Approved: January 27, 2000
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 January 13 , 2000 in Room 529-S of the Capitol.

All members were present except:

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

Conferees appearing before the committee: Bill Sneed, Guaranty Mortgage Companies
George Barbee, Kansas Association of Financial Services

Others attending: See attached list

Ken Wilke, Office of the Revisor of Statutes, requested the introduction of legislation relating to rules and regulations of the bank commissioner and the state banking code (Attachment 1).

Senator Clark moved for the introduction of the proposal into legislation. Motion was seconded by Senator Praeger. Motion carried.

Bill Sneed, representing the guaranty mortgage company industry, proposed legislation which would increase the limit on authorized real estate security from 97% to 100% (Attachment 2)

Senator Becker moved for the introduction of this proposal into legislation. Motion was seconded by Senator Praeger. Motion carried.

George Barbee, representing Kansas Association of Financial Services, presented proposed legislation which he considered to be minor changes to the Uniform Consumer Credit Code (Attachment 3).

Senator Clark moved that this proposal be introduced into legislation. Motion was seconded by Senator Biggs. Motion carried.

The Chairman suggested the following list of items be considered by the Committee during this session:

- The impact on individuals whose trust accounts are moved to other parts of the country when local banks are sold to out-of-state entities.
- The clean-up of archaic laws in the banking statutes.
- Fairness of bank service charges.
- ATM fees.

Senator Sandy Praeger presented an overview from a national perspective on health insurance issues (Attachment 4). Points covered were:

- Access to health care and coverage issues: outreach and enrollment of CHIP and Medicaid; surveying the uninsured regarding who they are, why are they uninsured and the availability of insurance; and small business and health coverage.
- Cost of health care: purchasing strategies, cost of pharmaceuticals.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

- Health data and information: privacy and confidentiality issues, decisions on what to collect, determination of what is quality health care and how to measure it.

- Managed care: insolvencies, market reforms, external review, mandates, options.

- Long term care: tax incentives, impact of the Olmstead decision, regulatory environment.

The meeting was adjourned at 10:00 a.m. The next meeting is scheduled for January ~~14~~ 18, 2000.

SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

GUEST LIST

DATE: 1/13/2000

NAME	REPRESENTING
Linda McCaunsey	KS Ins. Dept.
Mark Skinner	AIA
Jamie Zakaria	Senate Minority Office
Matt Goddard	HCBA
Doug Hollandsworth	DPS/State of KS
Michael Moser	KDHE
Sam Sellers	KAIA
Rich Guthrie	Health Midwest
Jerry Slaughter	KMS
Chip Wheelen	KAOM
Mike Huttles	Ks. Gov't Consulting
Tom Bell	Ks. Hosp. Assn.
Adam Moore	Intern.-Sen. Praeger
E.V. Knighton	Merck-Medco Managed Care, L.L.C.
Bill Sneed	MGIC
Barbara Belcher	Merck
John Federico	Humana
Kevin Barone	Hein & Weir

2000 9rs1414

SENATE BILL NO. ____

By Committee on Financial Institutions and Insurance

AN ACT concerning banks and banking; relating to rules and regulations of the bank commissioner; establishing the state banking code; amending K.S.A. 9-1713 and K.S.A. 1999 Supp. 9-539 and repealing the existing sections.

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

Section 1. K.S.A. 1999 Supp. 9-539 is hereby amended to read as follows: 9-539. The commissioner shall adopt such rules and regulations as shall be necessary to carry out the intent and purposes of K.S.A. 9-519 through 9-524, and amendments thereto, and K.S.A. 9-532 through ~~9-539~~ 9-541, and amendments thereto, which shall be known as the bank holding company act. All rules and regulations of general application shall first be submitted by the commissioner to the state banking board for its approval and upon approval shall be filed as provided by article 4 of chapter 77 of the Kansas Statutes Annotated.

Sec. 2. K.S.A. 9-1713 is hereby amended to read as follows: 9-1713. ~~The~~ Except as otherwise provided by law, the state bank commissioner shall adopt such rules and regulations as shall be necessary to carry out the intent and purposes of ~~K.S.A. 9-701 et seq.~~ section 3, and amendments thereto, commonly known as the state banking code. All rules and regulations of general application shall first be submitted by the commissioner to the state banking board for its approval and upon approval shall be filed as provided by article 4 of chapter 77 of the Kansas Statutes Annotated.

New Sec. 3. Articles 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20 and 21 of Chapter 9 of the Kansas Statutes Annotated, K.S.A. 74-3004, 74-3005, 74-3006, 75-1304, 75-1305 and 75-1306, and K.S.A. 1999 Supp. 75-1308, and amendments thereto shall constitute and may be cited as the state banking code.

Sec. 4. K.S.A. 9-1713 and K.S.A. 1999 Supp. 9-539 are hereby repealed.

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

Senate Financial Institutions & Insurance
Date 1/13/00
Attachment # 1

POLSINELLI
WHITE
VARDEMAN &
SHALTON

Memorandum

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

FROM: William W. Sneed, Legislative Counsel
Mortgage Guaranty Insurance Corporation

RE: Amendments To K.S.A. 40-3502

DATE: January 11, 2000

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I represent Mortgage Insurance Companies of America ("MICA"). MICA is a national trade association that represents all seven private mortgage guaranty insurer companies, each of which is licensed to transact mortgage guaranty insurance business in Kansas and throughout the United States.

This proposal would amend K.S.A. 40-3502 to permit mortgage guaranty insurers to insure mortgage loans up to 100% of the value of the underlying property. Kansas currently limits that percentage to 97%.

We believe that such an increase is favorable to the general public, and we will provide extensive detail on our proposal at the time of the hearing.

Thus, we respectfully request that this bill introduced in the Senate Financial Institutions and Insurance Committee.

Senate Financial Institutions & Insurance
Date 1/13/00
Attachment # 2

One AmVestors Place
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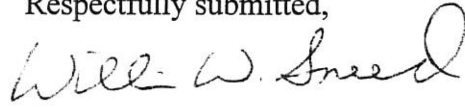
Topeka, KS 66603
Telephone: (785) 233-1446
Telecopy: (785) 233-1939
wsneed@pwvs.com

Thank you very much, and if you have any questions, please feel free to contact me.

Respectfully submitted,



William W. Sneed

Attachment

AN ACT concerning mortgage guaranty insurance companies, amending K.S.A. 40-3502 and repealing the existing section.

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

K.S.A. 40-3502 is hereby amended to read as follows: 40-3502. As used in this act the following terms shall have the meanings respectively ascribed to them herein:

(a) "Mortgage guaranty insurance company" means any corporation, company, association, reciprocal exchange, persons or partnerships writing contracts of mortgage guaranty insurance and shall be governed by the provisions of this act and the other provisions of chapter 40 of the Kansas Statutes Annotated applicable to companies organized or operating under the provisions of K.S.A. 40-1101 *et seq.*, and amendments thereto, to the extent such other provisions are not inconsistent with the requirements of this act.

