Approved: Robert Tomlinson
Date Feb. 4, 1999

MINUTES OF THE HOUSE COMMITTEE ON INSURANCE.

The meeting was called to order by Chairperson Rep. Bob Tomlinson at 3:30 p.m. on January 21, 1999 in Room 527-S of the Capitol.

All members were present except:	Rep. Hummerickhouse, Jenkins, O'Brien
Committee staff present:	Bill Wolff, Researcher Robert Nugent, Revisor Mary Best, Secretary
Conferees appearing before the committee:	Sen Sandy Praeger Jim Schwartz-KECH Terry Leatherman-KCCI Bob Van Crum-Greater KC Chamber-Written Only Brad Smoot-BCBS/BCBS of KC Larrie Ann Brown-KHAP Terry Bernatis-Dept of Admin.
Others attending:	No attendance sheet signed for this bill , however, room was full

The meeting was called to order by Chairman Tomlinson at 3:35 p.m.

.Representative Kirk was recognized to introduce a bill dealing with Agents Bill of Rights. Representative Kirk moved to introduce the bill. Motion was seconded by Representative Grant. Motion carried.

Chris Wilson of the Kansas Dairy Association, was then recognized and requested a bill be introduced to extend the Car Division of Kansas Law for group health insurance to be extended to cover individuals in these kind of trade associations.

Motion was made by Representative Cox and seconded by Representative Showalter. Motion carried.

Chairman Tomlinson then introduced a request for bill presentation on durable medical equipment.

Motion was made by Representative Kirk and seconded by Vice-Chair Myers. Motion carried.

HB 2005: Mandated health coverage, state health plan.

Chairman Tomlinson then recognized Dr. Bill Wolff, Research, to give an overview of the Bill worked over the summer. **SB 3, SB 4, HB 2005** covered mandates on insurance coverages. The Legislature supports two (2) this Session: (1) reconstruction of breast surgery (symmetrical),and (2) payment for certain oral surgeries, mainly those who cannot be treated in the chair.

Dr. Wolff gave written testimony to the committee and a copy of that testimony is (Attachment #1) attached hereto and incorporated into the Minutes by reference. A copy of the fiscal bill(Attachment #2) is attached hereto and incorporated into the Minutes by reference.

Senator Sandy Praeger gave Proponent's Testimony to the committee. Written testimony was furnished to the Committee and a copy of that testimony is (Attachment #3) attached and hereto and incorporated into the Minutes by reference. Sen. Praeger also testified that mandates do not apply to Medicaid/Medicare and therefore there should be a mandate imposed on state employers/employees programs first to see the cost effects.

James Schwartz, Consulting Director of Kansas Employer Coalition on Health, Inc., addressed the Committee and furnished copies of testimony. A copy is (Attachment #4) attached to these Minutes and incorporated herein by reference.

Terry Leatherman, Executive Director, Kansas Industrial Council, gave Proponent Testimony to the Committee. Written testimony was furnished to the committee and a copy of that testimony is (Attachment #5) attached hereto and incorporated into the Minutes by reference.

Ms,. Larrie Ann Brown, Executive Director of Kansas Association of Health Plans, gave Proponent Testimony to the Committee and furnished copies of testimony. A copy is (Attachment #6), attached hereto and incorporated into the Minutes by reference.

Bob Van Crum, Chairman, Kansas State Affairs Committee, Greater Kansas City Chamber of Commerce, submitted written Proponent Testimony to the Committee by way of Chairman Tomlinson. A copy is (Attachment #8) attached to these Minutes and incorporated herein by reference. Mr. Van Crum states **HB 2005** responsibly attempts to measure costs and benefits of various mandates. He feels this is a practical approach to the issue of health care coverage.

Brad Smoot, Legislative counsel for Blue Cross Blue Shield, addressed the Committee and gave Proponent Testimony to the Committee. A copy is (Attachment #'s 7) attached hereto and incorporated into the Minutes by reference. Mr. Smoot's testimony included charts and graphs showing categories of insured, and an Invoice of an insurance bill. Mr. Smoot offered testimony feeling **HB 2005** is "a reasonable method for legislators to evaluate the costs and benefits of the various insurance coverage issues". Mr. Smoot feels the "state employees benefits plan has the size and expertise to be of value" in the legislative deliberations . Mr. Smoot offered a technical amendment to impose at least a one (1) year time period of experience under a given mandate before it is imposed on the rest of Kansas.

Ms. Terry Bernatis, Health Benefits Administrator, gave Proponent Testimony to the Committee. A copy is (Attachment #9) attached hereto and incorporated into the Minutes by reference. Ms. Bernatis agreed with the previous testaments but suggested the time-frame be extended to eighteen (18) months.

G. Eugene Troehler, Chairman, State/Federal Affairs Task Force, furnished copies of testimony to the Committee. A copy is (Attachment #10) attached hereto and incorporated into the Minutes by reference.

Public hearings on **HB 2005** were called to a close.

Meeting adjourned 4:40 p.m.

Next meeting January 26, 1999

HOUSE INSURANCE COMMITTEE GUEST LIST

DATE: 1-21-99

NAME	REPRESENTING
Pat Morris	K.A.I.A.
John Federico	Humana
David Hanson	Ks Insur Assns
JOHN C. BOTTENBERG	DELT DENTAL
Michelle Peterson	Peterson Public Affairs Group
Jim Schmidt	KS Employer Coal. on Health
Larrie Ann Brown	KAHP
Stacy Soldan	Stein & Klein Chtd.
Brad Smoot	BCBS
Linda DeCoursey	KS Insurance Dept.
Rebecca Lee	KCA & KANA
Terry Heathermon	KCCI
Steve Ashley	Dept A
Paul Davis	Kansas Insurance Dept.
Bill Grosz	Saint Luke's - Shawnee Mission
Kathy Damron	" "
Teresa DiMenaver	HIAA
KAREN DiVITA	INTERN (SEN. BRADLEY)

SPECIAL COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE

VARIOUS HEALTH INSURANCE MANDATES AND THEIR EFFECTS ON INSURERS, HEALTH CARE PROVIDERS AND AFFORDABILITY AND AVAILABILITY OF HEALTH CARE COVERAGE*

CONCLUSIONS AND RECOMMENDATIONS

The Committee recommends that coverage for reconstructive breast surgery and for coverage for certain oral dental procedures be mandated by the 1999 Legislature. The Point of Service issue should be studied further, perhaps by the House Committee on Insurance early in the 1999 Session. The Committee recommends no action be taken to mandate coverage for durable medical equipment or to provide parity for mental illness conditions. Other proposed mandates—maternity benefits, infertility treatments, and certain patient protections—received no recommendation. Any new mandate enacted after the effective date of any enactment of the 1999 Legislature should be applied first to state employees under the state employee benefit plan before being applied to the public health insurance marketplace.

BACKGROUND

For nearly 30 years, legislatures across the country have been petitioned by various individuals, associations, and interest groups to assist them and their constituents with the payment of certain health care costs. At the same time, persons providing services also have sought legislation to ensure payment for the services they provide. In Kansas, the Legislature has responded by enacting 17 mandates for coverage of select treatments, conditions, or diseases and payments to certain providers.

Provider Mandates

The first mandates enacted in Kansas were on behalf of health care providers and are referred to as provider mandates. In 1973, optometrists, dentists, chiropractors, and podiatrists sought and secured legislation directing insurers to pay for services they performed, if those same services would be paid for by an insurer if performed by a practitioner of the healing arts (medical doctors (MDs) and doctors of osteopathy (DOs)). In the following year psychologists successfully petitioned for reimbursement for their services on the same basis. In that same year, the Legislature extended the scope of mandates to all policies renewed or issued in this state by or for an individual who resides or is employed in this state (extraterritoriality). Social workers sought and obtained their mandate in 1982. Advanced registered nurse practitioners were recognized for reimbursement in 1990. And pharmacists, in a 1994 mandate, gained inclusion in the emerging pharmacy network approach to providing pharmacy services to insured persons.

