Approved: March 10, 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 March 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: Kathleen Sebelius, Insurance Commissioner
Jerry Slaughter, Kansas Medical Society
John Parisi, Kansas Trial Lawyers Association
Larrie Ann Brown, Kansas Association of Health Plans
Brad Smoot, Blue Cross/Blue Shield
Bill Sneed, HIAA

Others attending: See Attached

Senator Becker moved that the minutes of the February 17, 18, 22, 23, and 24 be approved as presented. Motion was seconded by Senator Praeger. Motion carried.

Hearing on SB 80 - External Grievance Review

Commissioner Sebelius reviewed a situation in which an insured person became gravely ill and his insurance company denied coverage for the treatment prescribed by his physician (Attachment 1). This action required intervention and negotiation by the Insurance Department even though they could not order the private insurer to pay for the prescribed treatment. This demonstrated the need for a protective process which would allow medical experts to resolve complex medical complaints very quickly. Seventeen states now have in place a grievance model including an external, independent level of review; 22 states have such legislation in process. The bill establishes a process for providing financially independent medical experts to evaluate and resolve these "tough" issues in a timely and cost-effective fashion. Commissioner Sebelius explained the criteria for accessing the review process, the review process, and the insured's right to seek civil remedy if they disagree with the decision of the review board. The Kansas Insurance Department estimates its cost to be in the range of $150 per hour which could be absorbed in their budget. KID contracts with the Kansas Foundation for Medical Care, Inc., to provide information from their credentialed experts on complaints from health insurance consumers. Florida has set up a separate agency which licenses and qualifies HMO's. Commissioner Sebelius also presented amendments which she described as "language tightening."

Jerry Slaughter, Kansas Medical Society, described the bill as having the potential to resolve conflicts in coverage or care decisions between patient and insurance company (Attachment 2). An amendment offered would assure that external reviews are done by peers of the health care provider who provided the service in question, and that they would have to be practicing in the state of Kansas to do such reviews.

John Parisi of the Shamberg, Johnson & Bergman law firm in Overland Park, spoke before the Committee as a representative of the Kansas Trial Lawyers Association (Attachment 3). His testimony was in support of the proposed external review process but recommended it be extended to include the right for Kansas residents to seek redress when they are denied care by BlueCross/BlueShield. He pointed out a letter from the American Medical Society to Senate Majority Leader Trent Lott which highlighted the issues they believe are integral to effective patients' rights legislation (see Attachment 3).

Larrie Ann Brown, Kansas Association of Health Plans, pointed out in her testimony her association's concern with the current bill but indicated willingness to work with the Insurance Commissioner during the interim on an amenable external review process (Attachment 4).

Commissioner Sebelius agreed to work with the Committee on **SB 80** on establishing a trigger point.

Written testimony supporting the bill was presented by Charles Wheelen, Kansas Psychiatric Society (Attachment 5).

The hearing was left open by Chairman Steffes.

Hearing on SB 291 - Medicare Supplement Disability - creating a reinsurance program

Commissioner Sebelius explained that this bill would create a mechanism through the high risk pool to pay the excess costs of the disabled Kansans who are under 65 years old and qualify for Medicare due to health conditions (Attachment 6). Fifteen states have enacted such regulations to assist these individuals who were not able to purchase supplemental insurance due to a Congressional oversight in H.R. 5252. This bill only addresses those who came in before 1996 but Commission Sebelius recommends that it be on-going.

Brad Smoot, BlueCross/BlueShield, testified that this proposal was a fair way to distribute the risks and was good public policy as it does not rely upon taxpayers for funding (Attachment 7). All costs are absorbed by the carriers who are obliged by law to shoulder the burden of the Medicare disabled. BC/BS would have preferred the bill apply prospectively rather than only addressing the historical problem of BC/BS's willingness to do the right thing before it was required by law. They would support applying the reinsurance mechanism to losses occurring after 1996.

Bill Sneed, HIAA, said that although they supported the bill, the disabled are far sicker than people who become eligible for Medicare at age 65 thus they cost more to insure (Attachment 8). His association recommends using the mechanism which is already in place to cover the disabled who are eligible for Medicare – the Kansas Health Insurance Association. He recommends an amendment to state that the reinsurance or pooling program found within the KHIA should be applied to all medicare supplement policies issued to people who are eligible for Medicare because of their disability.

Written testimony was received from Brenda Eldridge, Topeka Independent Living Resource Center (Attachment 9).

Chairman Steffes closed the hearing on **SB 291**.

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

SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE GUEST LIST

DATE: 3/3/99

NAME	REPRESENTING
Chip Wheelen	KS Psychiatric Society
John M. Parisi	KS Trial Lawyers Assoc.
Stacy Soldan	Columbia HCA
Larrie Ann Bruun	KHAP
[illegible]	[illegible]
Ron Cheelahan	[illegible]
Paul Davis	Kansas Insurance Dept.
Fred Palenske	BCBSKS
Bruce Wiltse	Preferred Health Systems
Tom Bell	Ks. Hosp. Assn.
Gary Sweeney	Bd of Healing Arts
Barry W Pittman	KFMC
Stacy Cook	Ks Board of Healing Arts
Scott Schneider	McGill Gaches
Bud Grant	KCCI
Kevin Davis	Am. Family Ins.
Pat Morris	KAHA
Steve Montgomery	United Health Care
Steve Ashley	Dept of Admin. KS Emp. Health Care Com

SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE GUEST LIST

DATE: _____

NAME	REPRESENTING
Bill Sneed	HIAA
Kristin VanVoorst	Humana
John Federico	Humana
Tiama Wagner	KID
David Hanson	Ks Insur Assns
Brad Smoot	BCBS
Anna McCarney	KS Insurance Dept
Gene McDaniel	KTLA
Glenn Parisi	KTLA
Terry Humphrey	KTLA

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

TO: Senate Committee on Financial Institutions and Insurance

FROM: Kathleen Sebelius, Insurance Commissioner

RE: SB 80 – External Grievance Review Procedures

DATE: March 3, 1999

Mr. Chairman and members of the Committee:

Two years so, a young man called my office with a complaint. He was a 21-year old college football player, who was gravely ill and his insurance company refused to pay for the treatment prescribed by his doctor.

The treatment was a unique type of chemotherapy and the insurance company ruled the procedure was "experimental", and therefore not covered by his insurance plan. This kind of chemotherapy is also very expensive. Fortunately, after a week of negotiating, we were able to convince the insurer to cover the costs of the treatment.

While we were successful in getting the insurance company to pay, this experience clearly demonstrated to me the need for a new process that would allow medical experts to resolve complex medical complaints very quickly.

I am not alone in my call for a better consumer protection process to deal with medical grievance complaints. The National Association of Insurance Commissioners has recommended that the original grievance model be amended to include an external, independent level of

420 SW 9th Street
Topeka, Kansas 66612-1678

785 296-3071
Fax 785 296-2283

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

review. Seventeen states have already passed legislation that provides some type of independent appeals process. Twenty-two states, including Kansas, have laws before their current legislatures, to give consumers an independent medical appeal of an adverse decision.

The Henry J. Kaiser Family Foundation has conducted a study of these independent review panels. Their finding was that external review procedures improved medical decision-making. The risk of an independent review makes health plans "more cautious about ensuring that decisions are well supported by clinical standards", and they help resolve "the crisis of trust in this industry."

Aetna announced plans to offer a new type of program that allows patients denied coverage to have Aetna's decisions reviewed by outside experts (Wall Street Journal: January, 1999). Under the program, patients denied coverage for a service that Aetna deems experimental, investigational or "not medically necessary", and after the patient has exhausted Aetna's internal appeals process, are offered a "second opinion".

Recently I represented the NAIC in testimony before the U. S. Senate Labor Committee, and urged members of Congress to provide an external appeal for consumers enrolled in self-funded ERISA plans. Since state legislatures lack jurisdiction over these federal plans, it is important that Congress act to provide this important consumer protection.

It is important to note that one of the most valuable services that state insurance departments perform is the handling of consumer complaints. The Kansas Insurance Department Consumer Assistant Division's staff is dedicated to the fair resolution of questions and complaints from consumers about insurance. In 1998, we had a record year in that we obtained $10.3 million for consumers who couldn't resolve claims with their insurance companies. Now that consumer complaints involve medical protocol, not just financing, and the decision to cover a treatment

with insurance is often the key to obtaining the treatment, there are cases where medical expertise is required.

SB 80 establishes a process for providing financially independent medical experts to evaluate and resolve these tough issues, in a timely and cost-effective fashion.

SB 80 defines an adverse decision as a final decision from the health plan carrier that denies coverage of a service on the grounds that the service is not medically necessary, or is experimental or investigational. It defines health insurance plan to include all health insurance carriers, not just HMOs.

To access the external review process, either :1) the insured must exhaust all the internal appeal levels provided by the health benefit plan; or (2) 90 days has expired and the insured has not yet received a final decision on the internal appeal.

When the health plan makes a final adverse decision, or the 90 day time limit expires, they must notify the insured that they can contact the Kansas Insurance Department for an independent review. The insured, or someone acting on the behalf of the insured, provides the request in writing for an independent external review. There is no time limit to request an external review.

Once an external review has been requested, a preliminary determination is made for appropriateness, the health plans has five days from notice of an appeal to return to the Commissioner medical and other records pertaining to the insured's claim and their denial.

External reviews will be conducted by an independent review organization that has no interest in either party. Health care providers credentialed in the specialty will conduct reviews. If an emergency exists, the regulations will establish an expedited process with a determination

being rendered in less than seven days. The costs of the review will be covered by the Kansas Insurance Department.

The decision of the independent reviewer organization shall be binding on the health insurance plan and the insured. The insured may also seek a private civil remedy.

The experience of other states is that a relatively small number of complaints are appealed to the external process. Of the seven states paying for the cost of review, the yearly average number of reviews is 30 per year. The direct cost per case depends on the type of case, but states show costs ranging from $65 per hour to $650 per hour. It is estimated that cost to the Kansas Insurance Department would be in the range of $150 per hour.

The proposed law does establish a safety net for those consumers who now have no alternative, if our Department is unsuccessful in persuading a health plan to overturn an adverse decision.

I am convinced that no issue is of greater concern to consumers or health care providers than the timely resolution of consumer complaints about access to appropriate care. I encourage you to support this important initiative, and pass SB 80 to establish an independent external grievance procedure for Kansas.

EXTERNAL REVIEW OF HEALTH PLAN DECISIONS: AN OVERVIEW OF KEY PROGRAM FEATURES IN THE STATES AND MEDICARE

Prepared for the Henry J. Kaiser Family Foundation by:

Karen Pollitz, M.P.P.

Geraldine Dallek, M.P.H.

Nicole Tapay, J.D.

Institute for Health Care Research and Policy

Georgetown University

NOVEMBER 1998

TABLE 1. SUMMARY HIGHLIGHTS OF STATE AND MEDICARE EXTERNAL REVIEW PROGRAMS

Program	Scope of External Review	Who Performs Reviews?	Review Binding?	Review Cost	Who Pays for Review?	Number of Covered Enrollees	Number and Disposition of Cases *	Program Effective Date
AZ	Medical necessity determinations	Insurance Department-approved IRO or individual physicians	Yes	Negotiated between health plans and reviewers	health plan	not available	not applicable	July 1998
CA	Experimental and investigational therapies for terminally ill persons	Accredited IROs, which may also be academic health centers	Yes	Negotiated between health plans and reviewers	health plan	not available	not applicable	July 1998 (postponed)
CT	Medical necessity determinations	One of 3 contracting IROs	Yes	$ 285-$410 depending on contractor	state (with plan licensing fees) consumer pays $25 filing fee	not available	18 cases January - July 1998 (6 dismissed at preliminary review, 12 to full review) 66% decided for consumer (of 9 cases decided; 3 reviews pending)	January 1998
FL	Any consumer grievance not resolved by the plan	State employee panel, advised by outside physicians	Yes	$65/hour	state (with plan licensing fees)	4.4 million (include 400,000 Medicaid enrollees)	403 cases from 1993 through April 98 (100 cases settled prior to full review; 303 cases to full review) 60% decided for consumer (cases going to full review)	1985

TABLE 1. (continued) SUMMARY HIGHLIGHTS OF STATE AND MEDICARE EXTERNAL REVIEW PROGRAMS

Program	Scope of External Review	Who Performs Reviews?	Review Binding?	Review Cost	Who Pays for Review?	Number of Covered Enrollees	Number and Disposition of Cases	Program Effective Date
MI	Any consumer grievance not resolved by the plan	Health Department-appointed task force	Yes	Nominal (volunteer reviewers paid expenses)	state	1.8 million commercial and Medicaid HMO enrollees	49 cases from 1995 through June 1998 39% of cases decided for consumer	1978
MO**	Medical necessity determinations (statutory process) Informal regulatory process still applies to coverage issues and preexisting condition determinations	IRO contracting with state	Yes	$76/hour	state	1.6 million managed care enrollees	60 cases from 1994 through June 1998 50% of cases decided for consumer	1994
NJ	Medical necessity determinations	One of 2 IROs contracting with state	No	$330-$350 (depending on contractor)	health plan consumer pays $25 filing fee, reduced to $2 for hardship	3.5 million managed care enrollees	69 cases from March 1997 through July 1998 42% of cases decided for consumer	March 1997
NM	Medical necessity determinations	Insurance Department-appointed Independent Review Board	Yes	nominal (volunteer reviewers)	state	not available	10 cases March 1997-March 1998 (8 dismissed after preliminary review; 2 to full review) 50 % of cases decided for consumer	March 1997

TABLE 1. (continued) SUMMARY HIGHLIGHTS OF STATE AND MEDICARE EXTERNAL REVIEW PROGRAMS

Program	Scope of External Review	Who Performs Reviews?	Review Binding?	Review Cost	Who Pays for Review	Number of Covered Enrollees	Number and Disposition of Cases	Program Effective Date
OH	Experimental and investigational therapies for terminally ill persons	Insurance Department-approved IROs, which may be academic health centers	Yes	negotiated between health plans and reviewers	health plan	2.6 million HMO enrollees	Not applicable	October 1998
PA* **	Any consumer grievance not resolved by the plan	Committee of state regulatory staff, advised by outside physicians	No	$300 or less	state	5 million	729 cases from 1991 through June 1998; 185 cases in 1997 37% of cases decided for consumer	1991
RI	Emergency cases (prospective and retrospective) and prospective non-emergency medical necessity determinations	One of 2 IROs contracting with state	Yes	$250-$475 (depending on contractor)	plan pays half, consumer pays half	not available	59 cases in 1997 68% of cases decided for consumer	1997

TABLE 1. (continued) SUMMARY HIGHLIGHTS OF STATE AND MEDICARE EXTERNAL REVIEW PROGRAMS

Program	Scope of External Review	Who Performs Reviews?	Review Binding?	Review Cost	Who Pays for Review	Number of Covered Enrollees	Number and Disposition of Cases	Program Effective Date
TX	Medical necessity determinations	IRO contracting with state	Yes	$460-650 (depending on type of case)	health plan	2.7 million enrollees	218 cases from November 1997 to September 4,1998 (194 cases decided and 24 pending) 48% of cases decided for consumer (includes 11 partially overturned cases)	November 1997
VT****	Medical necessity determinations in mental health and substance abuse claims	Insurance Department-appointed panel of providers	Yes	volunteer reviewers paid honoraria and expenses	State (with licensing fees)	275,000	15 cases sent to independent panel (3 completed formal review; remainder were dismissed at preliminary review or plan paid for care prior to full review) 33% of cases decided for consumer	November 1996
Medicare	Any disputed HMO denial not resolved by the plan	IRO contracting with Medicare	Yes	less than $300 per case	Medicare	5.2 million	approximately 40,000 cases since 1989, 9025 cases in 1997 31.5% of cases decided for consumer	1989

* Percentage applies to number of cases reaching full external review.

**Table includes information about both Missouri's current external review program, mandated by law, and prior program established by regulatory authority.

***Information in table pertains to Pennsylvania's existing external review program established by regulatory authority. A modified program with different features was enacted in 1998 and will take effect in 1999.

****Information in table pertains to program for Vermont's mental health and substance abuse claims. The state recently enacted a law expanding a somewhat different external review program for other types of health claims. It will take effect in 1999.








More about KFMC | **Quality Improvement** | **Review Services** | **Medicare Information** | **Survey Vendor Services** | **Continuing Education** | **Employment Opportunities** | **KFMC Publicatio**

Kansas Foundation for Medical Care, Inc.

Mapping the Way to Quality

Health Care for Kansans

KFMC is a not-for-profit organization working to promote improvements in health care quality, to ensure cost savings in the Medicare and Medicaid programs while maintaining quality care, and to educate health care consumers so they can make informed decisions about health care.








