Approved: March 21, 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 March 20 , 2000 in Room 234-N of the Capitol.

All members were present except: Senator Dave Corbin, excused

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

Conferees appearing before the committee: Kathy Greenlee, General Counsel, Kansas Insurance Dept.
Larrie Ann Lower, Kansas Association of Health Plans
Cheryl Dillard, Healthnet
Gerard Grimaldi, Kaiser Permanente
Bob Day, SRS

Others attending: (See Attached)

Continued Hearing on SB 619–Insurance, health maintenance organization solvency

Kathy Greenlee, General Counsel for the Kansas Insurance Department, reviewed the new sections of the bill on risk-based capital; uncovered expenditures deposit; open enrollment; rehabilitation, liquidation, conservation of an HMO; hazardous financial condition; assessment, provisions of the act supplemental to other provisions of the law; rules and regulation authority; naming of the act; definitions; Kansas Consumer Protection Act; strengthening of HMO reporting requirements; net worth requirements; Insurance Company Insolvency Act; and Kansas Open Records Act (Attachment 1). Ms. Greenlee pointed out to the Committee that HMO's who are solely Medicaid- oriented are "carved out" of this legislation which means this bill would not apply to First Guard who took over the Horizon contracts. She praised the cooperation the industry has shown in working with the Insurance Department to reach a compromise. She pointed out that no HMO wants to pay for another's insolvency and the increased risk-based capital would address this issue up front rather than waiting for an insolvency to occur.

Larrie Ann Lower, Kansas Association of Health Plans, listed the portions of the legislation her agencies could support (Attachment 2):

- the increased net work requirements–HMO's must maintain a minimum net worth of $1.5 million
- financial reporting requirements
- increasing authority to the Insurance Commissioner over HMO's in liquidation

She expressed their willingness to continue working with the Kansas Insurance Department on the proposed legislation.

The Committee discussed how doctors and/or providers can be made aware that an HMO might be in trouble financially as the oversight agency, Kansas Insurance Department, is not allowed to release such information. The increased risk-based capital would help in addressing this issue. It is nearly impossible for physicians to negotiate with HMO's. It was pointed out that providers sign up to join the plan on a voluntary basis, however, sometimes they are virtually forced to become a provider for the HMO in order to remain part of the system.

Bob Day, SRS, said they supported the bill as written and will continue to work with the Kansas Insurance Department. Their monitoring of First Guard and Family Health will continue also.

Cheryl Dillard, HealthNet, testified in support of the phased-in increase of net worth and the enactment of the risk based capital formula (Attachment 3). A phase-in of the formula would allow HealthNet and other smaller plans to build up the necessary increased reserve over some period, possibly two to three years. She explained the detrimental effect it would have if they were required to meet the net worth and risk-based

capital requirements immediately.

Gerard Grimaldi, Kaiser Permanente, pointed out that quarterly financial statements are required from HMO's and these could be developed into a source of notification between HMO's and providers. His company is a nonprofit HMO serving the Kansas City area. Missouri does not have an HMO solvency law nor a risk-based capital statute. The Missouri Insurance Department does have similar oversight over HMO's as that of Kansas which is based upon the NAIC model.

Senator Brownlee requested Legislative Research to provide information on what other states are doing to address their HMO solvency issues.

Senator Praeger moved that the Minutes of March 15 and 16 be approved as presented. Motion was seconded by Senator Biggs. Motion carried.

The meeting was adjourned at 10:00 a.m. The next meeting is scheduled for March 21, 2000.

SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE
GUEST LIST
DATE: 3/20/00

NAME	REPRESENTING
Bill Sneed	HIAA
Jesse Manning	
Ted Urbanek	
Danielle Noe	DofA
Jennifer Crow	Federico Consulting
David Hanson	Ks Insur Assn
Linda DeCoursey	KS Insurance Dept
Kevin Davis	Am. Family Ins
Marty Kennedy	The Consortium, Inc.
Carole Gates	CIGNA
Larrie Ann Lower	KAHP
Tom Bell	Ks. Hosp. Assn.
GERARD · GRIMALDI	Kaiser Permanente
Cheryl Dillard	HealthNet
Joe Stasi	HEALTHNET
Kathy Sneeler	KS Insurance Dept.
Robert Day	SRS Medicaid

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

TO: Senate Financial Institutions & Insurance

FROM: Kathy Greenlee, General Counsel

RE: Senate Bill 619

DATE: March 20, 2000

Senate Bill 619 Overview

New Sections 1 through 28: HMO Risk Based Capital

Highlights: RBC is basically a financial formula and a regulatory response.
Formula will begin July 1, 2000 if legislation passes.
Regulatory response will have one year phase-in.

Issues: Industry reaction to HMO RBC varies.
RBC has serious impact on Medicaid-only HMOs.

Compromise: Commitment to work individually with companies.
Exempt Medicaid-only HMOs from this net worth requirement.
Continue working with SRS and industry for an appropriate net-worth standard for Medicaid plans.

New Section ~~29~~ 31: Uncovered Expenditures Deposit

Highlights: Requires new deposit for out-of-network expenditures

Issues: KID worked with industry on this language prior to introduction.
Uncertain if any significant issues remain.

Compromise: Increase uncovered expenditures threshold from 8% to 10%.

New Section ~~30~~ 32: Open Enrollment

Highlights: If an HMO becomes insolvent, allows commissioner to require other carriers to offer an open enrollment.
Provides some protections for individuals enrolling in Kansas uninsurable health insurance plan.

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Topeka, Kansas 66612-1678

785 296-3071
Fax 785 296-2283

Issues: KID worked with industry on this language prior to introduction. No issues remain.

New Section ~~31~~ 33: Rehabilitation, Liquidation, Conservation of an HMO

Highlights: Allows commissioner to treat an HMO like an insurance company for purposes of rehabilitation, liquidation or conservation

Issues. None.

New Section ~~32~~ 34: Hazardous Financial Condition

Highlights: Allows commissioner to supervise an HMO's activities in the event of a hazardous financial condition.

Issues: None.

New Section 33: Assessment

Highlights: If an HMO becomes insolvent, allows the commissioner to levy an assessment for out-of-network claims.

Issues: Industry response to this section is not favorable.

Compromise: Commissioner has agreed to strike the entire assessment section and focus, instead, on up-front solvency protections.

New Section 34: Provisions of this act supplemental to other provisions of the law.
New Section 35: Rule and reg authority.
New Section 36: Names this the "Health organization solvency act."

Section 37: Amends current definitions

Highlights: Add definition of health carrier
Amends definition of uncovered expenditure

Issues: Industry currently disagrees on proposed health carrier definition. We should be able to come up with mutually agreeable language.

Compromise: Delete definition of "health carrier" and add definition of "carrier."

Section 38: Unconscionable Act/Kansas Consumer Protection Act

Highlights: Makes it a violation for providers to bill HMO enrollees for money owed to the provider by the HMO.

Issues: None. AG's office is aware and supportive.

Section 39: Strengthen HMO reporting requirements

Highlights: Amends 40-225 to include HMOs, thus making specific references to accounting practices and procedures prescribed by the NAIC.

Issues: None.

Section 40: Net Worth Requirement

Highlights: Sets the minimum net worth requirement for new HMOs at $1,500,000.
Sets minimum net worth requirements for current HMOs at the greater of $1,000,000, or three different formulas based on premium revenues or expenditures.
Includes four year phase-in for current HMOs.

Issues: Industry reaction to net worth requirements varies.
Has serious impact on Medicaid-only HMOs.

Compromise: Exempt Medicaid-only HMOs from this net worth requirement. Continue working with SRS and industry for an appropriate net-worth standard for Medicaid plans.

Section 41: Amends Insurance Company Insolvency Act

Highlights: Provides statutory support for the insurance department to liquidate an HMO and a reciprocal insurer.

Issues: None.

Section 42: Amends Kansas Open Records Act

Highlights: Risk-based capital reports are not public records.
This bill adds specific reference to HMO RBC reports.

Issues: None.

SENATE BILL No. 619

By Committee on Financial Institutions and Insurance

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AN ACT concerning insurance; relating to health maintenance organizations; amending K.S.A. 1999 Supp. 40-3202, 40-3209, 40-3220, 40-3227, 40-3606 and 45-221 and repealing the existing sections.

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

New Section 1. As used in this act:

(a) "Adjusted RBC report" means an RBC report which has been adjusted by the commissioner in accordance with section [(2)] (4) and amendments thereto.

(b) "Corrective order" means an order issued by the commissioner specifying corrective actions which the commissioner has determined are required.

(c) "Domestic health organization" means any health organization which is licensed and organized in this state.

(d) "Foreign health organization" means any health organization licensed to do business in this state pursuant to [article 41 of chapter 40 of the Kansas Statutes Annotated or K.S.A. 40-209, and amendments thereto] not domiciled in this state which is articles 19a, 19c or 32

(e) "NAIC" means the national association of insurance commissioners.