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* _____ B. _____, _____ B. _____, and _____ B. _____, accompanies this report.

Benefit Mandates

The first benefit mandate was passed by the Legislature in 1974, with enactment of a bill to require coverage for newborn children. That mandate has been amended over the years to include adopted children and immunizations, as well as a mandatory offer of coverage for the expenses of a birth mother in an adoptive situation. In 1977, the Legislature took its first foray into coverage for alcoholism, drug abuse, and nervous and mental conditions. The new law enacted that year required insurers to make an affirmative offer of such coverage which could only be rejected in writing. This mandate, too, has been broadened over the years, first to become a mandated benefit and then a benefit with minimum dollar amounts of coverage specified in the law.

Mammograms and pap smears were the next benefits to be mandated as cancer patients and various cancer interest groups appealed for mandatory coverage by health insurers. The year was 1988. In 1998, male cancer patients and the cancer interest groups sought and received "reciprocity" for coverage of prostate cancer. Finally, after repeated attempts over the course of more than a decade, supporters of coverage for diabetes were successful in securing coverage for certain items of equipment used in the treatment of the disease, as well as for educational costs associated with self-management training.

Provider Mandates	Year		Benefit Mandates	Year
Optometrists	1973		Newborn and Adopted Children	1974
Dentists	1973		Alcoholism	1977
Chiropractors	1973		Drug Abuse	1977
Podiatrists	1973		Nervous and Mental Conditions	1977
Psychologists	1974		Mammograms and Pap Smears	1988
Social Workers	1982		Immunizations	1995
Advanced Registered Nurse Practitioners	1990		Maternity Stays	1996
Pharmacists	1994		Prostate Screening	1998
			Diabetes Supplies and Education	1998

Kansas and Other State Actions

The Kansas Legislature has enacted eight provider mandates and nine mandates to provide certain benefits or cover certain conditions. In contrast, Maryland and Florida have in place more than 30 mandates. Minnesota, California, Connecticut, and Arkansas each have more than 25 mandates on their statute books. Using the number of mandates as a basis for comparison, Kansas is closer to its neighbors which have enacted mandates numbering in the mid to higher teens. The mandates Kansas has adopted also correspond with what most other states have enacted as indicated in the following table.

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Provider Mandate	States*		Benefit Mandate	States*
Chiropractors	43		Alcohol Treatment	43
Dentists	34		Drug Abuse	31
Optometrists	37		Mammograms	47
Psychologists	41		Mental Health	32
Nurse Practitioners	21		Maternity Stays	51
			Prostate Screening	16
			Diabetes	27

* Data taken from "State Mandated Benefits and Providers," Blue Cross and Blue Shield Association, December 1997 and 1998 Health Policy Tracking Service, National Conference of State Legislatures (NCSL), May 1998. (Data are compiled by these groups and reflect what is reported to them. The data have not been independently verified and the classification of state laws and the definition of what constitutes a mandate is generally open to interpretation.)

Recent Trends

With the advent of managed care, the issue of mandates has taken on a new dimension. Now, the interests of consumer patients come more into play in legislative considerations and enactments both in state and federal legislative arenas. While enactment of provider and benefit mandates continues, patient protection bills are being introduced across the country and at the federal level. NCSL health policy tracking data shows that at least 17 states enacted comprehensive consumer rights and patient protection laws in 1997. At least four more states followed suit in 1998. Several other legislatures have the topic on their agendas. Kansas was one of that number in 1997, when the Patient Protection Act passed. The law identified the types of requirements the Legislature thought important for Kansas patients and upon which providers those mandates should be placed.

Current Issues

In Kansas, as in every other state, legislators are asked to confront numerous mandate bills and accompanying advocates and opponents each session. In some instances, the Legislature is literally left to make decisions body part by body part with advocates for each part in active competition for legislative attention with those advocating for another part. In the 1997 and 1998 Legislative Sessions mandates were introduced involving reconstructive breast surgery, osteoporosis, infertility treatment, managed care point of service, managed care patient notification, oral surgery for children, maternity benefits, durable medical equipment, health information privacy, and mental health parity. Judging from activities in other states' legislatures, waiting in the wings for introduction and consideration in Kansas are such issues as payment for contraceptives and off-label drugs, to mention only two outstanding issues.

Appointment of the interim Committee offered the Legislature the rare opportunity to connect all the body parts and look at all the mandates at one time to determine the necessity, the desirability, and the efficacy of enacting any new mandates. Further, the Committee had the opportunity to review the impact any new mandate may have on the ever expanding managed health care marketplace in Kansas.

COMMITTEE ACTIVITIES

The Special Committee on Financial Institutions and Insurance spent one and a half days on hearing each of the mandates currently before the Legislature. One-half day was devoted to hearing opponents of any new mandates. Additional time was spent in Committee discussion sorting out the issues and arriving at conclusions and recommendations.

Durable Medical Equipment. The Committee received testimony from representatives of Assistive Technology For Kansans, Community

Action, Inc., Independence Inc., Tenth Street Medical Inc., Envision, the Kansas Council on Developmental Disabilities, Families Together, Inc., the Statewide Independent Living Council of Kansas, and from the consumers and family members of consumers of durable medical equipment.

Briefly stated, conferees stressed that special medical equipment is essential to persons with disabilities. Such equipment allows the user to lead more normal and productive lives whether the equipment used be a power wheelchair, hearing aids, communicative devices, or handrails for home safety. Advocates for the mandate pointed out that traditional insurance coverage is minimal as compared to the cost of equipment and that an increase in the minimum level of coverage to $10,000 was reasonable.

Point of Service. Conferees on the requirement that point of service be an option in managed care plans included the Kansas Psychological Association, Kansas Optometric Association, Kansas Pharmacists Association, Kansas Association of Osteopathic Medicine, Kansas Chiropractic Association, the Silver Haired Legislature, and two physician specialists in private practice.

In General, proponents on the point of service mandate contended that provider choice is most important to patients, particularly to those patients with longstanding ties to a practitioner. Advocates for the mental health professions, especially certain other special treatment areas, voiced concern that managed care plans and health maintenance organizations (HMOs) imposed on existing provider and patient relationships are disruptive and jeopardizes the care critical to the patient. Some conferees discussed point of service as related to patient protection whereby the patient has the option to stay within a network if satisfied with the care received or step outside the network if dissatisfied with the level of care. The ability to choose, they said, serves to provide some check and balance to the system of managed care.

Mental Illness Parity. Among those appearing in favor of parity treatment for mental illness were representatives of The Alliance on Mental Illness Kansas, Kansas Mental Health Coalition, Kansas Medical Society, Kansas Psychiatric Society, Kansas Psychological Association, the Insurance Commissioner, Association of Community Mental Health Centers of Kansas, Inc., and individual consumers of mental health treatment.

By July 1998, conferees pointed out, at least 17 states had enacted some form of mental health parity legislation. They found it difficult to understand why diseases of the body are readily covered by insurance but diseases of the mind are not. Several proponents addressed the assumption that mandated coverage for mental illness would increase the utilization of such services, in-patient and out-patient, and raise the cost of care. Their data indicate patients tend to get more appropriate care in the proper setting with a reduction in the utilization of other medical services.

Infertility Treatment. Several Kansans, some associated with the Kansas chapter of the national advocacy group RESOLVE, made presentations in support of insurance coverage for infertility treatment.

They noted public advocacy on this subject was difficult given the very personal and private nature of the subject. Generally, the proponents described infertility as a medically recognized disease but one singled out for exclusion by insurers. Legislation requiring insurance coverage for infertility treatment, some said, would end the discriminatory practices of insurers and provide couples with the disease of infertility the opportunity to build a family, an experience most people take for granted.