More about KFMC | Quality Improvement | Review Services | Medicare Information | Survey Vendor Services | Continuing Education | Employment Opportunities | KFM Publicat

Kansas Foundation for Medical Care, Inc.

Health Care Review Services

- Review Expertise
- Review Services Available

1-12

KFMC Has Review Expertise

Since 1972, KFMC has provided review services to both governmental and private clients. KFMC is known as a leading quality improveme organization in Kansas because of the level of expertise and experience of KFMC's personnel in conducting health care reviews. The KFMC staff includes:

- Physicians
- Registered Nurses
- Statisticians
- Biostatistician
- Epidemiologist
- Certified Coding Specialist
- Health Information System Experts
- Health Information Management Professionals
- Quality and Utilization Professionals
- Data Analysts

In addition to the expert staff, KFMC has access to over 400 peer reviewers from across Kansas. Each physician reviewer is board-certified w his/her specialty.

Review Services Available:

KFMC contracts with health facilities, payor organizations, or health plans only to the extent that such contracts DO NOT duplicate the wor perform for HCFA or SRS in support of Medicare beneficiaries or Medicaid consumers. Review services KFMC can offer your organization

Quality/Utilization Services

- Provide a determination concerning the medical necessity of the admission and/or procedure, appropriateness of the care setting and the care based on medically accepted standards of care.
- Provide a determination of individual health care practitioner services by a colleague or peer reviewer.
- Provide an appeal mechanism for facility dissatisfaction with internal peer review determinations.
- Provide peer review of reportable incidents identified by the provider in order to comply with a mandated risk management program.
- Assign standard of care ratings to assist facilities with determining reportable incidents.
- Provide an unbiased peer review to assist any facility with credentialing/recredentialing process.
- Identify opportunities for process and system improvement through the investigation of individual cases.
- For more information about these services contact Jeanne at (785) 273-2552 or by e-mail at jbridgewater@kfmc.org.

1-12

1-13

Bill Audit

- Determine if facility charges are supported by documentation in the medical record.
- For more information about these services contact Jeanne at (785) 273-2552 or by e-mail at jbridgewater@kfmc.org.

Quality Improvement

- Assist with the development and analysis of quality improvement studies through consultation with our data analysts and statisticians.
- For more information about assistance with quality improvement projects contact Mike Speight at (785) 273-2552 or by e-mail at mspeight@kfmc.org.

Special Request

- KFMC can customize review services based on clients' needs. KFMC's experts have the flexibility to assist any facility with a special r review. These reviews may include, but are not limited to:
  - Utilizing in-house criteria in conducting a specialized review.
  - Assisting facilities with development of quality improvement and/or utilization management processes and other hospital policie and documentation.
  - Assisting medical decision-making through data analysis.
  - Assessing and assuring compliance with health care regulations (i.e., EMTALA, risk management).

HMO Quality Assurance Audits

KFMC will review the quality assurance plan and supporting medical record documentation to determine compliance with the individu state requirements.

- Currently KFMC conducts HMO QA audits in Kansas and Iowa. In Kansas KFMC is one of only two organizations authorized to conduct HMO audits.

3-1-13

Mission Statement

The mission of the Kansas Foundation for Medical Care, Inc. is to advance continuous improvement of health services through collaboration with the health care community to the benefit of consumers and to promote the health of patients.

Vision Statement

Our vision is to serve as the primary agent in focusing the statewide health care community to achieve significant and continuing improvement in the quality of health care. In this role, we will encourage the active involvement of the health care community. We strive to be both a partner and a resource to the health care community in our joint efforts to improve the health care provided to our citizens.

Board of Trustees

Chairman: **Gerald B. Pees, Jr., M.D.** 2200 Harvard Drive Lawrence, Kansas 66049	**Vice Chairman:** **Joseph K. Robertson, M.D.** 2911 N. Governour St., Apt. 216 Wichita, KS 67226
Secretary/Treasurer: **Douglas L. Young, M.D.** 3311 East Murdock Wichita, Kansas 67208	**President & CEO:** **Larry W. Pitman** 2947 S.W. Wanamaker Drive Topeka, Kansas 66614-4192
Ivan Anderson 635 S.W. Morningside Rd. Topeka, Kansas 66606	**C. Richard Bonebrake, M.D.** 634 SW Mulvane, Suite 104 Topeka, Kansas 66606
Carolyn Eichman Executive Director Trinity Association 408 Frontview	**Phillip A. Godwin, M.D.** 1311 Wakarusa Drive, Suite 1000 Lawrence, Kansas 66049

Dodge City, KS 67801	
Eugene A. Klingler, Jr., M.D. 1133 College Manhattan, Kansas 66502	**Denis D. Knight, D.O.** 8100 E. 22nd St. North Bldg. 2200 Wichita, KS 67226
E. Michael Nunamaker President & CEO Mercy Health Center 1823 College Ave. P.O. Box 1289 Manhattan, Kansas 66505	**Deborah E. Powell, M.D.** Executive Dean Office of the Executive Dean University of Kansas School of Medicine 3901 Rainbow Blvd. Kansas City, KS 66106
J. Steven Schwarting, M.D. 1405 N. Cedar Abilene, Kansas 67410	**T. Scott Webb, D.O.** 222 S. Kansas Russell, Kansas 67665

Back to Home Page Back to Top of This Page

SENATE BILL No. 80
By Committee on Financial Institutions and Insurance
1-21

AN ACT relating to accident and health insurance; concerning an external review process; providing certain requirements.

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

Section 1. (a) For purposes of this section:

(1) ``Adverse decision'' means a utilization review determination by a third-party administrator, an insurer, or a health care provider acting on behalf of an insured that a proposed or delivered health care service which would otherwise be covered under an insured's contract is not or was not medically necessary or the health care treatment has been determined to be experimental or investigational.

(2) ``Health insurance plan'' means any hospital or medical expense policy, health, hospital or medical service corporation contract, and a plan provided by a municipal group-funded pool, or a health maintenance organization contract offered by an employer or any certificate issued under any such policies, contracts or plans. Health insurance plan does

not include policies or certificates covering ~~only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, vision care, coverage issued as a supplement to liability insurance, insurance arising out of a workers compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.~~

Any specified disease, specified accident or accident only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance as defined by K.S.A. 40-2227 and amendments thereto, vision care or any other limited supplemental benefit nor to any medicare supplement policy of insurance as defined by the commissioner of insurance by rule and regulation, 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.

(3) ``Insured'' means the beneficiary of any insurance company, fraternal benefit society, health maintenance organization and nonprofit hospital and medical service corporation authorized to transact health insurance business in this state.

(b) The right to review under this section shall not be construed to change the terms of coverage under a health insurance plan.

(c) The insurer shall provide written notice to the insured of a final adverse decision and the opportunity ~~and time period~~ for requesting the commissioner's review.

(d) ~~An insured who has exhausted all available internal review pro-~~

~~43 cedures provided by the health insurance plan or has not received a final~~

~~decision from the insured within 90 days shall have the right to an in-~~
~~dependent external review of an adverse decision under a health insur-~~
~~ance plan. The independent review shall be available when the affected~~
~~person, provider acting on behalf of the insured or legally authorized~~
~~designee of the insured files a written request with the commissioner of~~
~~insurance within 60 days from receiving a final written determination~~
~~from the insured's health insurance plan.~~

An insured has the right to an independent external review of an adverse decision under a health insurance plan when:

(1) The insured has exhausted all available internal review procedures provided by the health insurance plan; or

(2) the insured has not received a final decision from the insurer within 90 days of seeking an appeal.

(e) The independent review may be available when the insured, provider acting on behalf of the insured or legally authorized designee of the insured files a written request with the commissioner of insurance.

~~(e)~~ ***(f)*** An insured shall provide all information ~~required by~~ the commissioner to make a preliminary determination ~~including the~~ appeal form~~, a copy of the final decision of denial~~ and a fully executed release to obtain any necessary medical records from the insurer and any other relevant provider.

in their possession pertaining to the claim in order for

. The insured shall also provide the commissioner with an

~~(f)~~ ***(g)*** In responding to the commissioner, the insurer shall provide a complete explanation as to the basis of the decision adverse to the insured

and all medical and other records pertaining to the insured's claim within 5 days of the notice of appeal.

~~(g)~~ ***(h)*** Pursuant to a contract negotiated with the insurance department, an independent reviewer organization shall conduct an external review of the adverse decision under a health insurance plan.

(1) The reviewer organization shall include health care providers credentialed with respect to the health care service under review and who have no conflict of interest relating to the performance of their duties under this section.

(2) The reviews shall be done in accordance with standards of decision-making based on objective clinical evidence and shall resolve all issues in a timely manner and provide expedited resolution when the decision relates to emergency or urgent health care services.

~~(h)~~ ***(i)*** The commissioner of insurance shall:

(1) Notify the insured or health care provider in writing as to whether the complaint will be sent for an external review;

(2) allow an insurer, an insured, a health care provider filing a complaint on behalf of an insured or a legally authorized designee of the insured to provide additional written information as may be relevant for

the commissioner to make a final decision on the complaint;

(3) make a decision on a complaint within 30 days after receiving all necessary information; and

(4) design an expedited procedure for use in an emergency case for purposes of rendering a decision ▼. in less than seven days

~~(i)~~ ***(j)*** The decision of the independent reviewer organization shall be binding on the health insurance plan and the insured. ▼ The insured shall not be barred from seeking a private remedy.

~~(j)~~ ***(k)*** The commissioner of insurance is hereby authorized to negotiate and enter into contracts necessary to perform the duties required by this section.

~~(k)~~ ***(l)*** The commissioner of insurance shall adopt rules and regulations necessary to carry out the purposes of this section. The rules and regu-

lations shall ensure that the commissioner of insurance is able to provide an effective and efficient external review of health care services.

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

KANSAS MEDICAL SOCIETY

March 3, 1999

To: Senate Financial Institutions & Insurance Committee

From: Jerry Slaughter
Executive Director

Subject: **SB 80; relating to the establishment of an external review process for health insurance coverage determinations**

The Kansas Medical Society appreciates the opportunity to appear today in support of SB 80, which establishes a process whereby consumers can access an independent reviews of the decisions made by insurers regarding their care.

One of the most contentious aspects of the current health insurance environment is the potential for an insurance company to make a care or coverage decision that appears to adversely affect an insured individual. Whether it has to do with experimental treatment options or a dispute over contractual language, the intersection of patient expectations and company care management decisions is increasingly problematic. This bill has the potential to resolve such conflicts before they become highly emotional, or more importantly, critical to the medically necessary care provided to an individual. The opportunity for both sides to submit the question to an objective, qualified review process is good for patient care and fair for all parties.

We have had the opportunity to review the proposed amendments of the Insurance Commissioner, and we support them. We also are recommending an additional amendment on page 2, line 18, which is attached. The amendment will assure that external reviews are done by peers of the health care provider who provided the service in question, and that they would have to be practicing in the state of Kansas to do such reviews.

We believe this bill has the potential of providing a fair and expeditious mediation process that will benefit patients, and we hope improve relationships between health plans and those they insure. We urge your favorable consideration of the bill.

623 SW 10th Ave. • Topeka KS 66612-1627 • 913.235.2383 • 800.332
Western Kansas office • 108 E 12th St. • Hays KS 67601 • 913.625.8215 • 8

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

KNS Amendment
3.3.09

2-2

decision from the insured within 90 days shall have the right to an independent external review of an adverse decision under a health insurance plan. The independent review shall be available when the affected person, provider acting on behalf of the insured or legally authorized designee of the insured files a written request with the commissioner of insurance within 60 days from receiving a final written determination from the insured's health insurance plan.

(e) An insured shall provide all information required by the commissioner to make a preliminary determination including the appeal form, a copy of the final decision of denial and a fully executed release to obtain any necessary medical records from the insurer and any other relevant provider.

(f) In responding to the commissioner, the insurer shall provide a complete explanation as to the basis of the decision adverse to the insured.

(g) Pursuant to a contract negotiated with the insurance department, an independent reviewer organization shall conduct an external review of the adverse decision under a health insurance plan.

(1) The reviewer organization shall ~~include health care providers~~ credentialed with respect to the health care service under review and who have no conflict of interest relating to the performance of their duties under this section.

provide that all reviews done pursuant to this section are conducted by health care providers actively engaged in the practice of their profession in the state of Kansas who are qualified and

(2) The reviews shall be done in accordance with standards of decision-making based on objective clinical evidence and shall resolve all issues in a timely manner and provide expedited resolution when the decision relates to emergency or urgent health care services.

(h) The commissioner of insurance shall:

(1) Notify the insured or health care provider in writing as to whether the complaint will be sent for an external review;

(2) allow an insurer, an insured, a health care provider filing a complaint on behalf of an insured or a legally authorized designee of the insured to provide additional written information as may be relevant for the commissioner to make a final decision on the complaint;

(3) make a decision on a complaint within 30 days after receiving all necessary information; and

(4) design an expedited procedure for use in an emergency case for purposes of rendering a decision.

(i) The decision of the independent reviewer organization shall be binding on the health insurance plan and the insured.

(j) The commissioner of insurance is hereby authorized to negotiate and enter into contracts necessary to perform the duties required by this section.

(k) The commissioner of insurance shall adopt rules and regulations necessary to carry out the purposes of this section. The rules and regu-

TESTIMONY BEFORE THE SENATE FINANCE COMMITTEE ON SENATE BILL 80, EXTERNAL REVIEW PROCESS OF DENIAL OF ACCIDENT AND HEALTH INSURANCE

Testimony provided by John M. Parisi
Shamberg, Johnson & Bergman, Chtd., on
behalf of the Kansas Trial Lawyers Association
(KTLA)

Mr. Chairman and distinguished members of the Committee:

My name is John Parisi and I am a lawyer with the firm of Shamberg, Johnson & Bergman, Chartered, in Overland Park, Kansas. I am honored to be here today on behalf of the Kansas Trial Lawyers Association (KTLA) to offer testimony on Senate Bill 80, pertaining to the establishment of an external review process for denial of healthcare coverage decisions by managed care organizations.

This bill takes an important and substantive step to provide Kansas insureds enrolled in private HMOs a meaningful procedure by which they can challenge a denial of health care benefits as inexpensively and expeditiously as possible.

The KTLA has reviewed the Insurance Commissioner's amendments to Senate Bill 80 and we believe that these changes will indeed strengthen the bill. However, these amendments do not include

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

the most significant change needed. That is a provision making HMOs liable for damages caused by wrongful denial of medical care. I am here today on behalf of the KTLA to applaud the Insurance Commissioner's effort to protect Kansas insureds from unfair denials of health insurance benefits in an HMO setting. However, KTLA must remain neutral on the passage of this bill, and does not oppose or support the bill in its current form. If the bill were to incorporate a liability provision holding HMOs legally responsible for damages caused by wrongful denial of insurance coverage, KTLA would strongly support it. Without an HMO liability provision, an essential ingredient is lacking and the independent review will not achieve its desired goal of protecting health benefits of HMO participants from overreaching of those running the HMOs and their quest to increase the bottom line.

THE BILL IS ONLY A FIRST STEP

As previously stated, KTLA believes that Senate Bill 80 is an important first step, but does not go far enough to protect Kansas insureds enrolled in private HMOs. KTLA and other consumer protection organizations are of the view that a liability provision is necessary in order to have a meaningful remedy coupled with external review.

The current version of Senate Bill 80 does provide an insured, who is denied health benefits by an HMO, an avenue of independent review of the denial by a qualified physician. However, in order for the Act to provide those enrolled in an HMO

with a timely and meaningful review of decisions denying them health care, we believe the following additional changes should be made to the proposed Act:

1. The Timeframe for Review. Section 1(c) of the Act states:

> "The insurer shall provide written notice to an insured of a final adverse decision and the opportunity for requesting the Commissioner's review."

This provision, which must be read in conjunction with Section 1(d), remains ambiguous. It does not provide a firm deadline within which an insurer must provide the insured with a decision on whether or not the requested benefits will be provided. In order to have the right to an external review of an adverse decision under a health benefit plan, subsection 1(d) of the Act requires an insured to (1) either exhaust "all available internal review procedures provided by the health benefit plan" or (2) proceed with an external review if the insured does not receive a "final decision from the insurer within 90 days of seeking an appeal."