(b) "Mortgage guaranty insurance" means and includes: (1) Insurance against financial loss by reason of nonpayment of principal, interest or other sums agreed to be paid under the terms of any note or bond or other evidence of indebtedness secured by a mortgage, deed of trust, or other instrument constituting a lien or charge on real estate, when the improvement on such real estate is a residential building or a condominium or townhouse unit or buildings designed for occupancy by not more than four families;

(2) insurance against financial loss by reason of nonpayment of principal, interest or other sums agreed to be paid under the terms of any note or bond or other evidence of indebtedness secured by a mortgage, deed of trust or other instrument constituting a lien or charge on real estate, when the improvement on such real estate is a building or buildings designed for occupancy by five or more families or designed to be occupied for industrial or commercial purposes; or

(3) insurance against financial loss by reason of nonpayment of rent or other sums agreed to be paid under the terms of a written lease for the possession, use or occupancy of real estate, when the improvement on such real estate is a building or buildings designed to be occupied for industrial or commercial purposes.

(c) "Authorized real estate security" means an amortized note, bond or other evidence of indebtedness, not exceeding ~~(97%)~~ *(100%)* of the fair market value of the real estate, secured by a mortgage, deed of trust, or other instrument which constitutes, or is equivalent to, a first lien or charge on real estate, when: (1) The real estate loan secured in such manner is one of a type which a bank, savings and loan association, or an insurance company, which is supervised and regulated by a department of this state or an agency of the federal government, is authorized to make, or would be authorized to make, disregarding any requirement applicable to such an institution that the amount of the loan not exceed a certain percentage of the value of the real estate;

(2) the improvement on such real estate is a building or buildings designed for occupancy as specified by paragraphs (1) or (2) of subsection (b); and

(3) the lien on such real estate may be subject to and subordinate to the following:

(i) The lien of any public bond, assessment or tax, when no installment, call or payment of or under such bond, assessment or tax is delinquent; and

(ii) outstanding mineral, oil, water or timber rights, rights-of-way, easements or rights-of-way of support, sewer rights, building restrictions or other restrictions or covenants, conditions or regulations of use, or outstanding leases upon such real property under which rents or profits are reserved to the owner thereof.

(d) "Contingency reserve" means an additional premium reserve established to protect policyholders against the effect of adverse economic cycles.

(e) "Single risk" means the insurance provided with respect to each separate loan or lease covered by an individual policy of mortgage guaranty insurance or an individual certificate issued pursuant to K.S.A. 40-3511, and amendments thereto.

Sec. 1. 16a-3-206. (UCCC) Compliance with rules and regulations; truth in lending. A creditor shall disclose to the consumer the information required by the rules and regulations adopted by the administrator pursuant to K.S.A. 16a-6-117, and amendments thereto. (L. 1987, ch. 80, § 2; July 1.) New Section 1.

(Editor's note: Tentative statute cite is 16a-3-207; however, you should continue to use the session law cite until January 1, 2000.) (1) The provisions of this section apply only to a consumer loan which is secured by a first mortgage or a second mortgage on the consumer's principal residence. The provisions of this section do not apply to a lender who is a supervised financial organization.

~~(2) Before making a loan subject to this section, a lender shall obtain the appraised value of the real estate to be encumbered. The appraisal evidencing the appraised value shall be retained by the lender and preserved in accordance with the record-keeping requirements set forth in K.S.A. 16a-2-304, and amendments thereto.~~

~~(3)~~ *(2)* ~~If, based on the appraisal, the loan-to-value ratio of the loan exceeds 100%, then~~ The lender shall deliver to the consumer:

~~(a) A free copy of the appraisal; and~~

~~(b)~~ A written notice regarding high loan-to-value mortgages and the availability of consumer credit counseling. The administrator may adopt rules and regulations regarding the form of the notice to be delivered to the consumer and the names, addresses and telephone numbers of selected consumer credit counseling providers.

~~(4)~~ *(3)* The notice referred to in subsection (3) shall be given to the consumer not less than ~~five~~ *THREE* days before the loan is made. The notice must be retained by the lender and preserved in accordance with the record keeping requirements set forth in K.S.A. 16a-2-304, and amendments thereto.

~~(5)~~ *(4)* If, within ~~five~~ *THREE* days after receiving the notice, the consumer elects not to enter into the loan transaction, then the lender must promptly refund to the consumer any application fees or other amounts paid by the consumer to the lender. However, the lender is not required to refund any bona fide out-of-pocket costs incurred by the lender before the consumer elected not to enter into the loan transaction, provided that such costs were paid or are payable to a person or persons not related to the lender. Notwithstanding the provisions of this subsection, a bona fide appraisal fee paid or payable to a person related to the lender need not be refunded to the consumer.

~~(6)~~ *(5)* This section shall be supplemental to and a part of the uniform consumer credit code. (L. 1999, ch.
107 , § 1; July 1.)

Sec. 2. 16a-1-301. (UCCC) General definitions. In addition to definitions appearing in subsequent articles, in K.S.A. 16a-1-101 through 16a-9-102, and amendments thereto:

(1) "Actuarial method" means the method of allocating payments made on a debt between the principal and the finance charge pursuant to which a payment is applied, assuming no delinquency charges or other additional charges are then due, first to the accumulated finance charge and then to the unpaid principal balance. When a finance charge is calculated in

Senate Financial Institutions & Insurance

Date 1/13/00

Attachment # 3

accordance with the actuarial method, the contract rate is applied to the unpaid principal balance for the number of days the principal balance is unpaid. At the end of each computational period, or fractional computational period, the unpaid principal balance is increased by the amount of the finance charge earned during that period and is decreased by the total payment, if any, made during the period after the deduction of any delinquency charges or other additional charges due during the period.

(2) "Administrator" means the deputy commissioner of the consumer and mortgage lending division appointed by the bank commissioner pursuant to K.S.A. 75-3135, and amendments thereto.

(3) "Agreement" means the bargain of the parties in fact as found in their language or by implication from other circumstances including course of dealing or usage of trade or course of performance.

(4) "Amount financed" means the net amount of credit provided to the consumer or on the consumer's behalf. The amount financed shall be calculated as provided in the rules and regulations adopted by the administrator pursuant to K.S.A. 16a-6-117, and amendments thereto.

(5) "Annual percentage rate" means the finance charge expressed as a yearly rate, as calculated in accordance with the actuarial method. The annual percentage rate shall be calculated as provided in the rules and regulations adopted by the administrator pursuant to K.S.A. 16a-6-117, and amendments thereto.

(6) "Appraised value" means, with respect to any real estate at any time~~, the greater of~~:

(a) The total appraised value of the real estate, as reflected in the most recent records of the tax assessor of the county in which the real estate is located; or

(b) the fair market value of the real estate, as reflected in a written appraisal of the real estate performed by a Kansas licensed or certified appraiser within the past 12 months.

