance Dept.
Tom Wilder	Kansas Insurance Dept
KAREN FRANCE	Ks. Assoc. of REALTORS
Susan Anderson	Hein + Weir
Teresa Henault	HIAA
Chuck Stones	KBA
Roger Francis	KGC
Matt Goddard	HCBA
Kevin Davis	Am Family
Bill Sneed	HIAA
Lori Callahan	kammco
Brad Smoot	BCBS

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

MEMORANDUM

To: Senate Financial Institutions and Insurance

From: Tom Wilder

Re: House Bill 2636 (Reinsurance)

Date: March 19, 1998

House Bill 2636 was introduced at the request of the Insurance Department to make a technical amendment to our law on reinsurance agreements. The current statute allows insurance companies which are authorized to do business in Kansas to reinsure risks with insurance carriers that are not licensed in the state under certain conditions. One of the provisions of our existing law allows reinsurance set up through a trust established with a United States financial institution in an amount of at least $20 million.

This law is based on a model reinsurance act developed by the National Association of Insurance Commissioners (NAIC). The statute provides that funds in the trust be held for the payment of the claims of "policyholders and ceding insurers." We are asking that the statute be amended to delete the reference to policyholders which would bring the act into compliance with the NAIC model law. The funds in the trust are paid for claims made by the ceding insurance companies which reinsure through the trust. The term "policyholders" is not appropriate when referring to reinsurance agreements.

I would ask that you approve House Bill 2636 favorably for passage.

Senate F.I.I
Attachment 1
3/19/98

420 SW 9th Street
Topeka, Kansas 66612-1678

913 296-3071
Fax 913 296-2283

Consumer Assistance Hotline
1 800 432-2484 (Toll Free)

PROPOSED AMENDMENT TO HOUSE BILL NO. 2636

On page 3, following line 39, by inserting two sections as follows:

"New Sec. 2. Any individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization which provides coverage for accident and health services and which is delivered, issued for delivery, amended or renewed on or after July 1, 1998, also, shall provide coverage for prostate cancer screening for men 40 years of age or over who are symptomatic or in a high-risk category and for all men 50 years of age or older. The screening shall consist, at a minimum, of a prostate-specific antigen blood test and a digital rectal examination. A policy, provision, contract, plan or agreement may apply to prostate cancer screening the same deductibles, coinsurance and other limitations as apply to other covered services.

Sec. 3. K.S.A. 1997 Supp. 40-19c09 is hereby amended to read as follows: 40-19c09. (a) Corporations organized under the nonprofit medical and hospital service corporation act shall be subject to the provisions of the Kansas general corporation code, articles 60 to 74, inclusive, of chapter 17 of the Kansas Statutes Annotated, applicable to nonprofit corporations, to the provisions of K.S.A. 40-214, 40-215, 40-216, 40-218, 40-219, 40-222, 40-223, 40-224, 40-225, 40-226, 40-229, 40-230, 40-231, 40-235, 40-236, 40-237, 40-247, 40-248, 40-249, 40-250, 40-251, 40-252, 40-254, 40-2,100, 40-2,101, 40-2,102, 40-2,103, 40-2,104, 40-2,105, 40-2,116, 40-2,117, 40-2a01 et seq., 40-2111 to 40-2116, inclusive, 40-2215 to 40-2220, inclusive, 40-2221a, 40-2221b, 40-2229, 40-2230, 40-2250, 40-2251, 40-2253, 40-2254, 40-2401 to 40-2421, inclusive, and 40-3301 to 40-3313, inclusive, K.S.A. 1997 Supp. 40-2,153, 40-2,154, 40-2,160 and 40-2,161, and amendments thereto, and section 1, except as the context

Senate F.D.I.
Attachment 2
3/19/98

otherwise requires, and shall not be subject to any other provisions of the insurance code except as expressly provided in this act.

(b) No policy, agreement, contract or certificate issued by a corporation to which this section applies shall contain a provision which excludes, limits or otherwise restricts coverage because medicaid benefits as permitted by title XIX of the social security act of 1965 are or may be available for the same accident or illness.