Section 1(d) could be interpreted to mean that the insurer has a maximum of 90 days to issue a "final decision" from submission of a claim or the insured gets the right to independent review. However, the provision is still not very clear on this point and it could mean that the insured must first go through the internal review procedure and if there is an appeal provision in

that review, then wait an additional 90 days for a final determination of the appeal. The problem is that Section 1(d) does not clearly state when the 90 days for a final decision by the insurer begins to run. Is it when the claim is presented, which appears to be what is intended, or is it after all available internal review procedures, including any appeal, have been exhausted, after which the insured must wait an additional 90 days? Another problem is that there is no deadline specified for termination of an internal review. KTLA believes Section 1(d) of the Act needs to clearly state that the insurer has a maximum of days from the time the claim is submitted to conduct its internal review procedures and issue a "final decision." If it does not do so within the stated timeframe, the claim should be "deemed denied," and the insured allowed to proceed with external review. KTLA believes the timeframe should be limited to 60 days, rather than the 90 days currently in the act. In other words, Section 1(d) should require the insurance company's decision to be made within 60 days following the initial submission of the claim, or the insured has the right to proceed with an independent external review through the Insurance Commissioner.

2. Collection of Information by the Commissioner. Section 1(f) of the Act requires the insured to provide "all information in their possession pertaining to the claim in order for the Commissioner to make a preliminary determination. The insured shall also provide the Commissioner with an appeal form, and a fully executed release to obtain any necessary medical

records from the insurer or any other relevant provider."

KTLA believes that a provision should be made for expediting the process of obtaining medical records. Obtaining medical records can be a lengthy and time-consuming process if left to the ordinary course of business. A requirement that medical providers produce copies of medical records within five days of receipt of the request from the Commissioner will eliminate needless delay. In expedited cases, this should be 24 hours.

3. Selection of External Review Organization. Pursuant to Section 1(h) of the Act, an independent review organization is to be retained by the insurance department by negotiated contract. Although KTLA supports the idea of independent review organizations to conduct an external review, it is KTLA's belief that the Commissioner contract with at least two, and preferably three, external review organizations to insure that no one entity dominates the decision making. The insured should also be given the option of selecting one of the three independent review organizations available to review their claim. Of the 13 states reviewed in the Kaiser Foundation Study*, five states use independent review organizations. Three of those five contract with multiple IRO's. (Kaiser Family Foundation Report, p. 27.)

4. Timeliness of the Review. Pursuant to Section 1(i)(3), a Commissioner is to make a decision on a complaint within 30 days after receiving all necessary information. Thus, it appears to be

*External Review of Health Plan Decisions: An Overview of Key Program Features in the States and Medicare. (November 1998)

contemplated that in the ordinary case, decisions are to be rendered by the Commissioner within 30 days. The "loophole" in this provision is the requirement that the Insurance Commissioner receive "all necessary information." KTLA believes a five-day period for records collection (referred to in paragraph 3) needs to be specified in the Act to insure that all information is obtained by the Insurance Commissioner in the shortest possible timeframe.

5. Expedited Procedure for Emergency Cases. Section 1(i)(4) provides that reviews are to be done on an expedited basis "when the decision relates to emergency or urgent healthcare services." These terms are not defined in the Act, but presumably will be dealt with in administrative regulations promulgated by the Insurance Commissioner. In Section 1(i)(4), the Act requires the Commissioner of Insurance to design an expedited procedure for use in emergency cases. KTLA applauds the seven day timeframe specified in the Act. KTLA also proposes (in accordance with paragraph 3 above) that medical records be produced to the Commissioner within 24 hours of the request in emergency cases. The Act should also contain a definition of "emergency or urgent healthcare services."

6. Judicial Review. In Section 1(f), the Act states that:

> "The decision of the independent reviewer shall be binding on the health benefit plan and the insured. The insured shall not be barred from seeking a private

remedy."

This provision is unclear. The insured should be given the right to an appeal. If what is intended as HMO liability, it should be specified and KTLA would strongly support it.

8 Lack of Remedy. In order for the Act to work for consumers, it will have to have teeth. At a minimum, it needs to include a provision for civil penalties, and for payment of attorney's fees upon successful appeal, in order for the review procedure and right of appeal to be meaningful. If an insured is denied benefits given them on review or successfully appeals the denial, all the insured gets under the Act is (presumably) retroactive benefits. Even that is not specifically spelled out in the language of the Act.

As presently worded, the Act offers insureds no more of a remedy than is currently available under ERISA. Under current ERISA law, if an HMO plan denies benefits, the insured can bring an action in federal court challenging that denial as arbitrary and capricious. If successful, the insured gets the value of the denied benefits and in some instances attorney's fees. The proposed Kansas Act does even less. It sets up a procedure by which the insured can go through all the hoops, only to find themselves in Court on appeal seeking to get insurance benefits which, if they are successful, they were entitled to all along. As presently worded, it does not even provide for attorney's fees incurred to get the benefits.

In order for the Act to provide a means to secure insurance

benefits which Kansans are entitled, the Act needs to have a damages provision when the insurer/benefit plan administrator steps from the realm of administration into the realm of a medical provider. Some of the most egregious cases of benefit denial occur where nonmedical provider/plan administrators make medical decisions regarding what is best for the patient. In these instances, the plan should be subject to liability in tort. This is the approach adopted in the State of Texas with their HMO Liability Act. I have provided with the materials a copy of the Texas Act as well as a copy of an Ohio Bill that provides for both independent review of denials of care and liability for harm caused due to an improper denial of benefits. It is KTLA's view that Kansas should adopt the same remedy as made available to insureds in Texas and proposed in Ohio. With the above changes, including a provision for HMO liability, KTLA would strongly support this Bill. Without these changes, KTLA believes the Act will not protect Kansas consumers, but will only create a layer of bureaucracy and the illusion of relief from wrongful denials of health benefits by an HMO. As currently drafted, the bill is a first step, but not one that KTLA can affirmatively support.

In managed care, the bottom line is just that, the bottom line. The HMO concept is about savings and profits for the insurance company without the important check of a liability provision to prevent overreaching by HMOs in their quest for profits, insureds given the right to an external review, without a remedy for a violation of their rights under their insurance

contracts are given a hollow victory. Without a liability provision, there is nothing in Senate Bill 80 to provide anything more than the insurance coverage which should have been provided to the insured in the first place.

The two pronged approach of an external review, coupled with a liability provision, is the approach adopted by the state legislature of Texas, which in 1997 enacted a ground breaking HMO liability bill. That law provides that the claimant must first go through an independent review procedure prior to having the right to bring an action against the carrier for wrongful denial of the benefits. The dual pronged approach of external review, coupled with liability, was also incorporated by a bill that has been proposed in Ohio. It is the view of KTLA that these bills represent a much sounder and better approach to the issue of protecting Kansas insureds enrolled in private HMOs than that currently embodied in Senate Bill 80.

On behalf of KTLA, I appreciate the opportunity to bring our concerns to the Committee. If you have any questions about any of my comments or materials, I will do my best to answer them.

Congressman Pete Stark's
Press Release

239 Cannon Building
Washington, D.C. 20515
(202) 225-5065
petemail@stark.house.gov

HMO Executives' Salaries are Sky High, Stark Says

Families USA Study Highlights CEO Compensation

April 1, 1998

Salaries and bonuses for HMO executives are increasing exponentially, results from a Families USA survey released April 1, 1998 show. "The study shows what we've known all along--that for-profit HMOs can easily afford to share the wealth by providing some basic consumer protections for their members," Rep. Stark (D-CA) said.

Premium Pay: Corporate Compensation in America's HMOs , is based on 1996 filings to the Securities and Exchange Commission for the top 20 for-profit, publicly traded companies that owned HMOs with more than 100,000 members. The report indicated that Stephen Wiggins, former CEO of Oxford Health Plans, was the highest paid executive that year. In 1996, Mr. Wiggins received $29.1 million in compensation.

Measured by average compensation per top executive in 1996, Oxford topped the charts again at $11.7 million. Close behind are Aetna ($5.7 million); CIGNA ($5.1 million); WellPoint Health Networks ($3.3 million); and Foundation Health ($2.3 million). These totals do not include unexercised stock options--almost $30 million for Oxford alone! Overall, the average compensation for the highest paid executives, not including unexercised stock options, was more than $6.2 million in 1996.

"At the same time HMOs are fighting legislation requiring that pennies more be spent for basic consumer protections, CEOs are pulling down multi-million dollar salaries paid out of premium dollars," Rep. Stark said. "Yet every day, there's another horror story in the newspaper about someone in an HMO who is denied access to care."

Rep. Stark urged his fellow members of Congress to support consumer protections for HMO enrollees. "HMOs are putting salaries and bonuses first and patient care second," Rep. Stark said. "We need legislation that puts managed care quality standards in place that will hold HMOs accountable for members' care. They can certainly afford it."

Contact: Anne Montgomery

You can E-Mail Pete

Families USA FOUNDATION **PRESS RELEASE**

September 16, 1998.
Contact: Lorie Slass
202-628-3030

Despite Industry Losses for 1997 Average Compensation of Top HMO Execs Tops $2 Million

Industry Hypocritically Wages Advertising Campaign About Lawyers Profiting From Consumers and Costs of Protections

As the managed care industry posted losses for 1997, its top executives continued to take home millions of dollars in compensation according to a new report released today by Families USA, the national consumer health watchdog organization. Top HMO executives in the nation's largest for-profit managed care companies, on average, made $2 million in 1997.

As an update to an analysis of 1996 compensation for managed care executives, Families USA compiled 1997 compensation and stock options numbers for top managed care executives and found the highest paid executive, for the second year in a row, was Stephen Wiggins, former CEO of Oxford Health Plans, Inc., who took home over $30.7 million in 1997 and was sitting on almost $8.7 million in stock options. In 1996, Wiggins made $29.1 million and was sitting on stock options valued at $82.8 million.

Despite industry losses in 1997, four out of five of the top paid HMO industry executives saw compensation, *exclusive of unexercised stock options,* increase significantly in 1997. In addition to Wiggins; Wilson Taylor, Chairman and CEO of CIGNA went from $11.6 million in 1996 to $12.5 million in 1997. William McGuire, CEO of United HealthCare saw his compensation increase by over $7 million, from $1.2 million in 1996 to $8.6 million in 1997. Compensation for James Stewart, Executive Vice President of CIGNA, went from $4.8 million in 1996 to $7.3 million in 1997. Of the top five, only Robert Smoler, Executive Vice President at Oxford Health Plans, saw a decrease in compensation, going from $10.1 million in 1996 to $6.9 million in 1997. (See attached, Table 1, for the 25 highest paid HMO executives.)

"The hypocrisy of the industry on the issue of health care costs is startling," said Ron Pollack, executive director of Families USA. "They lose money in 1997 but spend millions to compensate their top executives, spend millions on advertising and lobbying to kill patient protections, and then they go around scaring the American public saying they will need to raise premiums to cover the very minor costs of comprehensive patient protections."

At the launch of a recent advertising campaign against managed care consumer protections, the Health Benefits Coalition, an organization made up of for-profit managed care companies said patient protections would "boost trial lawyer's profits" and would force premiums to go up. Aetna/US

Healthcare, CIGNA, United Healthcare and Humana are members of the Health Benefits Coalition.

According to the Congressional Budget Office analysis of the Patients' Bill of Rights Act, comprehensive consumer protections would raise premiums only four percent. For consumers that means less than $2 per month.

"The industry's duplicitous concerns about costs are an attempt to hide the fact that they don't want to ensure that patients are protected and they do not want to be held accountable for the health care decisions they are making," added Pollack.

The analysis also found that the executives were sitting on stock option packages averaging $4.5 million, up from $4.2 million per executive in 1996. The five executives with the largest unexercised stock options packages were, William McGuire, ($61.2 million); Alan Hoops, President and CEO, PacifiCare Health Systems ($ million); Wilson Taylor, Chairman and CEO of CIGNA ($20.0 million); Jeffrey Folick, Executive Vice President of PacifiCare ($19.1 million); and Malik Hasan, Chairman of the Board and CEO of Foundation Health Systems ($17.8 million). (See attached, Table 2, for executives with the 25 largest unexercised stock option packages.)

The companies with the highest average compensation, exclusive of unexercised stock options, per top executive were: CIGNA at $7.2 million, up $2 million from the 1996 average of $5.1 million; Oxford Health Plans at $6.4 million, down over $5 million from the 1996 average of $11.7 million; United Health Care Corporation at $2.9 million, up almost $2 million from the 1996 average of $.9 million; Aetna at $1.7 million, down from $5.6 million in 1996; and Humana who up from $1.5 million in 1996 to $1.6 million in 1997. All averages are for the top executives as reported to the Securities and Exchange Commission.

The companies with the highest average unexercised stock option packages per top executive were: United HealthCare ($17.0 million); PacifiCare Health Systems ($15.5 million); CIGNA ($10.6 million); Foundation Health Systems ($7.5 million); and Oxford Health Plans ($3.2 million).

The analysis examined executive compensation using each company's filings to the Securities and Exchange Commission in 1997. Companies included in the analysis are Aetna, CIGNA, Coventry, Foundation Health Systems, Inc., Humana, Maxicare Health Plans, Mid-Atlantic Medical Services, Oxford Health Plans, PacifiCare Health Systems, RightCHOICE Managed Care, Sierra Health Services, Trigon Healthcare, United HealthCare, United Wisconsin Services, and WellPoint Health Networks.

Table 1

The 25 Highest Paid HMO Executives 1997 Annual Compensation (Exclusive of Unexercised Stock Options)	
1. Stephen Wiggins, Chairman & CEO, Oxford Health Plans, Inc.	$30,735,093
2. Wilson Taylor, Chairman and CEO, CIGNA Corporation	12,456,169
3. William McGuire, CEO, United HealthCare Corporation	8,607,743

4. James Stewart, Executive Vice President, CIGNA Corporation	7,306,921
5. Robert Smoler, Executive Vice President, Oxford Health Plans, Inc.	6,918,509
6. Gerald Isom, President, Property and Casualty, CIGNA Corporation	5,737,691
7. Ronald Compton, former Chairman and CEO, Aetna	5,383,148
8. H. Edward Hanway, President, CIGNA HealthCare, CIGNA Corporation	5,282,734
9. Donald Levinson, Executive Vice President, CIGNA Corporation	5,177,026
10. Eugene Froelich, Executive Vice President, Maxicare Health Plans, Inc.	4,720,483
11. David Jones, Chairman of the Board, Former CEO, Humana, Inc.	4,495,798
12. George Jochum, Chairman of the Board, President and CEO, Mid-Atlantic Medical Services, Inc.	3,779,358
13. Travers Wills, COO, United HealthCare Corporation	3,461,096
14. Gregory Wolf, President and CEO, Humana, Inc.	2,954,430
15. David Snow, Jr. Executive Vice President, Oxford Health Plans, Inc.	2,835,477
16. Peter Ratican, Chairman of the Board, President and CEO, Maxicare Health Plans, Inc.	2,620,483
17. Jeffrey Folick, Executive Vice President, PacifiCare Health Systems, Inc.	2,184,470
18. Jeffrey Elder, Senior Vice President, Foundation Health Systems, Inc.	2,129,008
19. Andrew Cassidy, Executive Vice President, Oxford Health Plans, Inc.	1,974,171
20. Allen Wise, President and CEO, Coventry Corporation	1,974,171
21. Alan Hoops, President and CEO, PacifiCare Health Systems, Inc.	1,745,788
22. Leonard Schaeffer, Chairman and CEO, WellPoint Health Networks, Inc.	1,596,097
23. Anthony Marlon, Chairman and CEO, Sierra Health Services,	1,555,184

Inc.	
24. Erin MacDonald, President and COO, Sierra Health Services, Inc.	1,540,315
25. Norwood Davis, Jr., Chairman, Trigon Healthcare, Inc.	1,437,744

Table 2:

The 25 Executives with the Largest Unexercised Stock Option Packages in 1997	
1. William McGuire, CEO, United HealthCare Corporation	$61,178,652
2. Alan Hoops, President and CEO, PacifiCare Health Systems, Inc.	32,777354
3. Wilson Taylor, Chairman and CEO, CIGNA Corporation	19,959,470
4. Jeffrey Folick, Executive Vice President, PacifiCare Health Systems, Inc.	19,076,327
5. Malik Hasan, Chairman and CEO, Foundation Health Systems, Inc.	17,778,014
6. Wayne Lowell, Executive Vice President, PacifiCare Health Systems, Inc.	13,224,331
7. Jay Gellert, President and COO, Foundation Health Systems, Inc.	12,263,445
8. Travers Wills, COO, United HealthCare Corporation	11,431,203
9. Eric Sipf, Regional Vice President, PacifiCare Health Systems, Inc.	10,313,347
10. James Stewart, Executive Vice President, CIGNA Corporation	9,800,057
11. Gerald Isom, President, CIGNA Property and Casualty, CIGNA Corporation	9,062,053
12. Stephen Wiggins, Chairman and CEO, Oxford Health Plans, Inc.	8,654,000
13. H. Edward Hanway, President, CIGNA HealthCare, CIGNA Corporation	7,295,973
14. Donald Levinson, Executive Vice President, CIGNA Corporation	6,631,215