STATE OF KANSAS

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SENATE CHAMBER

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

OVERVIEW OF HEALTH INSURANCE ISSUES

I. Access to Health Care and Coverage Issues

A. Outreach and enrollment for CHIP and Medicaid
1. Provider availability
2. Reimbursement issues
3. Dental provider availability
4. Upper payment limit issues

B. Surveying the uninsured (states want to know)
(Florida, Indiana – looking at states that have expanded coverage, Vermont 95% covered)

1. What has worked?
2. Who are they?
3. How long are they uninsured?
4. What is the health status of uninsured?
5. What is happening to employer-based coverage?
6. How do employees behave when offered employer-based coverage?
7. How has welfare reform impacted the uninsured ranks?

C. Small business and health coverage - (43 - 44m uninsured today)

1. What can states do to promote more affordable insurance options?
2. How is the Alliance Project doing?
3. Can states use CHIP to subsidize small groups for family coverage?
(Wisconsin, Mass.)

II. Cost of Health Care

A. Purchasing strategies

1. Small employee groups added to state employee plan
2. Focus on buying managed care - shifts risk/shared risk
3. Disease management - focus on high cost/chronic diseases

Senate Financial Institutions & Insurance

Date 1/13/00

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4. Consumer surveys to inform choices
5. Risk-based capitation for providers and plans
6. Limit choices in state employee plans

B. Cost of pharmaceuticals

1. Concerns about direct to consumer ads
2. Subsidies for low income elderly
   (Some using tobacco money)
3. Effectiveness of drug utilization review committees - can they control costs?
4. Restrictive formularies - cost benefits

III. Health data and information

A. Privacy and confidentiality issues - federal solution

B. Need to decide on what to collect - what will inform public policy?

C. What is quality in health care and how to measure it.

According to a report from the National Roundtable on Health Care Quality, the working definition of quality of care is "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

"Health services" are not limited to medical and physicians but include the entire system of care.

"Individuals and populations" are not limited to individuals but groups as well.

"Increase likelihood..." places and emphasis on probability.

"Desired health outcomes" covers a broad range of measures including satisfaction and patient choice.

"Consistent with current...." means professionally established standards and currently accepted medical practices.

A quality assessment should include the following:

1. Structure - a credentialing of individual professionals and facilities with safety codes, educational requirements, etc.

2. Process - an evaluation of what is done (i.e. appropriate procedures, etc.) Is it the correct procedure? Was too much or too little done? What is the average performance across a population? This is hard to qualify because of the

difficulties in aggregating data for comparisons.

3. Outcomes - measuring morbidity and mortality, infection rates in facilities, patient satisfaction, etc.

The overall question is which type of assessment is best? The answer: it depends.

In assessing quality there is good news and bad news. The good news is that good measures are available and growing in availability. The bad news is that collecting the information is only the beginning. That information (data) must be used to make improvements. Using data to print report cards without using it for continuous quality improvement just alienates those being assessed.

IV. Managed Care - What next?

A. Insolvencies raising concerns (Harvard Pilgrim, Tufts)

B. Managed care going through market reforms. (Example: United HealthCare)

C. External review adopted in several more states. It is working.

D. Mandates continue:
Diabetes, anesthesia for dental (calif) prostate screens, immunizations for children, emergency services, cleft lip and palate, mental health parity, telehealth, hospital-based rehab services, colorectal cancer screening, respite and rehab services for autism, bone density screens, off label drugs, contraceptive drugs and devices, newborn hearing screenings.

E. If not managed care, what?

V. Long term care

A. Tax incentives for purchasing insurance

B. Impact of the Olmstead decision- least restrictive environment

C. Regulatory environment
(Work on continuous quality improvement in a partnership with facilities and service providers.)

Local HMOs score higher

State report card finds better care at smaller companies

By Diana K. Sugg and M. William Salganik
Sun Staff

With the release yesterday of the third annual report card on Maryland's HMOs one theme has emerged: Local plans generally deliver better care than their larger national counterparts.

Regional plans such as Capital Care, Delmarva, Preferred Health Network and George Washington University Health Plan routinely performed above average.

Giants Aetna U.S. Healthcare-Maryland, Prudential and United HealthCare scored consistently below average on a range of quality-of-care measures.

The trend is troubling, since increasingly these smaller health maintenance organizations are being bought up by national managed-care plans.

In the past few years, HMO officials have blamed poor data collection and other reasons for low rankings. But legislators and others said yesterday that they no longer have an excuse.

"If you get a bad grade now ... after three years, you can't blame it on the teacher," said Casper R. Taylor Jr., speaker of the House in Maryland's General Assembly and a key player in health issues.

HMO [*See HMO, 20A*]

[*HMOs, from Page 1A*]

officials, explaining they were working to do better, defended their health plans.

"We believe any type of reporting has validity, and any type of reporting has problems," said Carol Rohn, director of quality improvement for United.

For example, she said, it doesn't make sense that United recorded an 82 percent childhood immunization rate in the state's Medicaid program, a typically hard group to reach, but posted just 49 percent in the report card for private patients — all by the same group of doctors.

Maryland is among a few states to develop report cards that give consumers objective ways to compare health plans. By law, each of Maryland's 15 commercial HMOs is required to submit figures, which are audited, on a range of measures such as adolescent checkups and mammograms.

In addition, to collect information on customer satisfaction, the state hired an independent organization to survey about 1,240 members in each HMO.

Such reports are useful, but measuring quality is an evolving science, experts say. Eventually, health quality groups want to offer consumers ratings of doctors, based on how their patients fare.

While yesterday's report presented one year of data, the significance is in three-year track records — some consistently good, others consistently bad, said John M. Colmers, executive director of the state's Health Care Access and Cost Commission, which developed the report cards.

Some of the more dismal ratings included Aetna U.S. Healthcare-Maryland, which ranked below average for each of the three years in childhood immunizations and breast cancer screenings.

"We think we did pretty well," said Walter J. Cherniak Jr., a regional spokesman for Aetna U.S. Healthcare.

"In a lot of cases, we believe our actual performance is better than the data would indicate. We need to do a better job of gathering and compiling the data."

United rated below average in the past two years for adolescent checkups, cervical cancer screening and prenatal care in the first trimester.

Dr. David Yalowitz, United's chief medical officer, said there might be some data problems, but his plan was "concerned" by its ratings. "We're not going to hide behind the veil of data collection," he said. "We're accountable for stepping up to the plate."

He said United had begun a system of sending letters to members who are due for preventive care, and to the doctors of those patients. That system, put in place last October after six months of planning, was too late to show results in this report card, which uses 1998 data, he said, but it should give United better marks next year. This winter, United is preparing report cards on each doctor.

Kaiser Permanente was an exception to the poor performance of national plans, consistently posting above-average marks in most categories. Mona Miller, a spokeswoman for Kaiser, said the report card was an indication that the HMO's "group model," in which most care is provided by full-time physicians in Kaiser centers, "encourages communication among professionals."

Locally, Delmarva ranked consistently above average in breast cancer screening, adult checkups and follow-up after mental illness.

Dr. Jon Shematek, medical director for quality improvement for CareFirst BlueCross BlueShield, which owns Delmarva, FreeState and Capital Care, says the three HMOs have been testing prevention efforts.