(c) Violation of subsection (b) shall be subject to the penalties prescribed by K.S.A. 40-2407 and 40-2411, and amendments thereto.";

And by renumbering sections accordingly;

Also on page 3, in line 40, by striking "is" and inserting ", 40-1909 and 40-19c09 are";

In the title, in line 9, after "concerning", by inserting "insurance; accident and health insurance;"; also in line 9, after "40-221a", by inserting "and 40-19c09"; in line 11, by striking "section" and inserting "sections; also repealing K.S.A. 1997 Supp. 40-1909";

Session of 1998

SENATE BILL No. 409

By Senators Jones and Becker

12-30

AN ACT relating to accident and health insurance; providing coverage for prostate cancer screening; amending K.S.A. 1997 Supp. 40-19c09 and repealing the existing section; also repealing K.S.A. 1997 Supp. 40-1909.

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

New Section 1. Any individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization which provides coverage for accident and health services and which is delivered, issued for delivery, amended or renewed on or after July 1, 1998, also, shall provide coverage for prostate cancer screening for men 40 years of age or over who are symptomatic or in a high-risk category and for all men 50 years of age or older. The screening shall consist, at a minimum, of a prostate-specific antigen blood test and a digital rectal examination. A policy, provision, contract, plan or agreement may apply to prostate cancer screening the same deductibles, coinsurance and other limitations as apply to other covered services.

Sec. 2. K.S.A. 1997 Supp. 40-19c09 is hereby amended to read as follows: 40-19c09. (a) Corporations organized under the nonprofit medical and hospital service corporation act shall be subject to the provisions of the Kansas general corporation code, articles 60 to 74, inclusive, of chapter 17 of the Kansas Statutes Annotated, applicable to nonprofit corporations, to the provisions of K.S.A. 40-214, 40-215, 40-216, 40-218, 40-219, 40-222, 40-223, 40-224, 40-225, 40-226, 40-229, 40-230, 40-231, 40-235, 40-236, 40-237, 40-247, 40-248, 40-249, 40-250, 40-251, 40-252, 40-254, 40-2,100, 40-2,101, 40-2,102, 40-2,103, 40-2,104, 40-2,105, 40-2,116, 40-2,117, 40-2a01 *et seq.*, 40-2111 to 40-2116, inclusive, 40-2215 to 40-2220, inclusive, 40-2221a, 40-2221b, 40-2229, 40-2230, 40-2250, 40-2251, 40-2253, 40-2254, 40-2401 to 40-2421, inclusive, and 40-3301 to 40-3313, inclusive, K.S.A. 1997 Supp. 40-2,153, 40-2,154, 40-2,160 and 40-2,161, and amendments thereto, *and section 1,* except as the context otherwise requires, and shall not be subject to any other provisions of the insurance code except as expressly provided in this act.

3/19/98 Senate FDI Attachment 3

Senate FDI
Attachment 3
3/19/98

(b) No policy, agreement, contract or certificate issued by a corporation to which this section applies shall contain a provision which excludes, limits or otherwise restricts coverage because medicaid benefits as permitted by title XIX of the social security act of 1965 are or may be available for the same accident or illness.

(c) Violation of subsection (b) shall be subject to the penalties prescribed by K.S.A. 40-2407 and 40-2411, and amendments thereto.

Sec. 3. K.S.A. 1997 Supp. 40-1909 and 40-19c09 are hereby repealed.

Sec. 4. This act shall take effect and be in force from and after its publication in the statute book.

(d) The provisions of this act shall not apply to any medicare supplement policy of insurance, as defined by the commissioner of insurance by rule and regulation, any policy of long-term care insurance, as defined by K.S.A. 40-2227, and amendments thereto, any specified accident coverage or any accident only coverage as defined by the commissioner of insurance by rule and regulation whether written on a group, blanket or individual basis.

BlueCross
BlueShield
of Kansas

An Independent Licensee of the
Blue Cross and Blue Shield Association

InterOffice Memo

To: Bill Pitsenberger

Cc: Don Lynn, Bev Obley, Mark Zillinger

From: Pam Miller

Date: September 4, 1997

Subject: LEGISLATIVE MANDATES

Attached is the information you requested. The dollars represent payment levels (allowed charges minus the insured's liability). Except for NM/SA, Birth Mothers, and High-Risk Pool, they are actual payment totals for claims incurred during 1996 as paid through 5/31/97 for insured business only, excluding HMOK, Premier Blue, Medicare Supplemental and Complementary, and FEP.

