Approved: February 8, 1999
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE .

The meeting was called to order by Chairperson Senator Don Steffes at 9:00 a.m. on February 3, 1999, in Room 529 S of the Capitol.

All members were present except:

Committee staff present: Dr. Bill Wolff, Research
Ken Wilke, Office of Revisor
Nikki Feuerborn, Committee Secretary

Conferees appearing before the committee: Linda DeCoursey, Kansas Insurance Department
Representative Carlos Mayans
John Pepperdine, American Cancer Society
Bob Williams, Kansas Pharmaceutical Association
Meg Draper, Kansas Medical Society
Larrie Ann Brown, KS Assoc of Health Plans
Terry Leatherman, KCCI
Jim Schwartz, KS Employer Coalition on Health
Chris McKenzie, KS League of Municipalities
Bob Kennedy, Assistant Commissioner of Insurance
John Peterson, Peterson Public Affairs Group
Marty Hazen, Kansas Insurance Department

Others attending: See Attached

Linda DeCoursey, Kansas Insurance Department, requested the conceptual introduction of legislation on Medicare Supplement policies for individuals with a disability (Attachment 1). This would create a mechanism within the Kansas Health Insurance Association (high risk pool) to spread the risk evenly and fairly.

Senator Feleciano moved for the introduction of legislation as conceptually requested by the Insurance Department. Motion was seconded by Senator Barone. Motion carried.

Senator Steffes requested the introduction of conceptual legislation concerning insurance and insurance guaranty association assessments (TIAA-CREFF) (Attachment 2).

Senator Feleciano moved for the introduction of legislation which would address this on-going issue. Motion was seconded by Senator Becker. Motion carried.

Senator Feleciano moved for the conceptual introduction of legislation addressing the exorbitant interest rates charged by Payday Loan companies and how to have such consumer issues fall under the auspices of the UCCC . Motion was seconded by Senator Praeger. Motion carried.

Hearing on SB 108 - Coverage for off-label use of prescription drugs

Representative Carlos Mayans recommended insurance coverage for drugs when they are prescribed by a physician but the condition for which they are being given is not specified on the drug label. He explained that many such drugs are used in the treatment of cancer and/or pain management associated with cancer and are prescribed by oncologists who have found success with said drugs. Representative Mayans said this bill was about fairness for those who are suffering. This should not be considered a mandate.

John Pepperdine, American Cancer Society, explained that after a drug has approval from the FDA, physicians may legally prescribe the drug for other conditions or diseases (Attachment 3). Health insurers are oftentimes reluctant to allow "off-label" reimbursement and this causes a great financial burden on many cancer patients as well as emotional stress.

Bob Williams, Kansas Pharmaceutical Association, said they advocated the removal of restrictions on reimbursement for pharmaceutical services and FDA-approved products when it is recommended by a

physician with the approval of a pharmacist (Attachment 4). Many drugs are approved but lack information on pediatric dosage. He requested that Pharmacy Benefit Management Companies be included in the bill. He asked if the bill as currently written would include drugs which insurance companies do not include in their formulary.

Meg Draper, Kansas Medical Society, said they supported the proposed insurance coverage of off-label drugs as it is a common and acceptable practice by physicians (Attachment 5). She used the example of a drug approved by the FDA to treat depression is often prescribed to treat migraine headaches or chronic pain.

Written testimony was received from the Association of Kansas Hospices (Attachment 6).

Larrie Ann Brown, Kansas Association of Health Plans, said they did not support the bill due to the idea of mandating health insurance benefits causing a financial impact on small businesses offering health insurance to their employees (Attachment 7). She questioned the number of insurance companies who refuse reimbursement for "off-label" drugs.

Terry Leatherman, KCCI, presented testimony in opposition to what they consider a mandate (Attachment 8). This legislation would demand coverage for any drug prescribed by a physician who could justify his/her treatment decision with an opinion from a medical journal. This could greatly increase the cost of insurance for individuals and small group policy holders.

Jim Schwartz, Kansas Employer Coalition on Health, Inc., reminded the Committee that one-half of the small businesses who offer health plans do not have prescription drug coverage (Attachment 9). This bill would make it very difficult for insurance companies to work with physicians in determining medical necessity. He voiced concern about such legislation opening the door to "quackery" for vulnerable patients.

Written testimony was later submitted by Kansas Public Health Association, Inc. (See Attachment 15).

Senator Steffes declared the Hearing closed.

Hearing on SB 79 - Municipal funded pools

Bob Kenney, Assistant Insurance Commissioner, explained that this bill fills in gaps in their regulatory authority over group self-funded pools (Attachment 10). This bill is particularly addressed to municipal group funded pools (cities and counties) and pools providing workers compensation coverage for employees. He reported they have had good experience with workers compensation pools. Problems arise when during investigations management is unwilling to accept the ruling of the KID regarding insolvency issues and they end up in court instead of implementing plans for rehabilitation. They have had problems with nine accident and health pools but now are down to one which is in litigation. This proposed legislation would allow reasonable changes to the group pool laws to strengthen the KID's ability to protect the solvency of pools. They want the ability to work early with management of pools to avoid potential problems. This bill would also grant broader investment powers to pools.

Hoot Gibson, Co-Chairman of Kansas Workers' Compensation Pool Coalition, presented written neutral testimony (Attachment 11).

Chris McKenzie, Kansas League of Municipalities, spoke in opposition for the Kansas Workers' Compensation Coalition (Attachment 12). He gave the history and success of the pool and listed the following concerns with this proposed legislation:

Approval of excess insurance (may be inconsistent with market)
Investment authority (same as insurance companies) (cannot use repurchase authority)
Language may prevent formation of pools by a future Insurance Commissioner

Chairman Steffes declared the Hearing closed.

Action on SB 60 - Title insurance; escrow accounts

Senator Feleciano announced he had met with the title companies, John Peterson, Kansas Insurance Department, Kansas Association of Realtors, and Johnson County Realtors and they have found the attached language in the amendment to be acceptable (Attachment 13). This deals with irrevocable letters of credit and

the surety bond issues based upon population of the counties involved. A $25,000 surety bond would cost between $250-$500.

Senator Feleciano moved that the proposed amendment be adopted and the revisor place the proposed language in the correct position in the bill. Motion was seconded by Senator Praeger. Motion carried.

John Peterson, representing the Kansas Title Companies Association, presented an amendment regarding "Good Funds" (limiting the type of funds acceptable for real estate closings) (Attachment 14).

Senator Feleciano moved to adopt the proposed amendment as presented. Motion was seconded by Senator Corbin. Motion carried with one dissenting vote.

Marty Hazen of the Insurance Department told the Committee that the title insurance companies want the oversight of their industry to be in the Insurance Department and do not view this as being in the banking arena.

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

The Committee requested the revised and amended bill be presented to them before it is run on the Senate floor.

The meeting was adjourned at 10:00 a.m. The next meeting will be on February 4, 1999.

SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE GUEST LIST

DATE: February 3, 1999

NAME	REPRESENTING
Linda McCarthy	KS Insurance Dept.
Teresa Dingfelder	HIAA
Art Gibson	BNSF
Kayrie S. McFarland	KS Homes & Services Aging
Bob Williams	KS Pharmacists Assoc
Bob Anderson	"
Rebecca Sanders	Kansas Insurance Dept
Paul Davis	Kansas Insurance Dept.
Dick Cook	" " "
Marty Kaye	" " "
David Hanson	KS Trial Attorneys Assoc.
Mary Spinks	DRS
Cyndria Giles	KS Health Care Assoc
Kathy Damron	St. Luke Evangelical Mission
Tom Bruno	AKIT
Rich Guthrie	Health Midwest
Michelle Peterson	PhRMA
Larry K Shaffer	KS Hosp Assoc.
Virginia Starr	Federico Consulting
Steve Montgomery	United Health Care
Meg Draper	KMS
Alan Steppat	A.E. Steppat & Co.
JEAN NEAL	SMITHKLINE BEECHAM

SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE GUEST LIST

DATE: _____

NAME	REPRESENTING
Pat Morris	KAIA
Bill Curtis	Ks Assoc. of School Bds
Larrie Ann Brown	KAHP

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

To: Senate Committee on Financial Institutions & Insurance

From: Linda J. De Coursey

Re: Bill Introduction Request – Medicare Supplement Disability Insurance

Date: February 3, 1999

Mr. Chairman and members of the committee:

On be half of Insurance Commissioner, Kathleen Sebelius, I am asking this committee to introduce a bill concerning Medicare Supplement policies to individuals with a disability.