15. Gregory Wolf, President and CEO, Humana, Inc.	5,821,274
16. Richard Huber Chairman, CEO and President, Aetna, Inc.	5,755,562
17. Leonard Schaeffer, Chairman and CEO, WellPoint Health Networks, Inc.	5,724,912
18. James Carlson, President, Health Plans, United HealthCare Corporation	4,867,000
19. William Sullivan, President and CEO, Oxford Health Plans, Inc.	4,617,000
20. Norwood Davis, Jr., Chairman, Trigon Healthcare, Inc.	4,478,573
21. Karen Coughlin, Senior Vice President, Humana, Inc.	4,195,934
22. David Koppe, CFO, United HealthCare Corporation	4,012,708
23. David Snow, Jr., Executive Vice President, Oxford Health Plans, Inc.	3,952,780
24. Thomas McDonough, CEO, Strategic Business Services, United HealthCare Corporation	3,801,120
25. Dale Berkbigler, Executive Vice President, Foundation Health Systems, Inc.	3,687,463


Return to the Families USA Home Page

to the top of the page

As Introduced

123rd General Assembly

Regular Session H. B. No. 4

1999-2000

REPRESENTATIVES GARDNER-TIBERI-BUCHY-HARRIS-ALLEN-BARNES-BARRETT-BENDER-BOYD-BRADING-BRITTON-CALLENDER-CAREY-CATES-CORBIN-CORE-COUGHLIN-EVANS-FORD-GOODMAN-GRENDELL-HAINES-HOOD-HOOPS-JACOBSON-JOLIVETTE-KILBANE-KREBS-KRUPINSKI-MAIER-MEAD-METELSKY-METZGER-MOTTLEY-MYERS-O'BRIEN-OGG-OLMAN-OPFER-PADGETT-PATTON-PRINGLE-ROMAN-SALERNO-SCHULER-SCHURING-SMITH-TAYLOR-TERWILLEGER-THOMAS-WILLAMOWSKI-WILLIAMS-WINKLER-WOMER BENJAMIN-YOUNG

A B I L L

To amend sections 1751.11, 1751.33, 1751.78, 1751.81, 1751.82, and 5747.01 and to enact sections 1751.88, 1751.89, 1753.02, and 1753.13 of the Revised Code to hold a health insuring corporation responsible for harm to an enrollee proximately caused by the health insuring corporation's failure to exercise ordinary care in making a health care coverage decision; to make changes to the Health Insuring Corporation Law to provide for speedy review of enrollee appeals of adverse determinations; to allow female enrollees to obtain health care services from a participating obstetrician or gynecologist without a referral; to require health insuring corporations to name a licensed physician to act as a corporation's medical director; to require that at least one telephone number provided to enrollees for health-care-plan information be a toll-free number and to make additional information available to enrollees; and to permit

3-16

superintendent determines within the sixty-day period that any evidence of coverage or amendment fails to meet the requirements of this section, the superintendent shall so notify the health insuring corporation and it shall be unlawful for the health insuring corporation to use such evidence of coverage or amendment. At any time, the superintendent, upon at least thirty days' written notice to a health insuring corporation, may withdraw an approval, deemed or actual, of any evidence of coverage or amendment on any of the grounds stated in this section. Such disapproval shall be effected by a written order, which shall state the grounds for disapproval and shall be issued in accordance with Chapter 119. of the Revised Code.

(D) No evidence of coverage or amendment shall be (vered, issued for delivery, renewed, or used:

(1) If it contains provisions or statements that are inequitable, untrue, misleading, or deceptive;

(2) Unless it contains a clear, concise, and complete statement of the following:

(a) The health care services and insurance or other benefits, if any, to which the enrollee is entitled under the health care plan;

(b) Any exclusions or limitations on the health care services, type of health care services, benefits, or type of benefits to be provided, including copayments;

(c) The enrollee's personal financial obligation for noncovered services;

(d) Where and in what manner general information and information as to how services may be obtained is available, including the A TOLL-FREE telephone number;

(e) The premium rate with respect to individual and conversion contracts, and relevant copayment provisions with respect to all contracts. The statement of the premium rate,) ver, may be contained in a separate insert.

(f) The method utilized by the health insuring corporation

3-17

for health care services rendered by a provider or health care facility that is not under contract to the health insuring corporation, whether or not the health insuring corporation authorized the use of the provider or health care facility;

(6) IF IT CONTAINS PROVISIONS THAT LIMIT A SUBSCRIBER'S OR ENROLLEE'S RIGHT TO A RECONSIDERATION OR APPEAL OF AN ADVERSE DETERMINATION PURSUANT TO SECTIONS 1751.77 TO 1751.86 OF THE REVISED CODE.

(E) Notwithstanding divisions (C) and (D) of this section, a health insuring corporation may use an evidence of coverage that provides for the coverage of beneficiaries enrolled in Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, pursuant to a medicare contract, or an evidence of coverage that provides for the coverage of beneficiaries enrolled in the federal employees health benefits program pursuant to 5 U.S.C.A. 8905, or an evidence of coverage that provides for the coverage of beneficiaries enrolled in Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, known as the medical assistance program or medicaid, provided by the Ohio department of human services under Chapter 5111. of the Revised Code, or an evidence of coverage that provides for the coverage of beneficiaries under any other federal health care program regulated by a federal regulatory body, or an evidence of coverage that provides for the coverage of beneficiaries under any contract covering officers or employees of the state that has been entered into by the department of administrative services, if both of the following apply:

(1) The evidence of coverage has been approved by the United States department of health and human services, the United States office of personnel management, the Ohio department of human services, or the department of administrative services.

(2) The evidence of coverage is filed with the superintendent of insurance prior to use and is accompanied by

3-18

(2) Nothing in sections 1751.77 to 1751.82 or section 1751.85 of the Revised Code shall be construed to require a health insuring corporation to provide or perform utilization review services in connection with health care services provided under a policy, plan, or agreement of supplemental health care services or specialty health care services.

(B)(1) Each health insuring corporation shall be responsible for monitoring all utilization review activities carried out by, or on behalf of, the health insuring corporation, and for ensuring that all requirements of sections 1751.77 to 1751.86 of the Revised Code, and any rules adopted thereunder, are met. The health insuring corporation shall also ensure that appropriate personnel have operational responsibility for the conduct of the health insuring corporation's utilization review program.

(2) If a health insuring corporation contracts to have a utilization review organization or other entity perform the utilization review functions required by sections 1751.77 to 1751.86 of the Revised Code, and any rules adopted thereunder, the superintendent of insurance shall hold the health insuring corporation responsible for monitoring the activities of the utilization review organization or other entity and for ensuring that the requirements of those sections and rules are met.

Sec. 1751.81. (A) As used in this section:

(1) "Enrollee" includes the representative of an enrollee.

(2) "Necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.

(B) A health insuring corporation shall maintain written procedures for making utilization review determinations and for notifying enrollees, and participating providers and health care facilities acting on behalf of enrollees, of its determinations.

(C) For initial determinations, a health insuring corporation shall make the determination within two business days

3-19

of the determination.

(E) For retrospective review determinations, a health insuring corporation shall make the determination within thirty business days after receiving all necessary information.

(1) In the case of a certification, the health insuring corporation may notify the enrollee and the provider or health care facility rendering the health care service in writing.

(2) In the case of an adverse determination, the health insuring corporation shall notify the enrollee and the provider or health care facility rendering the health care service, in writing, within five business days after making the adverse determination.

(F)(1) The time frames set forth in divisions (C), (D), (E) of this section for determinations and notifications shall prevail unless the seriousness of the medical condition of the enrollee otherwise requires a more timely response from the health insuring corporation. The health insuring corporation shall maintain written procedures for making expedited utilization review determinations and notifications of enrollees and providers or health care facilities when warranted by the medical condition of the enrollee.

(2) AN ENROLLEE MAY PROCEED WITH AN APPEAL PURSUANT TO SECTION 1751.82 OF THE REVISED CODE IF A HEALTH INSURING CORPORATION FAILS TO MAKE A DETERMINATION AND NOTIFICATION WITHIN THE TIME FRAMES SET FORTH IN DIVISIONS (C), (D), AND (E) OF THIS SECTION. THE HEALTH INSURING CORPORATION'S FAILURE TO MAKE A DETERMINATION AND NOTIFICATION WITHIN THESE TIME FRAMES SHALL BE DEEMED TO BE AN ADVERSE DETERMINATION BY THE HEALTH INSURING CORPORATION FOR THE PURPOSE OF AN ENROLLEE'S INITIATION OF AN APPEAL.

(G) A written notification of an adverse determination shall include the principal reason or reasons for the determination, instructions for initiating an appeal or reconsideration of the determination, and instructions for

3-20

between the provider or health care facility rendering the health care service and the reviewer who made the adverse determination. If that reviewer cannot be available within three business days, the reviewer may designate another reviewer.

(B) If the reconsideration process described in division (A) of this section does not resolve the difference of opinion, the adverse determination may be appealed by the enrollee or the provider or health care facility on behalf of the enrollee.

(C) Reconsideration is not a prerequisite to a standard or expedited appeal of an adverse determination.

(D) The time period allowed by division (A) of this section for a reconsideration of an adverse determination shall not apply if the seriousness of the medical condition of the enrollee requires a more expedited reconsideration. The health insuring corporation shall maintain written procedures for making such an expedited reconsideration.

(E)(1) THE SUPERINTENDENT OF INSURANCE SHALL PRESCRIBE, BY RULES ADOPTED IN ACCORDANCE WITH CHAPTER 119. OF THE REVISED CODE, PROCEDURES GOVERNING THE STANDARD APPEAL OF AN ADVERSE DETERMINATION.

(2) THE PROCEDURES SHALL REQUIRE ALL OF THE FOLLOWING:

(a) THE REVIEW OF AN APPEAL SHALL BE CONDUCTED BY A PHYSICIAN THAT HAS BEEN RETAINED FOR THIS PURPOSE. THE PHYSICIAN SHALL HAVE EXPERTISE IN THE TREATMENT OF THE ENROLLEE'S MEDICAL CONDITION. THE PHYSICIAN SHALL NOT HAVE ANY PROFESSIONAL, FAMILIAL, OR FINANCIAL AFFILIATION WITH THE HEALTH INSURING CORPORATION AND SHALL HAVE NO PATIENT-PHYSICIAN RELATIONSHIP OR OTHER AFFILIATION WITH THE ENROLLEE WHO HAS BROUGHT THE APPEAL. THIS NONAFFILIATION PROVISION DOES NOT PRECLUDE THE HEALTH INSURING CORPORATION FROM PAYING THE PHYSICIAN FOR THE CONDUCT OF THE REVIEW.

(b) ENROLLEES SHALL NOT BE REQUIRED TO PAY FOR THE PHYSICIAN'S REVIEW OF THEIR APPEAL. THE COSTS OF THE REVIEW SHALL BE BORNE BY THE HEALTH INSURING CORPORATION.

3-21

(2) "UTILIZATION REVIEW" AND "UTILIZATION REVIEW ORGANIZATION" HAVE THE SAME MEANINGS AS IN SECTION 1751.77 OF THE REVISED CODE.

(B) EACH HEALTH INSURING CORPORATION THAT IS SUBJECT TO SECTIONS 1751.77 TO 1751.86 OF THE REVISED CODE SHALL EXERCISE ORDINARY CARE WHEN MAKING UTILIZATION REVIEW DETERMINATIONS.

A HEALTH INSURING CORPORATION IS LIABLE FOR DAMAGES FOR HARM TO AN ENROLLEE THAT IS PROXIMATELY CAUSED BY THE HEALTH INSURING CORPORATION'S FAILURE TO EXERCISE SUCH ORDINARY CARE. WITH RESPECT TO UTILIZATION REVIEW DETERMINATIONS MADE BY ANY DESIGNEE OF A HEALTH INSURING CORPORATION OR BY ANY UTILIZATION REVIEW ORGANIZATION THAT PERFORMS UTILIZATION REVIEW FUNCTIONS ON BEHALF OF A HEALTH INSURING CORPORATION, THE HEALTH INSURING ORATION IS ALSO LIABLE FOR DAMAGES FOR HARM TO AN ENROLLEE THAT IS PROXIMATELY CAUSED BY THE DESIGNEE'S OR UTILIZATION REVIEW ORGANIZATION'S FAILURE TO EXERCISE SUCH ORDINARY CARE.

(C) THIS SECTION DOES NOT CREATE ANY LIABILITY ON THE PART OF AN EMPLOYER OR EMPLOYER GROUP PURCHASING ORGANIZATION THAT PURCHASES COVERAGE OR ASSUMES RISK ON BEHALF OF ITS EMPLOYEES.

Sec. 1751.89. NO HEALTH INSURING CORPORATION CONTRACT WITH A PROVIDER OR HEALTH CARE FACILITY SHALL CONTAIN AN INDEMNIFICATION OR HOLD HARMLESS CLAUSE OR ANY OTHER PROVISION THAT ATTEMPTS TO LIMIT OR ELIMINATE THE HEALTH INSURING CORPORATION'S LIABILITY FOR ANY OMISSION OF OR ANY ACTION TAKEN BY THE HEALTH INSURING CORPORATION THAT AFFECTS THE MEDICAL CARE OF AN ENROLLEE.

ANY SUCH INDEMNIFICATION, HOLD HARMLESS, OR SIMILAR PROVISION IN A HEALTH INSURING CORPORATION CONTRACT WITH A PROVIDER OR HEALTH CARE FACILITY, WHICH CONTRACT IS IN FORCE ON THE EFFECTIVE DATE OF THIS SECTION, IS VOID.

Sec. 1753.02. A HEALTH INSURING CORPORATION SHALL NAME A PERSON LICENSED TO PRACTICE MEDICINE AND SURGERY OR OSTEOPATHIC M CINE AND SURGERY UNDER CHAPTER 4731. OF THE REVISED CODE TO AC AS THE HEALTH INSURING CORPORATION'S MEDICAL DIRECTOR.

3-22

(5) Deduct benefits under Title II of the Social Security Act and tier 1 railroad retirement benefits to the extent included in federal adjusted gross income under section 86 of the Internal Revenue Code.

(6) Add, in the case of a taxpayer who is a beneficiary of a trust that makes an accumulation distribution as defined in section 665 of the Internal Revenue Code, the portion, if any, of such distribution that does not exceed the undistributed net income of the trust for the three taxable years preceding the taxable year in which the distribution is made. "Undistributed net income of a trust" means the taxable income of the trust increased by (a)(i) the additions to adjusted gross income required under division (A) of this section and (ii) the personal ptions allowed to the trust pursuant to section 642(b) of the Internal Revenue Code, and decreased by (b)(i) the deductions to adjusted gross income required under division (A) of this section, (ii) the amount of federal income taxes attributable to such income, and (iii) the amount of taxable income that has been included in the adjusted gross income of a beneficiary by reason of a prior accumulation distribution. Any undistributed net income included in the adjusted gross income of a beneficiary shall reduce the undistributed net income of the trust commencing with the earliest years of the accumulation period.

(7) Deduct the amount of wages and salaries, if any, not otherwise allowable as a deduction but that would have been allowable as a deduction in computing federal adjusted gross income for the taxable year, had the targeted jobs credit allowed and determined under sections 38, 51, and 52 of the Internal Revenue Code not been in effect.

(8) Deduct any interest or interest equivalent on public obligations and purchase obligations to the extent included in federal adjusted gross income.

(9) Add any loss or deduct any gain resulting from the sale, exchange, or other disposition of public obligations to the

3-23

dependents. No deduction under division (A)(11) of this section shall be allowed to any taxpayer who is eligible to participate in any subsidized health plan maintained by any employer of the taxpayer or of the spouse of the taxpayer. No IN THE CASE OF A SELF-EMPLOYED INDIVIDUAL AS DEFINED IN SECTION 401(c) OF THE INTERNAL REVENUE CODE, NO deduction under division (A)(11) of this section shall be allowed to the extent that the sum of such deduction and any related deduction allowable in computing federal adjusted gross income for the taxable year exceeds the taxpayer's earned income, within the meaning of section 401(c) of the Internal Revenue Code, derived by the taxpayer from the trade or business with respect to which the A plan providing the medical coverage is established.

(12) Deduct any amount included in federal adjusted gross income solely because the amount represents a reimbursement or refund of expenses that in a previous year the taxpayer had deducted as an itemized deduction pursuant to section 63 of the Internal Revenue Code and applicable United States department of the treasury regulations.