The assessment was provided by Corporate Accounting.

Birth Mother expenses was estimated based on birth rates and adoption rates as provided on the Internet.

Inpatient NM/SA facility payments for the first 30 days was provided by Bev Obley based on claims incurred in 1996 as paid through 7/31/97. The professional payments for the first 30 days were extracted, with some estimation, by my area.

The total 1996 health* premium income for these same lines of business was $326,823,006.

Please let me know if you have any questions concerning these amounts or how we extracted them.

*Excludes, in addition to excluded lines of business, dental, Plan 150, Security Plan, HIP, HCP, Stop-Loss, and LTC.

PM:jk
Attachment

Senate Ins. Comm.
Attachment 4
3/19/98

LEGISLATIVE MANDATES
1996 ESTIMATED IMPACT*

		Total Payments for Claims Incurred during 1996
1.	Chiropractors	$ 6,224,850
2.	Optometrists	$ 1,156,187
3.	Podiatrists	$ 726,930
4.	Dentists**	$ 1,599,324
5.	Inpatient NM/SA for First 30 Days	
	a. Facility	$ 5,904,379
	b. Professional	$ 464,268
6.	Outpatient Nervous & Mental/Substance Abuse	$ 4,709,330
7.	Advance Registered Nurse Practitioners	$ 446,724
8.	Birth Mother expense of Adopted Newborns	$ 373,800
9.	Mammographies and Pap Smears	$ 676,936
10.	Assessment to the High Risk Pool	$ 453,179
11.	Total	$22,735,907

*For BCBSK insured business only (excludes ASOs, HMOK, Premier Blue, Medicare Secondary, and FEP).

**For those claims paid as health coverage, not ancillary dental products.

BRIEF ANALYSIS
No. 237
For immediate release:
Wednesday, August 13, 1997

The Cost of Health Insurance Mandates

Legal Services

For more than 30 years, state legislatures have passed laws driving the cost of health insurance higher. Known as mandated health insurance benefit laws, they force insurers, employers and managed care companies to cover — or at least offer — specific providers or procedures not usually included in basic health care plans.

Recently, the federal government imposed two mandates that affect health insurance policies nationwide.

While actuaries, insurers and health economists agree that virtually all mandates increase the cost of health insurance, the magnitude of their effects has been subject to debate. A new analysis prepared for the National Center for Policy Analysis by the actuarial firm Milliman & Robertson estimates the costs of 12 of the most common mandates and finds that, collectively, they can increase the cost of insurance by as much as 30 percent.

The Explosion of Mandated Benefits. Although there were only seven state-mandated benefits in 1965, there are nearly 1,000 today. While many mandates cover basic providers and services, others require coverage for such nonmedical expenses as hairpieces, treatment for drug and alcohol abuse, pastoral and marriage counseling.

These mandates apply only to those health insurance policies controlled by state health insurance laws — usually policies purchased by small businesses and individuals. Most large companies avoid state mandates by self-insuring under the Employee Retirement Income Security Act (ERISA), which exempts self-insured companies from state oversight. However, the federal government's new mandates — banning "drive-through" baby deliveries and requiring that any cap on mental health benefits be the same as the cap on physical health benefits — apply to all insurance. Moreover, Congress appears likely to pass even more mandates in the future.

National Center for Policy Analysis
Estimated Additional Costs for Certain Benefits, Calendar Year 1997

Benefit	Estimated Additional Annual Cost	
1. Minimum Stay Maternity	less than 1%	<$35*
2. Speech Therapy	less than 1%	"
3. Drug Abuse Treatment	less than 1%	"
4. Mammography Screening	less than 1%	"
5. Well Child Care	less than 1%	"
6. Podiatry	less than 1%	"
7. Papanicolaou (Pap) Smears	less than 1%	"
8. Vision Exams	1% to 3%	$35-$105
9. Chiropractic Treatment	1% to 3%	$35-$105
10. Alcoholism Treatment	1% to 3%	$35-$105
11. Infertility Treatment	3% to 5%	$105-$175
12. Mental Health Care	5% to 10%	$175-$350
Total	15% to 30%	$525-$1,050

* Based on a standard family policy without mandates costing $3,500 per year.