For example, he said, Capital Care had an immunization registry that began at birth and worked mostly by notifying parents when shots were due, while FreeState started in the second year of life and concentrated on notifying doctors.

Now, he said, both plans use the elements that worked best in each — starting at birth but including doctors in the system.

4-4

Circles show the results of statistical tests between each HMO's score and the average for all HMOs.

NA - Not available. The HMO could not report this number because an insufficient number of members were included in the rate to allow for plan comparisons.
NR - Not reportable. Data did not pass independent audit.

SOURCE: Health Care Cost and Access Commission, 1999 Maryland Performance Report

SUN STAFF

[illegible] year's report card includes [illegible] new measures and two new plans — Innovation Health and Principal Health Care of Delaware. The Web site also features an interactive piece that allows employers to create customized report cards.

Tens of thousands of Marylanders, including nearly 80,000 state employees, are soon heading into an open enrollment period in which they must select a health plan. Last year, about 140,000 of the report cards were distributed, and the Web site recorded about 10,000 hits a month.

"The next generation of this information is whether or not the purchasers or consumers act on it," said Colmers.

So far, it is unclear how much the guide sways the choices of consumers and their employers. So many factors influence the selection of a health plan: cost, convenience, a friend's recommendation.

Initial reports aren't encouraging. Even though people say quality is their biggest concern, three-quarters would opt to go to a hospital they are familiar with over one rated much higher in quality by experts, according to a 1996 study by the Kaiser Family Foundation.

People generally don't use report cards or numbers to make judgments on health plans and most other purchases, said Dr. Robert J. Blendon, a professor of health policy and political analysis at Harvard University School of Public Health.

But with time and advertising, he said, people start to pay attention.

Dr. Dennis Batey, president and chief executive officer of Preferred Health Network, a small local HMO, said PHN, which scored above average on 11 measures, provides copies of the booklet to insurance brokers and does "a low-key media campaign in the days and weeks that follow the release," featuring PHN's performance.

Membership has grown from 54,000 two years ago, when the first report card was issued, to more than 72,000 now, he said. It's impossible to tell how much of the growth was produced by the report card, Batey said, but "it certainly helps."

Ernest B. Crofoot, senior health care coordinator for the AFL-CIO's Maryland and D.C. chapters, said his members read the guide cover-to-cover.

"My members grab them like crazy. I can't keep enough of them," Crofoot said. "I wish I could carry more."

Robert Davis, executive director of the Maryland Health Care Coalition, a nonprofit organization that represents about 60 employers, said businesses have taken the report card back to managed-care plans and pressured them to do better.

"It is important. Nobody wants to send their employees to the lowest-ranked HMOs; that's the bottom line," Davis said. But he said large employers usually offer more than one choice, so they might not drop a poorly performing plan, knowing that workers can switch on their own.

Shematek of CareFirst said that when he speaks to employers, "our larger accounts have the report card results and will question us about particular rates."

But as many as half of all workers have only one health option, and their employer makes the selection. For those small businesses, the information is useful but only one piece of the puzzle, Davis said. A good plan might not be offered in a rural area. Or it might be too expensive.

By 2001, the commission will produce similar report cards — with audited data — on Maryland's hospitals, nursing homes and ambulatory surgery centers.

JED KIRSCHBAUM : SUN STAFF

Discussion: *After announcement of the HMO performance scores, House Speaker Casper R. Taylor Jr. (left) talks with (left to right) Ernest B. Crofoot, senior health care coordinator for the Maryland State and D.C. AFL-CIO; John M. Colmers, executive director of the Health Care Access and Cost Commission; and Del. Michael E. Busch, chairman of the House Economic Matters Committee.*

4-5

Comparing the quality of Maryland HMOs: a guide for consumers

The data came from a survey of HMO members and HMO medical records that were audited by the state. All HMOs had to participate.

Access and service

HMO	Overall satisfaction	Getting care quickly	Doctor communication	Customer service	Coverage information	Information for choosing a physician	Information explaining referral rules	Few consumer complaints	Complaint resolution
Aetna US Healthcare-Md.	◒	◒	◒	◒	●	◒	●	◒	◒
Aetna US Healthcare-Va.	○	◒	◒	○	◒	◒	◒	○	◒
CapitalCare	◒	◒	◒	◒	○	◒	○	●	◒
CIGNA	○	◒	◒	◒	○	◒	○	○	◒
Delmarva	●	●	●	●	◒	◒	●	●	◒
FreeState Health Plan	●	◒	◒	◒	●	◒	◒	●	◒
Geo. Wash. Univ. Health Plan	◒	○	◒	○	◒	◒	◒	○	◒
Innovation	○	◒	◒	○	○	◒	○	○	◒
Kaiser	●	◒	○	●	●	◒	◒	●	◒
Mid-Atlantic Medical	◒	◒	◒	●	◒	●	◒	●	◒
NYLCare	◒	◒	◒	●	●	●	●	●	◒
Preferred Health Network	◒	◒	●	◒	○	◒	◒	◒	◒
Principal	●	●	◒	●	◒	●	◒	◒	◒
Prudential	○	◒	◒	○	◒	◒	◒	○	◒
United	◒	◒	◒	○	◒	◒	◒	◒	◒

Staying healthy*

HMO	Immunizations for children	Immunizations for adolescents	Well-child visits for infants	Well-child visits for children 3-6	Well-child visits for adolescents	Prenatal care	Check-ups for new moms	Breast cancer tests	Cervical cancer tests
Aetna US Healthcare-Md.	○	◒	◒	○–	◒	◒	◒	○	○–
Aetna US Healthcare-Va.	○	◒	○–	◒+	○	●+	◒	◒+	○–
CapitalCare	●	◒	●	●	◒–	●+	●+	◒	◒
CIGNA	○–	○	○–	◒+	◒	●	●+	○–	◒
Delmarva	●	○	◒–	○–	○–	●	●	●	●
FreeState Health Plan	●	◒	NR	NR	NR	○–	○–	◒–	◒
Geo. Wash. Univ. Health Plan	●	●	◒–	●	●	●+	●+	●	●+
Innovation	○	NA	◒	●	◒	○	◒	○	○
Kaiser	●	●	○	●+	◒	●	●	●	●
Mid-Atlantic Medical	●	NR	◒+	●	●	◒–	○	◒	◒
NYLCare	○–	◒	○–	○–	○–	○–	○–	◒	◒
Preferred Health Network	◒+	●	●	◒–	●+	○–	◒+	●+	●+
Principal	●	○	●	●	●	●	◒	●	○
Prudential	○	○	○–	○	○–	◒+	●+	◒	◒+
United	○	○	◒+	○	○	○	○	○–	○

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Getting better / living with illness

HMO	How much were you helped	Receiving necessary care	Eye exams for diabetics	Follow-up on mental illness
Aetna US Healthcare-Md.	◐	◐	○	◐
Aetna US Healthcare-Va.	◐	◐	● +	○
CapitalCare	◐	◐	◐	◐ –
CIGNA	◐	○	○	● +
Delmarva	●	●	○	◐ –
FreeState Health Plan	◐	●	○	◐
Geo. Wash. Univ. Health Plan	◐	◐	◐ –	◐ +
Innovation	◐	○	◐	NA
Kaiser	◐	◐	●	● +
Mid-Atlantic Medical	◐	◐	○ –	●
NYLCare	◐	●	NR	◐ +
Preferred Health Network	●	●	● +	◐
Principal	◐	●	◐	●
Prudential	◐	◐	● +	○
United	◐	◐	○	◐

● **Higher:** Score for HMO is *above the average score.*

◐ **Average:** Score for HMO is neither higher nor lower.

