Approved: February 15, 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 9, 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: Senator Tim Emert
John McCabe, Uniform Law Commission
Representative Nancy Kirk
Brad Smoot, Blue Cross/Blue Shield
Terry Bernatis, Health Benefits Administrator
Terry Leatherman, KCCI
Jim Schwartz, Kansas Employers Health Commission
Amy Campbell, Kansas Mental Health Coalition
Chip Wheelen, Kansas Psychiatric Society

Others attending: See Attached

Hearing on SB 117 - Uniform unclaimed property act

Senator Emert gave an overview of the bipartisan Uniform Law Commission which was originated 107 years ago in an attempt to uniform some types of non-controversial law throughout the country. He introduced John McCabe, Legal Counsel and Legislative Director of the Uniform Law Commission, Chicago, who further educated the Committee on the current Uniform Unclaimed Property Act which was adopted in 1995. The principal reason for the Act was to settle the type of judicial dispute which had been adjudicated by the Supreme Court in the early 90's. The Act provides better and faster reporting of abandoned or unclaimed property and clarification of ownership. Inasmuch as the state is the repository for unclaimed intangible and tangible goods, the states need to have a uniform and reciprocal law declaring in which state the goods actually belong. The state acts as a trustee for the goods. The State Treasurer of Kansas collects $10 million per year in unclaimed property.

The hearing remained open due to lack of representation from the Unclaimed Property Division due to illness. A Subcommittee was appointed to further explore the proposed legislation: Senator Stan Clark, Chairman; Senator Karin Brownlee, and Senator Donald Biggs.

Hearing on HB 2005 - Mandated health coverage, state health plan

Representative Nancy Kirk, member of the interim Joint Committee on Financial Institutions and Insurance, explained the bill which would require any mandate being considered for inclusion in health insurances sold in Kansas must be pre-tested in the State Health Insurance plan (Attachment 1). The test period will be for 18 months with a report of analyzed information regarding cost and need being made available to the Legislature.

The Committee expressed concern about the 18 month testing period being too short to critically analyze data and exactly when the report would be due to the Legislature. This bill does not have a penalty clause for not providing the report at the appointed time. The mandate testing should be done on a single mandate basis in order to get a true picture regarding that particular mandate rather than implementing more than one mandate at a time. Any mandate will cause a rise in the cost of insurance and close records should be kept of the number of people who drop out of the plan due to cost. Senator Barone explained that with an 18 month testing period, approved mandates for private carriers would not kick in until 2003 due to the following schedule which would effectively delay the mandate for 3 ½ years:

- June 1999 - Mandate becomes legislatively effective for Employees State Health Plan
- January 2000 - Mandate actually becomes effective in plan
- June 2001 - End of test period

- January 2002 - Report due to Legislature
- June 2002 - Mandate legislatively effective
- 2003 - Mandate appears in private carriers plans

Brad Smoot, Blue Cross/Blue Shield, reported they have 900,000 Kansans covered through their health plans (Attachment 2). When a proposed mandate is reported to only raise premiums by 1%, it translates into a $11.2 million increase on a $1.2 billion premium base. With the implementation of mandates and higher costs, there is a tendency in the private carrier or group carrier market for insureds to drop the plan if they are paying the premium or for employers to cost shift to employees. With the passage of this proposed legislation which indicates an 18 month testing period, the State Health Plan will be paying higher premiums for a longer length of time than if the test period was shortened to one year. Mr. Smoot said they endorsed the plan as it was the first time a mandate had actually been tracked and an actual cost analysis made after the fact. He did remind the Committee that mandates tend to create health plans on a "one size fits all" basis rather than crafting them to fit the workplace.

It was pointed out during Committee discussion that an incoming Legislature is not governed by the rules of the past Legislature and the intent of this proposal could be altered.

Terry Bernatis, Health Benefits Administrator, urged the Committee to be very careful in wording the legislation and suggested an amendment that would allow the testing of only one mandate at a time (Attachment 3). Consequences of this legislation may be to restrict the flexibility the Commission has had in negotiating the best possible rates, rising costs associated with carrier programming for exceptional requirements, pool of proposed carriers will be smaller due to lack of interest in bidding on the state plan as it is "different," and because no one has a vested interest in the mandate there will be no debate on how to control costs or set the parameters of the proposed mandate. Amendments were offered to address these issues. Mrs. Bernatis also explained that the data collected may be incorrect as there would be no claim data for the first three months of the period and Blue Cross/Blue Shield would allow claims for 15 months after the test period was over. She approximates the cost of the mandate would impact their plan approximately $30,000. If Health and Environment was charged with collecting the raw data, it would have to be "cleaned up" before it would be of use in the report preparation.