Source: Milliman & Robertson.

How Much Do Mandates Increase the Cost of Health Insurance? The Milliman & Robertson analysis of 12 of the most common mandates is based on policies in a representative state.

Assuming that a mandate-free, basic health insurance policy costs a family about $3,500 a year, the study found that [see the table.]:

4-3

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Washington Office: 727 15th St. N.W., 5th Floor • Washington DC 20005 • 202-628-6671 • Fax 202-628-6474
For more information: Katy Meaker Menges in Dallas at 972/386-6272 or Joan Kirby in Washington at 202/628-6671

- Several of the mandates would increase the cost of a policy by less than $35 each.
- Infertility treatment could increase the cost between $105 and $175 a year.
- Mental health parity, which requires insurers to treat mental illnesses like physical illnesses, could add between $175 and $350 to the cost of a policy.

Taken together, the package of 12 mandates could increase the cost of a family health insurance policy by as much as 15 to 30 percent, or $525 to $1,050 a year. Based on these estimates, we conclude that a small business employing 25 people — with a standard mix of 40 percent single and 60 percent family coverage — could see its premiums rise by $20,000 a year.

Who Pays for Mandated Benefits. Many employees believe their employers pay for the insurance they provide. However, economists recognize that employee benefits are a substitute for wages in the employee's total compensation package. Higher benefits often force employees to take lower wages whether they like it or not. A 1990 survey of the literature by National Bureau of Economic Research economist Olivia S. Mitchell found that the cost of mandated benefits is usually borne by employees in the form of reduced wages, reduced work hours or loss of employment.

The Impact of Mandates. While mandated benefits mean that people with health insurance have more health care options, they also mean that fewer people are insured. When employers who canceled their employees' health insurance policies have been polled on why they did so, the majority claimed that it was because the price was too high.

Lower-income employees are most likely to lose coverage. According to a 1989 study by health economists Gail Jensen and Jon Gabel, mandated coverage increases premiums by 6 to 8 percent for substance abuse, 10 to 13 percent for mental health care and as much as 21 percent for psychiatric hospital care for employee dependents.

The Threat to ERISA. Since 1974, many large- and medium-sized employers have escaped the cost-increasing impact of state health benefit mandates by self-insuring under the Employee Retirement Income Security Act. As a result, thousands of employers have been able to offer health insurance policies tailored to their employees' needs and their companies' budgets.

However, a number of proposals currently before Congress would impose new mandates at the federal level. For example, they would require coverage for mammograms for women under age 50, ban "drive-through" mastectomies and preclude managed care in many instances. Because the federal mandates would apply universally, self-insured companies would come under federal control.

Conclusion. The real threat behind the Congress's newfound interest in mandating health insurance benefits is incremental rather than immediate. One or two federal mandates may not increase the cost of health insurance significantly but, as in the states, once the door is open every special interest will hurry through to besiege the legislature.

When the legislators succumb and the dust settles, health insurance will cost more, employers and individuals will cancel more policies and Congress will face a growing uninsured "crisis" — a crisis largely of its own making.

This Brief Analysis was prepared by NCPA President John C. Goodman and Vice President of Domestic Policy Merrill Matthews Jr.

4-4

Self-insurance sees gains in health plan financing

More employers assume risk in HMOs, POS plans

By JOANNE WOJCIK

Self-insured health care is regaining popularity as employers that had shifted many of their employees into fully insured HMOs see those premiums start to climb.

While in the past, employers' self-funding was limited to their indemnity plans, employers today increasingly are self-funding the in-network component of point-of-service plans and even the once fully insured HMO plan.

And employers can escape expensive benefit mandates by self-insuring even a portion of their HMO risk, experts say.

Employers that self-insure their HMOs have the same utilization controls as the managed care plan offers insured clients; however, employers only pay costs associated with their own employee populations.

According to a recent William M. Mercer Inc. survey, 10% of large employers and 13% of small employers now self-insure their HMO plans. This compares with just 6% of large employers and 8% of small employers self-funding their HMOs in 1996.

While fewer large employers self-insured their POS plans in 1997—46% compared with 52% in 1996, more small employers are self-funding their POS plans.