Reconstructive Breast Surgery. Several women who survived the ordeal of breast cancer made presentations to the Committee. Additionally, a reconstructive breast surgeon graphically demonstrated the end results of breast surgery, explained the various procedures for reconstruction, and highlighted the frequent need to per-

form surgery on the healthy breast to obtain symmetry.

While the advocates for the mandate acknowledged that most companies provide coverage for reconstructing the diseased breast, the issue of coverage arises most frequently over the issue of symmetrical restorations. Through the 1998 sessions of state legislatures, they pointed out, 29 states had adopted coverage for reconstructive surgery and, in at least 20 of those states, the law specifically requires coverage for surgery to establish symmetry. Feeling strongly that insurance coverage should be mandated, proponents expressed some frustration with the legislative process necessary to achieve the mandate but gave assurances that, if legislation did not pass in 1999, "we'll be back."

Coverage for Oral Surgery. The Kansas Dental Association was the primary proponent for such coverage. A board certified pediatric dentist and a dentist in general practice with a large patient base of children testified on the need for certain dental procedures to be performed in an operating room setting.

They indicated that young children with severe dental caries and certain special needs patients, *i.e.*, both children and adults who are disabled either mentally, physically, or medically, are most appropriately treated in an operating room setting with anesthesia and life support systems. While many families with health care coverage believe such treatments to be covered, are surprised to discover that treatment in such a setting is excluded. This exclusion by private insurers, they said, is in contrast to benefits available under the Kansas Medicaid program which recognizes the treatment difficulties and pays for dental care provided in the operating room setting. The dentists noted that at least two states bordering Kansas, Missouri and Oklahoma, and some other states generally require insurance coverage for hospital and anesthesia charges for dental care provided to covered persons who are children under a certain age, severely disabled, or have special medical conditions.

Finally, each proponent spoke to the importance of early positive experiences with a dentist to ensure needed dental care will be sought in the future. Such experiences are not positive for some persons when care is restricted to the dental office.

Maternity Benefits. The Insurance Commissioner had requested a bill be introduced in the 1998 Legislature to require the mandatory offer of maternity benefits. While S.B. 461 was printed and referred to Committee, the Commissioner requested no action be taken as the bill did not address the issue at hand. She indicated that the issue was under review in the Department and if a bill was determined to be needed, a new request would be made in 1999.

Certain Patient Protection Provisions. Senator Karin Brownlee, author of 1998 S.B. 662, explained the patient protection provisions in the measure. She related personal incidents involving her family's encounters with managed care providers relating to the need to have referrals both to specialists and to walk-in health centers. She noted that the "gatekeeper" frequently seemed more like a "gate blocker" and the whole system like a "mother may I" system. She proposed in the bill that referrals be valid for two years, although the senator expressed a willingness to reduce that period to one year thereby accommodating the length of most health care contracts or to a specific episode of illness. The bill also would have allowed an OB/GYN to be the primary care physician; but, again, the senator commented that her intent was to make such a provider available without hurdles, such as referrals, getting in the way of care.

Remarks of the Commissioner

In addition to hearing conferees on the specific mandates, the Insurance Commissioner was invited to address the Committee to share her opinions on the subject of mandates in general. To give some perspective to the issue, the Commissioner reminded the Committee that 75 percent of Kansans covered by health insurance are under federal jurisdiction. That is, they are insured under Employee Retirement Income Security Act (ERISA) plans, Medicare, or

Medicaid. The significance of this fact is that legislative action at the state level can impact no more that one quarter of the insured population. Any mandate enacted affects only those under state jurisdiction.

With the advent of managed care, the Commissioner noted, those insured in larger groups enjoy level or lower costs for health care coverage. Persons covered under small group plans have not shared in the cost benefit associated with managed care. Insureds in both categories, have found managed care to be confining with limited choices to care whether primary or specialized and some concern that when care will be needed, it will not be available or, if available, not covered under the plan. State legislatures and Congress continue to deal with the "backlash" against the managed care concept.

Addressing the issue of mandates, the Commissioner acknowledged that mandates will have some impact on the cost of insurance for those included in the mandate. As a result, some employers may be driven out of the market or into self-insured plans. However, if employers, the purchasers of the coverage, choose coverages for their employees based solely on cost and the coverage does not provide the benefits needed by the beneficiaries, coverage is of limited value. If the cost of the coverage to the employer or employee is unaffordable, then the fact that coverage is available also is of little value.

Confronted with these difficult choices, what are legislators to do. The Commissioner suggested continued work with counterparts at the federal level and in national associations to retain supervisory jurisdiction over insurance at the state level. Further, and specific to the point of mandates, the Commissioner said the Committee and the Legislature need to evaluate each mandate on a cost and benefit basis. If the benefit is cost effective then it is good public policy to enact the mandate. She added that when costs are measured, potential savings also must be weighed. In those instances where the issue is not cost but fairness, *e.g.*, discriminatory on the basis of sex, again good public policy dictates that the issue be debated. Finally, she reminded the members of the importance of continuing the health safety net for that 10 percent of the Kansas population that receives its care from charity and public health clinics, children's programs, and other insurance and governmental programs.

The Cost of Mandates

Throughout the course of the study, proponents offered estimates as to the cost of their special mandate. For the most part, the estimates were based on other states' experiences or professional association judgments and expectations of costs. The Committee believed that decisions on proposed mandates should be based on the best information available. In that regard, the Kansas Department of Health and Environment, Statistical Agent for the Kansas Insurance Department, queried data in the Kansas Health Insurance Information System (KHIIS). The Actuary for KHIIS was asked to prepare an impact on premium statement for the mandates before the Committee. Since each mandate was supported by a bill, the provisions of the bills were used by the Actuary to determine the impact.

- **Breast Reconstruction (H.B. 2297).** Based upon the Kansas mastectomy rate of 3.5 per 10,000 women aged 20-65, the total premium impact on premiums in Kansas would be $900,000 (0.3 percent or 50 cents per year).
- **Mental Health Parity (H.B. 2138).** Dependent upon whether or not long-term care was excluded, the additional premium cost would be $13 million to $32.5 million (1.0+2.5 percent increase per year).

  The Committee did receive testimony summarizing various studies done on the cost of mental health parity which reflect actual cost savings associated with treatment. That is, the expected value of benefits from treatment does normally exceed the expected costs.

- **Durable Medical Equipment (S.B. 509).** With the current definition of durable medical equipment and assuming payments over $1,000 are already made for half the cases, the impact on premiums would be $5,525,000 for the state. Expanding the definition while

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making the same assumption of current payment over $1,000, the impact on premiums could be up to $150 million (0.85 percent up to 12 percent increase per year).

- **Point of Service (S.B. 331).** Assuming 40 percent of the plans would be affected, premium costs in Kansas would increase by $76.5 million (about 15 percent increase per year).

- **Infertility Treatment (S.B. 663).** Premium costs for families in the 20-40 age group would increase $6,280,000 (about 1 percent per year).

- **Oral Surgery (H.B. 2800).** The impact of this mandate is too small to be measured. There is no information available from the database.

The Industry Response

Conferees appearing before the Committee in opposition to any new mandate legislation, and in some cases to existing mandates, included the Kansas Chamber of Commerce and Industry, Preferred Health Systems, the National Center for Managed Health Care Administration, Kansas Association of Health Plans, Health Insurance Association of America, and Blue Cross and Blue Shield of Kansas and Blue Cross and Blue Shield of Kansas City. In addition, employers providing health insurance to their employees included Custom Metal Fabricators, Inc., Herington, Kansas; International Cold Storage Co., Inc., Andover, Kansas; Western Resources, Topeka, Kansas; Grandview Products Co., Parsons, Kansas; Bombardier Aerospace (Learjet, Inc.), Wichita, Kansas; and the Kansas Employer Coalition on Health, Inc. A single individual gave testimony specific to the mental health parity proposal, and the President of the Kansas Self-Insurers Association also appeared in opposition to mandates.