(f) "Health organization" means a health maintenance organization, limited health service organization, dental or vision plan, hospital, medical and dental indemnity or service corporation or other managed care organization licensed under articles 19a, 19c or 32 of chapter 40 of the Kansas Statutes Annotated, and amendments thereto. This definition shall not include an organization that is licensed as either a life and health insurer or a property and casualty insurer under articles 4, 5, 9, 10, 11, 12, 12a, 15 or 16 of chapter 40 of the Kansas Statutes Annotated, and amendments thereto, and that is otherwise subject to either the life or property and casualty RBC requirements in K.S.A. 1999 Supp. 40-2c01 *et seq.*, and amendments thereto.

(g) "RBC" means risk-based capital.

(h) "RBC instructions" means the [risk-based capital instructions promulgated by the NAIC which may be amended by NAIC from time to time in accordance with the procedures adopted by the NAIC] for managed care organizations which are in effect on December 31, 1999, or any later version as adopted by the commissioner in rules and regulations

(i) "RBC level" means a health organization's company action level RBC, regulatory action level RBC, authorized control level RBC, or mandatory control level RBC where:

(1) "Company action level RBC" means, with respect to any health organization, the product of 2.0 and its authorized control level RBC;

(2) "regulatory action level RBC" means the product of 1.5 and its authorized control level RBC;

(3) "authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions; and

(4) "mandatory control level RBC" means the product of .70 and the authorized control level RBC.

(j) "RBC plan" means a comprehensive financial plan containing the elements specified in section 6, and amendments thereto. If the commissioner rejects the RBC plan, and it is revised by the health organization, with or without the commissioner's recommendation, the plan shall be called the "revised RBC plan."

(k) "RBC report" means the report required by [section 2] and amendments thereto.

sections 2, 3 and 4

(l) "Total adjusted capital" means the sum of:

(1) A health organization's capital and surplus [or surplus only if a mutual insurer]; and

as determined in accordance with the annual financial statements required to be filed under articles 19a, 19c or 32 of chapter 40 of Kansas statutes annotated and amendments thereto

(2) such other items, if any, as the RBC instructions may provide.

(m) "Commissioner" means the commissioner of insurance.

New Sec. 2. [Every domestic health organization shall prepare and submit to the commissioner, on or before March 1, a report of its RBC levels as of the end of the calendar year just ended in a form and containing such information as is required by the RBC instructions. In addition, every domestic health organization shall file its RBC report:

(a) Except as provided in paragraph (b)

(1) With the NAIC in accordance with the RBC instructions; and

(2) with the insurance commissioner in any state in which the health organization is authorized to do business, if such insurance commissioner has notified the health organization of its request in writing, in which case, the health organization shall file its RBC report not later than the later of:

(1) 15 days from the receipt of notice to file its RBC report with that state; or

(2) the filing date otherwise specified in this subsection.

(b) The risk-based capital requirements of this section shall not apply to any health organization contracting with the Kansas Department of Social and Rehabilitation Services to provide services provided under Title XIX and Title XXI of the Social Security Act or any other public benefits, provided the public benefit contracts represent at least 90% of the premium volume of the health organization.

New Sec. 3. (a) A health organization's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take into account and may adjust for the covariance between:

(1) Asset risk;

(2) credit risk;

(3) underwriting risk; and

(4) all other business risks and such other relevant risks as are set forth in the RBC instructions; determined in each case by applying the factors in the manner set forth in the RBC instructions.

(b) An excess of capital over the amount produced by the risk-based capital requirements contained in this act and the formulas, schedules and instructions referenced in this act is desirable in the business of insurance. Accordingly, each health organization should seek to maintain capital above the RBC levels required by this act. Additional capital is used and useful in the insurance business and helps to secure an [insurer] against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in this act.

health organization

New Sec. 4. If a domestic health organization files an RBC report which in the judgment of the commissioner is inaccurate, the commissioner shall adjust the RBC report to correct the inaccuracy and shall notify such health organization of the adjustment. The notice shall contain a statement of the reason for the adjustment. A RBC report as so adjusted is referred to as an adjusted RBC report.

New Sec. 5. "Company action level event" means any of the following events:

(a) The filing of an RBC report by a health organization which indicates that a health organization's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC.

(b) The [notification by the commissioner to the health organization of an adjusted RBC report that indicates the event described in subsection (a), unless the health organization challenges the adjusted RBC report pursuant to section 19, and amendments thereto, and such challenge has not been rejected by the commissioner].

notification by the commissioner to the health organization of an adjusted RBC report that indicates the event described in subsection (a) if:

(1) The health organization does not challenge the adjusted RBC report pursuant to section 19, and amendments thereto; or

(2) the commissioner has rejected such challenge after a hearing

New Sec. 6. In the event of a company action level event, the health organization shall prepare and submit to the commissioner an RBC plan which shall:

(a) Identify the conditions in the health organization's operation which contribute to the company action level event;

(b) contain proposals of corrective actions which the health organization intends to take that would be expected to result in the elimination of the company action level event;

(c) provide projections of the health organization's financial results in the current year and at least the two succeeding years, both in the absence of the proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital and surplus, and RBC levels. The projections for both

balance sheets,

new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense and benefit component;

(d) identify the key assumptions impacting the health organization's projections and the sensitivity of the projections to the assumptions; and

(e) identify the quality of, and problems associated with, the health organization's business, including, but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance in each case, if any.

New Sec. 7. The RBC plan shall be submitted:

(a) Within 45 days of the company action level event; or

(b) within 45 days after notification to the health organization that the commissioner has rejected the health organization's challenge to an adjusted RBC report pursuant to section 19 and amendments thereto.

New Sec. 8. Within 60 days after the submission by a health organization of an RBC plan to the commissioner, the commissioner shall notify the health organization whether the RBC plan shall be implemented or is, in the judgment of the commissioner, unsatisfactory. If the commissioner determines the RBC plan is unsatisfactory, the notification to the health organization shall state the reasons for the determination, and may state proposed revisions which, in the judgments of the commissioner, will render the RBC plan satisfactory. Upon notification from the commissioner, the health organization shall prepare a revised RBC plan and shall submit the revised RBC plan to the commissioner:

(a) Within 45 days after the notification from the commissioner; or

(b) within 45 days after a notification to the health organization that the commissioner has, pursuant to section 19, and amendments thereto, rejected the health organization's challenge to the commissioner's original findings as authorized by this section.

New Sec. 9. In the event of a notification by the commissioner to a health organization's RBC plan or revised RBC plan is unsatisfactory, the commissioner, subject to the health organization's right to a hearing under section 19, and amendments thereto, may specify in the notification that the notification constitutes a regulatory action level event.

organization that the health

New Sec. 10. Every domestic health organization that files an RBC plan or revised RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in any state in which the health organization is authorized to do business if:

(a) Such state has an RBC provision substantially similar to section 20, and amendments thereto; and

(b) the insurance commissioner of that state has notified the health organization of such insurance commissioner's request for the filing in writing, in which case the health organization shall file a copy of the RBC

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plan or revised RBC plan in that state no later than the later of:

(1) 15 days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with the state; or

(2) the date on which the final RBC plan or revised RBC plan is filed under section 3 or 4, and amendments thereto.

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New Sec. 11. "Regulatory action level event" means, with respect to any health organization, any of the following events:

(a) The filing of an RBC report by the health organization which indicates that the health organization's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC;

(b) [the notification by the commissioner to a health organization of an adjusted RBC report that indicates the result described in subsection (a) if the health organization does not challenge the adjusted RBC report pursuant to section 19, and amendments thereto;

(c) the filing of an adjusted RBC report that indicates the result described in subsection (a) if the commissioner has rejected the health organization's challenge after a hearing held pursuant to K.S.A. 1999 Supp. 40-2c19, and amendments thereto;]

the notification by the commissioner to the health organization of an adjusted RBC report that indicates the event described in subsection (a) if:

(1) The health organization does not challenge the adjusted RBC report pursuant to section 19, and amendments thereto; or

(2) the commissioner has rejected such challenge after a hearing; and

(c) [(d)] the failure of the health organization to file an RBC report by the filing date, unless the health organization has provided an explanation for such failure which is satisfactory to the commissioner and has cured the failure within 10 days after the filing date;

(d) [(e)] the failure of the health organization to submit an RBC plan to the commissioner within the time period set forth in section 7, and amendments thereto;

(e) [(f)] notification by the commissioner to the health organization that:

(1) The RBC plan or revised RBC plan submitted by the health organization is, in the judgment of the commissioner, unsatisfactory; and

(2) (A) the health organization has not challenged the determination pursuant to section 19, and amendments thereto; or

(B) the commissioner has rejected such challenge.

(f) [(g)] Notification by the commissioner to the health organization that the health organization has failed to adhere to its RBC plan or revised RBC plan, but only if such failure has a substantial adverse effect on the ability of the health organization to eliminate the company action level event in accordance with its RBC plan or revised RBC plan and the commissioner has so stated in the notification, if:

(1) The health organization has not challenged such determination pursuant to section 19, and amendments thereto; or

(2) the commissioner has rejected such challenge after a hearing.

New Sec. 12. In the event of a regulatory action level event, the commissioner shall:

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(a) Require the health organization to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(b) perform such examination or analysis as the commissioner deems necessary of the assets, liabilities and operations of the health organization including a review of its RBC plan or revised RBC plan; and

(c) subsequent to the examination or analysis, issue a corrective order specifying such actions as the commissioner determines are required.