Prior to April 28, 1996, health insurers which sold Medicare Supplement policies to disabled applicants were permitted to medically underwrite the policies and could turn down individuals for coverage. In 1996, the Insurance Department issued regulations which required all insurance carriers to issue policies to the disabled at a reduced rate. We are preparing to require further reduction in the Medicare Supplement rates for disabled policyholders.

The Department believes that a mechanism needs to be created to spread the risk evenly and fairly among insurers. In the past, we have look at several ideas to accomplish this task, including asking for premium tax credits for those companies selling Medicare Supplement policies to the disabled. The bill we are now requesting would establish a reinsurance mechanism within the Kansas Health Insurance Association (high risk pool) to accomplish that purpose. This bill would not have a fiscal impact on state revenues.

We are asking for your conceptual introduction of the bill. We are putting the finishing touches on the bill draft and will deliver a draft to your Revisor later in the week.

Senate Financial Institutions & Insurance
Date 2/3/99
Attachment # 1

420 SW 9th Street
Topeka, Kansas 66612-1678

785 296-3071
Fax 785 296-2283

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

Session of 1997

SENATE BILL No. 226

By Committee on Financial Institutions and Insurance

2-7

~~AN ACT concerning insurance; reciprocity under certain conditions of certain amounts; amending K.S.A. 40-2702 and repealing the existing section.~~

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

Section 1. K.S.A. 40-2702 is hereby amended to read as follows: 40-2702. (a) As used in this act, unless the context otherwise requires, the term "insurer" means and includes all corporations, companies, associations, societies, fraternal benefit societies, mutual nonprofit hospital service and nonprofit medical service companies, partnerships and persons engaged as principals in the business of insurance of the kinds enumerated in articles 4, 5, 6, 7, 11, 18, 19, 19a, 19b, 19c, 22, 32 and 38 of chapter 40 of the Kansas Statutes Annotated, and ~~any~~ amendments thereto, insofar as the business of insurance of the kinds enumerated in such articles relate to life and accident or sickness. Whenever in this section there is reference to an act effected or committed by mail, the venue of such act shall be at the point where the matter transmitted by mail is delivered and takes effect.

It shall be unlawful for any insurer to transact insurance business in this state, as set forth in subsection (b) of this section, without a certificate of authority from the commissioner of insurance. This section shall not apply to:

(1) The lawful transaction of insurance procured by agents under the authority of K.S.A. 40-246b, 40-246c and 40-246d, and amendments thereto, relating to accident and sickness insurance;

(2) contracts of reinsurance issued by an insurer not organized under the laws of this state;

(3) transactions in this state involving a policy lawfully solicited, written and delivered outside of this state, covering only subjects of insurance not resident in this state at the time of issuance and which transactions are subsequent to the issuance of such policy;

(4) attorneys acting in the ordinary relation of attorney and client in the adjustment of claims or losses;

(5) transactions in this state involving group life and group sickness and accident or blanket sickness and accident insurance or group annui-

AN ACT concerning insurance and insurance guaranty association assessments; reciprocity under certain conditions of certain amounts; amending K.S.A. 40-2702 and repealing the existing section; and amending K.S.A. 40-3006(a) and K.S.A. 40-3009(e).

Senate Financial Institutions & Insurance

Date 2/3/99

Attachment # 2

s, where the master policy of such groups was lawfully issued and de-
ered in and pursuant to the laws of a state in which the insurer was
thorized to do an insurance business to a group organized for purposes
her than the procurement of insurance and where the policyholder is
miciled or otherwise has a bona fide residence;

(6) transactions in this state involving any policy of life or accident
d health insurance or annuity contract issued prior to the effective date
this act;

(7) contracts of insurance written by certain lodges, societies, persons
d associations specified in K.S.A. 40-202, and amendments thereto, and
ganizations preempted from state jurisdiction as a result of compliance
ith both the employees retirement income security act of 1974, as
nended, including all bonding provisions, and paragraph (9) of subsec-
on (c) of section 501 of the internal revenue code; and

(8) any life insurance company *which is not subject to guaranty fund assessments by the insurance company's state of domicile* organized and
perated, without profit to any private shareholder or individual, exclu-
ively for the purpose of aiding and strengthening educational institutions,
rganized and operated without profit to any private shareholder or in-
ividual, by issuing insurance and annuity contracts directly from the
ome office of the company, without insurance agents or insurance rep-
esentatives in this state, only to or for the benefit of such institutions
nd individuals engaged in the services of such institutions, but this ex-
mption shall be conditioned upon any such company complying with the
ollowing requirements:

(i) Payment of an annual registration fee of $500;

(ii) filing a copy of the form of any policy or contract issued to Kansas
esidents with the commissioner of insurance;

(iii) filing a copy of its annual statement prepared pursuant to the
aws of its state of domicile, as well as such other financial material as
may be requested, with the commissioner of insurance; and

(iv) providing, in such form as may be prescribed by the commis-
sioner of insurance, for the appointment of the commissioner of insurance
as its true and lawful attorney upon whom may be served all lawful process
in any action or proceeding against such company arising out of any policy
or contract it has issued to, or which is currently held by, a Kansas citizen
and process so served against such company shall have the same force
and validity as if served upon the company.

(b) Any of the following acts in this state effected by mail or otherwise
by or on behalf of an unauthorized insurer is deemed to constitute the
transaction of an insurance business in this state:

(1) The making of or proposing to make, as an insurer, an insurance
contract;

(2) the taking or receiving of any application for insurance;

(3) the receiving or collection of any premium, commission, membership fees, assessments, dues or other consideration for any insurance or any part thereof;

(4) the issuance or delivery of contracts of insurance to residents of this state or to persons authorized to do business in this state;

(5) directly or indirectly acting as an agent for or otherwise representing or aiding on behalf of another any person or insurer in the solicitation, negotiation, procurement or effectuation of insurance or renewals thereof or in the dissemination of information as to coverage or rates, or forwarding of applications or delivery of policies or contracts or investigation or adjustment of claims or losses or in the transaction of matters subsequent to effectuation of the contract and rising out of it or in any other manner representing or assisting a person or insurer in the transaction of insurance with respect to subjects of insurance resident in this state. Nothing herein shall be construed to prohibit full-time salaried employees of a corporate insured from acting in the capacity of an insurance manager or buyer in placing insurance in behalf of such employer;

(6) the transaction of any kind of insurance business specifically recognized as transacting an insurance business within the meaning of the statutes relating to insurance; or

(7) the transacting of or proposing to transact any insurance business, in substance equivalent to any of the foregoing, in a manner designed to evade the provisions of this act.

(c) (1) The failure of an insurer transacting insurance business in this state to obtain a certificate of authority from the commissioner of insurance shall not impair the validity of any act or contract of such insurer and shall not prevent such insurer from defending any action at law or suit in equity in any court of this state, but no insurer transacting insurance business in this state without a certificate of authority shall be permitted to maintain an action in any court of this state to enforce any right, claim or demand arising out of the transaction of such business until such insurer shall have obtained a certificate of authority.

(2) In the event of failure of any such unauthorized insurer to pay any claim or loss within the provisions of such insurance contract, any person who assisted or in any manner aided, directly or indirectly, in the procurement of such insurance contract shall be liable to the insured for the full amount of the claim or loss in the manner provided by the provisions of such insurance contract.

Sec. 2. K.S.A. 40-2702 is hereby repealed.

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

Sec. 3. K.S.A. 40-3006(a) is hereby amended to read as follows:

Sec. 4 K.S.A. 40-3009(e) is hereby amended to read as follows:

Sec. 5 Sections 1 and 2 of this Act shall take effect and be in force from and after their publication in the statute book and Sections 3 and 4 of this Act shall take effect and be in force and effect with respect to insurer impairments and insolvencies occurring on or after January 1, 1999.

by member insurers, except as limited by this act.