Terry Leatherman, KCCI, supported the bill which he said would be valuable in determining the cost effectiveness of mandates (Attachment 4).

Jim Schwartz, Kansas Employers Coalition on Health, complimented the Committee on this first step to actually test a mandate prior to implementing it for all health insurance companies (Attachment 5). He reminded the Committee that for every 1% increase in health premiums there are 300,000 Americans of which 3,000 are Kansans that fall off the insurance roles. He urged a periodic reevaluating of all mandates. Mr. Schwartz presented an amendment specifying the type and initiator of the report.

Amy Campbell, Kansas Mental Health Coalition, supported the bill with a request for an amendment to exempt coverages already available in the state health care benefits plan or an amendment implementing the mandate in the state health care benefits program (Attachment 6).

Chip Wheelen, Kansas Psychiatric Society, said that although they supported the bill, they were requesting an amendment which would correct the requirement of obtaining approval of a mandate from the Legislature for something that has already been adopted by the Kansas State Employees Health Care Commission, i.e., mental illness (Attachment 7).

Written testimony was received from Kansas Association of Health Plans (Attachment 8); the Greater Kansas City Chamber of Commerce (Attachment 9);and the Overland Park Chamber of Commerce (Attachment 10).

Chairman Steffes closed the Hearing.

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

SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE GUEST LIST

DATE: 2/9/99

NAME	REPRESENTING
Trish Hein	SBG1
Chip Wheelen	KS Psychiatric Society
Steve Montgomery	United HealthCare
Steve Richards	Yellow Corporation
Meyer Stan	Federico Consulting
Laurie Ann Brown	KAHP
Terry Bernatis	KS State Employee Health Care Com.
David L Koss	Kdoch
Sharon Huffman	KCDC
Amy A. Campbell	KMHC
Bill Sneed	Keane Tracers
Bill Sneed	HIRA
Kathy Olsen	KBA
George Barbee	Barbee & Assoc's
Teresa Ollis	St Treasurer's Office
Matt Goddard	HCBA
Chuck Stones	KBA
Rick Guthrie	Health Midwest
Tom Schaefer	City of Geneva

SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE GUEST LIST

DATE: 2/9

NAME	REPRESENTING
Ezra Ginzburg, staff attorney	Office of State Bank Commissioner
Stacey Sudan	Hein + Weir Chtd.
Ron Seiber	Dept of Admin
Alan Steppat	CBA
Linda McCoursey	KY Ins. Dept

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TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
RANKING MINORITY MEMBER
INSURANCE
MEMBER
JUDICIARY
TAXATION

TESTIMONY
FOR
SENATE COMMITTEE
ON
FINANCIAL INSTITUTIONS AND INSURANCE

HB 2005

During the summer hearings on insurance mandates, it became obvious that a more rational system for making decisions on these mandates was needed. Currently an impact study is supposed to be conducted on each mandate. The study is to consider the benefits to our state and the costs; the costs of doing something and the cost of doing nothing. However, each of us is aware there are usually two sides to each mandate issue and it is often very difficult to be certain that the costs projected are accurate.

In an effort to bring some rationality to the process, a group of providers, employers, and two legislators came togther to discuss possible options. The outcome is HB 2005. Any mandate considered for inclusion in health insurances sold in Kansas will be pre-tested in the State Health Insurance Plan. At the request of the State Health Commission, the House amended the original bill to extend the length of time for the test period . New mandates generally experience an upsurge in usage at the beginning of a new option and then level off reflecting a more realistic usage pattern. The test period for new mandates was extended to 18 months. The new mandates will begin at the start of a new benefit year, January 1. Effectively the Commission will have two and one half years of information available.

We are hopeful the Senate will see the benefit of this plan and pass this legislation.

Respectfully,

Rep. Nancy A. Kirk

Senate Financial Institutions & Insurance

Date 2/9/99

Attachment # 1

BRAD SMOOT

ATTORNEY AT LAW

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(785) 233-0016
(785) 234-3687 (fax)

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Statement of Brad Smoot, Legislative Counsel
Blue Cross Blue Shield of Kansas
Blue Cross Blue Shield of Kansas City
To
Senate Financial Institutions & Insurance Committee
Regarding 1999 House Bill 2005, as amended
February 9, 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 private health insurance coverage. You are being urged to dictate to consumers the terms of the health insurance contracts they can buy. Committee members may be interested to know just 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. Accident and health 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.