Sixteen percent of small employers, or those with fewer than 500 employees, self-insured their POS plans in 1997, compared with just 8% in 1996 (see chart).

"I wouldn't characterize self-funding of managed care plans as a huge movement, because some large employers are still getting good deals from their HMOs," said Tom Beauregard, a consultant in Rowayton, Conn., with Hewitt Associates L.L.C. "But we have been doing a lot of self-funding viability studies looking at the individual employer's loss ratio."

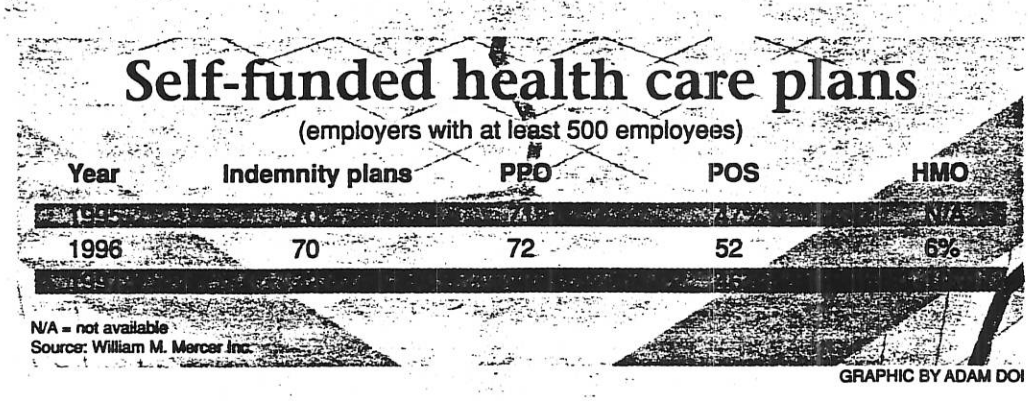
In some cases, especially where a majority of employees are enrolled in managed care plans, employers think "they can start taking the risk back," he said.

The managed care backlash, which has prompted lawmakers to mandate that managed care plans—especially HMOs—cover more treatment, also is a major catalyst for employers' return to self-insurance, industry experts say.

Self-funding can shave at least 2% to 3% off the cost of a fully insured HMO premium, mostly because the self-insured programs don't have to offer all the benefits mandated by state law, estimates Jim Dolstad, senior consulting actuary at benefit consultant Howard Johnson & Co. in Seattle.

Self-insuring also allows the employer, rather than the HMO, to decide which benefits to offer, said Ed Potanka, assistant general counsel-health care for CIGNA Corp. in Bloomfield, Conn.

See **Self-insure** *on page 6*



"This allows the multistate employer to have a uniform benefit plan," he said.

Employers that self-insure their managed care plans also avoid paying premium taxes, which typically run about 2%, he added.

CIGNA has offered a self-funded HMO option, called Flexcare, for nearly 20 years.

"Self-insuring HMOs is likely to be the trend in the future, especially as mandates are put on plans," predicts Helen Darling, manager of international compensation and benefits for Xerox Corp. in Stamford, Conn.

"It's the same as what led to the growth of self-insured indemnity plans," she said. "Just because you put in a mandate doesn't mean it's free. Somebody's got to pay. And, as the government loads on requirements, this increases costs, and cost pressures will lead to more self-insuring."

Self-funding is especially attractive to employers in states such as New York, where regulators preclude HMOs from offering employers experience-based rates, pointed out Bruce Taylor, director of national health care policy and plans at Stamford, Conn.-based GTE Corp.

If community HMO rates are high, an employer with a large employee base in New York may opt to self-fund, Mr. Taylor suggested.

GTE has self-funded about a half-dozen HMOs for about three years, though it does not yet self-insure any of the HMOs with which it contracts in New York because it doesn't have enough HMO enrollees in that state to make it worthwhile, according to Mr. Taylor.

In general, most large employers that self-insure their HMOs in New York can save 20% to 25% over community rates, estimates Hewitt's Mr. Beauregard.

In some cases, employers looking to self-insure their managed care plans "are questioning the logic behind contributing to HMO profit margins," said James Kreig, senior vp of Keenan & Associates, a Torrance, Calif.-based insurance brokerage.