New Sec. 13. In determining corrective actions, the commissioner may take into account such factors as are deemed relevant with respect to the health organization based upon the commissioner's examination or analysis of the assets, liabilities and operations of the health organization, including, but not limited to, the results of any sensitivity tests undertaken pursuant to the RBC instructions. The RBC plan or revised RBC plan shall be submitted:

(a) Within 45 days after the occurrence of the regulatory action level event;

(b) within 45 days after the notification to the health organization that the commissioner has rejected the health organization's challenge to an adjusted RBC report pursuant to section 19, and amendments thereto; or

(c) within 45 days after notification to the health organization that the commissioner has rejected the health organization's challenge to a revised RBC plan pursuant to section 19, and amendments thereto.

New Sec. 14. The commissioner may retain actuaries and investment experts and other consultants as may be necessary in the judgment of the commissioner to review the health organization's RBC plan or revised RBC plan, examine or analyze the assets, liabilities and operations of the health organization and formulate the corrective order with respect to the health organization. The reasonable fees, costs and expenses relating to consultants shall be borne by the affected health organization or other party as directed by the commissioner.

New Sec. 15. "Authorized control level event" means any of the following events:

(a) The filing of an RBC report by the health organization which indicates that the health organization's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC;

(b) the notification by the commissioner to the health organization of an adjusted RBC report that indicates the event described in subsection (a) if:

(1) The health organization does not challenge the adjusted RBC report pursuant to section 19, and amendments thereto; or

(2) the commissioner has rejected such challenge after a hearing;

(c) the failure of the health organization to respond, in a manner satisfactory to the commissioner, to a corrective order if the health organization has not challenged the corrective order under section 19, and amendments thereto; or

(d) if the commissioner has rejected the challenge to the corrective order or modified the corrective order pursuant to section 19, and amendments thereto, the failure of the health organization to respond, in a manner satisfactory to the commissioner, to the corrective order subsequent to rejection or modification by the commissioner.

New Sec. 16. In the event of an authorized control level event with respect to a health organization, the commissioner:

(a) Shall take such actions as are required under sections 11 through 14, and amendments thereto, regarding a health organization with respect to which a regulatory action level event has occurred; or

(b) if the commissioner deems it to be in the best interests of the policyholders and creditors of the health organization and of the public, shall take such actions as are necessary to cause the health organization to be placed under regulatory control pursuant to K.S.A. 40-3605 *et seq.*, and amendments thereto. In the event the commissioner takes such actions, the authorized control level event shall be deemed sufficient grounds for the commissioner to take action under K.S.A. 40-3605 *et seq.*, and amendments thereto, and the commissioner shall have the rights, powers and duties with respect to the health organization as are set forth in K.S.A. 40-3605 *et seq.*, and amendments thereto. In the event the commissioner takes actions under this subsection pursuant to an adjusted RBC report, the health organization shall be entitled to such protections as are afforded to health organizations under the provisions of K.S.A. 77-501 *et seq.*, and amendments thereto, pertaining to summar proceedings.

New Sec. 17. "Mandatory control event" means any of the following events:

(a) The filing of an RBC report which indicates that the health organization's total adjusted capital is less than its mandatory control level RBC;

by the health organization

(b) notification by the commissioner to the health organization of an adjusted RBC report that indicates the event described in subsection (a) if:

the

(1) The health organization does not challenge the adjusted RBC report pursuant to section 19 and amendments thereto; or

(2) the commissioner has rejected such challenge.

New Sec. 18. In the event of a mandatory control level event the commissioner shall take actions as are necessary to cause the health organization to be placed under regulatory control under K.S.A. 40-3605 *et seq.*, and amendments thereto. In that event, the mandatory control level

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event shall be deemed sufficient grounds for the commissioner to take action under K.S.A. 40-3605 *et seq.*, and amendments thereto, and the commissioner shall have the rights, powers and duties with respect to the health organization as are set forth in K.S.A. 40-3605 *et seq.*, and amendments thereto. In the event the commissioner takes actions pursuant to an adjusted RBC report, the health organization shall be entitled to such protections as are afforded to health organizations under the provisions of K.S.A. 77-501 *et seq.* and amendments thereto, pertaining to summary proceedings. Notwithstanding any of the foregoing, the commissioner may forego action for up to 90 days after the mandatory control level event if there is a reasonable expectation that the mandatory control level event may be eliminated within the 90-day period.

New Sec. 19. (a) Upon notification to a health organization by the commissioner of an adjusted RBC report; or

(b) upon notification to an health organization by the commissioner that:

(1) The health organization's RBC plan or revised RBC plan is unsatisfactory; and

(2) such notification constitutes a regulatory action level event with respect to such health organization; or

(c) upon notification to any health organization by the commissioner that the health organization has failed to adhere to its RBC plan or revised RBC plan and that such failure has a substantial adverse effect on the ability of the health organization to eliminate the company action level event with respect to the health organization in accordance with its RBC plan or revised RBC plan; or

(d) upon notification to an health organization by the commissioner of a corrective order with respect to the health organization, the health organization shall have the right to a hearing under the Kansas administrative procedure act, at which the health organization may challenge any determination or action by the commissioner. The health organization shall notify the commissioner of its request for a hearing within five days after the notification by the commissioner under subsections (a), (b), (c) or (d). Upon receipt of the health organization's request for a hearing, the commissioner shall set a date for the hearing, which date shall be no less than 10 nor more than 30 days after receipt of the health organization's request. Such hearing shall be governed by K.S.A. 77-513 through 77-532 and amendments thereto.

New Sec. 20. (a) All RBC reports, RBC plans and any corrective orders, including the working papers and the results of any analysis of a health organization performed under this act shall be kept confidential by the commissioner. This information shall not be made public or subject to subpoena, other than by the commissioner and then only for the pur-

pose of enforcement actions taken by the commissioner pursuant to this act or any other provision of the insurance laws of this state.

(b) RBC instructions, RBC reports, adjusted RBC reports, RBC plans and revised RBC plans are intended solely for use by the commissioner in monitoring the solvency of health organizations and the need for possible corrective action with respect to health organizations and shall not be used by the commissioner for ratemaking nor considered or introduced as evidence in any rate proceeding nor used by the commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance which an health organization or any affiliate is authorized to write.

New Sec. 21. The comparison of a health organization's total adjusted capital to any of its RBC levels is a regulatory tool, and shall not be used to rank health organizations generally. Therefore, except as otherwise required under the provisions of this act, the making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing an assertion, representation or statement with regard to the RBC levels of any health organization, or of any component derived in the calculation, by any health organization, agent, broker or other person engaged in any manner in the insurance business is prohibited. Notwithstanding the foregoing, if any materially false statement with respect to the comparison regarding a health organization's total adjusted capital to any of its RBC levels or an inappropriate comparison of any other amount to the health organization's RBC levels is published in any written publication and the health organization is able to demonstrate to the commissioner with substantial proof the falsity or misrepresentative nature of such statement, the health organization may publish a rebuttal if the sole purpose of such publication is to rebut the materially false or improper statement.

New Sec. 22. The provisions of this act are supplemental to any other provisions of the laws of this state, and shall not preclude nor limit any other powers or duties of the commissioner under such laws, including but not limited to K.S.A. 40-3605 *et seq.* and amendments thereto.

New Sec. 23. Any foreign health organization, upon the written request of the commissioner, shall submit to the commissioner an RBC report as of the end of the calendar year just ended the later of:

(a) The date an RBC report would be required to be filed by a domestic health organization under this act; or

(b) 15 days after the request is received by the foreign health

(c) (1) The commissioner may share or exchange any documents, materials or other information, including confidential and privileged documents referred to in subsection (a), received in the performance of the commissioner's duties under this act, with:

(A) the NAIC;

(B) other state, federal or international regulatory agencies; and

(C) other state, federal or international law enforcement authorities.

(2) The sharing or exchanging of documents, materials or other information under this subsection shall be conditioned upon the recipient's agreement to maintain the confidential and privileged status, if any, of the documents, materials or other information being shared or exchanged.

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organization.

Any foreign health organization, at the written request of the commissioner, shall submit promptly to the commissioner a copy of any RBC plan that is filed with the insurance commissioner of any other state.

New Sec. 24. In the event of a company action level event, regulatory action level event or authorized control level event with respect to any foreign health organization as determined under the RBC statute applicable in the state of domicile of the health organization or, if no RBC provision is in force in that state, under the provisions of this act, if the insurance commissioner of the state of domicile of the foreign health organization fails to require the foreign health organization to file an RBC plan in the manner specified under the RBC statute or, if there are no RBC provisions in force in the state, under section 5, 6, 7, 8, 9 and 10, and amendments thereto, the commissioner may require the foreign health organization to file an RBC plan with the commissioner. In such event, the failure of the foreign health organization to file an RBC plan with the commissioner shall be grounds to order the health organization to cease and desist from writing new insurance business in this state.

New Sec. 25. In the event of a mandatory control level event with respect to any foreign health organization, if no domiciliary receiver has been appointed with respect to the foreign health organization under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign health organization, the commissioner may make application to the district court as permitted under K.S.A. 40-3605 *et seq.* and amendments thereto with respect to the liquidation of property of foreign health organizations found in this state, and the occurrence of the mandatory control level event shall be considered adequate grounds for the application.