○ **Lower:** Score for HMO is *below the average score.*

\+ Score for HMO is higher than last year.

– Score for HMO is lower than last year.

For more information or to get a copy: Guides will be available free at local libraries or by calling **410-764-3460**, or on the Web site: **www.hcacc.state.md.us**
After Oct. 1, the Web site will be: **www.mhcc.state.md.us**

CAN'T AFFORD TO GET SICK: A REALITY FOR MILLIONS OF WORKING AMERICANS

The Commonwealth Fund
Task Force on the Future of Health Insurance for Working Americans

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The Commonwealth Fund
Task Force on the Future of Health Insurance for Working Americans

Mission and Activities

Employer-sponsored health insurance emerged as the nation's predominant source of insurance coverage based on a workforce and economy of the 1950s. While employers are still the dominant source of private health insurance coverage, 43 million Americans—most of whom work or are part of a working family—are currently uninsured. In response to renewed public interest in finding ways to expand health insurance to uncovered workers, The Commonwealth Fund has created the Task Force on the Future of Health Insurance for Working Americans.

The Task Force is a five-year effort approved by The Commonwealth Fund Board of Directors to provide a national, independent forum for debate and exploration of ways to expand coverage and build a health insurance system that meets the needs of a 21st-century workforce.

The mission of the Task Force is to:

- examine the changing workforce and economy and implications for availability, affordability, and stability of health insurance into the 21st century;
- improve the continuity, quality, and affordability of health insurance for working families; and
- put the debate on expanding health insurance coverage back on the national agenda and make significant progress toward reducing the number of uninsured workers.

In its first year, the Task Force will fund research by leading experts in health care economics and finance, tax policy, business management, government programs and other disciplines. The goal of this research will be to provide constructive analyses on a wide range of incremental "workable solutions" that offer a potential base to build on for the future.

The Task Force is non-partisan and aims to assist public policymakers and private sector leaders through the dissemination of thoughtful analyses; it will not advocate one specific solution over another.

James J. Mongan, M.D., president of Massachusetts General Hospital, is chair of the Task Force. Janet Shikles, vice president at Abt Associates, a national health care consulting firm, is the executive director.

Membership

James J. Mongan, M.D.
Chair
President
Massachusetts General Hospital

Janet Shikles
Executive Director
Vice President
Health Services Research and Consulting
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Former Comptroller General
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Diane Rowland
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Henry J. Kaiser Family Foundation

Kathleen Sebelius
Commissioner of Insurance
State of Kansas

Sandra Shewry
Executive Director
California Managed Risk Medical Insurance Board

Russ Toal
Commissioner for the Department of Community Health
State of Georgia

The Commonwealth Fund

The Commonwealth Fund is a philanthropic foundation established in 1918 by Anna M. Harkness with the broad charge to enhance the common good. The Fund carries out this mandate through its efforts to help Americans live healthy and productive lives and to assist specific groups with serious and neglected problems. In 1986, the Fund was given the assets of the James Picker Foundation, in support of Picker programs to advance the Fund's mission.

The Fund's current four national program areas are improving health care services, bettering the health of minority Americans, advancing the well-being of elderly people, and developing the capacities of children and young people. In all its national programs, the Fund emphasizes prevention and promoting healthy behavior. The Fund's international program in health policy seeks to build a network of policy-oriented health care researchers whose multinational experience and outlook stimulate innovative policies and practices in the United States and other industrialized countries. In its own community, the Fund makes grants to improve health care services and to make the most of public spaces and services.

CAN'T AFFORD TO GET SICK: A REALITY FOR MILLIONS OF WORKING AMERICANS

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September 1999

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CAN'T AFFORD TO GET SICK:
A REALITY FOR MILLIONS OF WORKING AMERICANS

While many Americans are prospering in the best economy in 30 years, national statistics often hide a more somber reality for a large number of working men and women. Even though unemployment is at a historic low, *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* finds a significant cross-section of Americans struggling to get the health care they need. Millions of working-age men and women lack health insurance or experience gaps in coverage, resulting in unmet medical needs when sick and an inability to pay medical bills. In an economy in which many middle-income families are stretching their budgets just to meet basic living expenses, the survey finds that adults too often cannot afford to get sick.

The Commonwealth Fund 1999 National Survey of Workers' Health Insurance surveyed 5,002 adults ages 18 to 64 about their health, health insurance, access to health care, and financial well-being. Interviews took place during the first five months of 1999. Representing 167 million men and women, the survey results provide an up-to-date comparison of working-age adults' experiences by four income groups.

GOOD TIMES HIDE DISTURBING STATISTICS

The generally rosy economic picture masks a troubling story. The survey reveals disturbingly high numbers of uninsured people who do not have the resources to pay medical bills and who live in insecurity about their health and finances. Nearly one of five adults ages 18 to 64 surveyed was uninsured. One of four adults—an estimated 40 million people—said they went without needed medical care when sick due to costs; a similar proportion (23%) said they did not have enough money in the past year to pay their medical bills.

For those with annual incomes below $35,000—the bottom half of the income distribution—the survey finds notably high levels of concern about insurance, health, and ability to afford needed medical care. Among these men and women, in the past year:

- one-third (32%) were uninsured, compared with 7 percent of those in the top half of the income distribution range;
- one-fourth (25%) were in fair or poor health—a rate more than three times as high as those in the top half of the income distribution range;
- nearly two of five (37%) went without needed medical care due to costs;

- more than two of five (41%) did not have enough money to pay medical bills at some time; and

- more than half (54%) said they had "just enough" or "not enough" money to pay for basic living expenses.