Hospital and health care organizations are especially leery of paying premiums to HMOs when they themselves are assuming risk through capitated contracts, pointed out Mr. Kreig, who is a consultant for hospitals and health care systems in their role as employers.

"T[illegible]asic question facing heal[illegible]re organizations is whether to offer their employees a managed care plan—most often, an HMO—or to explore the possibility of establishing a self-funded plan that includes the managed care components of an HMO," he said.

This is precisely the question AlliedSignal considered when it launched what then was considered a landmark point-of-service network in cooperation with CIGNA 10 years ago, pointed out Joe Checkley, director of group insurance for the Morristown, N.J.-based multistate employer.

"Despite the growth of capitation, our philosophy is to self-fund wherever we can," he explained.

That's because AlliedSignal executives thought that by paying even a capitated premium, especially one derived from community rating, it would be subsidizing its HMO's entire book of business, Mr. Checkly pointed out.

But by self-insuring, "we're only paying our own people's medical costs," he said.

Ninety-five percent of AlliedSignal's 40,000 employees are enrolled in the company's point-of-service plan that uses CIGNA's HMO networks.

While some of the providers in the network are capitated, AlliedSignal pays no capitated premium. Instead, the employer pays an administrative fee each month that provides for network access, and then it pays for medical services as they are billed on a fee-for-service basis.

Besides CIGNA, AlliedSignal has similar contracts with other HMO companies it contracts with in Arizona and California, according to Mr. Checkley.

"We have the best of both worlds," he said. "We get the managed care delivery vehicle, and we have self-funding."

While POS plans are easier to self-fund, many employers also are self-insuring their once fully insured HMO premium, according to Mr. Dolstad of Howard Johnson.

Self-funded HMOs often are called EPOs, or "exclusive provider organizations," and are regulated as preferred provider organizations, he explained.

Under such arrangements, the employer usually pays the plan administrator a basic capitation fee to cover the primary care physicians' services, a claims administration fee and a network access fee. Sometimes prescription drug costs are also capitated if a prescription benefit manager is involved.

"Then the employer just pays claims as they come in," usually on a discounted fee-for-service basis, Mr. Dolstad explained.

While POS plans are easier to self-fund, many employers also are self-funding their HMOs, says Jim Dolstad.

Between 50% and 60% of Howard Johnson's self-funded employer clients are also self-insuring their HMOs.

"We try to get all of our employer clients with CIGNA into the self-funded HMO that CIGNA offers," he said, because unlike some self-insured EPOs that are built around a PPO network, CIGNA's is built around its HMO network.

A more highly managed care environment can reduce stop-loss premiums by as much as 80% for the self-funded employer, Mr. Dolstad estimated.

"Managed care stop-loss is cheaper than traditional self-funded stop-loss insurance," agreed Dennis Heinzig, president of Presidio Excess, the underwriting manager for Combined Insurance Co. of America, a unit of Aon Corp. in Chicago.

Furthermore, while stop-loss premiums will rise for indemnity plans, they "have been falling steadily over the past six to seven years" for self-funded managed care plans, Mr. Heinzig.

"The premiums for managed care stop-loss are lower than for traditional self-funded plans' stop-loss," he said. "Attachment points are less as well."

Don Gasparro, managing director of benefit consultant Apex Management Group in Princeton, N.J., agreed that more employers are considering ways to self-fund their managed care plans.

But rather than self-insuring their HMOs, he sees more POS programs being created. "Most groups are going toward point-of-service," which is easier to self-fund because "usually POS is not capitated," he said.

In addition, the employers offering POS plans often contract directly with providers, eliminating the HMO as an intermediary in the transaction, said Mr. Gasparro.

Still, the arrangement can be structured much like the self-funded HMO Mr. Dolstad described.

"In direct-contracting situations, the employer tries to get some risk-sharing with providers, and typically both sides agree on a claims administrator," Mr. Gasparro explained.

Depending on how much risk each party is comfortable assuming, both or one buy medical stop-loss coverage, he said.