(13) Deduct any portion of the deduction described in section 1341(a)(2) of the Internal Revenue Code, for repaying previously reported income received under a claim of right, that meets both of the following requirements:

(a) It is allowable for repayment of an item that was included in the taxpayer's adjusted gross income for a prior taxable year and did not qualify for a credit under division (A) or (B) of section 5747.05 of the Revised Code for that year;

(b) It does not otherwise reduce the taxpayer's adjusted gross income for the current or any other taxable year.

(14) Deduct an amount equal to the deposits made to, and net investment earnings of, a medical savings account during the taxable year, in accordance with section 3924.66 of the Revised Code. The deduction allowed by division (A)(14) of this section does not apply to medical savings account deposits and earnings

3-24

IN COMPUTING ADJUSTED GROSS INCOME FOR THE TAXABLE YEAR, THE EXPENSES ARE NOT COMPENSATED FOR BY INSURANCE OR OTHERWISE, AND THE EXPENSES ARE DEDUCTIBLE FOR FEDERAL INCOME TAX PURPOSES UNDER SECTION 213 OF THE INTERNAL REVENUE CODE.

(19) DEDUCT THE AMOUNT PAID DURING THE TAXABLE YEAR FOR LONG-TERM CARE INSURANCE, TO THE EXTENT NOT OTHERWISE DEDUCTED IN COMPUTING FEDERAL ADJUSTED GROSS INCOME FOR THE TAXABLE YEAR OR DEDUCTED UNDER DIVISION (A)(18) OF THIS SECTION.

(B) "Business income" means income arising from transactions, activities, and sources in the regular course of a trade or business and includes income from tangible and intangible property if the acquisition, rental, management, and disposition of the property constitute integral parts of the

ılar course of a trade or business operation.

(C) "Nonbusiness income" means all income other than business income and may include, but is not limited to, compensation, rents and royalties from real or tangible personal property, capital gains, interest, dividends and distributions, patent or copyright royalties, or lottery winnings, prizes, and awards.

(D) "Compensation" means any form of remuneration paid to an employee for personal services.

(E) "Fiduciary" means a guardian, trustee, executor, administrator, receiver, conservator, or any other person acting in any fiduciary capacity for any individual, trust, or estate.

(F) "Fiscal year" means an accounting period of twelve months ending on the last day of any month other than December.

(G) "Individual" means any natural person.

(H) "Internal Revenue Code" means the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended.

(I) "Resident" means:

(1) An individual who is domiciled in this state, subject

ŧ section 5747.24 of the Revised Code;

(2) The estate of a decedent who at the time of death was

3-25

(1) "Subdivision" means any county, municipal corporation, park district, or township.

(2) "Essential local government purposes" includes all functions that any subdivision is required by general law to exercise, including like functions that are exercised under a charter adopted pursuant to the Ohio Constitution.

(R) "Overpayment" means any amount already paid that exceeds the figure determined to be the correct amount of the tax.

(S) "Taxable income" applies to estates only and means taxable income as defined and used in the Internal Revenue Code adjusted as follows:

(1) Add interest or dividends on obligations or securities ny state or of any political subdivision or authority of any state, other than this state and its subdivisions and authorities;

(2) Add interest or dividends on obligations of any authority, commission, instrumentality, territory, or possession of the United States that are exempt from federal income taxes but not from state income taxes;

(3) Add the amount of personal exemption allowed to the estate pursuant to section 642(b) of the Internal Revenue Code;

(4) Deduct interest or dividends on obligations of the United States and its territories and possessions or of any authority, commission, or instrumentality of the United States that are exempt from state taxes under the laws of the United States;

(5) Deduct the amount of wages and salaries, if any, not otherwise allowable as a deduction but that would have been allowable as a deduction in computing federal taxable income for the taxable year, had the targeted jobs credit allowed under sections 38, 51, and 52 of the Internal Revenue Code not been in :t;

(6) Deduct any interest or interest equivalent on public

3-26

(b) The amount resulted in a reduction in the taxpayer's federal taxable income as required to be reported for any of the taxpayer's taxable years under the Internal Revenue Code.

(T) "School district income" and "school district income tax" have the same meanings as in section 5748.01 of the Revised Code.

(U) As used in divisions (A)(8), (A)(9), (S)(6), and (S)(7) of this section, "public obligations," "purchase obligations," and "interest or interest equivalent" have the same meanings as in section 5709.76 of the Revised Code.

(V) "Limited liability company" means any limited liability company formed under Chapter 1705. of the Revised Code or under the laws of any other state.

(W) "Pass-through entity investor" means any person who, during any portion of a taxable year of a pass-through entity, is a partner, member, shareholder, or investor in that pass-through entity.

(X) "Banking day" has the same meaning as in section 1304.01 of the Revised Code.

(Y) "Month" means a calendar month.

(Z) "Quarter" means the first three months, the second three months, the third three months, or the last three months of the taxpayer's taxable year.

(AA) Any term used in this chapter that is not otherwise defined in this section and that is not used in a comparable context in the Internal Revenue Code and other statutes of the United States relating to federal income taxes has the same meaning as in section 5733.40 of the Revised Code.

Section 2. That existing sections 1751.11, 1751.33, 1751.78, 1751.81, 1751.82, and 5747.01 of the Revised Code are hereby repealed.

Section 3. The amendment by this act of section 5747.01 of the Revised Code applies to taxable years beginning on or after January 1, 1999.

3-27

Bill Number: TX75RSB 386 Date: 5/12/97

ENROLLED

AN ACT

relating to review of and liability for certain health care treatment decisions.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Title 4, Civil Practice and Remedies Code, is amended by adding Chapter 88 to read as follows:

CHAPTER 88. HEALTH CARE LIABILITY

Sec. 88.001. DEFINITIONS. In this chapter:

(1) "Appropriate and medically necessary" means the standard for health care services as determined by physicians and health care providers in accordance with the prevailing practices and standards of the medical profession and community.

(2) "Enrollee" means an individual who is enrolled in a health care plan, including covered dependents.

(3) "Health care plan" means any plan whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services.

(4) "Health care provider" means a person or entity as defined in Section 1.03(a)(3), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes).

(5) "Health care treatment decision" means a determination made when medical services are actually provided by the health care plan and a decision which affects the quality of

3-28

the diagnosis, care, or treatment provided to the plan's insureds or enrollees.

(6) "Health insurance carrier" means an authorized insurance company that issues policies of accident and sickness insurance under Section 1, Chapter 397, Acts of the 54th Legislature, 1955 (Article 3.70-1, Vernon's Texas Insurance Code).

(7) "Health maintenance organization" means an organization licensed under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code).

(8) "Managed care entity" means any entity which delivers, administers, or assumes risk for health care services with systems or techniques to control or influence the quality, accessibility, utilization, or costs and prices of such services to a defined enrollee population, but does not include an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer or a pharmacy licensed by the State Board of Pharmacy.

(9) "Physician" means:

(A) an individual licensed to practice medicine in this state;

(B) a professional association organized under the Texas Professional Association Act (Article 1528f, Vernon's Texas Civil Statutes) or a nonprofit health corporation certified under Section 5.01, Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes); or

(C) another person wholly owned by physicians.

(10) "Ordinary care" means, in the case of a health

3-29

insurance carrier, health maintenance organization, or managed care entity, that degree of care that a health insurance carrier, health maintenance organization, or managed care entity of ordinary prudence would use under the same or similar circumstances. In the case of a person who is an employee, agent, ostensible agent, or representative of a health insurance carrier, health maintenance organization, or managed care entity, "ordinary care" means that degree of care that a person of ordinary prudence in the same profession, specialty, or area of practice as such person would use in the same or similar circumstances.

Sec. 88.002. APPLICATION. (a) A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care.

(b) A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan is also liable for damages for harm to an insured or enrollee proximately caused by the health care treatment decisions made by its:

(1) employees;

(2) agents;

(3) ostensible agents; or

(4) representatives who are acting on its behalf and over whom it has the right to exercise influence or control or has actually exercised influence or control which result in the failure

3-30

to exercise ordinary care.

(c) It shall be a defense to any action asserted against a health insurance carrier, health maintenance organization, or other managed care entity for a health care plan that:

(1) neither the health insurance carrier, health maintenance organization, or other managed care entity, nor any employee, agent, ostensible agent, or representative for whose conduct such health insurance carrier, health maintenance organization, or other managed care entity is liable under Subsection (b), controlled, influenced, or participated in the health care treatment decision; and

(2) the health insurance carrier, health maintenance organization, or other managed care entity did not deny or delay payment for any treatment prescribed or recommended by a provider to the insured or enrollee.

(d) The standards in Subsections (a) and (b) create no obligation on the part of the health insurance carrier, health maintenance organization, or other managed care entity to provide to an insured or enrollee treatment which is not covered by the health care plan of the entity.

(e) This chapter does not create any liability on the part of an employer, an employer group purchasing organization, or a pharmacy licensed by the State Board of Pharmacy that purchases coverage or assumes risk on behalf of its employees.

(f) A health insurance carrier, health maintenance organization, or managed care entity may not remove a physician or health care provider from its plan or refuse to renew the physician

3-31

or health care provider with its plan for advocating on behalf of an enrollee for appropriate and medically necessary health care for the enrollee.

(g) A health insurance carrier, health maintenance organization, or other managed care entity may not enter into a contract with a physician, hospital, or other health care provider or pharmaceutical company which includes an indemnification or hold harmless clause for the acts or conduct of the health insurance carrier, health maintenance organization, or other managed care entity. Any such indemnification or hold harmless clause in an existing contract is hereby declared void.

(h) Nothing in any law of this state prohibiting a health insurance carrier, health maintenance organization, or other managed care entity from practicing medicine or being licensed to practice medicine may be asserted as a defense by such health insurance carrier, health maintenance organization, or other managed care entity in an action brought against it pursuant to this section or any other law.

(i) In an action against a health insurance carrier, health maintenance organization, or managed care entity, a finding that a physician or other health care provider is an employee, agent, ostensible agent, or representative of such health insurance carrier, health maintenance organization, or managed care entity shall not be based solely on proof that such person's name appears in a listing of approved physicians or health care providers made available to insureds or enrollees under a health care plan.

(j) This chapter does not apply to workers' compensation

3-32

insurance coverage as defined in Section 401.011, Labor Code.

(k) An enrollee who files an action under this chapter shall comply with the requirements of Section 13.01, Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes), as it relates to cost bonds, deposits, and expert reports.

Sec. 88.003. LIMITATIONS ON CAUSE OF ACTION. (a) A person may not maintain a cause of action under this chapter against a health insurance carrier, health maintenance organization, or other managed care entity that is required to comply with the utilization review requirements of Article 21.58A, Insurance Code, or the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), unless the affected insured or enrollee or the insured's or enrollee's representative:

(1) has exhausted the appeals and review applicable under the utilization review requirements; or

(2) before instituting the action:

(A) gives written notice of the claim as provided by Subsection (b); and

(B) agrees to submit the claim to a review by an independent review organization under Article 21.58A, Insurance Code, as required by Subsection (c).

(b) The notice required by Subsection (a)(2)(A) must be delivered or mailed to the health insurance carrier, health maintenance organization, or managed care entity against whom the action is made not later than the 30th day before the date the claim is filed.

(c) The insured or enrollee or the insured's or enrollee's representative must submit the claim to a review by an independent review organization if the health insurance carrier, health maintenance organization, or managed care entity against whom the claim is made requests the review not later than the 14th day after the date notice under Subsection (a)(2)(A) is received by the health insurance carrier, health maintenance organization, or managed care entity. If the health insurance carrier, health maintenance organization, or managed care entity does not request the review within the period specified by this subsection, the insured or enrollee or the insured's or enrollee's representative is not required to submit the claim to independent review before maintaining the action.

(d) Subject to Subsection (e), if the enrollee has not complied with Subsection (a), an action under this section shall not be dismissed by the court, but the court may, in its discretion, order the parties to submit to an independent review or mediation or other nonbinding alternative dispute resolution and may abate the action for a period of not to exceed 30 days for such purposes. Such orders of the court shall be the sole remedy available to a party complaining of an enrollee's failure to comply with Subsection (a).

(e) The enrollee is not required to comply with Subsection (c) and no abatement or other order pursuant to Subsection (d) for failure to comply shall be imposed if the enrollee has filed a pleading alleging in substance that:

(1) harm to the enrollee has already occurred because

3-34

of the conduct of the health insurance carrier, health maintenance organization, or managed care entity or because of an act or omission of an employee, agent, ostensible agent, or representative of such carrier, organization, or entity for whose conduct it is liable under Section 88.002(b); and

(2) the review would not be beneficial to the enrollee, unless the court, upon motion by a defendant carrier, organization, or entity finds after hearing that such pleading was not made in good faith, in which case the court may enter an order pursuant to Subsection (d).

(f) If the insured or enrollee or the insured's or enrollee's representative seeks to exhaust the appeals and review or provides notice, as required by Subsection (a), before the statute of limitations applicable to a claim against a managed care entity has expired, the limitations period is tolled until the later of:

(1) the 30th day after the date the insured or enrollee or the insured's or enrollee's representative has exhausted the process for appeals and review applicable under the utilization review requirements; or

(2) the 40th day after the date the insured or enrollee or the insured's or enrollee's representative gives notice under Subsection (a)(2)(A).

(g) This section does not prohibit an insured or enrollee from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or relief available under law, if the requirement of exhausting the process for appeal and review

3-35

places the insured's or enrollee's health in serious jeopardy.

SECTION 2. Section 6, Article 21.58A, Insurance Code, is amended by amending Subsection (b) and adding Subsection (c) to read as follows:

(b) The procedures for appeals shall be reasonable and shall include the following:

(1) a provision that an enrollee, a person acting on behalf of the enrollee, or the enrollee's physician or health care provider may appeal the adverse determination and shall be provided, on request, a clear and concise statement of the clinical basis for the adverse determination;

(2) a list of documents needed to be submitted by the appealing party to the utilization review agent for the appeal;

(3) a provision that appeal decisions shall be made by a physician, provided that, if the appeal is denied and within 10 working days the health care provider sets forth in writing good cause for having a particular type of a specialty provider review the case, the denial shall be reviewed by a health care provider in the same or similar specialty as typically manages the medical condition, procedure, or treatment under discussion for review of the adverse determination;

(4) in addition to the written appeal, a method for an expedited appeal procedure for emergency care denials and denials of continued stays for hospitalized patients, which shall include a health care provider who has not previously reviewed the case; such appeal must be completed no later than one working day following the day on which the appeal, including all information necessary to

complete the appeal, is made to the utilization review agent; and

(5) written notification to the appealing party of the determination of the appeal, as soon as practical, but in no case later than the 30th day after the date the utilization agent receives [~~30 days after receiving all the required documentation of~~] the appeal. If the appeal is denied, the written notification shall include a clear and concise statement of:

(A) the clinical basis for the appeal's denial;

(B) [~~and~~] the specialty of the physician making the denial; and

(C) notice of the appealing party's right to seek review of the denial by an independent review organization under Section 6A of this article and the procedures for obtaining that review.

(c) Notwithstanding any other law, in a circumstance involving an enrollee's life-threatening condition, the enrollee is entitled to an immediate appeal to an independent review organization as provided by Section 6A of this article and is not required to comply with procedures for an internal review of the utilization review agent's adverse determination. For purposes of this section, "life-threatening condition" means a disease or other medical condition with respect to which death is probable unless the course of the disease or condition is interrupted.

SECTION 3. Article 21.58A, Insurance Code, is amended by adding Section 6A to read as follows:

Sec. 6A. INDEPENDENT REVIEW OF ADVERSE DETERMINATIONS. A utilization review agent shall:

3-37

(1) permit any party whose appeal of an adverse determination is denied by the utilization review agent to seek review of that determination by an independent review organization assigned to the appeal in accordance with Article 21.58C of this code;

(2) provide to the appropriate independent review organization not later than the third business day after the date that the utilization review agent receives a request for review a copy of:

(A) any medical records of the enrollee that are relevant to the review;

(B) any documents used by the plan in making the determination to be reviewed by the organization;

(C) the written notification described by Section 6(b)(5) of this article;

(D) any documentation and written information submitted to the utilization review agent in support of the appeal; and

(E) a list of each physician or health care provider who has provided care to the enrollee and who may have medical records relevant to the appeal;

(3) comply with the independent review organization's determination with respect to the medical necessity or appropriateness of health care items and services for an enrollee; and

(4) pay for the independent review.

SECTION 4. Section 8, Article 21.58A, Insurance Code, is

amended by adding Subsection (f) to read as follows:

(f) Confidential information in the custody of a utilization review agent may be provided to an independent review organization, subject to rules and standards adopted by the commissioner under Article 21.58C of this code.