In general, whether representing the insurance industry, the managed care industry, or private employers, testimony was unanimous in the rejection of new mandates because they drive up the cost of coverage to the employer and, most likely the employee; they drive employers out of the insurance marketplace and likewise their employees; they drive employers into the unregulated self-insurance market; they impose a one size fits all benefit package on employers and insureds thereby removing the ability to tailor coverage to specific needs; they reduce the ability of small business to compete, especially in world markets; and, in some instances, mandates pervert the meaning and scope of health insurance and substitute for a finding of medical necessity personal, individual lifestyle choices.

One conferee representing the insurance industry, said in no uncertain terms that it was time for the Legislature to "just say no" to new mandates. Again, opponents of mandates seemed unanimous in support of the idea that the best way to achieve quality health care at an affordable price is to promote choice and competition in the marketplace, not by burdening the marketplace with government imposed mandates.

Finally, on a subject tangentially related to mandates, the Committee heard from the domestic health insurance industry and a representative of the American Family Life Assurance Company. These conferees suggested that certain policies be specifically and uniformly excluded from all existing and any new mandates that might be enacted. Policies to be excluded would be accident-only, specific disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited benefit supplemental insurance policies.

Conclusions and Recommendations

At its final meeting on health insurance mandates, the Special Committee on Financial Institutions and Insurance reviewed each mandate presented to it in the course of its study.

Reconstructive Breast Surgery. The Committee was aware that just one day prior to its meeting, Congress had enacted this mandate as a part of H.R. 4328, the omnibus consolidated appropriations act for 1999. Title IX of that act

contains the Women's Health and Cancer Rights Act of 1998. The new law applies to all health insurers and plans, including those covered by the Employee Retirement Income Security Act of 1974. Briefly, insurers will be required to cover reconstruction of a breast on which a mastectomy has been performed, surgery and reconstruction on the other breast to produce a symmetrical appearance, and prostheses and physical complications at all stages of the mastectomy, including lymphedemas. Coverage must be in a manner determined in consultation with the attending physician and the patient and may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Notice of coverage must be delivered to insureds not later than January 1, 1999.

The Committee was prepared to address the issue at the state level prior to the federal action; however, since the federal government has determined the scope of the benefit, the Committee agrees with the new law and recommends the introduction and passage of a bill to enact the same provisions into Kansas law.

Oral Surgery. The Committee concludes from its hearing on this issue that certain children and others with medical or behavioral conditions cannot be treated appropriately in the usual dental office setting. Therefore, the Committee recommends introduction and passage of a bill to require insurers to provide coverage for the administration of general anesthesia and medical care facility for dental care provided to a child eight years of age or younger or a person who is severely disabled and who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided. Coverage may require prior authorization and may be subject to the same deductibles, coinsurance, and other limitations as apply to other covered services.

Mental Health Parity and Durable Medical Equipment. The Committee debated extensively the issues contained within mandates for each of the proposals. Specific suggestions for legislative action were considered for each mandate, but by votes of 8 to 5, each of the suggestions failed to receive sufficient support to be recommended for legislative action. It is the Committee's recommendation that no legislation be passed by the 1999 Legislature to enact mandatory parity for mental health coverage or to establish minimum levels of coverage for durable medical equipment.

While no legislation is recommended for mental health parity, the consensus of the Committee is that the topic deserves and should receive further study.

Point of Service. The Committee recommends further investigation of the manner in which referrals, including self-referrals, are made for chronically ill patients to specialists practicing out-of-network from the patient. It is the Committee's belief that the investigation should continue in the House Committee on Insurance early in the 1999 Session of the Legislature.

As for mandates involving infertility, maternity, and certain patient protections, the Committee did not go beyond the early discussions of the topics at the time each was heard. Consequently, the Committee makes no recommendations on these subjects.

Finally, the Committee was made aware throughout the course of its deliberations on health insurance mandates that each has a separate cost associated with it and, collectively, the total cost of mandates is much greater than the sum of the individual requirement. This awareness of cost was heightened by the testimony of numerous employers who pay a substantial portion of health care costs through premium payments. Since the state, too, is an employer and payer of substantial dollars in health insurance premiums, the Committee concludes and recommends a bill that would make new mandates applicable only to the state employee benefit plan. After a sufficient trial period, the state could determine the financial impact the mandate has as well as the benefit derived from the mandate. With cost and benefit data in hand, the state could then decide whether the mandate should be continued for state employees and extended to other persons in

the health insurance marketplace. The trial plan for mandates would begin with any mandate enacted after the effective date of the bill.

STATE OF KANSAS

DIVISION OF THE BUDGET
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Bill Graves
Governor

Duane A. Goossen
Director

January 21, 1999

The Honorable Bob Tomlinson, Chairperson
House Committee on Insurance
Statehouse, Room 112-S
Topeka, Kansas 66612

Dear Representative Tomlinson:

SUBJECT: Fiscal Note for HB 2005 by Special Committee on Financial Institutions and Insurance

In accordance with KSA 75-3715a, the following fiscal note concerning HB 2005 is respectfully submitted to your committee.

HB 2005 would make all new mandates for health insurance coverage for specific health services, for specific diseases or for providers of specific health services applicable only to the State Health Care Benefits Program for state employees for a period of at least a year before they can be implemented by insurance providers. At the end of a specified period the bill would require that the Kansas State Health Care Commission submit to the President of the Senate and the Speaker of the House of Representatives a report on the impact of any mandated services on the State Health Care Benefits Program. That report would be made at the same time the Governor presents *The Governor's Budget Report*. The bill would require the report of the Kansas State Health Care Commission to include:

Data concerning the fiscal impact of the mandates

Utilization costs of the mandates

A recommendation as to whether the mandated coverage should continue for the State Health Care Benefits Program and all other insurance carriers in the state.

The Kansas State Employees Health Care Commission indicates that the fiscal effect of the act would include the cost any mandates, costs related to the analysis of those mandates and

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the preparation of a report concerning the costs of the mandates. The cost of the mandates could be determined only after completion of the study of the mandates required by the Legislature in other bills.

The cost of analysis of the mandate would include the cost of an information system, the cost of staff and actuarial costs. The analysis cost would be $300,000 from the Cafeteria Benefits Fund in FY 1999 and between $175,184 and $205,184 from the Cafeteria Benefits Fund in FY 2000. The $300,000 cost in FY 1999 would be for the purchase of an information system that would be capable of tracking the financial impact of legislative mandates. The cost in FY 2000 would include $50,184 for an additional 1.0 FTE Benefits Analyst, $120,000 for maintenance of the information system and between $5,000 and $30,000 for actuarial systems. The cost of these services would depend on the number of mandates and kinds of mandates analyzed.

The FY 2000 Governor's Budget Report includes $300,000 from the Cafeteria Benefits Fund to finance the cost of an information system. This system is needed whether or not HB 2005 were to pass. It is needed for program analysis and tracking. *The FY 2000 Governor's Budget Report* also includes the cost of $120,000 for maintenance of that system in FY 2000. The cost of the additional Benefits Analyst, $50,184, in FY 2000 and the cost of actuarial services would be in addition to the amounts included in *The FY 2000 Governor's Budget Report*.