Health Insurance mandates have a common purpose, namely to pay more money to more providers through third party reimbursement and thus reduce the out of pocket expenses of insureds 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. Most current mandates are listed on the attached exhibit titled "Invoice" as well as those proposed but not passed last session.

Senate Financial Institutions & Insurance

Date 2/9/99

Attachment # 2

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, greater utilization by consumers, increased charges per service, etc. Mandates merely add to the unavoidable inflation of health care and health insurance costs. See "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 "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 "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 "More workers opt against insurance," by Lee Bowman, Scripps Howard News Service, Topeka Capital Journal, February 20, 1998.

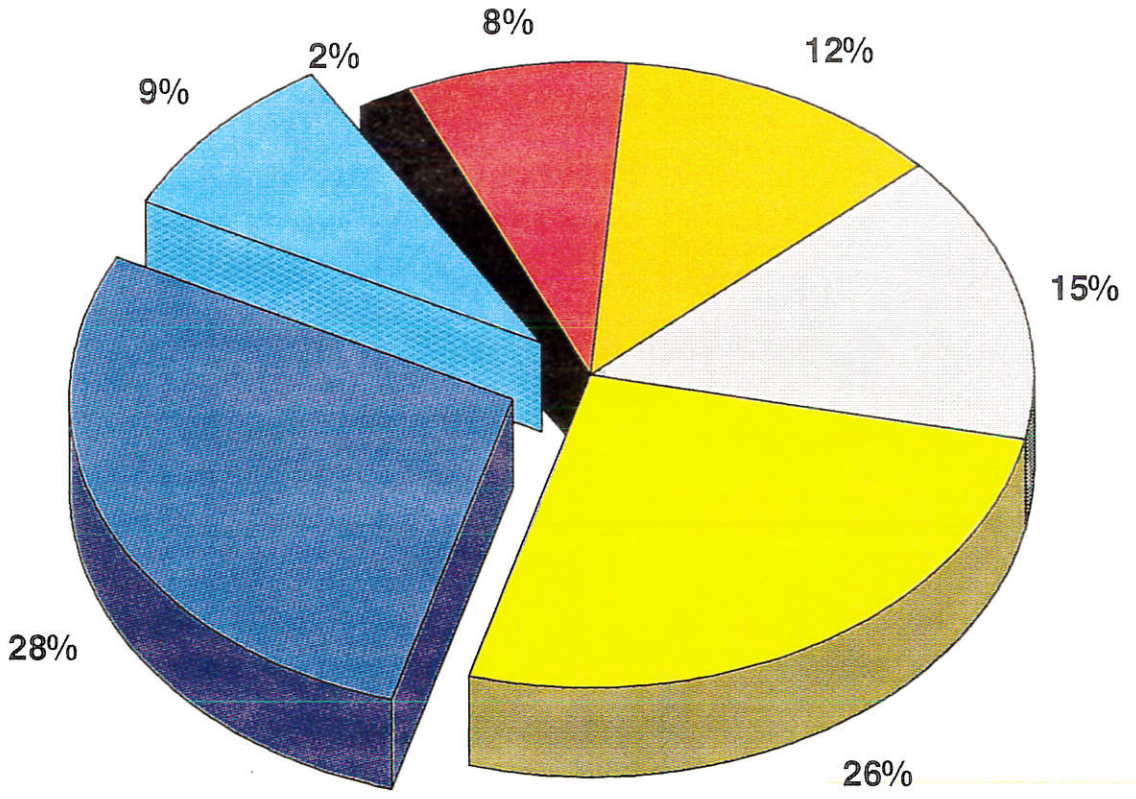
Other employers will continue to pay the same portion of insurance premium but will avoid pay raises, decrease other health benefits (dental or pharmacy) or reduce other business expenditures (capital improvements, job expansions, etc.).

And, as the marketplace becomes less capable of absorbing additional costs, insurers must 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.

For these reasons, we endorse H 2005, as amended by the House Committee. It is a reasonable method for legislators to evaluate the costs and benefits of the various insurance mandates before they become a permanent part of private sector insurance coverage. The state employees benefit plan has the size to give the mandate a real "test" and the expertise to provide information of real value in your deliberations.

Thank you for your time and consideration of our views.

ALL KANSANS



BCBSKS

INVOICE
(Your Insurance Bill)

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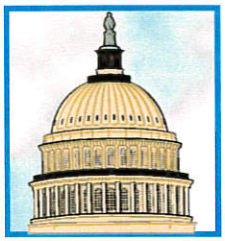

Legislative Mandates

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

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.