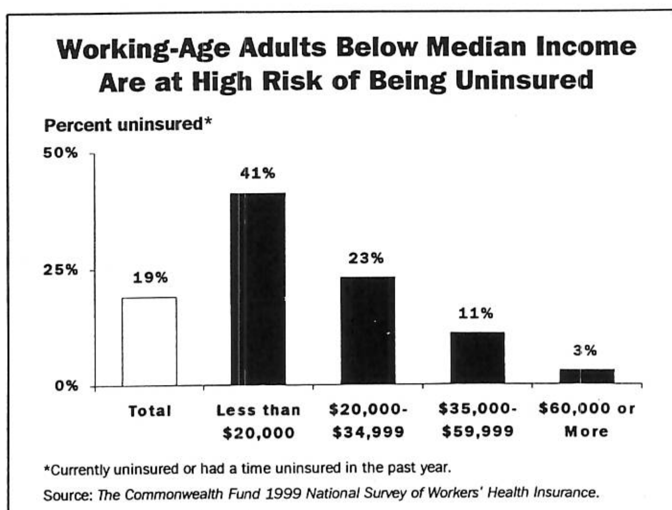
Table 1
Health and Economic Concerns Among Working-Age Adults

		INCOME*	
	All Adults	**Less than $35,000**	**$35,000 or More**
Adults 18–64, in millions	167	69	79
Uninsured	19%	32%	7%
In fair or poor health	16	25	7
Skipped needed medical care in the past year because of cost	24	37	13
Could not pay medical bills in the past year	23	41	9
Contacted by collection agency about unpaid medical bills in the past year	19	29	11
Struggling to meet basic living costs	32	54	15
Just enough for the basics	22	34	13
Not enough for the basics	10	19	2

*10 percent of those surveyed did not report income.

SICK AND UNINSURED: OFTEN A DOUBLE BURDEN FOR AMERICANS WITH MORE LIMITED INCOMES

Adults living on incomes already stretched to make ends meet often face a double burden of being at higher risk of being uninsured and sick. For those in the bottom fourth of the income distribution—those earning less than $20,000—a startling two of five were uninsured, compared with only 3 percent of those in the top fourth—those earning $60,000 or more. Working-age

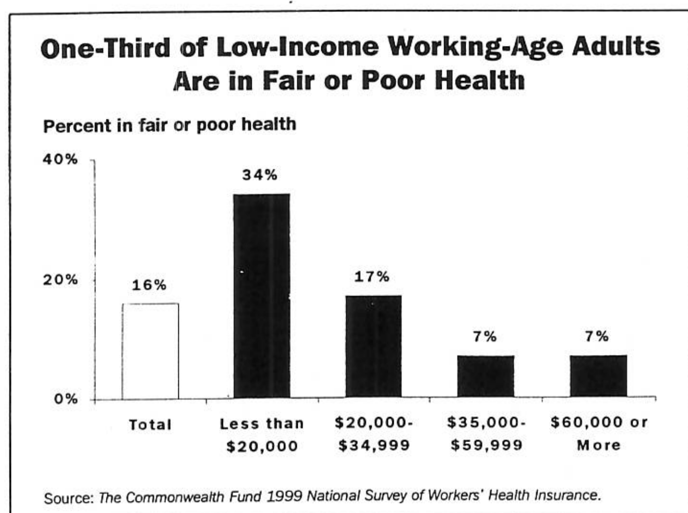


*Currently uninsured or had a time uninsured in the past year.
Source: *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance.*

adults living on incomes well into the middle class were also at high risk: nearly one of four (23%) with incomes between $20,000 and $35,000 was uninsured.

Adults living on incomes in the bottom half of the income distribution were at high risk for health problems as well as being uninsured. The estimated 69 million adults with incomes below $35,000 were more than three times as likely to rate their health as fair or poor as adults with incomes above $35,000 (25% vs. 7%). This same group of men and women was also nearly four times as likely to be uninsured as that in the top half (32% vs. 7%).

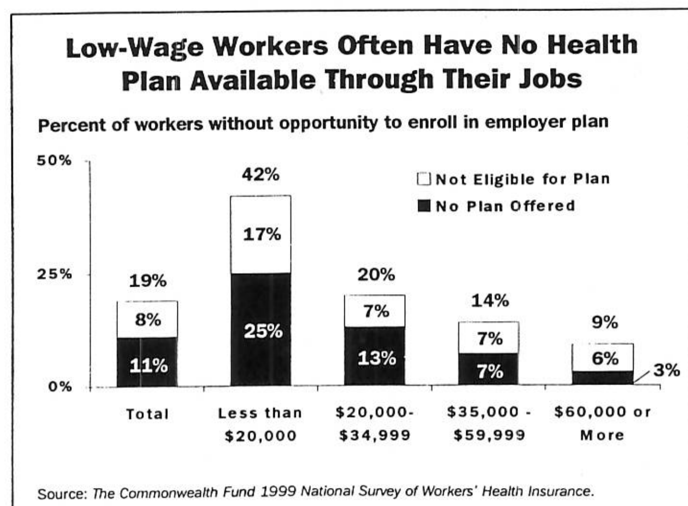
The chances of having health problems were strikingly high among adults with incomes in the bottom quarter of those surveyed. Those earning less than $20,000 were almost five times as likely to be in fair or poor health as those with incomes of $60,000 or more (34% vs. 7%).



Adults with incomes in the bottom two quarters of the income distribution accounted for a disproportionate share of the uninsured. Seven of ten uninsured adults had incomes below $35,000, and nearly half had incomes below $20,000.

MANY LOWER-INCOME WORKERS DO NOT HAVE AN OPPORTUNITY TO PARTICIPATE IN EMPLOYER-BASED COVERAGE

Although most Americans have health insurance through an employer, working is no guarantee of being insured. In fact, most uninsured adults surveyed were working or married to a worker. Typically, they were uninsured despite full-time work efforts: three of five worked full time or were married to a full-time worker. This lack of insurance was often due to the unavailability of employer-based insurance. Despite the importance of ready access to



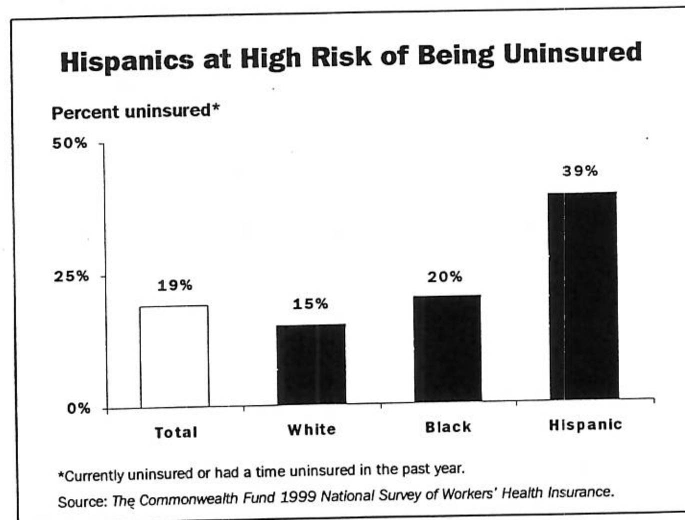
health care for a productive and stable work force, many employers do not offer health benefits to their employees or restrict eligibility for benefits. Nearly one-fifth of all workers (19%) were not offered an employer-based plan or were ineligible for coverage, based on reports of those employed when surveyed.

The opportunity to participate in an employer-sponsored insurance plan varied significantly by income. More than two of five (42%) workers with incomes below $20,000 and one-fifth (20%) with incomes between $20,000 and $35,000 said their employer did not offer a health plan or they were not eligible for benefits. In contrast, only 9 percent of employees with incomes of $60,000 or more were unable to participate in employer-sponsored health insurance coverage.