Sincerely,

Duane A. Goossen

Duane A. Goossen
Director of the Budget

cc: Linda DeCoursey, Insurance Department
Pat Higgins, Department of Administration

STATE OF KANSAS

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SENATE CHAMBER

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VICE CHAIR: FINANCIAL INSTITUTIONS AND INSURANCE
MEMBER: ASSESSMENT AND TAXATION
ELECTIONS AND LOCAL GOVERNMENT
HEALTH CARE REFORM LEGISLATIVE OVERSIGHT COMMITTEE
JOINT COMMITTEE ON CHILDREN AND FAMILIES
SRS TRANSITION OVERSIGHT COMMITTEE

January 20, 1999
Testimony before the House Insurance Committee
By Senator Sandy Praeger
House Bill 2005

Thank you Mr. Chairman for allowing me to speak before your committee today. I want to acknowledge the efforts of your committee member, Rep. Kirk, in support of this legislation on the Insurance Committee this summer. Her efforts to bring interested parties together resulted in this proposed method of dealing with insurance mandates.

Before I continue my testimony in support of the bill, I'd like to put this issue in some kind of historic context. Insurance has evolved over the years from a method of insuring against catastrophic health care events, especially hospitalization, to a method of paying for many health care services. This transition has been facilitated by the increase of employer-based coverage, which allows health benefits to increase without any income tax implications. In other words, employers can increase benefits with pretax dollars and employees can receive those benefits and the dollar value of the benefit is not counted as income. This is one of the reasons that over the years more and more of our health care services have been included in insurance coverage. The problem arises when one health plan covers a benefit and another does not. We in the legislature are then asked to pass mandates that require all insurers to cover that benefit. And we've

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done that a lot. In fact, the Senate Insurance Committee is considering two new mandates next week....which brings us to this piece of legislation.

Whenever we consider mandates we hear that the mandate will cause premiums to go up or employers to drop coverage. We don't always have reliable information to back up those claims. What this bill proposes to do is say that before we impose a mandate on other employers' benefit plans, we should impose the mandate on our own state employee plan. Let's "test track" the mandate or mandates to see what impact they do have on cost and on utilization of services. We now have in Health and Environment the capacity to analyze data regarding health insurance coverage and determine the cost of particular services and the extent to which that service has been utilized over a period of time. We can determine then if the mandate results in more people receiving a needed service and the overall impact of providing the service on the cost of coverage. This type of cost/benefit analysis will ensure that as we make mandate decisions, we do so armed with good information. It's also important to remember that mandates only affect the insured population that we can regulate at the state level. They do not apply to ERISA companies, and they do not apply to Medicaid and Medicare. And right now our state mandates do not have to be included in our state employees' health plan. This legislation is the right thing to do, and I hope you will give thoughtful consideration to its passage.

Thank you.

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Testimony to House Committee on Insurance

on HB 2005

(Trial period for health insurance mandates)

by James P. Schwartz Jr.
Consulting Director
January 21, 1999

I am Jim Schwartz, director of the Kansas Employer Coalition on Health. The Coalition is over 70 employers across Kansas, like Sprint, Hallmark, Learjet, and Western Resources, who share concerns about the cost-effectiveness of health care we purchase for over 200,000 Kansas employees and dependents.

It's unusual to find me in the proponents' camp on bills having to do with health insurance mandates. But I'm happy to be here today to lend support to a bill that represents a modest but sensible way to place new mandates under close observation.

Employers don't like health insurance mandates. That's partly because we're not partial to government mandates generally, but it's mostly because health insurance mandates increase the cost of a service that's already outrageously expensive. You've probably heard that health insurance costs are heading up again, after four years of stability. Trends are pointing to rate increases generally between 5 to 15% for 1999, depending on type of plan and size of group. I've heard from groups that are seeing upwards of 40% increases this year. And the increases tend to hit small businesses hardest.

Small businesses are the ones that are susceptible to state insurance mandates. Larger groups are exempt from state mandates because federal law shields groups that self-insure, as most large employers do. So we're when we're talking about health insurance mandates, we're talking about small business. Our own survey this year showed that about a quarter of small businesses in Kansas don't sponsor health coverage for employees. The main reason is cost, as you can imagine. Most of the nearly 200,000 uninsured Kansans are in households working for small businesses. According to a 1997 KU study of this subject, the uninsured are five times more likely than the insured to describe their health as "poor."

How do mandates affect this issue? According to a GAO report last year, for every 1% increase in health insurance rates, 300,000 Americans fall off the insurance rolls. That's about 3,000 Kansans. So when we're talking about mandates having only a small incremental effect on prices, it's good to remember that small increments translate into big numbers of newly uninsured.

The hardest thing to do about mandates is resisting them—when every single one of them would do some people some good. The question is: are they worth the cost. A related question is: should government mandate coverages just because they past the cost-benefit test? If you're a business person, you know you pass up "good deals" all the time, just because of their effect on cash flow.

HB 2005 won't help with the question of whether government should structure the products in a voluntary market. But it will shed a little light on the cost-benefit analysis. And more analysis is surely needed. One of the more recent Kansas insurance mandates is one that

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requires coverage of prostate screening. Right after the bill passed, research was published showing that such screening has the lowest payback of practically any kind of screening. We would have been better off to invest our money in almost any other mode of preventive medicine. If there had been a trial period in place, we would have an easy way to redirect that expense, but now it's probably too late for that mandate.

HB 2005, besides providing a kind of laboratory for new mandates, introduces an element of fairness into the whole equation. If mandates are good for private business, aren't they good enough for public employees? By applying new mandates first to your own coverage, you're endorsing them with more than lip service. That should make the medicine go down a little easier in the business community.

HB 2005 is a small step toward a cautious position on health insurance mandates. Bolder steps are needed still. But unless the commissioners of the state employees' health plan have practical objections, we think this bill is a positive step.

LEGISLATIVE TESTIMONY

Kansas Chamber of Commerce and Industry

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HB 2005

January 21, 1999

KANSAS CHAMBER OF COMMERCE AND INDUSTRY

Testimony Before the

House Committee on Insurance

by

Terry Leatherman
Executive Director
Kansas Industrial Council

Mr. Chairman and members of the Committee:

My name is Terry Leatherman. I am the Executive Director of the Kansas Industrial Council, a division of the Kansas Chamber of Commerce and Industry. Thank you for the opportunity to comment today on HB 2005.

The Kansas Chamber of Commerce and Industry (KCCI) is a statewide organization dedicated to the promotion of economic growth and job creation within Kansas, and to the protection and support of the private competitive enterprise system.

KCCI is comprised of more than 3,000 businesses which includes 200 local and regional chambers of commerce and trade organizations which represent over 161,000 business men and women. The organization represents both large and small employers in Kansas, with 47% of KCCI's members having less than 25 employees, and 77% having less than 100 employees. KCCI receives no government funding.

The KCCI Board of Directors establishes policies through the work of hundreds of the organization's members who make up its various committees. These policies are the guiding principles of the organization and translate into views such as those expressed here.

For some time now, the Kansas Chamber has opposed most health insurance mandate legislation. KCCI's opposition has been due to the concern that these insurance requirements add to

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the [illegible] of health care policies, to the detriment of small Kansas employers who struggle to provid an affordable health care benefit to their employees.

HB 2005 proposes to test future mandate proposals for at least a year in the state's health care program. This testing process should be valuable to the Legislature in determining the cost effectiveness of mandate proposals. It would also ease the emotions that often accompany mandate questions before the Legislature.

Because it provides a structure to more carefully explore new mandate concepts, and a process calling for the review of existing mandates, KCCI would urge this Committee's approval of HB 2005. Thank you for the opportunity to comment of HB 2005. I would be happy to answer any questions.

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Kansas Association of Health Plans

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Testimony before the
House Insurance Committee
The Honorable Robert Tomlinson, Chairman
Hearings on HB 2005
January 21, 1999

Chairman Tomlinson and members of the committee. Thank you for allowing me to appear before you today. I am Larrie Ann Brown Executive Director of the Kansas Association of Health Plans (KAHP).