Explaining the Growing Number Of Uninsured

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

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

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

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

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

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

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

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

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

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

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

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

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2/15/98

Self-insurance sees gains in health plan financing

More employers assume risk in HMOs, POS plans

By JOANNE WOJCIK

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

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

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

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

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

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

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

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

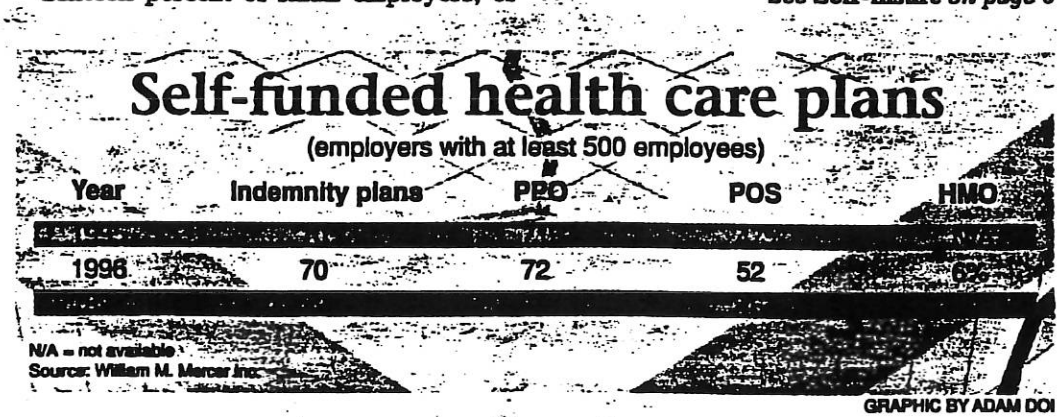
In some cases, especially where a majority of employees are enrolled in managed care plans, employers think "they can start taking the risk back," he said.

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

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

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

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



GRAPHIC BY ADAM DOI

"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.

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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

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.

2-9

Testimony To The

SENATE FINANCIAL INSTITUTIONS AND INSURANCE

By
Terry D. Bernatis
Health Benefits Administrator

Tuesday, February 9, 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 wish to consider during your deliberations. As with any action, there will be unintended consequences. My purpose is to explain the unintended consequences that this bill may pose.

I say nothing new when I say that mandates cost money. This is an issue that you struggle with and this bill is a proposed solution to get a better fix on the what the costs are before implementing it statewide. With the current employee/structure funding the cost of the mandate for employees only coverage will be mostly born by the state. For the past six or seven years, the Health Care Commission has taken the position that any cost increases will not be passed on to the employee, but born by the state. However, for dependent coverage, the vast majority of the cost increase is passed along to the participant. We currently have approximately 45% of our participants who enroll in some form of dependent coverage. The percentage had shrunk to a little over 30% by 1995. Feedback from participants was that cost was driving participants to not enroll in dependent coverage and dependents were going uninsured. With Plan Year 1996, the Health Care Commission reallocated the funds that had only been available for Blue Cross participants in dependent coverage to all dependents. As a result, we no longer have feedback regarding cost being a deciding factor in enrollment for dependents and in fact have seen a steady increase in dependent enrollment. The group that will be hardest hit by this proposal is our direct bill participants. They are currently paying almost the entire cost of health insurance and therefore will have to absorb the total increase cost of the "test" mandates. One

unintended consequence may be disenrollment in the plan and more uninsured citizens.

Secondly, I have heard from carriers indicating that they will no longer be able to commit to multi-year contracts. Since Plan Year 1996, the Health Care Commission has only negotiated multi-year contracts, unlike the single year contracts prior to 1996. This has allowed the commission to obtain better rates because the state commits to a partnership with the carriers. They can count on us and we can count on them. The most frequent complaint that I hear from providers during my work with the Purchaser/Provider Accountability Group is that organizations will not commit to multi-year relationships. The state has been able to bridge that issue and we are held out as the exception rather than the rule. An unintended consequence of this bill may be to restrict the flexibility that the Commission has had in negotiating the best possible rates.

Thirdly, there are costs associated with carrier programming for exceptional requirements. When statewide mandates are put in, carriers must make one change to their systems. With mandates only applicable to the state group, those costs will still be there, but will be charged to just the state. These increased programming costs, which will have to be born by the state, are unintended consequences.