Uninsured workers rarely had access to employer health plans. Only 16 percent of uninsured workers were eligible for an employer health plan, and many worked for employers where no health plan was offered.

HISPANIC ADULTS ARE AT HIGH RISK FOR BEING UNINSURED AND LACKING EMPLOYER-BASED COVERAGE

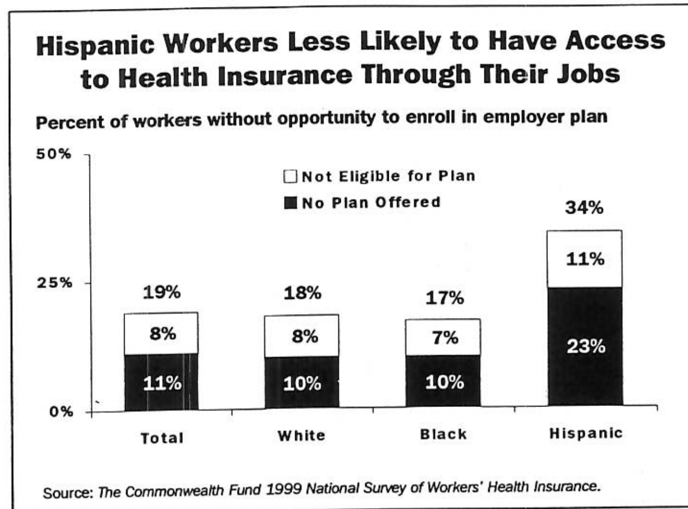
Working-age Hispanic adults are twice as likely to be uninsured as white or black adults. About two of five (39%) Hispanic men and women were uninsured, compared with 15 percent of white and 20 percent of black adults.



*Currently uninsured or had a time uninsured in the past year.
Source: *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance.*

Lack of access to employer-based health plans appears to be a major reason for high rates of Hispanics being uninsured. In the survey, Hispanic workers were at notably high risk of working for employers who did not offer health insurance or restricted eligibility for coverage. One-third (34%) of Hispanic workers did not have an opportunity to participate in an employer-based health plan, compared with 17 percent of black non-Hispanic and 18 percent of white non-Hispanic workers.

Typically, Hispanic employees lacked access to coverage because their employer did not offer a health plan; in fact, they were more than twice as likely as black or white workers (23% vs. 10%) to work for such an employer. In addition, 11 percent of Hispanic workers said they were ineligible to participate in their employer's health plan.



Source: *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance.*

LACK OF INSURANCE CONTRIBUTES TO GOING WITHOUT HEALTH CARE WHEN SICK

Forgoing medical care when sick can lead to further medical complications or prolonged illnesses. To the extent that poor health results in lost wages and unpaid medical bills, untreated illness may jeopardize family well-being as well as personal health.

The survey finds that medical costs that are not covered by insurance create access barriers to care. Nearly one of four (24%) adults—an estimated 40 million people—said they had not visited a doctor when sick, had not followed up on a recommended medical test or treatment, or had not filled a prescription in the past year because of the cost.

Reports of difficulty getting care when needed because of costs were particularly prevalent among adults in the bottom two quarters of the income distribution. Almost half (45 percent) of men and women with incomes below $20,000 said they had gone without at least one of these services when needed because of the cost, as did 29 percent of those with incomes between $20,000 and $35,000.

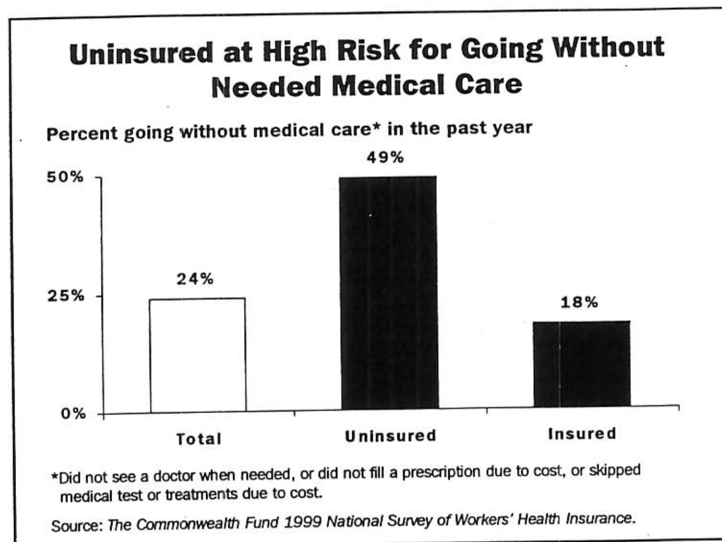
Table 2
Millions of Working-Age Adults Are Going Without Needed Health Care

	All Adults	INCOME* Less than $20,000	$20,000–$34,999	$35,000–$59,999	$60,000 or More
Adults 18–64, in millions	167	35	35	43	37
Percent who did not get needed care in past year due to costs:					
Had a medical problem but did not visit doctor	15%	33%	19%	9%	6%
Did not fill prescription	14	31	16	8	4
Skipped test or follow-up	16	29	17	12	7
Had at least one access problem	24	45	29	17	10
Contacted by collection agency about unpaid medical bills in the past year	19	34	25	13	8

*10 percent of those surveyed did not report income.

The high cost of health care can be a notable detriment to care even for adults with incomes above $35,000. One of six (17%) adults with incomes between $35,000 and $60,000 and one of ten adults with incomes above $60,000 said they had gone without needed health care in the past year because of the cost.

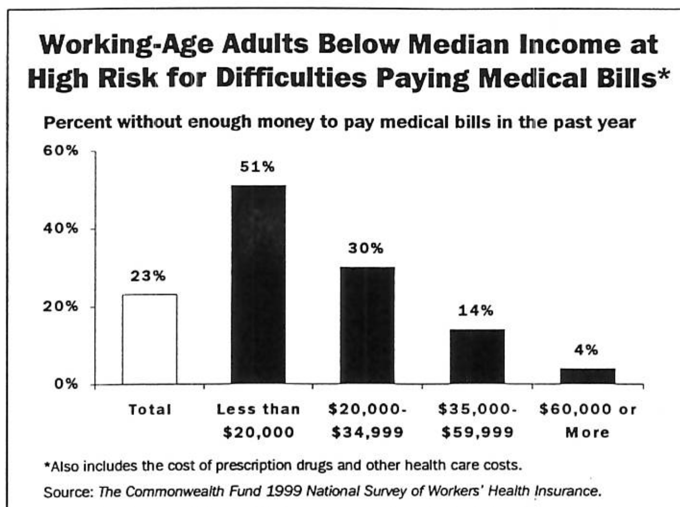
Across all income groups, being uninsured heightened the risk of not getting medical care because of the cost. Uninsured adults were more than three times as likely as insured adults to have gone without a needed doctor visit, not filled a prescription, or not followed up on a recommended medical test or treatment in the past year because of an inability to pay (49% vs. 18%).