That way, "everybody's taking a piece of the risk," he said, referring to the employer, provider and stop-loss underwriter. BI

Explaining the Growing Number Of Uninsured

Merrill Matthews Jr., National Center for Policy Analysis, January 12, 1998

"There is no mystery as to why the number of uninsured as well as health care costs are growing: Congress and several state legislatures keep trying to make health insurance more accessible and affordable.

The common denominator among the health care policy failures is a practice known as 'guaranteed issue,' [making] health insurance available to anyone regardless of their health.

A standard family health insurance policy ($500 deductible, 20% co-payment) in New Jersey purchased by the family itself (i.e., not employer-provided) averages $1,559 per month.

By contrast, neighboring Pennsylvania, which has not implemented guaranteed issue, has relatively low premiums—about $300 per month—for a policy similar to that in New Jersey.

[Under] the Kassebaum–Kennedy Health Insurance Reform Bill, small employers who might have been denied a group health insurance policy because one or more employees had a costly medical condition must be accepted. In addition, [employees] with group health insurance who leave their jobs and need to purchase individual health insurance cannot be denied coverage.

During the debate over the bill, the American Academy of Actuaries suggested that premiums might rise between 2% and 5%. However, [others] found that some premiums would eventually increase between 125% and 167%.

Why only individual and small group markets are affected. A relatively small percentage of people bear the brunt of these increases. Companies that self-insure under the federal Employee Retirement Income Security Act (ERISA) are exempt from state laws creating guaranteed issue and community rating, as well as many other state laws and taxes, and so avoid the health insurance price increases that small groups and individuals experience. Thus the latter must pick up all of the costs of guaranteed issue. And these are the people most likely to cancel their coverage if the costs become prohibitive.

More uninsured in the future? The Patient Access to Responsible Care Act (PARCA), sponsored by Sen. Alfonse D'Amato (R-N.Y.) and Rep. Charles Norwood (R-Ga.), has a guaranteed issue provision. As a result, PARCA could impose guaranteed issue nationwide, even on ERISA companies.

How to decrease the number of uninsured. If Congress really wants to address the problem of the uninsured, it should:

- Change the tax system so that it encourages everyone to obtain a basic health insurance policy.
- Avoid imposing mandates that make health insurance and managed care more expensive.
- Expand the availability of medical savings accounts.

Each of these reforms would reduce the cost of health insurance and health care and encourage more people to become insured." MB

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2/15/98

Date: February 20, 1998

(X) Topeka Capital Journal ( ) Wichita Eagle ( ) Wichita Business Journal
( ) Johnson County Sun ( ) Kansas City Star ( ) Lawrence Journal World

More workers opt against insurance

By LEE BOWMAN
Scripps Howard News Service

WASHINGTON — A new study suggests 6 million Americans have gone without employer-sponsored health care insurance over the past eight years because they couldn't afford to pay their share of the premiums.

The squeeze is expected to get even worse, according to an analysis prepared for labor groups, with between 8 million and 12.5 million more workers and their families forced to opt out of company-sponsored coverage in the next five years.

If health plan premiums continue rising and employers continue to shift the burden to workers, the study released Thursday by the AFL-CIO projects health premium costs for workers could average more than $2,600 a year by 2002, up $1,000 from the average today.

"With half the people who have employer coverage earning less than $50,000 a year, that could be a considerable burden," said Peggy Connerton, a health care specialist with the union.

Health care consultant John Sheils of The Lewin Group, chief author of the study, noted that in 1988 the average worker's share of health insurance premiums paid by employers was 10 percent; by 1996, that worker's share had risen to an average of 22 percent.

The study, based on a variety of government and private surveys and census statistics, says that between 1988 and 1996, the cost of family insurance coverage to employers rose by 111 percent, while the cost of the share of premiums paid by workers rose 146 percent.

The increase has been even steeper for single worker coverage, where the costs paid by employees have gone up 284 percent, while overall premium costs to employers have increased by just 79 percent. Sheils said that is largely because many companies only recently started requiring employee contributions for individual coverage, while most have required workers to share the cost of family coverage for decades.

"And this happened largely during a period when employers were able to keep their premium increases fairly low by turning to managed care," Sheils said. "Now, with premiums expected to rise 5 to 10 percent this year, the pressure may become considerably greater on workers."

"This study just confirms the concern I hear about the rising cost of health insurance from working families everywhere I go."