History: L. 1972, ch. 190, § 3; L. 1984, ch. 161, § 4; L. 1986, ch. 229, § 23; L. 1986, ch. 180, § 2; L. 1986, ch. 181, § 1; May 15.

40-3004. Liberal construction. This act shall be liberally construed to effect the purpose under K.S.A. 40-3002 which shall constitute an aid and guide to interpretation.

History: L. 1972, ch. 190, § 4; July 1.

40-3005. Definitions. As used in this act:

(a) "Account" means either of the three accounts created under K.S.A. 40-3006 and amendments thereto;

(b) "association" means the Kansas life and health insurance guaranty association created under K.S.A. 40-3006;

(c) "commissioner" means the commissioner of insurance of this state;

(d) "contractual obligation" means any obligation of a policy or contract or certificate under a group policy or contract, or portion thereof, for which coverage is provided under K.S.A. 40-3003 and amendments thereto;

(e) "covered policy" means any policy or contract within the scope of this act under K.S.A. 40-3003 and amendments thereto;

(f) "impaired insurer" means a member insurer which, after the effective date of this act, is not an insolvent insurer, and which: (1) Is deemed by the commissioner to be potentially unable to fulfill its contractual obligations; or

(2) is placed under an order of rehabilitation or conservation by a court of competent jurisdiction;

(g) "insolvent insurer" means a member insurer which, after the effective date of this act, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency;

(h) "member insurer" means any insurer licensed or holding a certificate of authority to transact in this state any kind of insurance for which coverage is provided under K.S.A. 40-3003 and amendments thereto, and includes any insurer whose license or certificate of authority in this state may have been suspended, revoked, nonrenewed or voluntarily withdrawn, but does not include: (1) A nonprofit hospital or medical service organization;

(2) a health maintenance organization;

(3) a fraternal benefit society;

(4) a mandatory state pooling plan;

(5) a mutual assessment company or any entity that operates on an assessment basis;

(6) an insurance exchange, except a reciprocal or interinsurance exchange governed by the provisions of article 16 of chapter 40 of the Kansas Statutes Annotated; or

(7) any entity similar to any of the above;

(i) "Moody's corporate bond yield average" means the monthly average corporates as published by Moody's investors service, inc., or any successor thereto;

(j) "premiums" means amounts received on covered policies or contracts less premiums, considerations and deposits returned thereon, and less dividends and experience credits thereon. Premiums does not include any amounts received for any policies or contracts or for the portions of any policies or contracts for which coverage is not provided under subsection (b) of K.S.A. 40-3003 and amendments thereto, except that assessible premiums shall not be reduced on accounts for subsection (n)(3) of K.S.A. 40-3008 and amendments thereto relating to interest limitations and subsection (o)(2) of K.S.A. 40-3008 and amendments thereto relating to limitations with respect to any one life and any one contract holder. Premiums shall not include any premiums on any unallocated annuity contract;

(k) "person" means any individual, corporation, partnership, association or voluntary organization;

(l) "resident" means any person who resides in this state at the time a member insurer is determined to be an impaired or insolvent insurer and to whom a contractual obligation is owed. A person may be a resident of only one state which, in the case of a person other than a natural person, shall be its principal place of business;

(m) "unallocated annuity contract" means any annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under such contract or certificate; and

(n) "supplemental contract" means any agreement entered into for the distribution of policy or contract proceeds.

History: L. 1972, ch. 190, § 5; L. 1986, ch. 180, § 3; July 1.

40-3006. Kansas life and health insurance guaranty association, creation; members; functions and powers; accounts; under supervision of commissioner and insurance laws of state; meetings or records. (a) There is hereby created a nonprofit legal entity to be known

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as the Kansas life and health insurance guaranty association. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under the plan of operation established and approved under K.S.A. 40-3010 and amendments thereto and shall exercise its powers through a board of directors established under K.S.A. 40-3007 and amendments thereto. ~~For purposes of administration and assessment, the association shall maintain three accounts: (1) The health insurance account; (2) the life insurance account, and (3) the annuity account, excluding unallocated annuities.~~

For purposes of administration and assessment, the association shall maintain two accounts:

(1) the health insurance account; and

(2) the life insurance and annuity account which includes the following subaccounts:

(a) life insurance subaccount;

(b) annuity subaccount, excluding unallocated annuities; and

(c) contracts qualified under Section 403(b) of the United States Internal Revenue Code.

(b) The association shall come under the immediate supervision of the commissioner and shall be subject to the applicable provisions of the insurance laws of this state. Meetings or records of the association may be opened upon majority vote of the board of directors of the association.

History: L. 1972, ch. 190, § 6; L. 1986, ch. 180, § 4; July 1.

40-3007. Board of directors of association; selection; approval; vacancies; compensation. (a) The board of directors of the association shall consist of not less than five nor more than nine member insurers serving terms as established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the commissioner. Vacancies on the board shall be filled for the remaining periods of the terms by a majority vote of the remaining board members, subject to the approval of the commissioner. To select the initial board of directors, and initially organize the association, the commissioner shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member insurer shall be entitled to one vote in person or by proxy. If the board of directors is not selected within 60 days after notice of the organizational meeting, the commissioner may appoint the initial members.

(b) In approving selections or in appointing members to the board, the commissioner shall consider, among other things, whether all member insurers are fairly represented.

(c) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the

(3) borrow money to effect the purposes of this act. Any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;

(4) employ or retain such persons as are necessary to handle the financial transactions of the association, and to perform such other functions as become necessary or proper under this act;

(5) take such legal action as may be necessary to avoid payment of improper claims; or

(6) exercise, for the purposes of this act and to the extent approved by the commissioner, the powers of a domestic life or health insurer, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform its obligations under this act.

(q) The association may join an organization of one or more other state associations of similar purposes to further the purposes and administer the powers and duties of the association.

History: L. 1972, ch. 190, § 8; L. 1986, ch. 180, § 6; L. 1993, ch. 130, § 1; July 1.

40-3009. Assessment of member insurers to provide funds for administration of association; classes of assessment; limitations; refunds to insurers; certificates of contribution. (a) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. Assessments shall be due not less than 30 days after prior written notice to the member insurers and shall accrue interest at 15% per annum on and after the due date.

(b) There shall be two classes of assessments, as follows: (1) Class A assessments shall be made for the purpose of meeting administrative and legal costs and other expenses and examinations conducted under the authority of subsection (e) of K.S.A. 40-3012 and amendments thereto. Class A assessments may be made whether or not related to a particular impaired or insolvent insurer.

(2) Class B assessments shall be made to the extent necessary to carry out the powers and duties of the association under K.S.A. 40-3008 and amendments thereto with regard to an impaired or an insolvent insurer.

(c) (1) The amount of any class A assessment shall be determined by the board and may be made on a pro rata or non-pro rata basis. If pro rata, the board may provide that it be credited against future class B assessments. A non-pro rata assessment shall not exceed $150 per member insurer in any one calendar year. The amount of any class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

(2) Class B assessments against member insurers for each account shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account for the three most recent calendar years for which information is available preceding the year in which the insurer became impaired or insolvent, as the case may be, bears to such premiums received on business in this state for such calendar years by all assessed member insurers.

(3) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be made until necessary to implement the purposes of this act. Classification of assessments under subsection (b) and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

(d) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section.

(e) ~~The total of all assessments upon a member insurer for each account shall not in any one calendar year exceed 2% of such insurer's average premiums received in this state on the policies and contracts covered by the account during the three calendar years pre-~~

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~~ceding the years in which the insurer became an impaired or insolvent insurer.~~

If the maximum assessment, together with the other assets of the association in any account does not provide in any one year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by this act.

The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(f) The board, by an equitable method as established in the plan of operation, may refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, net realized gains and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses.

(g) It shall be proper for any member insurer, in determining its premium rates and policyowner dividends as to any kind of insurance within the scope of this act, to consider the amount reasonably necessary to meet its assessment obligations under this act.