New Sec. 26. All notices by the commissioner to a health organization which may result in regulatory action under this act shall be effective upon dispatch if transmitted by registered or certified mail, or in the case of any other transmission shall be effective upon the health organization's receipt of such notice.

New Sec. 27. If any provision of this act, or the application of the act to any person or circumstance, is held invalid, such determination shall not affect the provisions or applications of this act which can be given effect without the invalid provision or application, and to that end the provisions of this act are severable.

New Sec. 28. [Under this act, the RBC instructions, RBC reports, adjusted RBC reports, RBC plans and revised RBC plans are intended solely for use by the commissioner in monitoring the solvency of health organizations and the need for possible corrective action with respect to health organizations and shall not be:

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(a) Used by the commissioner for ratemaking;
(b) considered or introduced as evidence in any rate proceeding; or
(c) used by the commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance that a health organization or any affiliate is authorized to write.

New Sec. 29. (a) If uncovered expenditures exceed ~~eight~~ ten percent of total health care expenditures for two consecutive months, a health maintenance organization shall place an uncovered expenditure insolvency deposit with the commissioner, with an organization or trustee acceptable to the commissioner through which a custodial or controlled account is maintained, cash or securities that are acceptable to the commissioner. The deposit at all times shall have a fair market value in an amount 120% of the health maintenance organization's outstanding liability for uncovered expenditures for enrollees in this state, including incurred but not reported claims, and shall be calculated as of the first day of the month and maintained for the remainder of the month. If a health maintenance organization is not otherwise required to file a quarterly report, such health maintenance organization shall file a report within 45 days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.

(b) The deposit required under this section shall be in addition to the deposit required under K.S.A. 40-3227, and amendments thereto, and shall be deemed to be an admitted asset of the health maintenance organization in the determination of such health maintenance organization's net worth. All income from deposits or trust accounts shall be deemed to be assets of the health maintenance organization and may be withdrawn from the deposit or account quarterly with the approval of the commissioner.

(c) A health maintenance organization that has made a deposit may withdraw that deposit or any part of the deposit if: (1) A substitute deposit of cash or securities of equal amount and value is made; (2) the fair market value of such substitute deposit exceeds the amount of the required deposit; or (3) the deposit required under subsection (a) is reduced or eliminated. Deposits, substitutions or withdrawals may be made only with the prior written approval of the commissioner.

(d) The deposit required under this section shall be held in trust and may be used only as provided under this section. The commissioner may use all or any portion of the deposit of an insolvent health maintenance organization for administrative costs associated with administering such deposit and the payment of any claim of an enrollee of this state for uncovered expenditures in this state. Each claim for uncovered expenditures shall be paid on a pro rata basis based on assets available to pay the ultimate liability for incurred expenditures. A partial distribution may

Any regulatory action based upon any RBC report required to be filed by a health organization for such health organization's operations during the calendar year 2000, shall be subject to the following:

(1) In the event of a company action level event with respect to a domestic health organization, the commissioner shall take no regulatory action under this act with respect to such domestic health organization.

(2) In the event of a regulatory action level event with respect to any health organization under either subsection (a) or subsection (b) of section 11 or an authorized control level event, the commissioner shall take such action with respect to such health organization under sections 6 through 10, inclusive, as the commissioner deems necessary.

(3) In the event of a regulatory action level event with respect to any health organization under any of subsections (d), (e), (f) or (g) of section 11, the commissioner shall take such action with respect to such health organization under sections 12 through 14, inclusive, as the commissioner deems necessary.

(4) In the event of a mandatory control level event with respect to any health organization, the commissioner shall take action with respect to such health organization as required under section 16.

(b) The provisions of subsection (a) shall not limit the right of the commissioner to proceed as authorized by any other provision of chapter 40 of the Kansas statutes annotated, and amendments thereto or any rule and regulation adopted thereunder.

(c) The provisions of this section shall expire on July 1, 2002.

New Sec. 29 The commissioner may adopt reasonable rules and regulations necessary for the implementation of this act.

New Sec. 30 Sections 1 through 30, inclusive, and amendments thereto shall constitute and may be cited as the health organization risk based capital act.

be made pending final distribution. Any amount of such deposit remaining shall be paid into the liquidation or receivership of the health maintenance organization.

(e) The commissioner by regulation may prescribe the time, manner and form for filing claims under subsection (d).

(f) The commissioner by regulation or order may require health maintenance organizations to file annual, quarterly or more frequent reports deemed necessary to demonstrate compliance with this section. The commissioner may require that the reports include liability for uncovered expenditures as well as an audit opinion.

(g) The deposit required under this section may be satisfied through other arrangement acceptable to the commissioner including parental guarantees and letters of credit.

(h) The commissioner may adopt rules and regulations to implement this section.

New Sec. 30. (a) In the event of an insolvency of a health maintenance organization, the commissioner may order that all other carriers that participated in the enrollment process with the insolvent health maintenance organization at a group's last regular enrollment period shall offer the group's enrollees of the insolvent health maintenance organization a 30-day enrollment period commencing upon the date of insolvency. Under such order each carrier shall offer to each enrollee of the insolvent health maintenance organization the same coverages that such insolvent health maintenance organization had offered to each enrollee of the group at such group's last regular enrollment period at rates determined in accordance with the successor health maintenance organization's existing rating methodology.

(b) Any individual or enrollee who has health insurance coverage involuntarily terminated because of the insolvency of such individual's or enrollee's health maintenance organization shall be treated as the equivalent of a federally defined eligible individual for the purposes of the Kansas uninsurable health insurance plan act, K.S.A. 40-2117 *et seq.* and amendments thereto.

New Sec. 31. (a) A rehabilitation liquidation or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation or conservation of an insurance company and shall be conducted under the supervision of the commissioner pursuant to the law governing the rehabilitation, liquidation or conservation of insurance companies. The commissioner may apply for an order directing the commissioner to rehabilitate, liquidate or conserve a health maintenance organization upon any one or more grounds set out in the insurers supervision, rehabilitation and liquidation act, K.S.A. 40-3605 *et seq.*, and amendments thereto, or when in the commissioner's discretion the con-

tinued operation of such health maintenance organization would be hazardous either to the enrollees of such health maintenance organization or to the people of this state. Each enrollee of such health maintenance organization shall have the same priority in the event of liquidation or rehabilitation as the law provides to policy holders of an health organization.

(b) For purpose of determining the priority of distribution of general assets, any claim of any enrollee or enrollees' beneficiary shall have the same priority as established by K.S.A. 40-3641, and amendments thereto, for policyholders and beneficiaries of insureds of insurance companies. If an enrollee is liable to a nonparticipating provider for services provided pursuant to and covered by the health maintenance organization, such liability shall have the status of such enrollee's claim for distribution of general assets. A provider who is obligated by statute or agreement to hold any enrollee harmless from liability for services provided pursuant to and covered by a health maintenance organization shall have a priority of distribution of the general assets immediately following that of enrollees and enrollees' beneficiaries as described herein, and immediately preceding the priority of distribution described in subsection (d) of K.S.A. 40-3641 and amendments thereto.

34 New Sec. 34. (a) Whenever the commissioner determines that the financial condition of a health maintenance organization is such that its continued operation might be hazardous to its enrollees, creditors or the general public, or that such health maintenance organization has violated any provisions of this act, the commissioner, after notice and hearing, may order such health maintenance organization to take action reasonably necessary to rectify the condition or violation. Such action may include, but not limited to one or more of the following:

(1) Reduce the total amount of present and potential liability for benefits by reinsurance or other method acceptable to the commissioner;

(2) reduce the volume of any new business being accepted;

(3) reduce expenses by specified methods acceptable to the commissioner;

(4) suspend or limit the writing of any new business for a period of time;

(5) increase the health maintenance organization's capital and surplus by contribution; or

(6) take such other steps the commissioner may deem appropriate under the circumstances.

(b) The commissioner may adopt rules and regulations which set uniform standards and criteria for early warning that the continued operation of any health maintenance organization might be hazardous to its enrollees, creditors or the general public and set standards for evaluating the

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financial condition of any health maintenance organization.

~~New Sec. 35. (a) When a health maintenance organization in this state is declared insolvent by a court of competent jurisdiction, the commissioner may levy an assessment on any or all other health maintenance organizations doing business in this state to pay claims for uncovered expenditures for subscribers or enrollees of such insolvent health maintenance organization who are residents of this state and to provide continuation of coverage for such subscribers or enrollees. The commissioner may not assess in any one calendar year more than two percent of the aggregate premium written by each health maintenance organization in this state for the prior calendar year.~~

~~(b) The commissioner may use funds obtained under subsection (a) to pay claims for uncovered expenditures for subscribers or enrollees for an insolvent health maintenance organization who are residents of this state, provide for continuation of coverage for subscribers or enrollees who are residents of this state, and administrative costs. The commissioner by regulation may prescribe the time, manner and form for filing claims under this section or may require claims to be allowed by any ancillary receiver or the domestic liquidator or receiver of such insolvent health maintenance organization.~~

~~(c) (1) A receiver or liquidator of an insolvent health maintenance organization shall allow a claim in the proceeding in an amount equal to the administrative costs and any uncovered expenditures paid under this section.~~

~~(2) Any person receiving benefits under this section for uncovered expenditures shall be deemed to have assigned to the commissioner such person's rights under the covered health care plan certificates to the extent of the benefits received. The commissioner may require an assignment to it of such rights by any payee, enrollee, or beneficiary as a condition precedent to the receipt of any rights or benefits conferred by the section upon that person. The commissioner shall be subrogated to these rights against the assets of an insolvent health maintenance organization held by a receiver or liquidator of another jurisdiction.~~

~~(3) The assignment of subrogation rights of the commissioner and allowed claims under this subsection have the same priority against the assets of the insolvent health maintenance organization as those possessed by any person entitled to receive benefits under this section or for similar expenses in the receivership or liquidation.~~

~~(d) When assessed funds are unused following the completion of the liquidation of a health maintenance organization, the commissioner shall distribute to the health maintenance organizations that have been assessed under this section on a pro rata basis any amounts received under subsection (a) which are not de minimis.~~

35

Delete entire section.