SECTION 5. Subdivision (3), Subsection (a), Section 9, Texas Health Maintenance Organization Act (Article 20A.09, Vernon's Texas Insurance Code), is amended to read as follows:

(3) An evidence of coverage shall contain:

(A) no provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, which encourage misrepresentation, or which are untrue, misleading, or deceptive as defined in Section 14 of this Act; and

(B) a clear and complete statement, if a contract, or a reasonably complete facsimile, if a certificate, of:

(i) the medical, health care services, or single health care service and the issuance of other benefits, if any, to which the enrollee is entitled under the health care plan or single health care service plan;

(ii) any limitation on the services, kinds of services, benefits, or kinds of benefits to be provided, including any deductible or co-payment feature;

(iii) where and in what manner information is available as to how services may be obtained; and

(iv) a clear and understandable description of the health maintenance organization's methods for resolving enrollee complaints, including the enrollee's right to

appeal denials of an adverse determination, as that term is defined by Section 12A of this Act, to an independent review organization and the procedures for making an appeal to an independent review organization. Any subsequent changes may be evidenced in a separate document issued to the enrollee.

SECTION 6. Section 12, Texas Health Maintenance Organization Act (Article 20A.12, Vernon's Texas Insurance Code), is amended to read as follows:

Sec. 12. COMPLAINT SYSTEM. (a) Every health maintenance organization shall establish and maintain a complaint system to provide reasonable procedures for the resolution of oral and written complaints initiated by enrollees concerning health care services.

(b) The commissioner [~~or board~~] may examine the [~~such~~] complaint system.

SECTION 7. The Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code) is amended by adding Section 12A to read as follows:

Sec. 12A. REVIEW OF ADVERSE DETERMINATIONS. (a) The complaint system required by Section 12 of this Act must include:

(1) notification to the enrollee of the enrollee's right to appeal an adverse determination to an independent review organization;

(2) notification to the enrollee of the procedures for appealing an adverse determination to an independent review organization; and

(3) notification to an enrollee who has a

life-threatening condition of the enrollee's right to immediate review by an independent review organization and the procedures to obtain that review.

(b) The provisions of Article 21.58A, Insurance Code, that relate to independent review apply to a health maintenance organization under this section as if the health maintenance organization were a utilization review agent.

(c) In this section:

(1) "Adverse determination" means determination by a health maintenance organization that the health care services furnished or proposed to be furnished to an enrollee are not medically necessary.

(2) "Independent review organization" means an organization selected as provided under Article 21.58C, Insurance Code.

(3) "Life-threatening condition" has the meaning assigned by Section 6, Article 21.58A, Insurance Code.

SECTION 8. Subchapter E, Chapter 21, Insurance Code, is amended by adding Article 21.58C to read as follows:

Art. 21.58C. STANDARDS FOR INDEPENDENT REVIEW ORGANIZATIONS

Sec. 1. DEFINITIONS. In this article:

(1) "Life-threatening condition" has the meaning assigned by Section 6, Article 21.58A of this code.

(2) "Payor" has the meaning assigned by Section 2, Article 21.58A of this code.

Sec. 2. CERTIFICATION AND DESIGNATION OF INDEPENDENT REVIEW ORGANIZATIONS. (a) The commissioner shall:

(1) promulgate standards and rules for:

(A) the certification, selection, and operation of independent review organizations to perform independent review described by Section 6, Article 21.58A of this code; and

(B) the suspension and revocation of the certification;

(2) designate annually each organization that meets the standards as an independent review organization;

(3) charge payors fees in accordance with this article as necessary to fund the operations of independent review organizations; and

(4) provide ongoing oversight of the independent review organizations to ensure continued compliance with this article and the standards and rules adopted under this article.

(b) The standards required by Subsection (a)(1) of this section must ensure:

(1) the timely response of an independent review organization selected under this article;

(2) the confidentiality of medical records transmitted to an independent review organization for use in independent reviews;

(3) the qualifications and independence of each health care provider or physician making review determinations for an independent review organization;

(4) the fairness of the procedures used by an independent review organization in making the determinations; and

(5) timely notice to enrollees of the results of the

3-42

independent review, including the clinical basis for the determination.

(c) The standards adopted under Subsection (a)(1) of this section must include standards that require each independent review organization to make its determination:

(1) not later than the earlier of:

(A) the 15th day after the date the independent review organization receives the information necessary to make the determination; or

(B) the 20th day after the date the independent review organization receives the request that the determination be made; and

(2) in the case of a life-threatening condition, not later than the earlier of:

(A) the fifth day after the date the independent review organization receives the information necessary to make the determination; or

(B) the eighth day after the date the independent review organization receives the request that the determination be made.

(d) To be certified as an independent review organization under this article, an organization must submit to the commissioner an application in the form required by the commissioner. The application must include:

(1) for an applicant that is publicly held, the name of each stockholder or owner of more than five percent of any stock or options;

3-43

(2) the name of any holder of bonds or notes of the applicant that exceed $100,000;

(3) the name and type of business of each corporation or other organization that the applicant controls or is affiliated with and the nature and extent of the affiliation or control;

(4) the name and a biographical sketch of each director, officer, and executive of the applicant and any entity listed under Subdivision (3) of this subsection and a description of any relationship the named individual has with:

(A) a health benefit plan;

(B) a health maintenance organization;

(C) an insurer;

(D) a utilization review agent;

(E) a nonprofit health corporation;

(F) a payor;

(G) a health care provider; or

(H) a group representing any of the entities described by Paragraphs (A) through (G) of this subdivision;

(5) the percentage of the applicant's revenues that are anticipated to be derived from reviews conducted under Section 6A, Article 21.58A of this code;

(6) a description of the areas of expertise of the health care professionals making review determinations for the applicant; and

(7) the procedures to be used by the independent review organization in making review determinations with respect to reviews conducted under Section 6A, Article 21.58A of this code.

(e) The independent review organization shall annually submit the information required by Subsection (d) of this section. If at any time there is a material change in the information included in the application under Subsection (d) of this section, the independent review organization shall submit updated information to the commissioner.

(f) An independent review organization may not be a subsidiary of, or in any way owned or controlled by, a payor or a trade or professional association of payors.

(g) An independent review organization conducting a review under Section 6A, Article 21.58A of this code is not liable for damages arising from the determination made by the organization. This subsection does not apply to an act or omission of the independent review organization that is made in bad faith or that involves gross negligence.

SECTION 9. Chapter 88, Civil Practice and Remedies Code, as added by this Act, applies only to a cause of action that accrues on or after the effective date of this Act. An action that accrues before the effective date of this Act is governed by the law applicable to the action immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 10. (a) The change in law made by Sections 2 through 4 and 6 through 8 of this Act applies only to an adverse determination of a utilization review agent or health maintenance organization made on or after the effective date of this Act.

(b) The change in law made by Section 5 of this Act to Section 9, Texas Health Maintenance Organization Act (Article

20A.09, Vernon's Texas Insurance Code), applies only to an evidence of coverage that is delivered, issued for delivery, or renewed on or after January 1, 1998. An evidence of coverage that is delivered, issued for delivery, or renewed before January 1, 1998, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 11. This Act takes effect September 1, 1997.

SECTION 12. The importance of this legislation and the crowded condition of the calendars in both houses create an emergency and an imperative public necessity that the constitutional rule requiring bills to be read on three several days in each house be suspended, and this rule is hereby suspended.

S.B. No. 386

_____ _____

President of the Senate Speaker of the House

I hereby certify that S.B. No. 386 passed the Senate on March 17, 1997, by a viva-voce vote; and that the Senate concurred in House amendments on May 12, 1997, by the following vote: Yeas 25, Nays 5.

_____

Secretary of the Senate

I hereby certify that S.B. No. 386 passed the House, with amendments, on May 8, 1997, by a non-record vote.

_____

Chief Clerk of the House

Approved:

_____

Date

_____

Governor

etter sent to full Congress. Prepared by R.Szabat x427

American Medical Association
Physicians dedicated to the health of America

E. Ratcliffe Anderson, Jr., MD
Executive Vice President, CEO

515 North State Street
Chicago, Illinois 60610

312 464-5000
312 464-4184 Fax

January 19, 1999

The Honorable Trent Lott
United States Senate
S-230 Capitol Building
Washington, DC 20510

Dear Senator Lott:

On behalf of the 300,000 physician and student members of the American Medical Association (AMA), we are writing to highlight the issues that we believe are integral to effective patients' rights legislation in the 106th Congress. As you know, advancing managed care fairness reforms through a patients' bill of rights remains a foremost concern of Americans everywhere. In fact, according to a recent poll conducted by the Kaiser Family Foundation and the Harvard School of Public Health, four of every five Americans support essential reforms we are advocating. Similar findings were reported in a post-election survey in Newsweek magazine.

The AMA is committed to working on a bipartisan basis to pass meaningful and comprehensive patient protection legislation this year. To this end, the AMA firmly believes that the following elements must be included in any patients' rights bill:

The "Medical Necessity" of Patient Care Must Be Determined by Treating Physicians, Not Health Plan Bureaucrats

On behalf of our patients, the AMA believes that properly defining the "medical necessity" of patient care is absolutely essential. Emerging legislation must protect the historic role of American physicians to determine what care is necessary and appropriate *for individual patients* consistent with "generally accepted principles of professional medical practice."

Specifically, the AMA supports a definition of "medical necessity" as follows:

> *Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (1) in accordance with generally accepted standards of medical practice; (2) clinically appropriate in terms of type, frequency, extent, site, and duration; and (3) not primarily for the convenience of the patient, physician, or other health care provider.*

It is critical that the Congress not be swayed by the misleading and false statements being made by those who would arbitrarily seek to deny needed patient care. Make no mistake about it, this is not about covering every conceivable medical service for every patient in every instance. On the contrary, the AMA is principally concerned that some health plans have sought to manipulate the definition of "medical necessity" to deny patient care by arbitrarily linking it to lowest cost measures without considering the individual patient's medical condition. The AMA believes that

health plans should not be allowed to unfairly deny medical care across-the-board based on the application of such unfair "medical necessity" definitions. If health plans are able to narrowly define "medical necessity," the external appeals process will be seriously undermined. While the AMA supports the ability of health plans and employers to establish health benefits packages, health plans must allow treating physicians, not health plan bureaucrats, to make individual medical care decisions.

Aggrieved Patients Must Have Prompt and Fair Redress through Independent External Review Procedures When Medical Care is Denied

A grievance system should have rapid internal and external appeals mechanisms, so that patients can seek an independent third party review, within the appeals process, of health plan denials of care and other treatment decisions. Essential to a sound review process, this provision should require that only a duly licensed physician, with the same specialty expertise and licensed in the same state, be allowed to function as a clinical peer to review the treatment rendered by another physician.

Patients and Prospective Enrollees Must Have Adequate Information from the Health Plan

A patients' rights bill should ensure that patients are fully informed about available covered medical benefits, quality assurance protections, and utilization review methods at regular intervals. Not only do enrollees need this information, they have a right to it so they can understand and make informed medical care decisions within the managed care system.

Health Plans Gag Clauses and Gag Practices Should be Banned Once and For All and Physicians Should Not Face Retaliation for Patient Advocacy

The bill should also promote better patient-physician relationships by prohibiting plans or insurance issuers from interfering with physicians' communications with their patients. It is unethical for health plans to gag physicians and keep patients in the dark about medical treatment options, including what are truly covered services. Based on a recent court filing in Texas, alleged "gag clauses" are still being forced on physicians by large health plans.

Patients Should Be Guaranteed Prompt Access to Needed Emergency Medical Care

In addition, patient protection legislation should institute a "prudent layperson standard" for determining when emergency medical services are medically necessary and must be covered by a plan that provides such benefits. Establishing this as a standard is not only fair, but essential. Managed care participants who seek emergency services when they genuinely believe they need immediate medical attention should not be subject to retrospective review or denial of care or reimbursement. We urge that Congress adopt the same "prudent layperson" standard that applies to the Medicare program.

Patients Should Be Ensured Choice, Continuity of Medical Care and Access to Specialty Medical Care

A full and fair patients' rights bill should also ensure that managed care plan patients are guaranteed reasonable continuity of care from treating physicians when the plan changes

patients' physicians without the patient's consent. At the same time, the bill must recognize the unique health care needs of women, children and the chronically ill. It should also require plans to offer patients a "point-of-service" option when plans otherwise limit their access to a closed medical panel, enabling patients to receive services with reasonable cost-sharing from non-participating physicians, should they desire to purchase this added option. Along these lines, adequate access to medical specialty care is paramount.

Health Plans Should be Accountable to Patients When Their Negligent Medical Decisions Cause Injury or Death

Patients' rights legislation should take the essential step of making health plans accountable for their negligent medical decision-making. Current interpretation of ERISA law immunizes employer-sponsored health plans from state-based liability claims by injured patients. Any proposed legislation should remove that insulation, and make those health plans that make medical decisions accountable for those decisions. This remains an issue of fundamental fairness. Americans covered by ERISA plans should have the same right of redress as those who are covered by non-ERISA plans. Permitting plans to escape liability for negligence due to legal loopholes places patients in serious jeopardy. The AMA does not intend to increase employer liability, as it is generally health plans, not employers, that are making unfair "medical necessity" decisions.

In addition, it is critical that any new legislation affecting ERISA fully preserve the application of positive case law precedent that has included holding health plans accountable under state law for the quality of benefits and the adequacy of the health plan network.

Stronger Existing State Law Patient Protections Should Not Be Pre-empted by Any Federal Patients' Rights Bill

As a matter of fundamental fairness, any Federal patient protection measure should become a floor and not a ceiling for managed care fairness reforms.

Patients need protection now. A comprehensive and meaningful patient protection bill would provide that protection while ensuring that plans accept their responsibility in providing health care. We urge you to support or sponsor an effective and meaningful patient protection bill and to call for its passage and enactment this year in order to help restore confidence in our health care system.

Respectfully,

E. Ratcliffe Anderson, Jr., MD

Kansas Association
of Health Plans

1206 SW 10th St.
Topeka, KS 66604

785-233-2747
Fax 785-233-3518
kahp@kansasstatehouse.com

Testimony before the
Senate Financial Institutions and Insurance Committee
The Honorable Don Steffes, Chairman
Hearings on SB 80
March 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. Members of the KAHP serve many of the Kansans who are insured by an HMO.

Our Association generally supports the concept of external review and believes that a carefully crafted external review provision may help restore consumer confidence in the managed care industry. However, we do have some concerns with SB 80 that we would like to address.

SB 80 while a bit unclear, appears to provide the Insurance Commissioner with the right to determine whether the request for an external review will be forwarded to the independent external review entity. (page 2 sec. (h) (1) lines 26-28). At the same time the newly proposed amendments establish specifically when an insured has the right to an independent external review. If the insured has such rights as long as the specific criteria are met, it is unclear to us what the Commissioner is going to be deciding.

Moreover, the bill establishes the right to an external review of adverse decisions regarding medical necessity determinations or when the health care treatment has been determined to be experimental or investigational. We believe those issues are medical issues, not coverage issues. Therefore, it seems more appropriate to have medical experts (the external review entity) making determinations regarding these medical decisions rather than the Insurance Department.

While the NAIC model is written to include similar rights for this type of involvement by the Insurance Commissioner, the model includes a drafting note that states in summary:

Some states may prefer not to establish an external review process in the Commissioner's office. Instead, they may have the Commissioner's office responsible for receipt of all requests for external review, but then require that the Commissioner's office delegate the responsibility of conducting all aspects, including final decision making authority of the review to an independent review organization. Some states may choose to have the health insurance carrier

responsible for the receipt of all requests for external review and transmittal of the requests to an independent review organization.

The point is, even the NAIC recognizes in the drafting note the various alternatives states may choose to pursue this matter.

We question the intent of the Commissioner's amendment that states external review is available when a provider acting on behalf of the insured files a written request with the commissioner's office. It is unclear whether this language means that any provider may seek an external review or only the enrollee's own treating physician.

The Commissioner's proposed amendments give the insured the right to a private remedy subsequent to the external review procedure. We believe that the decision of the external review organization should be binding on both the insured and the insurer. States have dealt with this issue in a variety of ways. Some legislation states that if the decision is not binding then the findings of the external reviewer would be admissible in the subsequent court proceedings. For instance, Tennessee legislation states that a determination by the expert reviewer in favor of the health plan will create a rebuttable presumption that the plan's coverage determination was appropriate.

We also question the portion of the bill which states that the insured may appeal if the insured has not received a final decision from the insurer within 90 days of seeking an appeal. 90 days is reasonable, but there are no safeguards if a member, provider or other entity is untimely in supplying the health plan with the necessary information to enable the health plan to make an informed appeal decision.