(h) The association shall issue to each insurer paying an assessment under this act, other than a class A assessment, a certificate of contribution, in a form prescribed by the commissioner, for the amount of the assessment paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the commissioner may approve.

History: L. 1972, ch. 190, § 9; L. 1986, ch. 180, § 7; July 1.

40-3010. Plan of operation; powers of commissioner; rules and regulations; mandatory and permissive provisions of plan; reimbursement for certain payments. (a) (1) The association shall submit to the commissioner a plan of operation and any amendments thereto

The total of all assessments upon a member insurer for the life and annuity account and for each subaccount thereunder may not in any one calendar year exceed 2% and for the health account may not in any one calendar year exceed 2% of such insurer's average premiums received in this state on the policies and contracts covered by the account during the three calendar years preceding the year in which the insurer became an impaired or insolvent insurer. If a one percent assessment for any subaccount of the life and annuity account in any one year does not provide an amount sufficient to carry out the responsibilities of the association, then pursuant to subsection (c)(1), the board shall access all subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in this subsection.

AMERICAN CANCER SOCIETY® Hope. Progress. Answers.

February 3, 1999

Written testimony by John Pepperdine
Manager of Government Relations

SUPPORT OF SENATE BILL 108 UNDER REVIEW BY THE SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

Thank you for allowing me to speak. My name is John Pepperdine and I am Manager of Government Relations for the American Cancer Society. Representing over 270,000 volunteers and supporters in Kansas, I am here to support Senate Bill 108 in it's current form.

After a drug is approved for one purpose, physicians legally may prescribe the drug for other purposes or diseases. This is called "off-label" use of drugs or use for "unlabeled indications." The US General Accounting Office estimates that about 56 percent of cancer patients received an off-label drug.

It is important to note that cancer is unique and depends on novel approaches, even more so than most diseases. Such novel approaches often require access to novel treatments and drugs. Unfortunately, this may be blocked by insurers who only cover FDA approved use of the drug. For the cancer patient, the risk of side effect is far less than the risk of death from cancer.

In the words of Dr. Katie Rhoades, a American Cancer Society Board member and volunteer as well as President-elect of the Kansas Medical Society, **"unforeseen numbness in the foot is a lot better than cancer progressing to the rest of your body."**

Many health insurers limit access to "off-label" uses of approved drugs by refusing to provide financial reimbursement for them. This presents an undue financial and emotional strain on cancer patients and may result in unnecessary suffering and even death if the treatment is denied.

Requiring FDA approval for every new indication may take more than five years each and millions of dollars on behalf of the drug manufacturers. In addition, once the patent for a drug expires, there is little incentive for the drug company to seek FDA approval for a new indication because the company may not be able to recoup the investment in research without exclusive manufacturing and marketing capability.

The American Cancer Society concurs with the FDA position that "off-label" use of approved cancer drugs may be an appropriate treatment regimen for many patients, as determined by medical experts and prescribed in accepted medical compendia and journals.

Continued

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AMERICAN CANCER SOCIETY® Hope. Progress. Answers.

Again, the American Cancer Society supports legislative and regulatory initiatives to require health insurance companies, Medicaid, Medicare, and public employee benefits plans to provide reimbursement for off-label use of approved cancer drugs, provided that such drugs have been recognized for treatment of the specific types of cancer in established medical reference compendia.

On a final note, insurers who have testified in the past, point out that legislation of this type or mandates are a burden to them. While this may be true, I would hope the committee not only looks at the burden on these companies but considers the burden placed on the individual cancer patient. The insurance providers may be forced to raise their rates, however, the cancer patient may be forced to decide between medication that can save their life or food on the table.

As of July 1998, 31 states had laws for private insurers to cover off-label use of drugs, including Missouri and Oklahoma. Our organization sincerely hopes Kansas will be the next state to enact such legislation.

Thank you for your time.

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THE KANSAS PHARMACISTS ASSOCIATION
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ROBERT R. (BOB) WILLIAMS, M.S., C.A.E.
EXECUTIVE DIRECTOR

TESTIMONY
Senate Committee on Financial Institutions and Insurance
February 3, 1999

SB-108

My name is Bob Williams, I am the Executive Director of the Kansas Pharmacists Association. Thank you for this opportunity to address the Committee.

I have attached to my testimony a copy of the testimony I presented to the Health Care Reform Legislative Oversight Committee this summer regarding off-label drug use. In that testimony you will find a brief description of the drug approval process, accepted texts recognized as authoritative resources on off-label uses, definitions of label and labeling, and examples of drugs and their off-label uses. I would like to reiterate that the Kansas Pharmacists Association does not have a policy specifically addressing the mandated coverage of off-label drug uses. However, the American Pharmacy Association advocates removal of restrictions on reimbursement of pharmaceutical services and FDA-approved products when, in the judgement of the pharmacist and physician, those products are for medically acceptable, off-label uses.

The Kansas Pharmacists Association is in support of SB108, however they do not think it goes far enough. We would suggest that SB-108 be modified to mandate the coverage of **all** off-label drug uses. We believe this would allow for better patient care and more positive outcomes.

Senate Financial Institutions & Insurance
Date 2/3/99
Attachment # 4

There are two areas we believe need to be clarified. Because Pharmacy Benefit Management Companies (PBMs) are not included in the listing of those entities mandated to cover drugs for off-label uses, it is our interpretation of SB-108 that PBMs would not be mandated to cover drugs for off-label uses. While it is not unusual for insurance companies to subcontract with PBMs to provide drug coverage, increasingly, as in the case of the state employee drug benefit program, employers are contracting directly with PBMs for drug coverage. Since PBMs are not defined as being insurance companies in Kansas, we suggest the Committee consider specifically identifying PBMs in New Sec. 2. In addition, SB-108 does not clearly identify if the mandating of off-label drug use would include drugs not listed on the insurance companies' (or PBMs) drug formulary. The Committee may also want to clarify this issue.

We encourage your support of SB-108. Thank you.

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ROBERT R. (BOB) WILLIAMS, M.S., C.A.E.
EXECUTIVE DIRECTOR

TESTIMONY
Health Care Reform Legislative Oversight Committee
September 22, 1998

Off-Label Drug Mandate

My name is Bob Williams, I am the Executive Director of the Kansas Pharmacists Association. Thank you for this opportunity to address the Committee.

While the Kansas Pharmacists Association does not have a policy specifically addressing the mandated coverage of off-label drug uses, the American Pharmacy Association advocates removal or restrictions on reimbursement of pharmaceutical services and FDA-approved products when, in the judgment of the pharmacist and physician, those products are for medically acceptable, off-label uses.

The Kansas Pharmacists Association has received member reports of difficulties and frustrations in seeking compensation for drugs dispensed for off-label but widely accepted indications and/or dosages.

A defined use for a drug approved by the Food and Drug Administration (FDA) can be included in a drug product's labeling only after the pharmaceutical manufacturer submits that use in a New Drug Application (NDA) or in a supplemental NDA, and gains approval for that use from the FDA.

The use of approved drugs for off-label uses is escalating. There are currently three accepted texts recognized as authoritative resources on off-label uses: the American Hospital Formulary Service Drug Information (AHFSDI); the American Medical Association Drug Evaluations (AMADE) and the United States Pharmacopeial Drug Information (USPDI). These texts establish and support the standards of practice for the use of FDA-approved drugs for off-label indications. These references are accepted by Blue Cross/Blue Shield and the Health Industry Association of America, however, there is substantial variation among these reference texts.

There is little incentive for manufacturers to supply FDA with studies or data on additional uses for new or established products. There are situations in which one company has pursued extensive indications when others who market the same drug under their own brand names have not. The decision to pursue additional indications for use often rests on financial rewards to be derived by the manufacturer. There was a piece related to off-label uses included in the Food and Drug Administration Modernization Act of 1997 (FDAMA). This provision allows pharmaceutical manufacturers to share information (i.e. medical journal articles) on off-label uses of FDA-approved products with certain health professionals or organizations such as physicians and PBMs. Although the FDA expresses no intent to influence payors in their decision as to whether a drug is covered for an off-label use, many payors respond by not paying for "unapproved uses."