The KAHP is a nonprofit association 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 many Kansans.

For all of the reasons talked about today the KAHP does not support the idea of mandating health insurance benefits. However, the KAHP does support the concept of HB 2005 which is to monitor the impact a mandate will have on health insurance by providing that the mandate first applies to the state employees health insurance plan. This will then enable the legislature to look at the various impacts a mandate will have on health insurance.

As you know current law KSA 40-2248 and 40-2249 requires a group requesting a mandate to file an "impact report." This impact report includes such things as reporting the social impact, including the extent to which such insurance coverage is already available and the fiscal impact, including the extent to which insurance coverage of the kind proposed would increase or decrease the cost of the treatment or service.

During the interim we worked on a bill that would give more details as to the types of studies and impact reports that should be made. One such recommendation would be to request that a medical impact including the extent to which the service is generally recognized by the medical community as being effective in the treatment of patients be included in the impact report. These additional details and strengthening of the impact report would help ensure that the legislature makes informed decisions about a certain mandate and its impact on health insurance. I would be happy to provide you with copies of these additional recommendations should the need arise. These recommendations could be added into this bill or introduced as another bill.

Thank you again for allowing me to make comments on this bill and I will be happy to try and answer any questions the committee may have.

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January 21, 1999

BRAD SMOOT

ATTORNEY AT LAW

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Statement of Brad Smoot, Legislative Counsel
Blue Cross Blue Shield of Kansas
Blue Cross Blue Shield of Kansas City
House Insurance Committee
Regarding 1999 House Bill 2005
January 21, 1999

Blue Cross Blue Shield of Kansas is a not-for-profit mutual insurance company providing health insurance to more than 700,000 Kansans in 103 counties. Blue Cross Blue Shield of Kansas City is a non-profit hospital and medical service corporation serving more than 200,000 Kansans in Johnson and Wyandotte Counties. Both Blue Cross and Blue Shield plans generally oppose mandated benefits because they tend to increase the costs of health insurance and thereby decrease the number of Kansas businesses and individuals who can afford coverage. On behalf of thousands of Kansans, we are pleased to support House Bill 2005.

For the last several years, provider and advocacy groups have asked the legislature to intervene to force changes in health insurance coverage. These proposals have a common purpose, namely, to expand the scope of services covered by insurance and increase the insurance payments to providers of such services. You are being asked to dictate to consumers the terms of the health insurance contracts they can buy. Committee members may be interested to know who are the health care consumers affected by these mandates. See the pie chart showing percentage of Kansans subject to state mandates.

You may also want to know how much more the affected Kansans (represented by these two "pieces of the pie") will have to pay. Health and Accident premiums in Kansas are more than $1.7 billion annually based on 1996 Kansas Insurance Department figures. Adjusting for A&H policies that will not be affected by mandates (e.g. Medigap), we estimate the group and non-group insured premium base to be $1.12 billion annually. Thus, a 1% increase would equal $11.2 million and would be spread among only 37% of Kansans.

Most current mandates are listed on the exhibit titled "Invoice" as well as those proposed but not passed last session. There are dozens of other mandates which have been considered in this and other states which could be added to the list under the category of "Other."

The only reason to request a legislative mandate is so that more providers will be paid by third party reimbursement and that insured individuals will pay less out of pocket for previously uncovered services. Greater money paid out by third party payers (insurance) means greater amounts must be collected from individuals and employers in the form of premium. Whether a given proposal costs one tenth of a percent or 10%, it adds something to the cost of coverage. Moreover, each mandate cannot be looked at in a vacuum since there is no limit to the number of other mandates the legislature could adopt this year or next and it is unlikely that legislators will choose to repeal those already enacted. Thus, even though the effect of any given mandate might seem slight, the cumulative effect of several such benefit enhancements can be significant.

As legislators, you are no doubt aware the cost of medical services is increasing regardless of mandates. New expensive technologies, more provider types and services, an aging population,

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greater utilization by consumers, increased charges per service, etc. Mandates merely add to the unavoidable inflation of health care and health insurance costs. See article entitled "As health care costs climb, look for insurance rates to follow suit," John Hendren, Associated Press, Kansas City Star, June 3, 1998.

As health insurance costs rise, what happens? Some consumers (employers and individuals) will simply pay more premium and pass this cost on in the form of higher prices for their goods or services. Other individuals and employers may cease purchasing coverage at all (they go bare) thus shifting the inevitable costs of health care to others and contributing less of their own resources to the insurance pool. See article entitled "Explaining the Growing Number of Uninsured," Merrill Matthews, Jr., National Center for Policy Analysis, January 12, 1998.

Some employers will continue to provide coverage but self-insure so they can control the benefit package and its costs. See article entitled "Self-insurance sees gains in health plan financing," Joanne Wojcik, Business Insurance, February 16, 1998. Self insurers not only avoid state mandates but also state premium taxes.

Some employers will pay a smaller portion of the insurance premium for single or family coverage, thus forcing employees to pay more out of pocket or drop coverage for themselves or their dependents. See article entitled "More workers opt against insurance," by Lee Bowman, Scripps Howard News Service, Topeka Capital Journal, February 20, 1998.

Some employers will continue to pay the same portion of insurance premium but will avoid pay raises, decrease other health benefits (dental or pharmacy) or reduce other business expenditures (capital improvements, job expansions, etc.). It is no wonder employers are concerned. See article entitled "Health Insurance," published by U.S. Chamber of Commerce, Nations Business subscriber survey, September, 1998.

And finally, as the marketplace becomes less capable of absorbing additional costs, insurers will try to force even lower reimbursements on existing contract providers (doctors and hospitals).

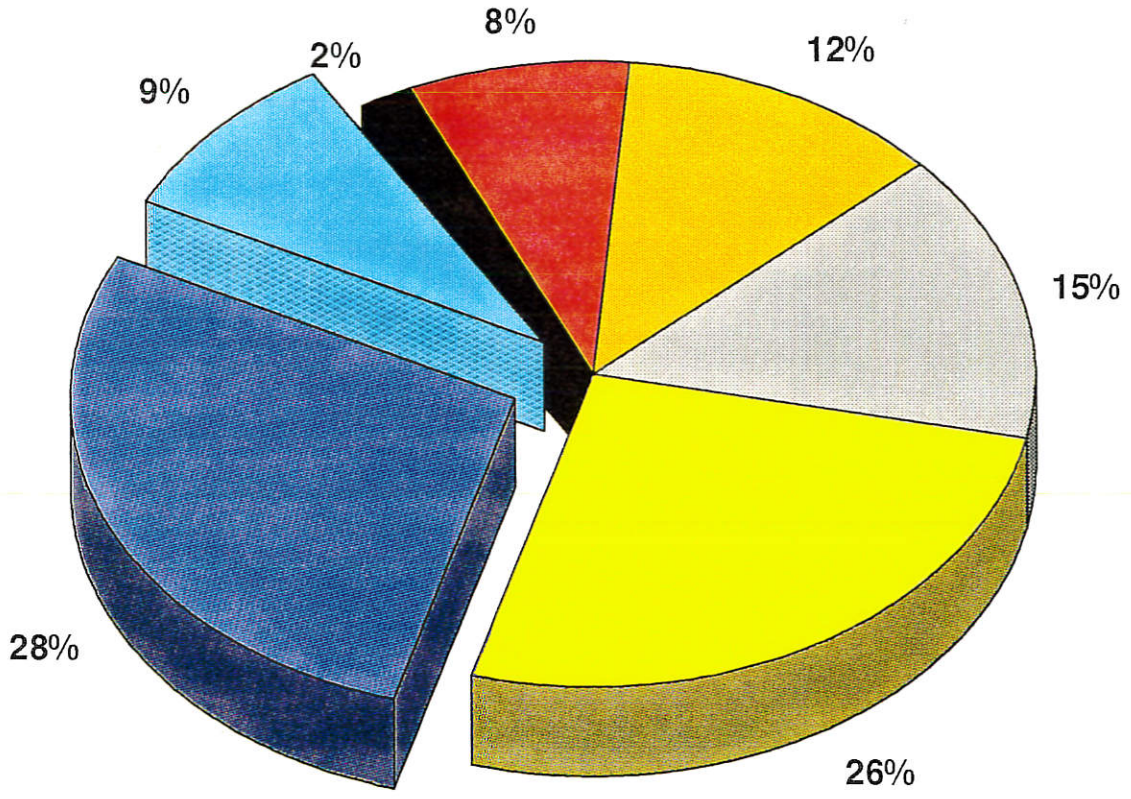
In other words, the dollars which will pay for these new mandates, are not being derived from "idle" funds. These mandates compete with existing health care services, employee wages, other business expenses and family obligations. Please remember: Kansans do not go without health insurance because it does not cover enough. They go without insurance because it already costs too much!