Fourthly, because of these programming costs and the fact that the state plan is "different," there are carriers that will no longer be interested in even bidding on the state plan. We currently contract with some local companies that provide excellent competitive rates that may no longer be interested in bidding on the state business. We also contract with a large national carrier. Although our enrollment is not high in the plan, again they provide excellent competitive rates. We are pushing the envelope with them already because of the things we require. Additional requirements will make the state unattractive. The unintended consequence is that we will have fewer players, and therefore, less leverage to negotiate rates.

And finally, the structure of the mandate will play a large roll in the cost of it. With prior mandates, there has been considerable debate about the structure and parameters of the mandates. You will not have that type of debate because no one is going to have a vested interest in exploring alternatives or discussing consequences, because "somebody else" is going to be dealing with it first. If I may point out two cases in point with current legislation. SB 3 dealing with a dental mandate has taken out language regarding medical necessity. Without a control

regarding at least a medical need for a procedure, there will be no way to control costs. SB 160 regarding biologically based mental health parity is another case. The Commission adopted biologically based mental health parity and made it a provision for the HMO's and the PPO. Every participant in the state has access to mental health parity. The Commission specifically did not put it in the Blue Cross program. The Blue Cross program is the most expensive option in the health program. The Commission is encouraging people to chose less expensive alternatives, but the Commission is committed to assuring quality in those less expensive options. I don't think there is a doubt in anyone's mind that the medical plans that we offer are quality/cost effective plans. However, SB 160 would require us to put biologically based mental health parity in an option (Blue Cross) over which we have no controls in place like in an HMO. Just the way the mandates are written will have an incredible potential cost impact. They need to be crafted carefully crafted to assure that normal insurance standards are in place. Without that assurance, again, there is no way to control costs. Since the mandates may one day apply to HMO's and the remaining insured plans which are offered by smaller employers who cannot self insure, it is important to get the language "right." If mandates are not crafted carefully the potential cost, if implemented statewide, may unintentionally drive more employers to drop health insurance and more Kansans will be uninsured.

In order to help mitigate these unintended consequences, the Department of Administration offers the attached amendments.

Thank you. I stand for questions.

As Amended by House Committee

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

(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.

There shall be no more than one mandate tested during any given testing period. The Kansas state employees health care commission shall determine the plan option or component of the state health benefits program to which the mandate will apply based upon the intent of the mandate.

, but not limited to,

3-4

3-4

As Amended by Senate Committee

Session of 1999

SENATE BILL No. 3

By Special Committee on Financial Institutions and Insurance

12-15

AN ACT relating to accident and health insurance; providing coverage for general anesthesia and medical care facility charges for certain dental care; amending K.S.A. 1998 Supp. 40-2,103 and 40-19c09 and repealing the existing sections; also repealing K.S.A. 1998 Supp. 40-1909.

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

New Section 1. (a) Any individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization which provides coverage for accident and health services and which is delivered, issued for delivery, amended or renewed on or after July 1, 1999, also, shall provide coverage for the administration of general anesthesia and medical care facility charges for dental care provided to the following covered persons:

(1) A child ~~eight~~ ***five*** years of age and under; or

(2) a person who is severely disabled; ~~and~~ ***or***

(3) ~~such~~ ***a*** person has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

(b) A policy, provision, contract, plan or agreement may:

(1) Apply to the covered procedures under this section the same deductibles, coinsurance***, network requirements*** and other limitations***, including but not limited to medical necessity determinations,*** as apply to other covered services;

(2) require prior authorization for hospitalization for the covered procedures under this section in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

(c) The provisions of this section shall not apply to any policy or certificate providing coverage for any specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care, as defined by K.S.A. 40-2227, and amendments thereto, medicare supplement, as defined by the commissioner of insurance by rules and regulations, vision care or other limited-benefit supplemental insurance, nor any coverage issued as a supplement to liability

insurance, workers' compensation or similar insurance, automobile medical-payment insurance, or any insurance under which benefits are payable with or without regard to fault, whether written on a group, blanket or individual basis.

(d) Nothing herein shall be construed to require any individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, fraternal benefit society or health maintenance organization to provide benefits for any dental procedures.

(e) The provisions of this section shall apply to the state health care benefits program and municipal self-funded pools.

(f) As used in this section ``medical care facility'' shall have the meaning ascribed to the term in K.S.A. 65-425, and amendments thereto.