The terminology linked to this subject contributes to some of the confusion that exists. The definitions of labeling and label are contained within the Food, Drug and Cosmetic Act (FDCA). Labeling refers to "all labels and other written, printed, or graphic matter upon any

articles or any of its containers or wrappers, or accompanying such article" (e.g. package inserts, advertisements). The term label refers to "a display of written, printed, or graphic matter upon the immediate container." When a product's label or labeling is false or misleading, the product is misbranded. Therefore, a pharmaceutical manufacturer or marketer that promotes or labels a product for an "unapproved" use is in violation of the FDCA because the product would be deemed "misbranded." The "package insert" often referred to as professional labeling, establishes the limits to be used by the company for promotion of the drug product. The FDCA does not, however, limit the manner in which a physician may use and approve drugs. Once a product has been approved for marketing, a physician may prescribe it for uses or in treatment regimes for patient populations that are not included in approved labeling. Such "unapproved," or more precisely "unlabeled" uses may be appropriate and rational in certain circumstances and may, in fact, reflect approaches to drug therapy that have been extensively reported in medical literature. A more suitable term is "off-label" use because the specific indication is not found in the labeling.

There are numerous examples of off-label uses of drugs that were well-established in the medical field long before the FDA officially approved their uses. For example, by 1969, the efficacy of propranolol in angina and hypertension were well-established. These uses were not approved by the FDA until 1973 for angina and 1976 for hypertension. Studies indicating amantadine's effectiveness in Parkinson's date back to 1969; the FDA did not approve its use in Parkinson's disease until 1976. The use of lidocaine for management of cardiac arrhythmias dates back to 1950 and was finally approved by the FDA for that use in 1969. Finally, diazepam

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was being used for status epilepticus in the early 1960's, but approval by FDA for that use did not occur until 1967.

Numerous drugs are currently being used for off-label indications. Some common examples include fluoxetine for weight loss, clonidine for the pain of shingles lesions, propranolol for generalized anxiety disorders associated with "stage freight" or "stress," and tetracycline for non-specific mouth ulcerations. According to one study, one-third of all uses for commonly used antineoplastic drugs were for off-label indications. Many pediatric doses of drugs are considered to be off-label.

Current FDA regulations dictate that a drug cannot be manufactured, packaged, or labeled for pediatric use unless the drug manufacturer has completed extensive testing on pediatric patients. Moreover, without such testing, the drug's manufacturer is prohibited from including instructions pertaining to pediatric use in its official dosing guidelines. In fact, according to the FDA, the dosing information for more than 80% of drugs approved between 1984 and 1989 for adult use contain no information whatsoever relevant to the administration of those drugs to pediatric patients.

Coverage and reimbursement for off-label use has been recognized as an important issue by numerous private insurers, the Health Care Financing Administration (HCFA), and state Medicaid departments. Coverage and reimbursement for what is determined to be "medically reasonable and necessary" has been the general standard for government and private third party payors. Views about what constitutes "medically reasonable and necessary" are quite varied.

While insurance companies and other third party payors provide reimbursement for labeled uses in accepted standards of practice, each company's policy varies in regard to

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compensation for off-label uses, evolving therapies, and investigational therapies. Some third party payors cover these drugs when established protocols have been followed and other medications have been tried beforehand without satisfactory outcomes. Some third party payors seem to view inclusion of an indication in the labeling as a prerequisite for coverage and reimbursement. An off-label use of a FDA-approved drug refers to a use which is not included in the approved labeling. An off-label use may be appropriate and rational in certain circumstances, and may reflect approaches to drug therapy that have been extensively reported. Because the FDA does not prefer comparative evaluations, and does not make an official determination about uses outside of the label that might affect a special population, such as those covered by Medicare, the FDA is comfortable with health professionals and third party payors making determinations on "medical necessity" beyond those based on the "safety and efficacy" standards that must be met for inclusion in the official label.

Thank you.

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KANSAS MEDICAL SOCIETY

February 3, 1999

TO: Senate Financial Institutions and Insurance Committee

FROM: Meg Draper M. Draper
Director of Government Affairs

SUBJ: SB 108: Coverage for off-label use of prescription drugs

The Kansas Medical Society appreciates the opportunity to testify on SB 108, which relates to off-label use of prescription drugs for cancer treatment and pain management. KMS supports giving physicians the flexibility to prescribe drugs for purposes other than those indicated on the label, using their medical judgment and in accordance with credible peer review literature.

Off-label prescribing is a common and acceptable practice by physicians. The Food and Drug Administration (FDA) comprehensively tests drugs for safety and effectiveness for a specific condition or conditions before allowing the drug to be marketed. Once a drug has been approved by the FDA, physicians may prescribe that drug for the purpose or purposes indicated on the drug label, but they may also prescribe it for an off-label use to achieve other therapeutic goals. Drugs are prescribed off-label for many different conditions. For example, a drug approved by the FDA to treat depression is often prescribed to treat migraine headaches or chronic pain. Other conditions for which drugs are prescribed off-label include cancer, obesity and AIDS, and these drugs often provide very effective treatment for these conditions.

KMS understands that most insurance companies that cover prescription drugs currently are covering drugs for off-label purposes. However, this bill covers only off-label drugs to treat cancer and manage pain. KMS encourages the committee to make sure that by passing this law, the legislature does not send a message to insurance companies that they should cover only cancer and pain management drugs, but no drugs for any other off-label purpose.

Thank you very much for considering our comments.

Senate Financial Institutions & Insurance
Date 2/3/99
Attachment # 5

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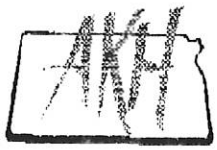

ASSOCIATION OF KANSAS HOSPICES

February 2, 1999

Dear Senators,

The Association of Kansas Hospices voices support for Senate Bill No. 108. Dealing daily with patients in pain, we are well aware of the appropriate utilization of prescription medications in managing pain and symptoms of discomfort. Patients need the availability of medications to relieve pain and nausea and other symptoms; physicians need the ability to prescribe as they determine appropriate; and, insurers need to know that drug utilization is appropriate. It appears to AKH that this bill provides a measure of support to each of these groups needs.

Consumers, who have paid for prescription coverage, need to receive appropriate medications to treat cancer and to minimize pain. To deny coverage for medications to a patient in need, who has secured coverage for prescriptions, is an unacceptable practice. Consumers have a right to expect that, when they pay for prescription coverage, insurers will cover legal and appropriate medications that the physician prescribes and can document as appropriate. Failing to offer such coverage causes additional grief, worry, fear and anger to those who are already suffering.

When dealing with cancer patients and persons in pain, physicians work diligently to determine what medications and treatments will best alleviate pain and suffering. Physicians need to be entrusted with the power to make these decisions based on careful thought and responsible practice. The bill requires that physicians provide, when asked, a documentation of the decision

Insurers need to know that prescription dollars are being well spent. The bill clearly states that illegal, contraindicated and non-approved drugs are automatically excluded. The bill gives the insurer right to ask for supporting documentation or, if you will, to hold the physician accountable for decisions. The bill speaks explicitly to cancer treatment and pain management. To deny coverage to patients needing cancer treatment and pain management seems unwarranted. The limitations and stipulations within the bill, related to unlawful, contraindicated, and experimental drugs, minimize the risk to the insurer.

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Senate Financial Institutions & Insurance

Date 2/3/99

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It is our belief that the bill addresses the needs of consumers, provides discretion to the physician, and allows the insurer to seek documentation. The bill, thereby, protects the insured, the insurer, and the public of Kansas. AKH supports S.B. No. 108.

Sincerely,

Donna M. Bales
President/CEO

Kansas Association
of Health Plans

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Testimony before the
Senate Financial Institutions and Insurance Committee
The Honorable Don Steffes, Chairman
Hearings on SB 108
February 3, 1999

Good Morning Chairman Steffes 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.