MEDICAL BILLS: A THREAT TO FAMILIES' FINANCIAL SECURITY

Families often lack the resources to pay for their personal or their family's uninsured medical expenses. An estimated 39 million adults—nearly one of four (23%) surveyed—reported a time in the past year when they did not have enough money to pay for medical bills, prescription drugs, or other health care costs.

Inability to pay for medical care costs is especially problematic for those already struggling to make ends meet. More than half (51%) of those in the bottom fourth of the income distribution (incomes below $20,000) and almost one-third (30%) of those with incomes between $20,000 and $35,000 had experienced a time when they could not pay medical bills in the past year.



An inability to pay for medical bills can have serious financial consequences. An estimated 31 million adults—nearly one of five (19%)—said they or their family had to face collection agencies because they owed money for medical bills during the past year. The more limited the income, the higher the risk: one of three (34%) working-age adults with incomes below $20,000 and one of four (25%) with incomes between $20,000 and $34,999 were contacted by a collection agency in the past year.

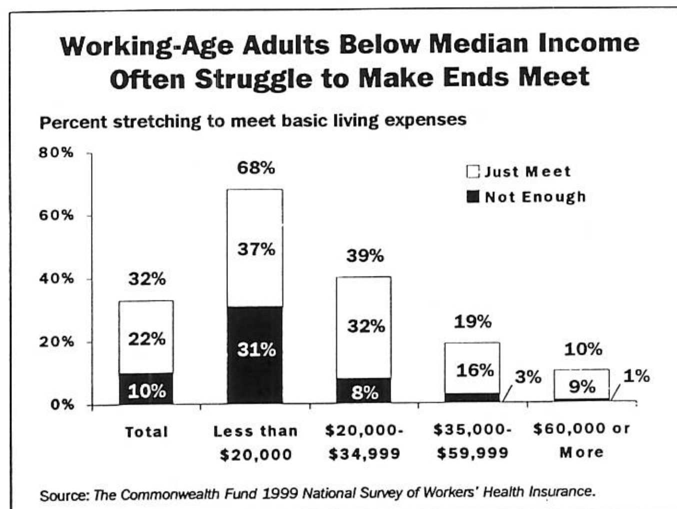
Even those who otherwise felt financially secure experienced difficulties when faced with an unexpected family illness. Fourteen percent of adults with incomes between $35,000 and $60,000 and 4 percent with incomes of $60,000 or more said they had been unable to pay medical bills at some time during the past year. Such expenses tended to be major. One of eight (13%) adults with incomes between $35,000 and $60,000, and one of twelve (8%) adults with incomes $60,000 and more, said they had been contacted by a collection agency in the past year about medical bills.

LIVING FROM PAYCHECK TO PAYCHECK

Financial difficulties arising from medical care often exacerbate budgets already stretched thin just to meet daily costs of living. Despite a robust economy in 1999, the survey finds that a significant number of adults describe themselves as living from paycheck to paycheck, with little financial protection in the event of a major illness or injury. One-third of all working-age adults surveyed—representing 54 million men and women—said that, at best, they have just enough money or are not able to pay for the basic costs of living. Nearly one-fourth (23%) said they "just meet" their basic living expenses and another 10 percent said they "do not have enough to meet basic expenses."[1]

[1] Adults participating in the survey were asked which description best fit their financial situation: live comfortably; meet your expenses with a little left over for extras; just meet your basic living expenses; or don't even have enough to meet basic expenses.

The experience of living from paycheck to paycheck extends well into the middle class. Nearly two of five (39%) adults with incomes between $20,000 and $35,000 were stretching their budgets just to make ends meet.



Source: *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance.*

Not surprisingly, those in the bottom quarter of the income distribution were most likely to describe themselves as unable to cover basic expenses. Two-thirds (68%) were living on the edge financially: one-third (31%) said they did not have enough money to meet basic expenses, and another 37 percent were just able to meet expenses.

A GROWING IMPETUS TO ADDRESS PROBLEMS

The survey findings underscore the disparity between statistics touting record economic growth and the daily struggles of many working Americans trying to make ends meet. Currently, more than 43 million Americans lack health insurance coverage, and experts predict that up to 54 million people or more could be uninsured in 2007, even if the economy remains strong.[2] If the economy turns sour or health insurance premiums begin rising faster than inflation, even more adults will be at risk for not getting the health care they need for fear of costs and mounting financial burdens from unpaid bills.

Lack of confidence in their health care future and the plight of the uninsured remain a top concern of Americans.[3] Amidst a booming economy, public support continues for new strategies that would improve access to affordable health insurance coverage. With most of the uninsured working, the challenge to policymakers is to craft solutions that fit the workforce of the 21st century.

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[2] John Sheils, Lewin Group, testimony before the Subcommittee on Health, House Committee on Ways and Means, Hearing on Uninsured Americans, June 15, 1999.

[3] CBS News, July 20, 1999, http://www.cbs.com/flat/story_168972.html; The Pew Research Center for the People and the Press, January 1999 and July 1999, http://www.people-press.org/jan99rpt.htm and http://www.people-press.org/july99rpt.htm.

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The Commonwealth Fund 1999 National Survey of Workers' Health Insurance, conducted by Princeton Survey Research Associates from January through May 1999, consisted of 20- to 25-minute telephone interviews with a random, national sample of 5,002 adults ages 18 to 64, with over-samples of adults in telephone areas with a high proportion of lower-income residents. The analysis weights responses to reflect national demographic characteristics. Some numbers may not add due to rounding.

The report divides the sample into four income groups: less than $20,000 (21%); $20,000–$34,999 (21%); $35,000–$59,999 (26%); and $60,000 or more (22%). Ten percent of respondents did not report sufficient detail for income classification. The "uninsured" includes adults without insurance when surveyed plus those who had been uninsured at some time during the year. The latter accounts for less than 5 percent of the sample.

The survey has an overall margin of error of +/- 2 percent.

Table 3
Demographic Characteristics of Working-Age Adults, by Annual Income

		INCOME*			
	All Adults	Less than $20,000	$20,000–$34,999	$35,000–$59,999	$60,000 or More
Adults 18–64, in millions	167	35	35	43	37
Gender					
Male	48%	43%	49%	51%	54%
Female	52	57	51	49	46
Age					
18–29	26	39	31	26	12
30–39	25	21	28	28	29
40–49	25	18	21	26	34
50–64	23	22	19	20	25
Race/Ethnicity					
White	73	57	69	80	86
Black	11	17	14	8	6
Hispanic	11	22	12	8	3
Family Composition					
Single, no children	28	42	29	25	18
Single, with children	14	26	18	10	5
Married, no children	22	12	20	24	26
Married, with children	36	19	32	41	51
Family Work Status					
Full-time worker	76	48	80	87	90
Part-time worker	7	14	6	5	5
No current worker	14	33	11	6	4
Among Those Working:					
Type of Employer					
Public	23	17	22	25	25
Private	76	77	75	75	75
Size of Private Employer					
Less than 25	23	31	25	21	17
25–99	15	16	17	15	15
100 or more	52	39	47	58	64

*10 percent of those surveyed did not report income.