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~~(e) The aggregate coverage of uncovered expenditures under this section shall not exceed $300,000 with respect to one individual. Any continuation of coverage shall not continue for more than:~~

~~(1) The lesser of one year after the health maintenance organization coverage is terminated by insolvency; or~~

~~(2) the remaining term of the contract. The commissioner may provide continuation of coverage of any reasonable basis, including, but not limited to, continuation of the health maintenance organization contract or substitution of indemnity coverage in a form determined by the commissioner.~~

~~(f) The commissioner may waive an assessment of a health maintenance organization if such health maintenance organization would be or is impaired or placed in financially hazardous condition. Any health maintenance organization which fails, within 30 days after notice, to pay any assessment made under this section shall be subject to a civil forfeiture of not more than $1,000 per day and suspension or revocation of its certificate of authority. Any health maintenance organization which is affected by an action taken by the commissioner to enforce the provisions of this section shall be given an opportunity for a hearing in accordance with the provisions of the Kansas administrative procedures act.~~

~~(g) The commissioner may establish a health maintenance organization assessment oversight board which shall be activated only when a health maintenance organization has been declared insolvent and an assessment will be levied against health maintenance organizations doing business in this state. The commissioner shall:~~

~~(1) Request that members of the health maintenance organization industry submit the names and qualifications of persons who are interested in serving on the health maintenance organization assessment oversight assessment board;~~

~~(2) select four members from among the names submitted in paragraph (1);~~

~~(3) select one member from the general public, not identified with the managed care or health insurance industry;~~

~~(4) designate two classes of assessment, one for the purpose of meeting administrative and legal costs and one necessary to carry out the powers and duties of the health maintenance organization assessment board with regard to the insolvent health maintenance organization.~~

~~(h) The health maintenance organization assessment board shall be deactivated when the assessment is complete and the commissioner determines that such board has fully discharged its responsibilities.~~

~~(i) The commissioner may adopt rules and regulations necessary to carry out the provisions of this section.~~

New Sec. 34. The provisions of this act are supplemental to any other

Delete entire section.

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provisions of the laws of this state and shall not preclude or limit any other powers or duties of the commissioner under such laws including, but not limited to, K.S.A. 40-3605 *et seq.*, and amendments thereto.

New Sec. 35. The commissioner may adopt reasonable rules and regulations necessary for the implementation of this act.

New Sec. 36. [Sections 1 through 30, inclusive, and amendments thereto shall constitute and may be cited as the health organization solvency act.]

Sec. 37. K.S.A. 1999 Supp. 40-3202 is hereby amended to read as follows: 40-3202. As used in this act:

(a) "Commissioner" means the commissioner of insurance of the state of Kansas.

(b) "Basic health care services" means but is not limited to usual physician, hospitalization, laboratory, x-ray, emergency and preventive services and out-of-area coverage.

(c) "Capitated basis" means a fixed per member per month payment or percentage of premium payment wherein the provider assumes risk for the cost of contracted services without regard to the type, value or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities.

(e)(d) "Certificate of coverage" means a statement of the essential features and services of the health maintenance organization coverage which is given to the subscriber by the health maintenance organization, medicare provider organization or by the group contract holder.

(f)(e) "Copayment" means an amount an enrollee must pay in order to receive a specific service which is not fully prepaid.

(g)(f) "Deductible" means an amount an enrollee is responsible to pay out-of-pocket before the health maintenance organization begins to pay the costs associated with treatment.

(h)(g) "Director" means the secretary of health and environment.

(i)(h) "Disability" means an injury or illness that results in a substantial physical or mental limitation in one or more major life activities such as working or independent activities of daily living that a person was able to do prior to the injury or illness.

(j)(i) "Enrollee" means a person who has entered into a contractual arrangement or on whose behalf a contractual arrangement has been entered into with a health maintenance organization or the medicare provider organization for health care services.

(k)(j) "Grievance" means a written complaint submitted in accordance with the formal grievance procedure by or on behalf of the enrollee regarding any aspect of the health maintenance organization or the medicare provider organization relative to the enrollee.

(l)(k) "Group contract" means a contract for health care services which

Sections 31 through 35 shall be part of and supplemental to the health maintenance organization act cited at K.S.A. 40-3201 et seq., and amendments thereto.

(d) "Carrier" means a health maintenance organization, an insurer, a nonprofit hospital and medical service corporation, or other entity responsible for the payment of benefits or provision of services under a group contract.

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by its terms limits eligibility to members of a specified group. The group contract may include coverage for dependents.

~~(s)~~ (k) "Group contract holder" means the person to which a group contract has been issued.

~~(t)~~ (m) "Health care services" means basic health care services and other services, medical equipment and supplies which may include, but are not limited to, medical, surgical and dental care; psychological, obstetrical, osteopathic, optometric, optic, podiatric, nursing, occupational therapy services, physical therapy services, chiropractic services and pharmaceutical services; health education, preventive medical, rehabilitative and home health services; inpatient and outpatient hospital services, extended care, nursing home care, convalescent institutional care, laboratory and ambulance services, appliances, drugs, medicines and supplies; and any other care, service or treatment for the prevention, control or elimination of disease, the correction of defects or the maintenance of the physical or mental well-being of human beings.

~~(u) "Health Carrier" means a person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles or both. Insurers subject of K.S.A. 40-3001 et seq., and amendments thereto, and dental service corporations as defined in K.S.A. 40-19a01 et seq., and amendments thereto, shall not be considered health carriers for the purposes of this act.~~

Delete definition

(o) "Health maintenance organization" means an organization which:

(1) Provides or otherwise makes available to enrollees health care services, including at a minimum those basic health care services which are determined by the commissioner to be generally available on an insured or prepaid basis in the geographic area served;

(2) is compensated, except for reasonable copayments, for the provision of basic health care services to enrollees solely on a predetermined periodic rate basis;

(3) provides physician services directly through physicians who are either employees or partners of such organization or under arrangements with a physician or any group of physicians or under arrangements as an independent contractor with a physician or any group of physicians;

(4) is responsible for the availability, accessibility and quality of the health care services provided or made available.

~~(v)~~ (p) "Individual contract" means a contract for health care services issued to and covering an individual. The individual contract may include dependents of the subscriber.

~~(p)~~ (q) "Individual practice association" means a partnership, corporation, association or other legal entity which delivers or arranges for the delivery of basic health care services and which has entered into a services

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arrangement with persons who are licensed to practice medicine and surgery, dentistry, chiropractic, pharmacy, podiatry, optometry or any other health profession and a majority of whom are licensed to practice medicine and surgery. Such an arrangement shall provide:

(1) That such persons shall provide their professional services in accordance with a compensation arrangement established by the entity; and

(2) to the extent feasible for the sharing by such persons of medical and other records, equipment, and professional, technical and administrative staff.

~~(q)~~ *(r)* "Medical group" or "staff model" means a partnership, association or other group:

(1) Which is composed of health professionals licensed to practice medicine and surgery and of such other licensed health professionals, including but not limited to dentists, chiropractors, pharmacists, optometrists and podiatrists as are necessary for the provision of health services for which the group is responsible;

(2) a majority of the members of which are licensed to practice medicine and surgery; and

(3) the members of which: (A) As their principal professional activity over 50% individually and as a group responsibility are engaged in the coordinated practice of their profession for a health maintenance organization; (B) pool their income and distribute it among themselves according to a prearranged salary or drawing account or other plan, or are salaried employees of the health maintenance organization; (C) share medical and other records and substantial portions of major equipment and of professional, technical and administrative staff; and (D) establish an arrangement whereby the enrollee's enrollment status is not known to the member of the group who provides health services to the enrollee.

~~(r)~~ *(s)* "Medicare provider organization" means an organization which:

(1) Is a provider-sponsored organization as defined by Section 4001 of the Balanced Budget Act of 1997 (PL 105-33); and

(2) provides or otherwise makes available to enrollees basic health care services pursuant to Section 4001 of the Balanced Budget Act of 1997 (PL 105-33).

~~(s)~~ *(t)* "Net worth" means the excess of assets over liabilities as determined by the commissioner from the latest annual report filed pursuant to K.S.A. 40-3220 and amendments thereto.

~~(t)~~ *(u)* "Person" means any natural or artificial person including but not limited to individuals, partnerships, associations, trusts or corporations.