Although the KAHP has worked on language for this bill the KAHP does not generally support the idea of mandating health insurance benefits due to the financial impact a mandate could have on small businesses offering health insurance to their employees. Mandates raise costs and therefore decrease access to insurance. We know that nationwide every 1% of premium increase leads to 200,000 to 400,000 people losing their health insurance. Another result of the increased costs imposed by mandates is that employers may choose to self insure. Self insured plans are regulated by federal law, not state law. Not only do mandates passed by the Kansas Legislature not apply to self insured plans, the Kansas Legislature and the Kansas Insurance Department lose the ability to regulate plans once they become self insured. An off label drug use mandate, like all other health mandates, could have the effects of companies self

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insuring or people losing their health insurance. The KAHP also believes that the most effective regulation of health insurance takes place in the marketplace and not in a statute book.

KAHP members believe that mandate bills have not been in response to any substantive problems currently existing in the Kansas marketplace. In fact, health mandates have been enacted even where there has been no evidence that the proposed mandated benefits are not currently covered or that Kansans have been denied coverage. Mandated coverage of off label use appear to be similar in these respects to other mandate bills. Kansas managed care entities are currently covering medication even where it is prescribed for an off label use. A survey of KAHP members revealed a variety of coverage policies. Some plans make no distinction between coverage of medication prescribed for an approved use or an off label use. Other plans cover off label prescriptions as long as there is at least one study to support the drugs' off label uses. In some instances, coverage of medication requires establishment that certain medical criteria be met. However, coverage of these drugs is based not only on FDA labeled uses but uses supported in medical literature as well which includes off label uses. Because companies are not distinguishing between off label uses and FDA approved uses in making coverage decisions, a mandate of off label use coverage is unwarranted.

As I stated earlier KAHP members have been working on language for this bill. However this does not mean we support the idea of this mandate. If the committee feels that a mandate is needed we ask that you consider the language in the amendments before you. But, because Kansas consumers are currently receiving coverage of medication prescribed for an off label use, and because of the potential impact a health insurance mandate could have on small employers, KAHP members respectfully request that the committee not adopt SB 108. Thank you and I'll try to answer any questions you may have.

LEGISLATIVE TESTIMONY

Kansas Chamber of Commerce and Industry
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SB 108

February 3, 1999

KANSAS CHAMBER OF COMMERCE AND INDUSTRY

Testimony Before the

Senate Committee on Financial Institutions and Insurance

by

Terry Leatherman
Executive Director
Kansas Industrial Council

Mr. Chairman and members of the Committee:

I am 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 this opportunity to briefly explain why KCCI opposes further state coverage mandates to insurance policies, as called for in SB 108.

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 members who make up its various committees. These policies are organization and translate into views such as those expressed her

In the case of SB 108, insurance companies would be mandated to extend their prescription coverage in certain cases at the direction of a physician, who can justify his/her treatment decision

an opinion from a medical journal. As a result, SB 108 generates the same concerns for KC as other mandate issues. It represents government rulemaking into a private sector product. The bill also could make insurance more expensive for individual and small group policy holders, who already find it hard to locate affordable health insurance.

KCCI respectfully requests rejection of SB 108. I would be happy to attempt to answer any questions.

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Testimony to Senate Committee on Financial Institutions and Insurance on Senate Bill 108 (Off-Label Prescription Drug Mandates)

by James P. Schwartz Jr.
Consulting Director
February 3, 1999

Mr. Chairman, I'm Jim Schwartz with the Kansas Employer Coalition on Health. Since 1983 the Coalition has been the primary voice of corporate Kansas in matters of health insurance. Our membership of over 70 major employers covers about 250,000 Kansans for health care.

If there's a part of health insurance that lawmakers might be particularly reluctant to mandate, it's the area of drug benefits. Here are four reasons why.

First, and most generally, health insurance is not a right for working-age Americans. It's still a privilege accorded to whoever can pay for it. Labor and management make difficult tradeoffs between desirable coverages and other types of compensation, including wages. As a result, about a quarter of small businesses in Kansas sponsor no coverage at all. About a quarter of the ones that do sponsor coverage do not include a drug benefit. This is a fragile market. Anything the law does to burden that pony with additional baggage is risky.

Second, even where health insurance is a right, such as in Medicare, prescription drug coverage is not necessarily included, much less coverage for off-label use. We might wonder how we can justify mandating expanded drug coverage in the commercial population when such coverage is excluded entirely from the population that would benefit the most from it, the elderly.

Third, I fear we step onto a slippery slope when we venture down the path of off-label drug mandates. All health insurance policies try to limit coverage to include only treatments of proven safety and efficacy. To do otherwise is to subsidize quackery. I'm not suggesting that any particular off-label prescription is in any way improper. But I am suggesting that it will be difficult to enforce any reasonable standard of "medical necessity" if insurers must pay for drug uses other than intended ones. Unintended uses might best be thought of as experimental until they are shown to meet generally accepted criteria. And insurers, I'm sure you can appreciate, have to be very careful about how they cover experimental treatments. To mandate such coverage, even in as narrow an area as prescription dru[illegible] uncontrollable costs.

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Fourth, the timing of this deliberation suggests we ought to be concerned about how we might unintentionally fan the flames of medical inflation. According to a report released last fall by the Health Care Financing Administration, medical costs are expected to accelerate in the next year and continue to climb throughout the next decade. The report projects a doubling of costs, to $2.1 trillion during that time. The report further projects that of all the components of that inflation, the largest driver will be prescription drug costs.

There may be little you can do to prevent this resurgence of costs, but you certainly don't have to facilitate it. We ask you to say no to this mandate.

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Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

To: Senate Committee on Financial Institutions and Insurance

From: Bob Kennedy, Assistant Commissioner of Insurance

Re: S. B. 79 (Group Funded Pools)

Date: February 3, 1999

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to discuss Senate Bill 79. This bill fills in gaps in our regulatory authority over group self funded pools. In brief, the bill provides some financial solvency tools which exist for insurance companies but which are not provided for us in our financial oversight of pools. The bill addresses both (1) municipal group funded pools, established by cities and counties (K.S.A. 12-2616 et seq.) and (2) pools allowing employers to provide workers compensation coverage for their employees (K.S.A. 44-581 et seq.). These laws were designed to give cities and counties and employers the means to insure risks where coverage might not be available in the standard insurance market. Although the pool option was provided by the Legislature to allow municipalities and employer groups to self insure in difficult insurance markets, it has also proven to be a very valuable mechanism to stimulate competition in the standard insurance market and to bring down prices, especially in workers compensation. In addition, and more importantly, we have found that most workers compensation pools provide better and more hands-on loss prevention and loss control measures for their members than many employers enjoy with standard workers compensation insurance companies. In brief, these are mechanisms that work well and which provide benefits beyond supplying a source for self-insurance.

Over the 10-15 years since these laws were enacted by the Legislature, we have had to manage several of these pools because they got into financial difficulty. In the case of several workers compensation pools, we have succeeded in rehabilitating or helping the pools return to good financial health. Those successes were the result of good partnerships between the pools and our Department and the sincere efforts of people managing the pools. In 1998, we had severe problems with several municipal pools, which culminated in an Attorney General's opinion pointing out several gaps in our regulatory

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authority. Basically, this opinion concluded we have few choices other than proceeding to court and putting a group pool into court supervised receivership. None of the rehabilitation or preventive tools we have available in our supervision of insurance companies, such as some kind of control over the rates they charged for coverage and the ability to force management to sit down and come up with a corrective plan to turn a pool around, are available to us.

As a result the Commissioner concluded we needed to propose reasonable changes to the group pool laws to strengthen our ability to protect the solvency of pools.

In addition to strengthened financial solvency tools, the bill proposes reasonable expansion of current law to give experienced pools the flexibility to better manage idle funds and their allocations for pool expenses. The proposed changes would retain current restrictions on pool's allocations of expenses for new pools, until they can demonstrate the ability to manage pool experience.

In brief, Senate Bill 79 makes the following changes to current statutes:

Section 1 (K.S.A. 12-2618) - Clarifies the authority the Commissioner has to approve excess insurance policies used by the municipal group funded pool, to insure the pool selects the kind of insurance that fully protects them.