Sec. 2. K.S.A. 1998 Supp. 40-2,103 is hereby amended to read as follows: 40-2,103. The requirements of K.S.A. 40-2,100, 40-2,101, 40-2,102, 40-2,104, 40-2,105, 40-2,114 and 40-2250, and amendments thereto and K.S.A. 1998 Supp. 40-2,160*, and amendments thereto, and section 1*shall apply to all insurance policies, subscriber contracts or certificates of insurance delivered, renewed or issued for delivery within or outside of this state or used within this state by or for an individual who resides or is employed in this state.

Sec. 3. K.S.A. 1998 Supp. 40-19c09 is hereby amended to read as follows: 40-19c09. (a) Corporations organized under the nonprofit medical and hospital service corporation act shall be subject to the provisions of the Kansas general corporation code, articles 60 to 74, inclusive, of chapter 17 of the Kansas Statutes Annotated, applicable to nonprofit corporations, to the provisions of K.S.A. 40-214, 40-215, 40-216, 40-218, 40-219, 40-222, 40-223, 40-224, 40-225, 40-226, 40-229, 40-230, 40-231, 40-235, 40-236, 40-237, 40-247, 40-248, 40-249, 40-250, 40-251, 40-252, 40-254, 40-2,100, 40-2,101, 40-2,102, 40-2,103, 40-2,104, 40-2,105, 40-2,116, 40-2,117, 40-2a01 *et seq.*, 40-2111 to 40-2116, inclusive, 40-2215 to 40-2220, inclusive, 40-2221a, 40-2221b, 40-2229, 40-2230, 40-2250, 40-2251, 40-2253, 40-2254, 40-2401 to 40-2421, inclusive, and 40-3301 to 40-3313, inclusive, K.S.A. 1998 Supp. 40-2,153, 40-2,154, 40-2,160, 40-2,161, 40-2,163 ~~and~~, 40-2,164 *and section 1*, and amendments thereto, except as the context otherwise requires, and shall not be subject to any other provisions of the insurance code except as expressly provided in this act.

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

(c) Violation of subsection (b) shall be subject to the penalties pre-

scribed by K.S.A. 40-2407 and 40-2411, and amendments thereto.

Sec. 4. K.S.A. 1998 Supp. 40-2,103, 40-1909 and 40-19c09 are hereby repealed.

Sec. 5. This act shall take effect and be in force from and after its publication in the statute book.

LEGISLATIVE TESTIMONY

the Kansas Chamber of Commerce and Industry
The Unified Voice of Business

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HB 2005

February 9, 1999

KANSAS CHAMBER OF COMMERCE AND INDUSTRY

Testimony Before the

Senate Committee on Financial Institutions & 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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cost of health care policies, to the detriment of small Kansas employers who struggle to provide 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.

Kansas Employer Coalition on Health, Inc.
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Testimony to Senate Committee on Financial Institutions & Insurance

on HB 2005

(Trial period for health insurance mandates)

by James P. Schwartz Jr.
Consulting Director
February 9, 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 the State Employees' group, 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.

At the same time, I'm aware of potential liabilities this bill imposes on the State Health Benefits Administration. Questions of additional cost and health-plan response remain unanswered. Since the session is still young, I would recommend a "go-slow" approach to advancing this bill until those questions can be answered and a fuller cost/benefit evaluation can be made.

Our support for this bill stems partly from employers' general dislike for health insurance mandates. That disfavor is rooted in the long experience of health insurance mandates increasing 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 to resist 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 pass the cost-benefit

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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 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.

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 your vote. That should make the medicine go down a little easier in the business community.

We also applaud the section of the bill that calls for periodic reevaluation of existing mandates. We would recommend, however, that this section be made more specific. Presently it is unclear who is supposed to initiate these actions and what guidelines should apply. Perhaps an amendment would help, saying that Legislative Research shall annually supply an outline of existing mandates to the relevant committees, listing those mandates, their last date of review, results of any cost/benefit evaluations, and the source and nature of any recent pertinent research.

HB 2005 is a small step toward a cautious position on health insurance mandates. But even this small step has consequences on the State Health Benefits Administration. Let's use the time available to us this session to discover the probable fallout for that group, and then, if the bill still looks like a winner, we would support it enthusiastically.

Testimony presented by Amy A. Campbell to the
Senate Financial Institutions and Insurance Committee
on behalf of the
Kansas Mental Health Coalition

February 9, 1999

Thank you, Mr. Chairman, for the opportunity to speak to you today on behalf of the Kansas Mental Health Coalition. The Kansas Mental Health Coalition (KMHC) is a coalition of numerous consumer and family advocacy groups, provider associations, direct services providers, pharmaceutical companies and others which share a common mission of improving the lives of adults and children in Kansas with severe and persistent mental illnesses and severe emotional disorders. Within the group, participants forge a consensus agenda which provides the basis of legislative advocacy efforts each year. This process enables many groups, who would otherwise be unable to participate in the legislative process, to have a voice in public policy matters that directly affect the lives of their constituencies. A list of our members is included on the back of this testimony.