~~(u)~~ *(v)* "Physician" means a person licensed to practice medicine and surgery under the healing arts act.

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~~(v)~~ *(w)* "Provider" means any physician, hospital or other person which is licensed or otherwise authorized in this state to furnish health care services.

~~(w)~~ *(x)* "Uncovered expenditures" means the costs of health care services that are covered by a health maintenance organization for which an enrollee would also be liable in the event of the organization's insolvency as determined by the commissioner from the latest annual statement filed pursuant to K.S.A. 40-3220 and amendments thereto *and which are not guaranteed, insured or assumed by any person or organization other than the health carrier.*

Sec. 38. K.S.A. 1999 Supp. 40-3209 is hereby amended to read as follows: 40-3209. (a) All forms of group and individual certificates of coverage and contracts issued by the organization to enrollees or other marketing documents purporting to describe the organization's health care services shall contain as a minimum:

(1) A complete description of the health care services and other benefits to which the enrollee is entitled;

(2) The locations of all facilities, the hours of operation and the services which are provided in each facility in the case of individual practice associations or medical staff and group practices, and, in all other cases, a list of providers by specialty with a list of addresses and telephone numbers;

(3) the financial responsibilities of the enrollee and the amount of any deductible, copayment or coinsurance required;

(4) all exclusions and limitations on services or any other benefits to be provided including any deductible or copayment feature and all restrictions relating to pre-existing conditions;

(5) all criteria by which an enrollee may be disenrolled or denied reenrollment;

(6) service priorities in case of epidemic, or other emergency conditions affecting demand for medical services;

(7) in the case of a health maintenance organization, a provision that an enrollee or a covered dependent of an enrollee whose coverage under a health maintenance organization group contract has been terminated for any reason but who remains in the service area and who has been continuously covered by the health maintenance organization for at least three months shall be entitled to obtain a converted contract or have such coverage continued under the group contract for a period of six months following which such enrollee or dependent shall be entitled to obtain a converted contract in accordance with the provisions of this section. The converted contract shall provide coverage at least equal to the conversion coverage options generally available from insurers or mutual nonprofit hospital and medical service corporations in the service area at the ap-

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plicable premium cost. The group enrollee or enrollees shall be solely responsible for paying the premiums for the alternative coverage. The frequency of premium payment shall be the frequency customarily required by the health maintenance organization, mutual nonprofit hospital and medical service corporation or insurer for the policy form and plan selected, except that the insurer, mutual nonprofit hospital and medical service corporation or health maintenance organization shall require premium payments at least quarterly. The coverage shall be available to all enrollees of any group without medical underwriting. The requirement imposed by this subsection shall not apply to a contract which provides benefits for specific diseases or for accidental injuries only, nor shall it apply to any employee or member or such employee's or member's covered dependents when:

(A) Such person was terminated for cause as permitted by the group contract approved by the commissioner;

(B) any discontinued group coverage was replaced by similar group coverage within 31 days; or

(C) the employee or member is or could be covered by any other insured or noninsured arrangement which provides expense incurred hospital, surgical or medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination. Written application for the converted contract shall be made and the first premium paid not later than 31 days after termination of the group coverage or receipt of notice of conversion rights from the health maintenance organization, whichever is later, and shall become effective the day following the termination of coverage under the group contract. The health maintenance organization shall give the employee or member and such employee's or member's covered dependents reasonable notice of the right to convert at least once within 30 days of termination of coverage under the group contract. The group contract and certificates may include provisions necessary to identify or obtain identification of persons and notification of events that would activate the notice requirements and conversion rights created by this section but such requirements and rights shall not be invalidated by failure of persons other than the employee or member entitled to conversion to comply with any such provisions. In addition, the converted contract shall be subject to the provisions contained in paragraphs (2), (4), (5), (6), (7), (8), (9), (13), (14), (15), (16), (17) and (19) of subsection (j) of K.S.A. 40-2209, and amendments thereto;

(8) (A) group contracts shall contain a provision extending payment of such benefits until discharged or for a period not less than 31 days following the expiration date of the contract, whichever is earlier, for covered enrollees and dependents confined in a hospital on the date of

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termination;

(B) a provision that coverage under any subsequent replacement contract that is intended to afford continuous coverage will commence immediately following expiration of any prior contract with respect to covered services not provided pursuant to subparagraph (8)(A); and

(9) an individual contract shall provide for a 10-day period for the enrollee to examine and return the contract and have the premium refunded, but if services were received by the enrollee during the 10-day period, and the enrollee returns the contract to receive a refund of the premium paid, the enrollee must pay for such services.

(b) No health maintenance organization or medicare provider organization authorized under this act shall contract with any provider under provisions which require enrollees to guarantee payment, other than copayments and deductibles, to such provider in the event of nonpayment by the health maintenance organization or medicare provider organization for any services which have been performed under contracts between such enrollees and the health maintenance organization or medicare provider organization. Further, any contract between a health maintenance organization or medicare provider organization and a provider shall provide that if the health maintenance organization or medicare provider organization fails to pay for covered health care services as set forth in the contract between the health maintenance organization or medicare provider organization and its enrollee, the enrollee or covered dependents shall not be liable to any provider for any amounts owed by the health maintenance organization or medicare provider organization. If there is no written contract between the health maintenance organization or medicare provider organization and the provider or if the written contract fails to include the above provision, the enrollee and dependents are not liable to any provider for any amounts owed by the health maintenance organization or medicare provider organization. *Any action by a provider to collect or attempt to collect from a subscriber or enrollee any sum owed by the health maintenance organization to a provider shall be deemed to be an unconscionable act within the meaning of K.S.A. 50-627 and amendments thereto.*

(c) No group or individual certificate of coverage or contract form or amendment to an approved certificate of coverage or contract form shall be issued unless it is filed with the commissioner. Such contract form or amendment shall become effective within 30 days of such filing unless the commissioner finds that such contract form or amendment does not comply with the requirements of this section.

(d) Every contract shall include a clear and understandable description of the health maintenance organization's or medicare provider organization's method for resolving enrollee grievances.

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(e) The provisions of subsections (A), (B), (C), (D) and (E) of K.S.A. 40-2209 and 40-2215 and amendments thereto shall apply to all contracts issued under this section, and the provisions of such sections shall apply to health maintenance organizations.

(f) In lieu of any of the requirements of subsection (a), the commissioner may accept certificates of coverage issued by a medicare provider organization in conformity with requirements imposed by any appropriate federal regulatory agency.

Sec. 39. K.S.A. 1999 Supp. 40-3220 is hereby amended to read as follows: 40-3220. Every health maintenance organization and medicare provider organization authorized under this act shall annually on or before the first day of March, file a verified report with the commissioner, showing its condition on the last day of the preceding calendar year, on forms prescribed by the commissioner. Such report shall include:

(a) A financial statement of the organization, including its balance sheet and receipts and disbursements for the preceding year; and

(b) such other information relating to the performance of health maintenance organizations as shall be required by the commissioner. *Every health maintenance organization and medicare provider organization authorized under this act shall be subject to the provisions of K.S.A. 40-225 and amendments thereto.*

Sec. 40. K.S.A. 1999 Supp. 40-3227 is hereby amended to read as follows: 40-3227. (a) *Before issuing any certificate of authority, the commissioner shall require that the health maintenance organization have an initial net worth of $1,500,000 and shall thereafter maintain the minimum net worth required under subsection (b).*

(b) Except as provided in subsections (c) and (d) of this section, every health maintenance organization shall maintain a minimum net worth equal to the greater of:

(1) $1,000,000; or

(2) two percent of annual premium revenues as reported on the most recent annual financial statement filed with the commissioner on the first $150,000,000 of premium and 1% of annual premium on the premium in excess of $150,000,000; or

(3) an amount equal to the sum of three months uncovered health care expenditures as reported on the most recent financial statement filed with the commissioner; or

(4) an amount equal to the sum of:

(A) Eight percent of annual health care expenditures except those paid on a capitated basis or managed hospital payment basis as reported on the most recent financial statement filed with the commissioner; and

(B) four percent of annual hospital expenditures paid on a managed hospital payment basis as reported on the most recent financial statement

Except as provided in paragraph (e),

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filed with the commissioner.

(c) A health maintenance organization licensed on or before the day preceding the effective date of this section must maintain a minimum net worth of:

(1) Twenty-five percent of the amount required by subsection (b) by December 31, 2000;

(2) 50% of the amount required by subsection (b) by December 31, 2001;

(3) 75% of the amount required by subsection (b) by December 31, 2002; and

(4) 100% of the amount required by subsection (b) by December 31, 2003.

(d) In determining net worth, no debt shall be considered fully subordinated unless the subordination clause is in a form acceptable to the commissioner. An interest obligation relating to the repayment of any subordinated debt shall be similarly subordinated. The interest expenses relating to the repayment of a fully subordinated debt shall be considered covered expenses. A debt incurred by a note meeting the requirements of this section, and otherwise acceptable to the commissioner, shall not be considered a liability and shall be recorded as equity.

(f) (e) Unless otherwise provided below, each health maintenance organization do ing business in this state shall deposit with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities or any combination of these or other measures, for the benefit of all of the enrollees of the health maintenance organization, that are acceptable in the amount of $150,000 for a medical group or staff model health maintenance organization or $300,000 for an individual practice association.