Five days to compile all medical records seems unreasonable, especially if the consumer requests external review months after a health plan has issued its appeal decision. However, we do not believe that it is unreasonable to require that the health plan provide an explanation of the basis of the health plan's decision within five days.

Finally, SB 80 does not address who will be responsible for the cost of the external review, whether there is a minimum amount that should be in controversy or whether a filing fee should be required.

As I stated earlier, we are generally in favor of an external review procedure. However, we have concerns about this particular legislation. We would be happy to work with the Commissioner over the interim to come up with a bill that is acceptable to all interested parties. Along those lines, we understand that the NAIC has a draft version of an external review bill and expects to finalize it in the next couple of months. ALEC is also working on a model act concerning external review. In addition, virtually every federal patient protection initiative includes an external review provision. If one believes that this is the year that federal legislation will be passed on patient protection (and we do), the federal legislation will likely include an external review provision. Our suggestion is to monitor the happenings on the federal level and in the interim work with the Commissioner and other interested parties on legislation acceptable to all parties.

Thank you for allowing us to express our concerns on SB 80. I will be happy to try to answer any questions that you have concerning this issue.

K Psychiatric Society

Founded 1942

A District Branch of the American Psychiatric Association

623 SW 10th Avenue
Topeka KS 66612-1627
(785) 266-7173
fax (785) 235-5114
kps@cjnetworks.com

Statement
to the
Senate Financial Institutions and Insurance Committee
by
Charles Wheelen
March 3, 1999

Thank you for the opportunity to express our support for Senate Bill 80. The provisions of SB80 would provide patients an opportunity for recourse in the event of an adverse decision by an insurer.

We believe that all patients, regardless of circumstances or their health insurance plan, have a right to receive quality health care services. When an insurer decides that a recommended service or treatment regimen is not medically necessary, the patient's right to quality care is jeopardized.

Senate Bill 80 would provide a method for reconciling differences of clinical opinion by referring the question of medical necessity to an independent third party. This would add another important patient protection to those protections already enacted by our Legislature.

Thank you for considering our comments. We respectfully request that you recommend SB80 for passage.

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

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

TO: Senate Committee on Financial Institutions and Insurance

FROM: Kathleen Sebelius, Insurance Commissioner

RE: SB 291 – Medicare Supplement Disability – creating a reinsurance program

DATE: March 3, 1999

Mr. Chairman and members of the Committee:

I am appearing in support of SB 291 which would create a mechanism, through the high risk pool, to pay the excess costs of the disabled Kansans who are under-65 years old, and qualify for Medicare by virtue of their health condition. There are approximately 3,300 Kansans who share similar characteristics with the policyholders of the Kansas Health Insurance Association plan; they are considerably sicker than the average Kansan.

When Congress passed the legislation which revised federally regulated Medicare supplemental insurance (October 31, 1994 – H. R. 5252), the law did not mandate an open enrollment period for those individuals who become eligible for Medicare because of a medical disability. The Congressional legislation only addressed those Americans who reached age 65 and became eligible for Medicare. In spite of Congressional oversight, by 1996, there were 15 states which enacted regulations to make sure that those Medicare beneficiaries, who were ill and disabled, had an opportunity to buy supplemental policies in the marketplace. Kansas was not one of the states with a guaranteed issue, and, in fact, most of the companies who sold Medicare

420 SW 9th Street
Topeka, Kansas 66612-1678

785 296-3071
Fax 785 296-2283

Supplemental insurance in Kansas either refused to underwrite these policyholders or charged such extremely high rates that the policies were unaffordable.

After receiving dozens of anguished pleas from Kansas consumers, and following several meetings with insurers in the marketplace, I implemented a new policy for the sale of Medicare Supplemental insurance policies in Kansas. While I was willing to take the issue to the Legislature, the insurers urged that the policy be enacted by regulation, and not by statute. Kansas Insurance Department Bulletin 1996-4 was issued (it is attached), and companies selling Medicare supplemental insurance in Kansas were required to offer supplemental insurance plans to medically-disabled Kansans, when they became Medicare-eligible, and charge age-65 rates.

While that took care of the problem prospectively, there were approximately 4,000 Kansans, who were already Medicare eligible, who had either very high priced Medicare Supplemental policies, or were refused the sale of a policy, or priced entirely out of the marketplace.

The 1996 proposal included an enrollment period for six months in 1996, advertisements about the new opportunity for Medicare-eligible disabled Kansans to purchase a supplemental insurance policy, and a plan to phase-down the rates of current policyholders on a graduated scale, until they reached age-65 rates by the year 2000.

In 1996, Blue Cross and Blue Shield of Kansas had the bulk of the policyholders, because they were one of the only companies voluntarily offering supplemental insurance to disabled Kansans. Consequently, the company has experienced major losses due to the higher claims experience, and the agreement to phase down the rate differential. I discussed this issue with the Legislature last year and suggested that the company be given a premium tax credit for these additional losses. For a variety of reasons, that bill was not successful.

The Department supports the creation of a mechanism to spread the risk evenly and fairly among insurers. By developing a reinsurance and assessment mechanism, which would be administered by the KHIA board, with administrative costs paid by the companies selling Medicare supplement insurance, we can accomplish that purpose.

The bill, as drafted, only applies to those disabled Kansans who became Medicare eligible prior to 1996, and, by virtue of their ill health, this is a dwindling population. The losses in excess of 65%, (the loss ratio allowed by Congress for this business), would be tabulated each year and allocated back to those providers in the marketplace based on a market-share formula.

It is a mechanism which makes sure that older Kansans don't bear the entire cost of this positive public policy for medically-disabled Kansans; that the costs are shared by all companies doing business in the Medicare supplemental marketplace.

KHIA was originally established by the Legislature to provide comprehensive health insurance for those Kansans who had serious pre-existing health conditions. Creation of the risk pool allowed the excess claims costs to be shared by companies in the marketplace, and ultimately to be shared by taxpayers through premium tax credits. What the Legislature recognized was that those buying health insurance shouldn't bear the excess costs of those Kansans who had serious illnesses.

The disabled, under-65 Medicare population has the same high health claims as the current KHIA policyholders. Now their excess losses are paid only by those over-65 year old Kansans who purchase Medicare supplemental insurance. Higher costs could drive some older Kansans out of the marketplace. This bill creates a risk-sharing arrangement, so the excess costs are spread among all the companies selling Medicare supplemental insurance in the marketplace, similar to the companies which currently are assessed for excess health costs by KHIA.

This bill only provides risk-sharing for excess losses of disabled Kansans who became Medicare eligible prior to 1996, because that is the initial problem we were seeking to address. But the rate disparity is ongoing, and the once the mechanism is established, we may ask for your consideration for an extended risk-sharing, so that these excess costs don't fall exclusively on older Kansans.

I would be pleased to respond to any questions or inquiries about this proposal.

6-4

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

Bulletin 1996-4

TO: All Insurance Companies authorized to transact Medicare Supplement Insurance Business in the State of Kansas

FROM: Kathleen Sebelius
Commissioner of Insurance

SUBJECT: Revisions to the Kansas Medicare Supplement Regulation K.A.R. 40-4-35

DATE: April 29, 1996

The Kansas Insurance Department sent a copy of the captioned revisions to you on April 9, 1996, which enumerated the various areas where changes would occur. The hearing for the proposal was held on Wednesday, April 17, 1996, during which testimony was heard. After considering testimony, no changes were made to alter the content of the proposed regulation. The proposed regulation became effective April 28, 1996, to meet the deadline specified by the Health Care Financing Administration (HCFA).

The purpose of this bulletin is to provide additional information which will assist you in complying with the 1995 Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act and its revisions. All individual and group Medicare supplement plans issued or delivered in Kansas must comply with the requirements of the revised K.A.R. 40-4-35 as of its effective date.

K.A.R. 40-4-35, as revised, includes several technical corrections made to the Medicare Supplement Model Regulation by the Health Care Financing Committee as required by the Social Security Act Amendments of 1994 (SSAA-94). The following additional changes were made by the Kansas Insurance Department to K.A.R. 40-4-35.

- Disabled individuals under the age of 65 who became eligible for Medicare Part B prior to the effective date of this regulation receive a six-month open enrollment period beginning April 28, 1996. Such disabled individuals may purchase, during this six-month period, any standardized Medicare supplement plan offered by a Medicare supplement issuer.

- Disabled individuals under the age of 65 who become eligible for Medicare Part B after the effective date of this regulation receive a six-month open enrollment period beginning the first day of the first month the applicant becomes eligible for Medicare. Such disabled individuals may purchase any standardized Medicare supplement plan offered by a Medicare supplement issuer.

6-5

420 SW 9th Street
Topeka, Kansas 66612-1678
913 296-3071
Fax 913 296-2283
Consumer Assistance Hotline
1 800 432-2484 (Toll Free)

- Premium rates charged to disabled individuals who became eligible for Medicare Part B prior to the effective date of this regulation shall not exceed 150% of the premium rate charged to Medicare supplement insureds who are age 80 for such plan.

- Premium rates charged to disabled individuals who became eligible for Medicare Part B after the effective date of this regulation shall not exceed those rates charged to Medicare supplement insureds age 65 for such plan.

Section 14(C)(2) of the 1995 NAIC Medicare Supplement Model has been amended by deleting subsection (d) --"The offering of coverage to individuals eligible for Medicare by reason of disability," and allowing up to "three (3) additional policy forms or certificate forms of the same standard Medicare supplement benefit plan, one for each of the following cases:." Such changes were necessary as a result of the amendments to Section 11(A). Due to these revisions, a Medicare supplement issuer shall not offer, after the effective date of this regulation a separate, distinct disability policy or certificate. Each disabled applicant shall be offered the same plan an applicant who is eligible for Medicare by reason of age is offered, making a separate disabled policy or certificate unnecessary.

Section 17 of the 1991 NAIC Medicare Supplement Model has been amended to incorporate changes which were made to provide sufficient information to follow the SSAA-94 revisions to the anti-duplication provisions of OBRA 1990. These changes were made to both the Statements and Questions sections. Specifically, changes were made concerning Medicaid eligibility in order to determine whether an applicant is a Qualified Medicare Beneficiary (QMB) or a Specified Low-Income Medicare Beneficiary (SLMB).

Section 10 of the 1995 NAIC Medicare Supplement Model has been adopted by the Kansas Insurance Department. This adoption provides the regulation needed to allow companies wishing to offer Medicare SELECT policies and/or certificates in Kansas to do so.

To comply with the aforementioned revisions to K.A.R. 40-4-35, it will be necessary make the necessary revisions to the application and rates you currently have approved. The following changes shall be made expeditiously to the aforementioned forms:

- Each Medicare supplement application needs to be amended to facilitate the determination of Medicaid eligibility (i.e. whether an applicant is a QMB or a SLMB).

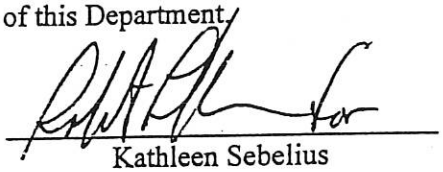
- A revised premium rate schedule addendum for your Medicare supplement policies and/or certificates should be submitted incorporating those rates to be charged to disabled Medicare beneficiaries. The appropriate rates to be charged to disabled Medicare supplement insureds under the age of 65 shall be charged as of the effective date of the regulation. Those insurers currently charging disabled Medicare supplement insureds a rate less than 150% of the age 80 rate shall charge those rates currently on file with the Kansas Insurance Department. The crediting and/or refunding of premium shall be made for those current disabled Medicare beneficiaries under the age of 65 who have paid premium for any period after April 28, 1996, including April 28, 29, and 30. For those companies that, prior to the effective date of this

regulation, provided disabled Medicare supplement coverage to insureds, it will be necessary to provide us with detailed information including the number of disabled insureds receiving refunds and the method used by companies to credit or refund premiums paid for any period after the effective date.

Another issue to bring to your attention involves the enactment of 1996 Substitute for Senate Bill No. 529 to become effective July 1, 1996. Senate Bill No. 529 amends K.S.A. 40-2221a requiring Medicare supplement issuers to reinstate any Medicare supplement policy in the event of lapse if the issuer is provided proof of cognitive impairment or the loss of functional capacity within five months after termination and the insured requests such reinstatement. The standard used to determine proof of impairment shall be established by clinical diagnosis by a person licensed to practice medicine and surgery and qualified to make such determination.

It is imperative that your company notify your agents certified by your company to write Medicare supplement business in Kansas of these changes. In addition, it is of importance for your company to notify those individuals working internally of these revisions to K.A.R. 40-4-35 and K.S.A. 40-2221a, including but not limited to the marketing personnel, underwriting personnel, and claims personnel. The aforementioned changes must be made by your company to comply with K.A.R. 40-4-35 as soon as possible. The Kansas Insurance Department will expedite the review of forms and rates submitted to comply with the revisions.

If you should have questions concerning K.A.R. 40-4-35 as revised, you may contact the Accident and Health Division of this Department.



Kathleen Sebelius
Kansas Insurance Commissioner

KS:gcj
Enclosure

6-7
~~6-6~~

K.A.R. 40-4-35. Medicare supplement policies; minimum standards; requirements. Sections 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, and 24 and appendices A, ~~and~~ B, and C of the national association of insurance commissioners' "model regulation to implement the national association of insurance commissioners' medicare supplement insurance minimum standards model act," ~~July 1991~~ April 1995 edition, are hereby adopted by reference, subject to the following additions or exceptions:

(a) Section 3 is hereby amended to read as follows: "B. This regulation shall not apply to:

"(1) A policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations; and

"(2) individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when the ~~such~~ group or individual policy or contract includes provisions which are inconsistent with the requirements of this regulation."

(b) Section 3 is hereby amended by the addition of subsection C., which ~~reads~~ shall read: "This regulation shall supersede any other Kansas administrative regulation to the extent the regulation or any provision of it is inconsistent with or contrary to this regulation."

(c) Section 7(A)(3) is hereby amended to read as follows: "Each ~~A~~ medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible amount and co-payment percentage factors. Subject to the requirements of section 14B of this regulation or any applicable statutory requirements, premiums may be modified to correspond with such changes."

(d) Section 7(B)(2) is hereby amended to read as follows: "Coverage for all of the medicare part A inpatient hospital deductible amount."

6-8

(e) Section 8(A)(3) is hereby amended to read as follows: "Each ~~A~~ medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible amount and co-payment percentage factors. Subject to the requirements of section 14B of this regulation or any applicable statutory requirements, premiums may be modified to correspond with such changes."

(f) Section 11(A) is hereby amended to read as follows: "An issuer shall not deny or condition the issuance or effectiveness of any medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and enrolled for benefits under medicare part B, or becomes enrolled for benefits under medicare part B without regard to age. An issuer shall not deny coverage to an applicant under 65 years of age who enrolled for benefits under medicare part B prior to the effective date of this regulation when the applicant applies for coverage during the six-month period beginning with the effective date of this regulation. Each medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under this subsection without regard to age."

(g) Section 14(B) is hereby amended to read as follows: "An issuer shall not use or charge premium rates for a medicare supplement policy or certificate unless the rates, rating schedule, and supporting documentation have been filed with and approved by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner. An issuer shall not charge individuals who become eligible for medicare by reason of disability after the effective date of this regulation, and who are under the age of 65, premium rates for any medicare supplement insurance benefit plan offered by the issuer that exceed the issuer's premium rates charged for such plan to individuals who are age 65 or older. An issuer shall not charge those individuals who became eligible for medicare by reason of disability prior to the effective date of this

APPROVED
ATTORNEY GENERAL

APPROVED
ATTORNEY GENERAL

6-9 6-8

APR 23 1996

REVIEWED BY FDI

regulation, and who are under the age of 65, premium rates for any medicare supplement insurance benefit plan offered by the issuer that exceed 150% of the rate charged for such plan to medicare supplement insureds who are age 80."

(h) Section 14(C)(2) is hereby amended to read as follows: "With the approval of the commissioner, any issuer may offer up to three additional policy forms or certificate forms of the same type for the same standard medicare supplement benefit plan. One additional form may be offered for each of the following cases:

"(a) The inclusion of new or innovative benefits;

"(b) The addition of either direct response or agent marketing methods; or

"(c) The addition of either guaranteed issue or underwritten coverage."

~~(f) Section 15C is hereby amended to read as follows: "No issuer or other entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced."~~

~~(g)~~ (i) Section 16(A)(5) is hereby amended to read as follows: "Medicare supplement policies or certificates shall have a notice prominently printed on or attached to the first page of the policy or certificate ~~or attached thereto~~ stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason. Any refund made pursuant to this section shall be paid directly to the applicant by the insurer in a timely manner. The ~~Such~~ notice shall be printed in not less that 10-point type and shall be printed in bold face type or in some other manner that distinguishes it from the print otherwise appearing in the policy."