For these reasons, we endorse H 2005. It is a reasonable method for legislators to evaluate the costs and benefits of the various insurance coverage issues which come before you. The state employees benefit plan has the size and expertise to be of real value in your deliberations.

We have a technical amendment, attached, to clarify the intent of the bill that the state plan develop at least one (1) year of experience under a given mandate before it can be imposed on the rest of Kansas.

Thank you for your time and consideration of our views.

ALL KANSANS



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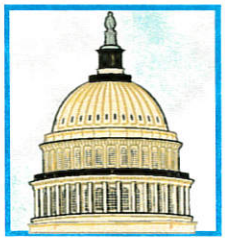
INVOICE
(Your Insurance Bill)



Legislative Mandates

CURRENT MANDATES	ANNUAL ESTIMATED COST
Chiropractors	$
Optometrists	
Podiatrists	
Dentist (paid under health coverage)	
Inpatient Nervous & Mental/Substance Abuse	
a. Facility	
b. Professional	
Outpatient Nervous & Mental/Substance Abuse	
Advance Registered Nurse Practitioners	
Birth Mother Expense of Adopted Newborns	
Mammographies & Pap Smears	
Assessment to the High Risk Pool	
Diabetes Supplies and Education	
Prostate Screening	
Sub Total	
PROPOSED MANDATES	
Durable Medical Equipment	
Individual Point of Service	
Mental Health Parity	
Infertility Treatment	
Breast Symmetry Surgery	
Bone Mass Measurement Testing (Osteoporosis)	
Oral Surgery - Mandatory Inpatient Coverage	
Pain = Emergency Medical Condition	
Geographic Accessibility to Network Providers	
Two Year Standing Referrals	
OB/GYN's as PCP's	
Other	
Sub Total	
Total	

Thank You

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.

"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

"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," 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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Session of 1999

HOUSE BILL No. 2005

By Special Committee on Financial Institutions and Insurance

1-11

AN ACT relating to accident and health insurance; concerning mandated coverages; requirements.

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

Section 1. (a) After July 1, 1999, in addition to the requirements of K.S.A. 40-2248 and 40-2249, and amendments thereto, any new mandated health insurance coverage for specific health services, specific diseases or for certain providers of health care services approved by the legislature shall apply only to the state health care benefits program, K.S.A. 75-6501, *et seq.*, and amendments thereto, for a period of at least one year. At the end of such time period, the Kansas state employees health care commission shall submit to the president of the senate and to the speaker of the house of representatives, on the day the governor's budget report is submitted to the legislature, a report indicating the impact such mandated coverage has had on the state health care benefits program, including data on the utilization and costs of such mandated coverage. Such report shall also include a recommendation whether such mandated coverage should be authorized by the legislature to apply to the state health care benefits program and to all individual or group health insurance policies, medical service plans, contracts, hospital service corporation contracts, hospital and medical service corporation contracts, fraternal benefit societies or health maintenance organizations which provide coverage for accident and health services.

beginning with the first anniversary date of the state health care benefits program subsequent to the approval of the mandate by the legislature.

(b) The legislature shall periodically review all current and any future mandated health insurance coverages.

Sec. 2. This act shall take effect and be in force from and after its publication in the statute book.

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6-12

Date:

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

As health-care costs climb, look for insurance rates to follow suit

By JOHN HENDREN
The Associated Press

NEW YORK — Pricey lifestyle drugs such as Viagra, costly health-care mergers and an aging population are expected to lead to double-digit increases in health-care costs next year.

For many workers that will mean more-restrictive health plans that offer fewer choices, and higher rates from health insurers.

Many health insurers lost money last year, and they are expected to be less willing to hold the line on rates for 1999, analysts say.

Health costs will rise the most — 12 percent to 15 percent — in traditional plans that let the patient choose the doctor, according to health-care consulting firm Watson Wyatt Worldwide. That compares with 5 percent to 7 percent for health maintenance organizations.

Prescription drug plans in which pharmacies charge insurers directly will cost 15 percent to 22 percent more in 1999, the group said.

The company issued its estimate this week based on an informal survey of 445 executives who buy health-care coverage in companies with more than 500 employees in large metropolitan areas.

"The insurance companies and HMOs have underestimated the rate of increase in the cost of providing managed care," said John Salek, a vice president and health-care analyst at REL Consultancy Group. "I think a lot of these insurers just lowballed the price to get market share."

Cut-rate prices are unlikely next year, industry watchers say. Insurers such as Aetna U.S. Healthcare and United Healthcare are coping with expensive mergers. Consumers are pressuring companies to cover costly new drugs such as the $10-a-pill impotence treatment, Viagra.

Rates industrywide began to edge up in 1998 after increases of only 3 percent to 5 percent from 1994 to 1996.

"I think the honeymoon's over...and that's a big concern because I have to tell my clients that the providers want to raise their rates 20 percent," said Henry Moyer, a health-care consultant with Hirschfeld, Stern, Moyer & Ross in New York.

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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 Pota[illegible] assistant general counsel-health care for CIGNA Corp. in Bloomfield, Conn.

"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.

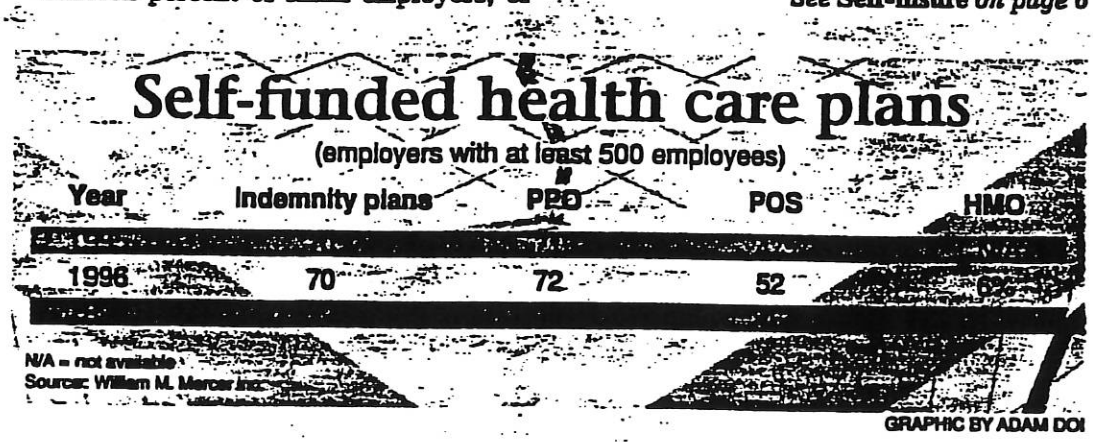
GTE has self-funded about a half-dozen HMOs for about three years, though it does not yet self-insure any of the HMOs with which it contracts in New York because it doesn't have enough HMO enrollees in that state to make it worthwhile, according to Mr. Taylor.