(g) (b) (f) The commissioner may waive any of the deposit requirements set forth in subsection [(a)] whenever satisfied that: (1) The organization has sufficient net worth and an adequate history of generating net income to assure its financial viability for the next year; or (2) the organization's performance and obligations are guaranteed by an organization with sufficient net worth and an adequate history of generating net income; or (3) the assets of the organization or its contracts with insurers, hospital or medical service corporations, governments or other organizations are reasonably sufficient to assure the performance of its obligations.

~~(e) When an organization has achieved a net worth not including land, buildings and equipment of at least $1,000,000 or has achieved a net worth including land, buildings and equipment of at least $5,000,000, the annual deposit requirement shall not apply.~~

~~(d) If the organization has a guaranteeing organization which has been in operation for at least five years and has a net worth not including~~

[(e) (f)]

(e) The net worth requirements of sections (a) through (d) shall not apply to any health organization contracting with the Kansas Department of Social and Rehabilitation Services to provide services provided under Title XIX and Title XXI of the Social Security Act or any other public benefits, provided the public benefit contracts represent at least 90% of the premium volume of the health organization.

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~~land, buildings and equipment of at least $1,000,000 or which has been in operation for at least 10 years and has a net worth including land, buildings and equipment of at least $5,000,000, the annual deposit requirement shall not apply. If the guaranteeing organization is sponsoring more than one organization, the net worth requirement shall be increased by a multiple equal to the number of such organizations. This requirement to maintain a deposit in excess of the deposit required of an accident and health insurer shall not apply during any time that the guaranteeing organization maintains for each organization it sponsors a net worth at least equal to the capital and surplus requirements set forth in article 11 of chapter 40 of the Kansas Statutes Annotated for an accident and health insurer.~~

(~~d~~)(e) (~~g~~) The deposit requirements imposed by this act shall not apply to health maintenance organizations not organized under the laws of this state to the extent an amount equal to or exceeding that required by this act has been deposited with the commissioner or an organization or trustee acceptable to the department of insurance of its state of domicile for the benefit of Kansas enrollees. | re-letter

(~~e~~)(f) (~~h~~) All income from deposits shall belong to the depositing organization and shall be paid to it as it becomes available. A health maintenance organization that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities or any combination of these or other measures of equal amount and value. Any securities shall be approved by the commissioner before being substituted. | re-letter

(~~f~~) (~~i~~) *Every health maintenance organization, when determining liability, shall include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures that have been incurred, whether reported or unreported, that are unpaid and for which the organization is or may be liable, and to provide for the expense of adjustment or settlement of those claims.* | re-letter

(~~g~~)(g) (~~j~~) The commissioner shall require that each health maintenance organization have a plan for handling insolvency which allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits. In considering such a plan, the commissioner may require: | re-letter

(1) Insurance to cover the expenses to be paid for continued benefits after an insolvency;

(2) provisions in provider contracts that obligate the provider to provide services for the duration of the period after the health maintenance organization's insolvency for which premium payment has been made and

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until the enrollees' discharge from inpatient facilities;

(3) insolvency reserves;

(4) acceptable letters of credit; or

(5) any other arrangements to assure that benefits are continued as specified in this subsection ~~(g)~~ *(j)*.

Sec. 41. K.S.A. 1999 Supp. 40-3606 is hereby amended to read as follows: 40-3606. This act shall apply to all insurance companies, fraternal benefit societies, *health maintenance [organization]s, reciprocal insurance exchanges,* mutual nonprofit hospital and medical service corporations, captive insurance companies, group funded pools except municipal group funded pools governed by K.S.A. 12-2616 through 12-2629 and amendments thereto, prepaid service plans operating under article 19a of chapter 40 of the Kansas Statutes Annotated, regardless of whether such entities are authorized to do business in this state, and such entities which are in the process of organization.

organizations

Sec. 42. K.S.A. 1999 Supp. 45-221 is hereby amended to read as follows: 45-221. (a) Except to the extent disclosure is otherwise required by law, a public agency shall not be required to disclose:

(1) Records the disclosure of which is specifically prohibited or restricted by federal law, state statute or rule of the Kansas supreme court or the disclosure of which is prohibited or restricted pursuant to specific authorization of federal law, state statute or rule of the Kansas supreme court to restrict or prohibit disclosure.

(2) Records which are privileged under the rules of evidence, unless the holder of the privilege consents to the disclosure.

(3) Medical, psychiatric, psychological or alcoholism or drug dependency treatment records which pertain to identifiable patients.

(4) Personnel records, performance ratings or individually identifiable records pertaining to employees or applicants for employment, except that this exemption shall not apply to the names, positions, salaries and lengths of service of officers and employees of public agencies once they are employed as such.

(5) Information which would reveal the identity of any undercover agent or any informant reporting a specific violation of law.

(6) Letters of reference or recommendation pertaining to the character or qualifications of an identifiable individual.

(7) Library, archive and museum materials contributed by private persons, to the extent of any limitations imposed as conditions of the contribution.

(8) Information which would reveal the identity of an individual who lawfully makes a donation to a public agency, if anonymity of the donor is a condition of the donation.

(9) Testing and examination materials, before the test or examination

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is given or if it is to be given again, or records of individual test or examination scores, other than records which show only passage or failure and not specific scores.

(10) Criminal investigation records, except that the district court, in an action brought pursuant to K.S.A. 45-222, and amendments thereto, may order disclosure of such records, subject to such conditions as the court may impose, if the court finds that disclosure:

(A) Is in the public interest;

(B) would not interfere with any prospective law enforcement action;

(C) would not reveal the identity of any confidential source or undercover agent;

(D) would not reveal confidential investigative techniques or procedures not known to the general public;

(E) would not endanger the life or physical safety of any person; and

(F) would not reveal the name, address, phone number or any other information which specifically and individually identifies the victim of any sexual offense in article 35 of chapter 21 of the Kansas Statutes Annotated, and amendments thereto.

(11) Records of agencies involved in administrative adjudication or civil litigation, compiled in the process of detecting or investigating violations of civil law or administrative rules and regulations, if disclosure would interfere with a prospective administrative adjudication or civil litigation or reveal the identity of a confidential source or undercover agent.

(12) Records of emergency or security information or procedures of a public agency, or plans, drawings, specifications or related information for any building or facility which is used for purposes requiring security measures in or around the building or facility or which is used for the generation or transmission of power, water, fuels or communications, if disclosure would jeopardize security of the public agency, building or facility.

(13) The contents of appraisals or engineering or feasibility estimates or evaluations made by or for a public agency relative to the acquisition of property, prior to the award of formal contracts therefor.

(14) Correspondence between a public agency and a private individual, other than correspondence which is intended to give notice of an action, policy or determination relating to any regulatory, supervisory or enforcement responsibility of the public agency or which is widely distributed to the public by a public agency and is not specifically in response to communications from such a private individual.

(15) Records pertaining to employer-employee negotiations, if disclosure would reveal information discussed in a lawful executive session under K.S.A. 75-4319, and amendments thereto.

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(16) Software programs for electronic data processing and documentation thereof, but each public agency shall maintain a register, open to the public, that describes:

(A) The information which the agency maintains on computer facilities; and

(B) the form in which the information can be made available using existing computer programs.

(17) Applications, financial statements and other information submitted in connection with applications for student financial assistance where financial need is a consideration for the award.

(18) Plans, designs, drawings or specifications which are prepared by a person other than an employee of a public agency or records which are the property of a private person.

(19) Well samples, logs or surveys which the state corporation commission requires to be filed by persons who have drilled or caused to be drilled, or are drilling or causing to be drilled, holes for the purpose of discovery or production of oil or gas, to the extent that disclosure is limited by rules and regulations of the state corporation commission.

(20) Notes, preliminary drafts, research data in the process of analysis, unfunded grant proposals, memoranda, recommendations or other records in which opinions are expressed or policies or actions are proposed, except that this exemption shall not apply when such records are publicly cited or identified in an open meeting or in an agenda of an open meeting.

(21) Records of a public agency having legislative powers, which records pertain to proposed legislation or amendments to proposed legislation, except that this exemption shall not apply when such records are:

(A) Publicly cited or identified in an open meeting or in an agenda of an open meeting; or

(B) distributed to a majority of a quorum of any body which has authority to take action or make recommendations to the public agency with regard to the matters to which such records pertain.

(22) Records of a public agency having legislative powers, which records pertain to research prepared for one or more members of such agency, except that this exemption shall not apply when such records are:

(A) Publicly cited or identified in an open meeting or in an agenda of an open meeting; or

(B) distributed to a majority of a quorum of any body which has authority to take action or make recommendations to the public agency with regard to the matters to which such records pertain.

(23) Library patron and circulation records which pertain to identifiable individuals.

(24) Records which are compiled for census or research purposes and

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which pertain to identifiable individuals.

(25) Records which represent and constitute the work product of an attorney.

(26) Records of a utility or other public service pertaining to individually identifiable residential customers of the utility or service, except that information concerning billings for specific individual customers named by the requester shall be subject to disclosure as provided by this act.

(27) Specifications for competitive bidding, until the specifications are officially approved by the public agency.