KMHC supports the concept of analyzing data on the impact of adding health care benefits to the state employees health care program. We do, however have some concerns regarding the amendment added to HB 2005 in the House Insurance Committee.

As many of you know, KMHC supports an initiative promoting equal health insurance coverage for serious mental illnesses. Later during this session, we will bring you more detailed information supporting the removal of discriminating practices in the coverage of treatments for mental versus physical illnesses.

Last year, the State Employee Health Care Commission implemented an initiative requiring all managed care programs under the state employee benefits program to offer equal coverage for mental illnesses. State employees were able to take advantage of these enhanced benefits beginning January 1, 1999.

The House amendment to HB 2005 could require an equal coverage bill to be passed in the Legislature requiring implementation in the state plan, duplicating the accomplishments of the Commission. By the time the clock starts on benefits under this act, mental illness parity for state employees choosing managed care coverage will have been in effect for at least one year.

KMHC respectfully requests one of the following:

- An amendment to exempt coverages already available in the state health care benefits plan from this new statutory obligation.

OR

- An amendment implementing the mandate in the state health care benefits program.

Thank you for your consideration of this request. Contact information for the Kansas Mental Health Coalition is available on the back of this testimony.

Over 30 organizations and many individuals were members of KMHC in 1998. They included: NAMI Kansas • Kansas Organization of Nurse Leaders • Kansas Psychiatric Society • National Association of Social Workers, Kansas Chapter • Breakthrough House, Topeka • Menninger • Association of Community Mental Health Centers of Kansas • Parkview Hospital • Kansas Mental Illness Awareness Council • Topeka Independent Living Resource Center • Kansas Hospital Association • Pfizer • Kansas Psychological Association • Mental Health Consortium • Meadowlark Homestead • Eli Lilly • Johnson & Johnson • 16 Community Mental Health Centers located in Franklin County, Johnson County, Cowley County, Hutchinson, Liberal, Leavenworth, Kansas City, Wichita, Hiawatha, Salina, Lawrence, Independence, Emporia, Hays, Crawford County and Columbus.

• Individual members included primary consumers, one pharmaceutical representative and several mental health professionals.

Please direct questions to any of the following individuals:

Amy A. Campbell, KMHC Lobbyist - 785-234-9702
Mike Horan, KMHC Chair - 785-232-6807
Chip Wheelen, Legislative Co-Chair - 785-266-7173
Terry Larson, Legislative Co-Chair - 785-233-0755

K. s Psychiatric Society

Founded 1942

A District Branch of the American Psychiatric Association

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Testimony
to the
Senate Financial Institutions and Insurance Committee
February 9, 1999
by Charles Wheelen

Thank you for the opportunity to express our concerns about HB2005. This testimony is provided on behalf of the Kansas Mental Health Coalition as well as the Kansas Psychiatric Society. The KPS is an association of physicians who specialize in the diagnosis and treatment of mental illnesses, whereas the Kansas Mental Health Coalition is a voluntary association of several organizations and individuals with common interests in seeking the best possible model of care for Kansans with mental illnesses. One of our principal goals is the elimination of discrimination against people who have a mental illness, particularly in regard to health insurance coverage.

After the 1998 Special Committee on Financial Institutions and Insurance concluded its work and recommended the concept embodied in HB2005, the KMHC discussed at great length whether we should oppose the bill. I argued that the principle in HB2005 is sound and that because the Kansas State Employees Health Care Commission had already decided to provide equal coverage for severe mental illnesses in this year's plan, we could comply with the required study and analysis and by the year 2000 have the evidence we need to prove that the previous studies were correct; *accurate diagnosis and appropriate treatment of mental illnesses is cost effective*. The other members of the Coalition acceded to my arguments and we assumed a neutral position on HB2005; that is, until it was amended by the House Committee.

The House Committee amendment (lines 20-22) creates a redundant situation for us. It requires that we obtain approval of a mandate from the Legislature for something that has already been adopted by the Kansas State Employees Health Care Commission. This appears to be a unique situation but may also apply to other types of health insurance coverage. It creates an unnecessary requirement that simply makes no sense.