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.

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



GRAPHIC BY ADAM DOI

7-8

"The basic question facing health care 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

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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." ■

To obtain a free copy of this Brief Analysis (No. 251), contact the National Center for Policy Analysis, Suite 720, Attn. Jan Chisholm, (972) 386-6272; or visit Website *http://www.ncpa.org* on the Internet.

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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.

"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.

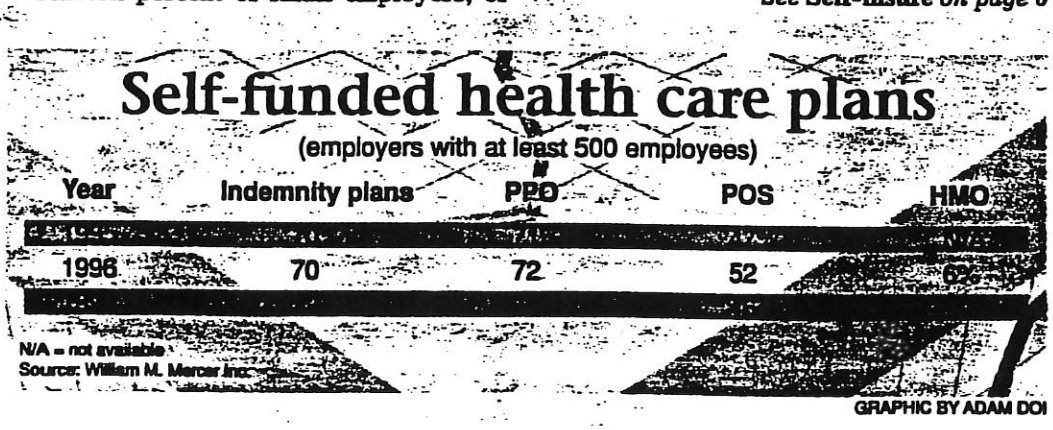
GTE has self-funded about a half-dozen HMOs for about three years, though it does not yet self-insure any of the HMOs with which it contracts in New York because it doesn't have enough HMO enrollees in that state to make it worthwhile, according to Mr. Taylor.

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.

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



GRAPHIC BY ADAM DOI

"T[illegible]sic question facing health care 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.

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THE CHAMBER
Greater Kansas City Chamber of Commerce

TESTIMONY BEFORE THE HOUSE INSURANCE COMMITTEE
ON HB 2005
by Bob Vancrum
Chairman, Kansas State Affairs Committee, Greater Kansas City Chamber of Commerce

January 21, 1999

Thank you Chairman Tomlinson and committee members.

As chairman of the Kansas State Affairs Committee of the Greater Kansas City Chamber of Commerce, I am here to express The Chamber's strong support for HB 2005, which requires that all new mandates be tested on the state health care benefits program so that the Legislature may study their costs and benefits.

Virtually all private sector health care is purchased by employers for their employees. It is a non-taxable benefit to the employee and a fully deductible business expense to employers. Combined with the purchasing power of large groups, the very competitive market for employees and the collective bargaining practices of unions, Kansas employers have a huge interest in health insurance issues.

The Chamber has long expressed blanket opposition to insurance mandates for two principal reasons: 1) Increases in coverage or the types of providers which must be reimbursed for services increases the cost of health care and correspondingly, the premiums of health insurance. 2) Employers and employees like to design their own benefit packages that best suit the needs of their workforce, which may vary widely from industry to industry. Mandates tend to force a one-size-fits-all policy on employers and employees alike.

Government action which raises costs or imposes unwanted coverage on employers can result in fewer employees being covered, fewer dependents electing coverage, greater costs to employers and employees alike, an election to get out from under state insurance laws by self-insuring or the complete abandonment of a group health plan altogether. Small businesses, and their employees, who are most affected by state mandates, are the least able to absorb increased health insurance costs. None of these results benefit Kansans.

HB 2005 appears to be a responsible attempt to measure the costs and benefits of the various mandates that will be proposed and to evaluate them in a real world setting. The concept of the bill truly puts legislators in the shoes of employers in evaluating the costs and benefits of health insurance coverages and we believe it will result in a more practical, rather than political, approach to the issues of health insurance coverage.

Thank you for permitting me to testify on this issue and for your consideration of The Chamber's position on HB 2005.

Attachment #8
1-29-99
House Insurance Comm.

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816/221-2424 • FAX 816/221-7440 • www.kcchamber.com

Testimony To The

HOUSE INSURANCE COMMITTEE

By
Terry D. Bernatis
Health Benefits Administrator

Thursday, January 21, 1999
RE: House Bill 2005 – Health insurance mandates in the state of Kansas Health Benefits Plan prior to implementation of mandates statewide

Mr. Chairperson and members of the committee. Thank you for the opportunity to appear before you today regarding House Bill 2005. I appear as neither a proponent nor opponent of the bill. Rather, I would like to provide you information that you may wish to consider during your deliberations.

The first issue I would like to bring to your attention is that the timeframe outlined in the bill for the collection of claims information may not be adequate to provide a complete picture of utilization and cost. Given that the state's health care plan is on an annual basis, claims information at the very earliest will not be available until April of a plan year. In order to conduct the analysis and provide a report by the first of the next Plan Year (i.e. the day of the Governor's budget submission) utilization data will only be available through approximately October. Therefore, at the best, there will only be six or seven months of immature data upon which the utilization and cost analysis will be performed and a report written. Lengthening the timeframe to 18 months will allow analysis of a full year of mature data and will also allow an analysis of any migration between plans as a result of the mandates.

The second issue deals with timing of the effective date of the mandate. The Health Care Commission has contracted for multiyear contracts. Carriers provide their rate requests for the next plan year in April based on caps in the contract. Insurance carriers will likely reserve the option to change premium rates if the mandates are not effective at the beginning of the next plan year. Effective dates other than the beginning of the plan year will have the effect of changing premium rates during the plan year. The composite rate, the rate charged to the agencies for the employer contribution, would

House Commerce
Attachment # 9
1-29-99

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need to be adjusted mid-year. This makes it more difficult to budget for the cost of the health plan. Just for an historical perspective, there has not been a mid-year adjustment since 1995.

Thank you. I stand for questions.

OVERLAND PARK
CHAMBER OF COMMERCE

January 21, 1999

The Honorable Robert Tomlinson
Chairman, House Insurance Committee
State House
Topeka, KS 66612

Dear Chairman Tomlinson and Members of the Committee:

As chairman of the chamber's State/Federal Affairs Task Force, I am writing to express the chamber's strong support for HB 2005, which directs that new health insurance mandates shall apply only to the state employees' health care program for at least one year, to be followed by a cost/benefit analysis and a recommendation as to whether such mandates should apply to all private policies.

Health insurance mandates are a top concern of chamber members. New mandates increase the costs of health insurance. Higher costs mean fewer employers can afford to provide critical health care coverage for employees and their families, particularly among small businesses.

Passage of HB 2005 would be a positive step toward addressing this issue. Trial implementation within the state employees' system would provide strong empirical evidence regarding the impact of new mandates. This information would be instrumental in avoiding unintended consequences and ensuring that any increased costs, borne by all Kansans, are justified by significant and appropriate benefits.

For these reasons, the chamber respectfully urges the House Insurance Committee to recommend HB 2005 favorably for passage. Thank you for your time and consideration of our position.

Sincerely,

G. Eugene Troehler

G. Eugene Troehler
Chairman, State/Federal Affairs Task Force

Kansas Commerce Fed.
Attachment #10
1-29-99

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