(28) Sealed bids and related documents, until a bid is accepted or all bids rejected.

(29) Correctional records pertaining to an identifiable inmate or release, except that:

(A) The name; photograph and other identifying information; sentence data; parole eligibility date; custody or supervision level; disciplinary record; supervision violations; conditions of supervision, excluding requirements pertaining to mental health or substance abuse counseling; location of facility where incarcerated or location of parole office maintaining supervision and address of a releasee whose crime was committed after the effective date of this act shall be subject to disclosure to any person other than another inmate or releasee, except that the disclosure of the location of an inmate transferred to another state pursuant to the interstate corrections compact shall be at the discretion of the secretary of corrections;

(B) the ombudsman of corrections, the attorney general, law enforcement agencies, counsel for the inmate to whom the record pertains and any county or district attorney shall have access to correctional records to the extent otherwise permitted by law;

(C) the information provided to the law enforcement agency pursuant to the sex offender registration act, K.S.A. 22-4901, *et seq.*, and amendments thereto, shall be subject to disclosure to any person, except that the name, address, telephone number or any other information which specifically and individually identifies the victim of any offender required to register as provided by the Kansas offender registration act, K.S.A. 22-4901 *et seq.* and amendments thereto, shall not be disclosed; and

(D) records of the department of corrections regarding the financial assets of an offender in the custody of the secretary of corrections shall be subject to disclosure to the victim, or such victim's family, of the crime for which the inmate is in custody as set forth in an order of restitution by the sentencing court.

(30) Public records containing information of a personal nature where the public disclosure thereof would constitute a clearly unwarranted invasion of personal privacy.

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(31) Public records pertaining to prospective location of a business or industry where no previous public disclosure has been made of the business' or industry's interest in locating in, relocating within or expanding within the state. This exception shall not include those records pertaining to application of agencies for permits or licenses necessary to do business or to expand business operations within this state, except as otherwise provided by law.

(32) The bidder's list of contractors who have requested bid proposals for construction projects from any public agency, until a bid is accepted or all bids rejected.

(33) Engineering and architectural estimates made by or for any public agency relative to public improvements.

(34) Financial information submitted by contractors in qualification statements to any public agency.

(35) Records involved in the obtaining and processing of intellectual property rights that are expected to be, wholly or partially vested in or owned by a state educational institution, as defined in K.S.A. 76-711, and amendments thereto, or an assignee of the institution organized and existing for the benefit of the institution.

(36) Any report or record which is made pursuant to K.S.A. 65-4922, 65-4923 or 65-4924, and amendments thereto, and which is privileged pursuant to K.S.A. 65-4915 or 65-4925, and amendments thereto.

(37) Information which would reveal the precise location of an archeological site.

(38) Any financial data or traffic information from a railroad company, to a public agency, concerning the sale, lease or rehabilitation of the railroad's property in Kansas.

(39) Risk-based capital reports, risk-based capital plans and corrective orders including the working papers and the results of any analysis filed with the commissioner of insurance in accordance with K.S.A. 1999 Supp. 40-2c20 *and section 20*, and amendments thereto.

(40) Memoranda and related materials required to be used to support the annual actuarial opinions submitted pursuant to subsection (b) of K.S.A. 40-409, and amendments thereto.

(41) Disclosure reports filed with the commissioner of insurance under subsection (a) of K.S.A. 1999 Supp. 40-2,156, and amendments thereto.

(42) All financial analysis ratios and examination synopses concerning insurance companies that are submitted to the commissioner by the national association of insurance commissioners' insurance regulatory information system.

(43) Any records the disclosure of which is restricted or prohibited by a tribal-state gaming compact.

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(44) Market research, market plans, business plans and the terms and conditions of managed care or other third party contracts, developed or entered into by the university of Kansas medical center in the operation and management of the university hospital which the chancellor of the university of Kansas or the chancellor's designee determines would give an unfair advantage to competitors of the university of Kansas medical center.

(b) Except to the extent disclosure is otherwise required by law or as appropriate during the course of an administrative proceeding or on appeal from agency action, a public agency or officer shall not disclose financial information of a taxpayer which may be required or requested by a county appraiser or the director of property valuation to assist in the determination of the value of the taxpayer's property for ad valorem taxation purposes; or any financial information of a personal nature required or requested by a public agency or officer, including a name, job description or title revealing the salary or other compensation of officers, employees or applicants for employment with a firm, corporation or agency, except a public agency. Nothing contained herein shall be construed to prohibit the publication of statistics, so classified as to prevent identification of particular reports or returns and the items thereof.

(c) As used in this section, the term "cited or identified" shall not include a request to an employee of a public agency that a document be prepared.

(d) If a public record contains material which is not subject to disclosure pursuant to this act, the public agency shall separate or delete such material and make available to the requester that material in the public record which is subject to disclosure pursuant to this act. If a public record is not subject to disclosure because it pertains to an identifiable individual, the public agency shall delete the identifying portions of the record and make available to the requester any remaining portions which are subject to disclosure pursuant to this act, unless the request is for a record pertaining to a specific individual or to such a limited group of individuals that the individuals' identities are reasonably ascertainable, the public agency shall not be required to disclose those portions of the record which pertain to such individual or individuals.

(e) The provisions of this section shall not be construed to exempt from public disclosure statistical information not descriptive of any identifiable person.

(f) Notwithstanding the provisions of subsection (a), any public record which has been in existence more than 70 years shall be open for inspection by any person unless disclosure of the record is specifically prohibited or restricted by federal law, state statute or rule of the Kansas supreme court or by a policy adopted pursuant to K.S.A. 72-6214, and

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amendments thereto.

Sec. 43. K.S.A. 1999 Supp. 40-3202, 40-3209, 40-3220, 40-3227, 40-3606 and 45-221 are hereby repealed.

Sec. 44. This act shall take effect and be in force from and after its publication in the statute book.

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Kansas Association of Health Plans

Testimony before the
Senate Financial Institutions and Insurance Committee
The Honorable Don Steffes, Chairman
Hearings on SB 619
March 20, 2000

Good morning Chairman Steffes and members of the committee. Thank you for allowing me to appear before you today. I am Larrie Ann Lower, 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 entities that support managed care. Members of the KAHP serve many of the Kansans who are insured by an HMO.

Throughout the past couple of months I and various members of KAHP have been working with the Commissioner's office on this bill through meetings and conference calls concerning the many issues included in this legislation. The KAHP would like to state that we have been very supportive of the Commissioner's efforts with this issue. We certainly appreciate the opportunity we have had to work with the Commissioner's office to this point.

The KAHP believes that protections should be in place to assure consumers that they are enrolled in financially viable health plans that have the resources to provide or arrange for their enrollees' health care needs. With that in mind, there are portions of this legislation that KAHP can support.

Among the portions we support include: Section 40, the increased net worth requirements, in general, HMO's must maintain an minimum net worth of $1.5 million; Section 39, the financial reporting requirements; and Sections 31 and 32, which would give increased authority to the Insurance Commissioner over HMO's in liquidation. There are also portions of this bill with the amendments proposed, that we should be able to support, but we do need some additional time for review.

Senate Financial Institutions & Insurance
Date 3/20/00
Attachment
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We appreciate the deletion of Section ~~33~~ 35 which we adamantly opposed. That section would have provided for an assessment mechanism in the event of a HMO insolvency. The KAHP supports the proper mechanisms being put in place to help prevent insolvencies before they occur. The front end solutions offer consumers much more protection than an assessment, which is used only after a plan has become insolvent.

In conclusion, this legislation has come an extremely long way from the earlier drafts and the Commissioner's office should be commended for their hard work. The industry would request additional time simply to review the proposed changes in the legislation presented to you today. We will be glad to continue to work with the Commissioner's office on this issue. If you have questions for me, I will be happy to try and answer your questions.

Memorandum

To: Senator Don Steffes, Chairman

Kansas Senate Committee on Financial Institutions and Insurance

CC: Larrie Ann Lower

From: Cheryl Dillard

Vice President, Public Affairs

HealthNet

Date: 03/19/00

Re: Kansas Senate Bill 619

Mr. Chairman, thank you for the opportunity to appear before the Committee today favoring solvency protections for Kansans.

HealthNet supports the phased-in increase of net worth and the enactment of the Risk Based Capital formula. We believe that, with these two tools, the Commissioner can provide Kansans with adequate protection. We appreciate the Commissioner's flexibility in how best to achieve this protection.

Having said that HealthNet supports the enactment of RBC, HealthNet would request consideration of a phase-in or a grace period in advance of the full implementation of the RBC formula. HealthNet is a locally owned and operated health plan in Kansas City. Our majority shareholder is the Saint Luke's Shawnee Mission Health System. A phase-in of the formula would allow HealthNet and other smaller plans to build up the necessary increased reserves over some period, say 2-3 years. HealthNet currently meets the net worth requirement in Missouri which is about 2% of premium. RBC, if implemented immediately after enactment, would raise the net worth requirement for HealthNet to 7% of premium, more than tripling our current requirement. We support the concept of requiring that increase but would need time to phase in the reserves. Immediate

implementation of RBC could put plans like HealthNet at a competitive disadvantage with national health plans.

Thank you very much for your attention and I am happy to respond to questions.