Section 2 (K.S.A. 12-2620) – Requires a municipal pool to file with the commissioner an actuarial certification that their rates are actuarially sound, unless they use rates from an approved rating organization.

Allows the Commissioner to use the same rehabilitation tools presently available for insurance companies (K.S.A. 40-222b) in dealing with pools in need of corrective action.

Section 3 (K.S.A. 1998 Supp. 12-2621) - Allows the commissioner to permit experienced pools to allocate a different percentage of assessment to the claims fund and to expenses, so long as their solvency would not be endangered. Currently, the law fixes the percentage of assessments to the claims fund and to expenses at 70% and 30% respectively, with no exceptions. Any pool, which has operated at least five years, could seek permission to use a different claim/expense ratio.

Section 4 - Allows municipal pools to invest idle funds in the same investments as HMOs are now allowed to invest. Under current law, pools are restricted to government instruments or deposits in insured banks.

Section 5 (K.S.A. 1998 Supp. 12-2627) – Requires the administrator of the financial affairs of the pool be an experienced administrator of group or self-funded pools, a licensed third party administrator, or a risk manager. It is our intent to allow "grandfathering" of current administrator of pools in Kansas, but of similarly qualified persons who may be retained by the pool in the future. We do not believe that

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the pool should be limited to consideration of only risk managers or administrators with certain degrees or designations.

Section 6 (K.S.A. 1998 Supp. 44-584) – Clarifies the Commissioner can use existing insurance company rehabilitation tools for workers compensation self-funded pools also. [Same as section 2]

Section 7 (K.S.A. 1998 Supp. 44-585) - Allows the Commissioner to permit experienced pools to use a different claims/expense allocation. [Same as Section 3]

Section 8 (K.S.A. 44-586) - Allows work comp pools to invest idle funds in the same investments as HMOs are now allowed to invest. [Same as Section 4]

S. B. 79 would provide the Insurance Department with improved regulatory authority over municipal group funded pools and employer workers compensation pools. We believe these changes are necessary given the potential financial problems which pools may face in the future. I urge your support for S.B. 79.

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TESTIMONY BEFORE THE SENATE

FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

BY HOOT GIBSON, CO-CHAIRMAN

KANSAS WORKERS' COMPENSATION POOL COALITION

FEBRUARY 3, 1999

Chairman Steffes and members of the committee, Senate Bill 79 was introduced at the request of the Kansas Insurance Department. Kansas group self-funded workers' compensation pools are for the most part supportive of the majority of the changes proposed in Senate Bill 79. Specifically, the pools were pleased that the insurance department provided parameters for relaxing loss/administration fund allocation as well as the opportunity for expansion of investment options. However, workers' compensation pools that were formed under Chapter 12 are not supportive of the proposed changes to their pools with the exception of the department's relaxation of the losses/administration fund allocation as well as the opportunity for expansion of investment options. The Chapter 12 pools are very concerned about several areas of the proposed legislation. The revision of Section One K.S.A. 12-2618(h) could potentially be very harmful to the Chapter 12 pools should the commissioner be given subjective approval

authority for specific and aggregate excess insurance. Market conditions tend to drive the availability, price and attachment points of excess insurance. The financial position of an individual pool guides the administrator and trustees to make decisions on attachment points versus the cost and the amount of risk the trustees believe the pool can retain. This responsibility should remain with the respective pool. The change to section five K.S.A. 12-2627(a) that gives the insurance commissioner the authority to approve a pool administrator is too vague. The intent seems to give the department assurances that a competent person is administering the pool. However, the coalition members are not comfortable in discussing how the department would deem an individual as an "experienced administrator".

In summary, the coalition recognizes the difficulty the Kansas Insurance Department has recently encountered with accident and health pools formed under Chapter 12. The changes in the proposed legislation in most cases seems inappropriate and unduly burdensome to workers' compensation pools formed under Chapter 12. Our hope would be that the department could find another avenue in carving out "accident health pool issues" without restricting the business course of workers' compensation pools that have done such

a good job of controlling workers' compensation costs in this state.

Accordingly, the Kansas Workers' Compensation Pool Coalition cannot support Senate Bill 79.

League of Kansas Municipalities

PUBLISHERS OF KANSAS GOVERNMENT JOURNAL 300 S.W. 8TH TOPEKA, KS 66603-3896 (785) 354-9565 FAX (785) 354-4186

TO: **Senate Committee on Financial Institutions and Insurance**
FROM: Chris McKenzie, Executive Director
DATE: February 3, 1999
SUBJECT: League Opposition to SB 79, Concerning the Regulation of Group Funded Pools

Thank you for the opportunity to appear today in opposition to SB 79 on behalf of the 528 member cities of the League of Kansas Municipalities. We appreciate and join in the testimony offered by Hoot Gibson on behalf of the Kansas Workers' Compensation Coalition.

In 1993 the League helped form the Kansas Municipal Insurance Trust (KMIT), a municipal workers compensation pool organized to provide workers compensation coverages to the cities of Kansas. KMIT began operation with 13 cities plus the League on January 1, 1994. Today its membership numbers 85 cities, ranging in size from Dodge City (22,430) to Beverly (122). A map of the KMIT member cities is attached for your information.

The KMIT pool has provided some major benefits to its member cities and their taxpayers since its inception in 1994. Some of the highlights of its operations, include:

- **Loss Control.** KMIT provides an extensive loss control program, which includes accident prevention workshops, safety manual training, a bi-monthly newsletter and training tools. All such programs are provided at no additional charge to every member city.

- **Member Information.** KMIT provides a monthly mailing to every member reflecting the current status of all open and closed claims for that city. In addition, other information related to the financial position of the Trust is included.

- **Board of Trustees of City Officials.** An elected eleven-member Board of Trustees composed of city officials represents KMIT members and establishes the policies for the Trust. Trustees serve on a staggered basis and are elected each year at KMIT's annual membership meeting.

- **Workplace Inspections.** KMIT inspects the workplace environment of every member, every year, at no additional charge to the city.

- **Case Management Program.** KMIT utilizes an aggressive program of case

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management to help reduce claims expenses. This program has been expanded every year since 1994 and now includes a medical and pharmaceutical discount program. These discounts are in addition to the State's workers' compensation fee schedule.

- **Experience Modification Reductions.** Since KMIT's inception in 1994, the average experience modification for all members has declined by over 12%.

- **Average Experience Modification.** Beginning in 1999, the average experience modification ratio for all members is .99, which represents a remarkable accomplishment for a pool with this many members.

- **Kansas Funds Stay in Kansas.** Approximately 95% of all KMIT funds remain in Kansas, invested in Kansas banks.

Forming KMIT was not an easy endeavor, and we are keenly aware of the challenges posed by the Kansas Municipal Group-Funded Pool Act (K.S.A. 12-1216 et seq.) to those municipal entities that will try. We did succeed, however, and the League is proud of KMIT's track record of responsive services and fiscal integrity. In fact, many of the members of the Trust were not able to secure workers compensation insurance coverage from the traditional market. These cities were invited into KMIT, subscribe to its commitment to safety and risk management, and have experienced major benefits as a result.

We value our relationship with the Kansas Insurance Department, and we appreciate the guidance its officials have provided KMIT over the years. We are aware of the Commissioner's concerns about the financial condition of certain pools providing health insurance type coverages to local units of government, and will support changes in the Kansas Municipal Group-Funded Pool Act which give the Department additional tools to address these concerns without erecting impossible barriers to either the formation of new municipal pools or the operation of existing pools.

Our specific concerns about this legislation can be summarized by the following points:

❶ Approval of Excess Insurance--Page 2, Lines 15 - 17. Under current law municipal pools in the process of formation are required to secure **either** (1) specific and aggregate excess insurance provided by an insurance company holding a Kansas certificate of authority, **or** (2) maintain adequate surplus funds. The proposed amendment would require approval by the commissioner of the amount of excess insurance secured by the municipal pool. The reality is that it is very difficult for new pools to secure excess insurance. The insurance marketplace will effectively dictate

what can be secured by a new pool in its start-up year. If the Commissioner imposed requirements inconsistent with the market, many new pools would be prevented from forming.