~~(h)~~ (j) Section 16(C) is hereby amended by the addition of the following:

"(5) A description of policy provisions relating to renewability, cancellation, or continuation of coverage, including any reservation of rights to change premium.

"(6) The amount of premium for this policy. The premiums for the policy or certificate shall be shown separately from the premiums for any optional or supplemental riders.

6-10
~~6-9~~

"(7) The name and address of the insurance agent, or the employee of the insurer who assumes responsibility for completing the outline."

~~(i)~~ (k) Section 17(E) is hereby amended by the deletion of paragraphs (1) and (2), ~~(applicable~~ relating to preexisting conditions~~)~~, in their entirety.

~~(j)~~ (l) Section 17(F) is hereby amended to read as follows: "If a medicare supplement policy or certificate of insurance issued for delivery in this state replaces an existing medicare supplement policy, regardless of the company issuing the policy, the insurer issuing the new policy, in applying any preexisting conditions provisions, waiting periods, elimination periods, and probationary periods, shall make available by rider or otherwise, coverage which provides credit for the satisfaction or partial satisfaction of the same or ~~smaller~~ similar provisions under a previously existing plan."

~~(k)~~ (m) Section 22 is hereby amended to read as follows: "A. If a medicare supplement policy or certificate replaces another medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new medicare supplement policy or certificate to the extent such time was spent under the original policy.

"B. If a medicare supplement policy or certificate replaces another medicare supplement policy or certificate which has been in effect for at least six months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods."

~~(l)~~ (n) This regulation shall become effective ~~April 1, 1992 or 45 days following its publication in the Kansas Register, whichever is later~~ April 28, 1996. (Authorized by K.S.A. 40-103, 40-2221; implementing K.S.A. 40-2221; effective May 1, 1982; amended May 1, 1984; amended May 1, 1986; effective, T-40-12-16-88, Dec. 16, 1988; amended, T-40-3-31-89, March 31, 1989; amended June 5, 1989; amended Oct. 15, 1990; amended April 1, 1992; amended P-_____.)

DEPT. OF ADMINISTRATION

APR 23 1996

APPROVED BY FDI

6-11

~~6-10~~

BRAD SMOOT

ATTORNEY AT LAW

MERCANTILE BANK BUILDING
800 SW JACKSON, SUITE 808
TOPEKA, KANSAS 66612
(785) 233-0016
(785) 234-3687 (fax)

10200 STATE LINE ROAD
SUITE 230
LEAWOOD, KANSAS 66206
(913) 649-6836

Statement of Brad Smoot, Legislative Counsel
Blue Cross Blue Shield of Kansas
To
Senate Financial Institutions & Insurance
Regarding 1999 SB 291
March 3, 1999

Blue Cross Blue Shield of Kansas is a not for profit mutual life insurance company providing insurance benefits to 700,000 Kansans in 103 counties. We actively sell Medicare supplement policies to tens of thousands of Kansans and for more than thirty years we have sold policies to the disabled who qualify for Medicare. We very much appreciate the Commissioner's introduction of SB 291 and are pleased to offer our support.

Prior to the effective date of the Kansas Insurance Department's regulation requiring open enrollment, we were one of only a few companies which issued polices to the disabled without underwriting (meaning we did not exclude applicants based on health). As you would suspect, persons who qualify for Medicare by reason of disability rather than age often suffer serious, debilitating illnesses and are frequent users of health care services. As a group, these Kansans will always cost far more to serve than they will ever contribute in premium.

While Blue Cross Blue Shield of Kansas has a substantial portion of the Medicare supplement business in Kansas, prior to 1996 we attracted virtually all the disabled Medicare business. In 1996, the KID decided to reduce the disabled premium contribution for new enrollees to the age 65 rate (the lowest in the Medicare Supp business) and 120% of the age 80 rate for existing enrollees. The latest KID regulation will drop all disabled premiums to the lowest MediGap rates available. With its disproportionate share of high risk, high cost disableds, BCBS's elderly policyholders will further subsidize the disabled.

Last year, the Insurance Department proposed, and we supported, a bill before this committee to allow premium tax credits (just as we now do for the high risk pool assessments) for losses suffered by our Medicare pool of elderly insureds (1998 SB 457). Because the bill would have passed all the cost of such losses on to the state general fund, this committee was less than enthused about SB 457. SB 291 takes a different approach by creating a reinsurance mechanism within the high risk pool (Kansas Health Insurance Association) which shares the losses among the carriers who are obliged by law to shoulder the burden of the Medicare disabled. No state tax dollars are involved.

Blue Cross Blue Shield of Kansas would have preferred that the bill apply prospectively, because the problem all carriers face is the likelihood of acquiring a disproportionate share of disabled insureds. SB 291 only addresses the historical problem of BCBS's willingness to "do the right thing" before it was required by law. Consequently, we could support applying the reinsurance mechanism to losses occurring after 1996 as well. However, whether SB 291 remains the same or is amended to apply prospectively, we support the measure as a necessary and appropriate response to a real marketplace distortion that requires correction.

Thank you for your interest in our views.

Senate Financial Institutions & Insurance
Date 3/3/99
Attachment # 7

SB 291

Kansas Insurance Department Survey

July 10, 1998

Disabled Kansas Under Age 65 Covered by Medicare Supplement Insurance			
# of Disabled Covered in Kansas	Company	Statewide Premium Total through 1997	Total # of Lives Covered in Kansas
1,945	Blue Cross Blue Shield of Kansas, Inc.	$155,734,944	132,924
0*	Prudential Insurance Company of America	$27,872,037	22,800
207	Bankers Life and Casualty Company	$18,039,694	12,813
132	Blue Cross and Blue Shield of Kansas City	$10,266,209	5,877
1	United American Insurance Company	$6,855,985	4,867
24	Federal Home Life Insurance Company	$3,724,787	3,294
17	American Republic Insurance Company	$3,017,236	2,867
81	Physicians Mutual Insurance Company	$2,799,630	2,730
5	Union Bankers Insurance Company	$2,681,071	1,624
42	Mennonite Mutual Aid Association	$2,645,658	2,384
110	Principal Mutual Life Insurance Company	$2,308,859	1,272
6	Standard Life and Accident Insurance Company	$2,270,968	1,462
10	Reserve National Insurance Company	$2,261,737	2,194
50	Pioneer Life Insurance Company	$2,253,855	1,950
13	Hartford Life Insurance Company	$2,062,662	2,438
29	Mutual Of Omaha Insurance Company	$1,928,375	1,403
35	Continental General Insurance Company	$1,673,923	1,640
50	American Family Mutual Insurance Company	$1,007,085	923
10	Aid Association for Lutherans	$868,980	542
229	Order of United Commercial Travelers of America	$835,953	1,281
4	Humana Health Plan Inc	$674,478	451

*Prudential lost AARP Business to United Healthcare Insurance Company in 1997, affecting group business.

7-2

July 10, 1998

8	Mutual Protective Insurance Company	$534,365	619
6	Combined Insurance Company of America	$534,110	485
1	Pyramid Life Insurance Company	$522,534	326
	Time Insurance Company	$452,558	760
26	Central States Health and Life Company of Omaha	$444,662	458
	Fortis Insurance Company	$434,527	732
	Allianz Life Insurance Company of North America	$410,365	545
6	American Family Life Assurance Company of Comumbus	$381,309	284
0	Golden Rule Insurance Company	$377,926	248
0	American General Life Insurance Company	$365,644	244
7	Monumental Life Insurance Company	$308,149	205
2	USAA Life Insurance Company	$305,620	361
1	Life Investors Insurance Company of America	$245,061	285
12	Life Insurance Company of Georgia	$234,746	135
6	National Foundation life Insurance Company	$180,327	105
0	New York Life Insurance Company	$168,257	123
	Globe Life and Accident Insurance Company	$131,346	125
2	Provident Life and Accident Insurance Company	$127,674	N/A
3	World Insurance Company	$126,325	104
3	Guarantee Trust Life Insurance Company	$107,840	159
	Atlas Insurance Company	$95,656	95
	Allied Life Insurance Company	$93,672	112
2	Bankers United Life Assurance Company	$84,852	84
0	Harvest Life Insurance Company	$60,268	78

*Prudential lost AARP Business to United Healthcare Insurance Company in 1997, affecting group business.

0	Union Labor Life Insurance Company	$41,529	36
0	United Teacher Associatas Insurance Company	$33,834	18
0	Healthy Alliance Life Insurance Company	$30,910	29
8	Medico Life Insurance Company	$27,262	29
0	Providian Life and Health Insurance Company	$24,255	15
8	Humana Insurance Company	$23,342	31
	Celtic Life Insurance Company	$22,492	19
2	PFL Life Insurance Company	$20,032	16
0	Academy Life Insurance Company	$15,565	14
	Union Fidelity Life Insurance	$14,680	17
0	Bankers Multiple Line Insurance Company	$14,610	9
0	Hartford Life and Accident Insurance Company	$9,216	9
	National Travelers Life Company	$8,265	4
0	Colonial Life and Accident Insurance Company	$3,393	8
2	Central Benefits National Life Insurance Company	$3,351	3
	American Travellers Life Insurance Company	$3,084	2
0	National Helath Insurance Company	$2,795	10
3	Lincoln National Life Insurance Company	$2,171	3
0	Bankers Fidelity Life Insurance Company	$0	0
0	Continental Life and Accident Company	$0	0
0	Health and Life Insurance Company of America	$0	0
159	United Healthcare Insurance Company	N/A	N/A
Total		**Total**	**Total**
3,267		$258,812,804	214,660

*Prudential lost AARP Business to United Healthcare Insurance Company in 1997, affecting group business.

MEMORANDUM

TO: The Honorable Don Steffes, Chairman
Senate Financial Institutions & Insurance Committee

FROM: Bill Sneed, Legislative Counsel
Health Insurance Association of America

DATE: March 3, 1999

RE: S.B. 291

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I am here today representing the Health Insurance Association of America ("HIAA"). HIAA is the nation's leading advocate for the private, market-based health care system. Our 255+ members provide health insurance to approximately 110 million Americans. We appreciate this opportunity to provide comments on S.B. 291. After reviewing the bill, we concur that changes need to be made, but we do not believe that S.B. 291 adequately addresses those concerns, and we respectfully request that if the Committee desires to work this bill, it should attempt to create a comprehensive solution to the problem.

BACKGROUND

It is our understanding that prior to 1996, Blue Cross/Blue Shield of Kansas had voluntarily issued Medicare supplement policies to the disabled and had a large block of disabled policyholders. The practice of Blue Cross/Blue Shield was to charge this block of disabled policyholders according to the claims experience of the group, which means they paid a higher premium than other Medicare supplement policyholders.

In 1996, the Kansas Insurance Department held a public hearing on a proposed regulation dealing with this issue. This regulation would require insurance companies to issue

POLSINELLI, WHITE, VARDEMAN & SHALTON
555 South Kansas Avenue, Suite 301
Topeka, Kansas 66603-3443
(785) 233-1446
(785) 233-1939 (FAX)

Senate Financial Institutions & Insurance
Date 3/3/99
Attachment # 8

Medicare supplement policies to people who are eligible for Medicare because of their disability. The regulation would also require that the group of disabled Medicare recipients would not be charged any different rate than the other non-disabled Medicare recipients. At the time of the public hearing on this regulation, HIAA stated its opposition to the implementation of the regulation. We argued that, as a group, the disabled are far sicker than people who become eligible for Medicare at age 65. Many of them suffer from end-stage renal disease and would not be eligible for insurance from most insurance companies. Because the disabled are sicker than the over-65 category of Medicare supplement policyholders, they also cost far more to insure.

Notwithstanding our objections, the Insurance Department adopted the regulation in 1996. In its implementation, the Department permitted Blue Cross/Blue Shield of Kansas to continue to charge its existing block of disabled policyholders more than the over-65 category. However, the regulation did require Blue Cross/Blue Shield and all other insurers to charge new Medicare disabled policyholders the same rate as the over-65 category. The regulation also required that Blue Cross/Blue Shield phase in equal rates for all Medicare supplement policyholders, so that by the year 2000 Blue Cross/Blue Shield could no longer charge disabled and over-65 Medicare supplement policyholders different premiums.

DISCUSSION

Because insurers can no longer charge a rate equal to the risk that the disabled category represents, it has incurred substantial losses on its pre-1996 business. Thus, insurers end up with a disproportionate share of Medicare disabled policyholders. As long as insurers can not charge a premium corresponding to the higher risks of the disabled, these losses will continue to mount. As long as the higher risks and resulting losses are spread unevenly among insurers, competitive pressures will prevent insurers with more disabled policyholders from charging their

Medicare supplement policyholders an adequate premium. Without a long term solution, the losses will increase, insurers will leave the market, and all Medicare beneficiaries will find they have fewer choices and higher costs in the Medicare supplement policies.

PROPOSED SOLUTION

As we understand S.B. 291, it is an attempt to limit its scope to the pre-1996 block of policyholders. We believe that a more global solution will better serve the Medicare beneficiaries in the Kansas market. Kansas already has a high risk pool for people who are uninsurable by reason of their health conditions. The person who is eligible for Medicare because of disability is exactly the person for whom the pool was designed. The one difference is that such a person needs only a Medicare supplement policy, not a comprehensive policy. The mechanism to cover this person, and to assess all insurers fairly for the cost, is already in place -- the Kansas Health Insurance Association. KHIA's risk-sharing mechanism provides a broad-based, long-term solution that is fair to all participants. If there is logic in having the pre-1996 losses covered by reinsurance or pooling programs, the post-1996 losses incurred by everyone else deserve the same remedy. Thus, we contend that S.B. 291, if acted upon, should be amended to state that the reinsurance or pooling program found within the Kansas Health Insurance Association should be applied to all Medicare supplement policies issued to people who are eligible for Medicare because of their disability.

We appreciate the opportunity to present this testimony, and if you have any questions, please feel free to contact me.

Respectfully submitted,

William W. Sneed

POLSINELLI, WHITE, VARDEMAN & SHALTON
555 South Kansas Avenue, Suite 301
Topeka, Kansas 66603-3443
(785) 233-1446
(785) 233-1939 (FAX)

8-3

Offices located in
the Historic Crawford Building

Topeka Independent Living Resource Center

785-233-4572 V/TDD • Fax 785-233-1561 • Toll Free 1-800-443-2207
501 SW Jackson Street • Suite 100 • Topeka, KS 66603-3300

February 25th;

State of Kansas
State House
Senator Don Steffe; Chairperson
300 SW 10th Ave.; Rm 128S

Honorable Senator Steffes;

Topeka's Independent Living Resource Center, (TILRC) Would like to formally state its support for Senate Bill 291. For those individuals that this bill would provide reinsurance for, this bill implements existing law in a meaningful way in that its impact present a "win-win" situation for all parties involved in provision of such a reinsurance program. Some of those aspects are;

1.) Those individuals that have exhausted their COBRA Insurance and choose to go without care due to high end out-of-pocket costs and the inherent structure of having to wait for two years for Medicare eligibility will suffer long term consequence and greater costs overall.

2.) Individuals that do choose to get care are left with the option of ineffective, inefficient emergency care services, at a much greater cost to the surrounding community of tax payers and community inputs.

3.) Another choice that an individual has is to impoverish themselves in order to qualify immediately for poverty program, i.e. Medicaid, coverage.

The logic behind this approach seems oddly backwards when our goal is to provide efficient, effective treatment, avoidance of high cost and long term consequence and complications. Another aspect of the present approach is that it inadvertently punishes those that contribute to the economy through wage taxes and input and yet conversely, if impoverished, immediate coverage is available. This bill effectively covers a worker's time frame gap between COBRA and Medicare eligibility, and thereby lessens the long term effects of inadequate or non-existent coverage.

Again, TILRC would lend its support to Senate Bill 291 and will be presenting testimony on March 3rd, 1999 to the full committee. We want to thank you as well as the committee in advance for your consideration and would welcome any ideas on how we could assist the committee in this endeavor and urge you to adopt Senate Bill 291 into a meaningful piece of legislation. For questions or concerns, please feel free to contact Mike Oxford, Executive Director at 233-4572.

Respectfully Submitted;

Brenda Eldridge

Brenda Eldridge; L.B.S.W.
Public Policy Advocate
Topeka Independent Living Resource Center

Senate Financial Institutions & Insurance
Date 3/3/99
Attachment # 9

Advocacy and services provided by and for people with disabilities.