— John Sweeney, AFL-CIO president

"This study just confirms the concern I hear about the rising cost of health insurance from working families everywhere I go," said AFL-CIO President John Sweeney.

"I hear story after story from workers who had to drop their family coverage because they were paying more for health coverage than for any other expense, including rent or groceries or clothes for their kids. I don't know how many times I've heard workers say their recent pay increase, as small as it was, got eaten up by an increase in health insurance costs."

The Lewin study echoes a report by government economists last fall that found even though 75 percent of workers are offered health coverage through their jobs, only 60 percent are covered, and that the percentage of workers opting for coverage had fallen by 8 percent between 1987 and 1993. The economists also said it appeared this decline was due to increased cost-sharing demanded by employers.

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Kansas Association of Health Plans

March 17, 1998

The Honorable Don Steffes
Senate Committee on Financial Institutions and Insurance
Kansas Statehouse, Room 128-S
Topeka, KS 66612

Dear Chairman Steffes:

I am writing to you with regard to the March 19 committee meeting of the Senate Committee on Financial Institutions and Insurance. I understand that the committee will be discussing possible topics for interim study. On behalf of the Kansas Association of Health Plans I am writing to express our interest in an interim study on health insurance mandates and health insurance regulation.

As you know, a number of mandated health insurance benefit bills have been introduced over the past several years. Such bills have attempted to address a variety of concerns about health insurance coverage. The insurance industry has consistently opposed mandate bills because of the cost impact that mandates have on health insurance premiums employers and individuals must pay.

KAHP members do not believe that any of the mandate bills introduced over the past two years were in response to any substantive problems currently existing in the Kansas marketplace. Rather, the mandate bills are reflective of what we believe to be perceived problems with the health care system in general. Unfortunately, the mandate bills go beyond regulating for the good of public health and safety, and instead attempt to regulate the market by dictating what covered benefits and services health plans must offer.

Moreover, mandate bills have often been introduced even where there has been no evidence that the proposed mandated benefits are not currently covered. Examples of such bills include 1998 SB 409, the prostate cancer screening bill, and unamended 1997 SB 386, the diabetes bill. In both cases, KAHP offered testimony in committee hearings that the services and treatment to be mandated were already covered to some extent by health plans.

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Senate FI&I
Attachment 5
3/19/98

KAHP members are greatly concerned about the trend towards regulation of health plans by mandate because excessive regulation will result in less consumer choice and higher health insurance premium costs. Health insurance premiums are already too high. If there is less choice and higher premium costs then more employers may be unable to provide health insurance as a benefit of employment. As you know, 76 percent of individuals, including children, in families headed by a full-year, full-time worker are covered under employment-based health insurance nationwide and the percentage of citizens with employment-based health coverage has been increasing since 1993. Many people depend on their employers for their health insurance and their coverage should not be jeopardized.

Alternatively, employers may choose to self-insure in order to lower their insurance costs. Under ERISA, self-insured employer based group health insurance plans are exempt from state regulation. Passage of mandates by the state legislature has no effect whatsoever on self-insured plans because self-insured plans are regulated federally. Currently, 40% of Kansans have coverage under a self-insured plan: if mandates continue to be enacted at the state level even more employers will be encouraged to eschew state regulation by self-insuring in order to lower their costs. We must be skeptical of any regulatory scheme that could erode employment-based insurance, encourage the loss of private health insurance, or cause employers to seek exemption from state regulation.

The Kansas Association of Health Plans respectfully requests an interim study be considered for the 1998 Interim Session that would fully address the many issues surrounding health insurance benefit mandates. Hopefully, a review of the various mandated benefit bills as a whole rather than body part by body part will enable the Legislature to view the costs of mandated benefits on an aggregate level. The KAHP believes such a study will provide the clearest picture of the overall effect of mandated benefits on the ability of Kansans to obtain affordable, quality health insurance.

If the Kansas Association of Health Plans can be of assistance, please do not hesitate to contact me.

Sincerely,

Callie J Denton

Callie Jill Denton, J.D.
Executive Director

cc: The Honorable Sandy Praeger, Vice Chairman
The Honorable Paul Feleciano, Ranking Minority Member
Dr. Bill Wolff, Legislative Research