❷ Investment Authority.-Page 4, Sec. 4. Under current law, the investment powers of municipal group funded pools are more restrictive than political subdivisions with regard to "active" funds and slightly less restrictive for "idle" funds of the pool (e.g., funds may be invested in obligations of U.S. government agencies). The proposal contained in Section 4 would give municipal group funded pools the same broad investment powers as insurance companies.

❸ Pool Manager--Page 5, lines 24-25.As Mr. Gibson pointed out, this language is too broad and imprecise to prevent its use to prevent the formation of pools by a future Commissioner.

RECOMMENDATION: Based on the foregoing, the League recommends opposition to SB 79. In the alternative, we would be happy to meet with representatives of the Department and other municipal pools to try to work out agreeable compromise language.

Thank you.

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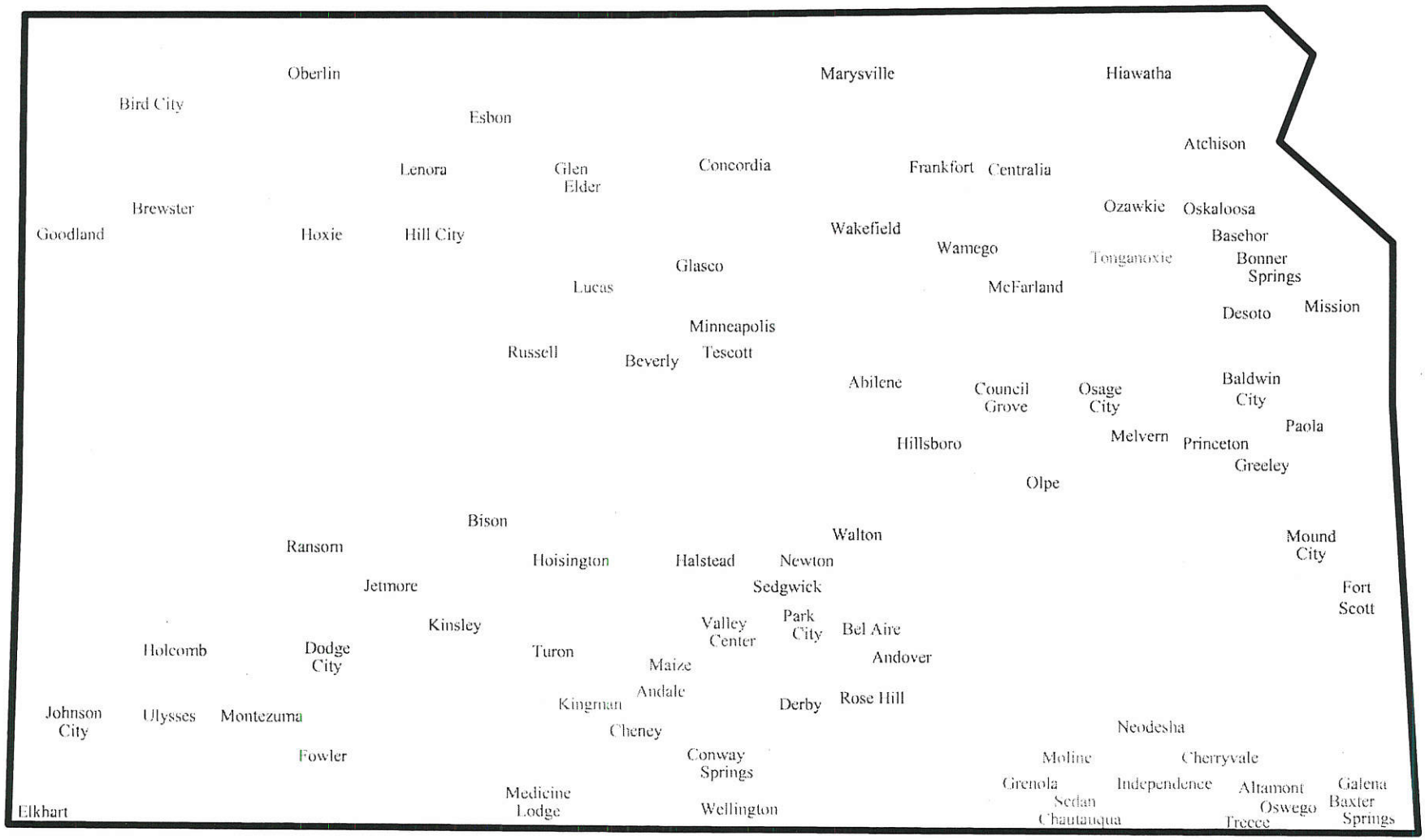
1999 KMIT Members

85 Cities plus the League



Sec. 5. (a) The title insurance agent who handles escrow, settlement or closing accounts shall file with the commissioner a surety bond or irrevocable letter of credit in a form acceptable to the commissioner, issued by an insurance company or financial institution authorized to conduct business in this state, securing the applicant's or title insurance agent's faithful performance of all duties and obligations set out in this act.

(b) The terms of the bond or irrevocable letter of credit shall be:

(1) the surety bond shall provide that it may not be terminated without 30 days prior written notice to the commissioner.

(2) an irrevocable letter of credit shall be issued by a bank which is insured by the federal deposit insurance corporation or its successor if such letter of credit is initially issued for a term of at least one year and by its terms is automatically renewed at each expiration date for at least an additional one-year term unless at least 30 days prior written notice of intention not to renew is given to the commissioner of insurance.

(c) The amount of the surety bond or irrevocable letter of credit for those agents servicing real estate transactions on property located in counties having a certain population shall be required as follows:

(1) $100,000 surety bond or irrevocable letter of credit in counties having a population of 40,001 and over;

(2) $ 50,000 surety bond or irrevocable letter of credit in counties having a population of 20,001 – 40,000; and

(3) $ 25,000 surety bond or irrevocable letter of credit in counties having a population of 20,000 or under.

(d) The surety bond or irrevocable letter of credit shall be for the benefit of any person suffering a loss if the title insurance agent converts or misappropriates money received or held in escrow, deposit or trust accounts while acting as a title insurance agent providing any escrow or settlement services.

Proposed Amendment

All funds deposited for real estate closings, including refinances of existing mortgage loans, which exceed $2,500.00, shall be in one of the following forms:

1) lawful money of the United States;

2) wire transfers such that the funds are unconditionally received by the title insurance agent or the agent's depository;

3) cashier's checks, certified checks or bank money orders issued by a federally insured financial institution and unconditionally held by the title insurance agent;

4) funds received from governmental entities or drawn on an escrow account of a real estate broker licensed in the state of Kansas or drawn on an escrow account of a title insurer or title insurance agency licensed to do business in Kansas, or;

5) other negotiable instruments which have been on deposit in the escrow account for at least ten days.

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KANSAS PUBLIC HEALTH ASSOCIATION, INC.

KANSAS PUBLIC HEALTH ASSOCIATION, INC.
AFFILIATED WITH THE AMERICAN PUBLIC HEALTH ASSOCIATION
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Testimony on SB 108
Submitted by Sally Finney, Executive Director
on February 3, 1999

The Kansas Public Health Association supports SB 108, a bill to allow off-label use of prescription drugs. Once the U.S. Food and Drug Administration approves a drug for one use, physicians may, based on published findings showing that drug to be effective for other uses, prescribe it for purposes not specified in the FDA's original approval. Unfortunately, their patients typically must bear the cost of such treatment because insurers do not reimburse for this "off-label" usage. The process for a pharmaceutical manufacturer to gain FDA approval for each new indication for a drug sometimes takes more than five years at a cost the company is usually unable to recoup. Ultimately, patients may be forced to forego treatment with drugs showing promising new uses because they cannot bear the added cost of already expensive care.

Because SB 108 includes a measure whereby physicians may be required to submit documentation to the insurer supporting the proposed off-label use, we are confident the intentions of this legislation will be carried out in the best interest of patients without abuse by providers or insurers.

We ask your support of SB 108.

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