Perhaps more important, HB2005 says the Legislature cannot make a public policy decision about health insurance coverage requirements without a prerequisite study using state employees as a test group. While the concept and the process may be prudent, this bill is not needed. The Legislature would still have to impose these same requirements on all health insurance coverage decisions; one issue at a time.

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Date 2/9/99

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Furthermore, the requirement for a test on the state employees health plan could be suspended or waived at any time. If any member of the Legislature or any interest group wishes to bypass the State Employees Health Care Commission and pursue a bill enacting a new health insurance mandate, the bill could simply begin section one with "Notwithstanding the provisions of K.S.A. [provisions of HB2005]." If the Legislature decides to pass a bill creating a new health insurance mandate, the existence of a section of the statutes with the provisions of HB2005 would not interfere with the lawmaking authority of the legislative branch of government. The bill could be passed the same session and made effective as early as publication in the *Kansas Register*.

We are not asking you to report HB2005 adversely. We're asking you to correct a flaw for the sake of fairness. The House Committee amendment was requested by a conferee who described the amendment as "technical." We too are requesting a technical amendment to make the bill acceptable and we have drafted two options for your consideration. The first version would be preferred because it would give specific direction to the Kansas State Employees Health Care Commission. The second option would be more general but would suffice.

Thank you for considering our requested amendment. We urge you to make an appropriate revision prior to making a recommendation on the bill.

Proposed amendment#1 by the Kansas Mental Health Coalition

Session of 1999

HOUSE BILL No. 2005

By Special Committee on Financial Institutions and Insurance
1-11
As Amended by House Committee

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

(b) Beginning with the first anniversary date of the state health care benefits program following the effective date of this act, the state health care benefits program shall provide coverage for diagnosis and treatment of mental illnesses under terms and conditions which are equal to coverage provided for diagnosis and treatment of other sicknesses and health conditions. For purposes of this section, mental illnesses means the following:

(1) Schizophrenia, schizoaffective disorder, schizophreniform disorder, brief reactive psychosis, paranoid or delusional disorder, and atypical psychosis;

(2) major affective disorders (bipolar disorder and major depression), cyclothymic and dysthymic disorders;

(3) obsessive compulsive disorder;

(4) panic disorder; and

(5) pervasive developmental disorder, including autism.

(c) On the day the governor's budget report is submitted to the 2001 legislature the Kansas state employees health care commission shall submit to the president of the senate and to the speaker of the house of representatives, a report indicating the impact equal health insurance coverage for mental illnesses has had on the state health care benefits program, including statistics on the utilization and costs of such coverage. Such report shall also include a recommendation whether such mandated coverage should be required by the legislature to apply 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.

(d) 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.

Proposed amendment#2 by the Kansas Mental Health Coalition

Session of 1999

HOUSE BILL No. 2005

By Special Committee on Financial Institutions and Insurance
1-11

As Amended by House Committee

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

(b) The provisions of subsection (a) shall not apply to those covered services adopted by the Kansas state employees health care commission prior to the effective date of this act.

(c) 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.

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 HB 2005
February 9, 1999

Senator Steffes and members of the committee:

The Kansas Association of Health Plans(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.

As you know, the KAHP does not support the idea of mandating health insurance benefits. However, the KAHP does support the concept of HB 2005 as amended which is to monitor the impact a mandate will have on health insurance by providing that the mandate must first apply to the state employees health insurance plan for a period of time. This will then enable the legislature to make informed decisions about a certain mandate and the various impacts a mandate could have on health insurance.

Thank you for your consideration of this issue and if you have any questions please feel free to contact me.

Sincerely,

Larrie Ann Brown

Larrie Ann Brown
Executive Director

Senate Financial Institutions & Insurance

Date

Attachment # 8

THE CHAMBER

Greater Kansas City Chamber of Commerce

TESTIMONY BEFORE THE SENATE
FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE
ON HB 2005
by Bob Vancrum
Chairman, Kansas State Affairs Committee, Greater Kansas City Chamber of Commerce
February 9, 1999

Thank you Chairman Steffes 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.

Senate Financial Institutions & Insurance

Date

Attachment # 9

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

OVERLAND PARK
CHAMBER OF COMMERCE

February 9, 1999

The Honorable Don Steffes
Chairman, Senate Financial Institutions & Insurance Committee
State House
Topeka, KS 66612

Dear Chairman Steffes 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 18 months, 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 Senate Financial Institutions and Insurance committee to recommend HB 2005 favorably for passage. Thank you for your time and consideration of our position.

Sincerely,

Gene Troehler

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

Senate Financial Institutions & Insurance

Date

Attachment # 10

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