Approved: ______________________
Date *March 28, 2000*

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 22, 2000 in Room 234-N of the Capitol.

All members were present except:

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

Conferees appearing before the committee: Kathleen Sebelius, Insurance Commissioner
Kathy Greenlee, Kansas Insurance Department
Larrie Ann Lower, Kansas Association of Health Plans
Terry Leatherman, KCCI

Others attending: (See Attached)

Continued hearing and action on SB 619–Insurance, health maintenance organization solvency
Kathleen Sebelius, Insurance Commissioner, said she was pleased with the final bill as it is a compromise that is workable for the Insurance Department and the industry. It balances public safety with the difficulty of demanding higher solvency rates through a phase-in. The Department has been granted additional oversight over HMO's and will continue to work with the industry in the development of future policy regarding reserves.

Kathy Greenlee, General Counsel for the Kansas Insurance Department, explained the three changes to the bill and presented copies of their suggested amendments (Attachment 1). Subjects addressed were confidentiality, risk-based capital phase-in, technical changes, and striking the word "health" from the definition of uncovered expenditures.

The Committee discussed the necessity of Kansas being a good business partner in the HMO's which handle Medicaid only contracts. The state must take some of the responsibility for the demise of Horizon as SRS was the payer of these Medicaid contracts. The public should not be held to a higher standard than what is expected of the state. Community Health Plan, a commercial HMO company, failed this past year in Kansas. The Committee suggested an interim be requested which would include studying the following topics:

1. Is an HMO the best delivery of Medicaid or should it be fee for service?

2. Discussion and comparison of the reimbursement level.

3. Would it be more efficient and effective if the Medicaid contracts were provided through several different HMO's?

4. Exploration of why some providers choose to write-off Medicaid accounts rather than seek reimbursement.

5. Possibility of offering tax credits for health care providers who write-off Medicaid accounts.

Larrie Ann Lower, Kansas Association of Health Plans, reported they are in agreement with the proposed legislation and will continue to work with the Department on HMO solvency issues.

Senator Feleciano moved to adopt the amendments as proposed by the Insurance Department. Motion was seconded by Senator Praeger. Motion carried.

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

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

Discussion on SB 668–Establishment of Kansas business health partnership

Senator Praeger walked the Committee through the different sections of the bill which would make available affordable health insurance for small businesses. It is anticipated that partial funding could be transferred from the Children's Health Insurance Plan and expanded for full family coverage rather than for the qualifying children only. Money from the Tobacco Settlement may be available for this proposal. The debate with this bill will be affordability vs. comprehensive. The plans presented must be basic and take a "no frills" approach. This is the first time any type of subsidy has been available for insurance for small employers. The seed money which will be needed to start up the plan may be available through foundations. This plan would be available to all employees of a company which met the small business standards, however, subsidies would only be available for those low-income employees whose gross wage does not exceed 200% of the poverty level. It was suggested that the political parties represented on the Board of the Kansas Business Health Policy Committee be chosen from the Republican and Democratic parties. Senator Praeger suggested that the sequence for the plan of action should be:

- Passage of **SB 668**
- Establishment of Kansas Business Health Policy Committee
- Seek waiver from CHIP
- Send out RFP
- Interested parties respond

It was reemphasize that the paperwork portion of the plan must be kept very simple and easily understood and implemented or small employers would not participate.

Terry Leatherman, KCCI, agreed to poll their members to see if interest was there to participate in such a plan. All other interested parties were asked to send in written comments to the Secretary of the Committee.

Senator Becker moved that the Minutes of the March 21st meeting be approved as presented. Motion was seconded by Senator Corbin. Motion carried.

The meeting was adjourned at 10:00 a.m.

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SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE
GUEST LIST
DATE: March 22, 2000

NAME	REPRESENTING
Robert Day	SRS / Medical Policy
Elaine Frisbie	Div. of the Budget
Pat Morris	KAIA
Kevin Davis	Am. Family
Rich Guthrie	Health Midwest
Terry Leatherman	KCCI
Bill Sneed	HIAA
Stan Kramer	WR, Inc.
Jay Wheeler	Ind. Guard
Carole Yates	CIGNA
Larrie Ann Lower	KAHP
Bill Hongell	Governor's Office
Mike Huttles	First Guard
Tom Bell	Ks. Hosp. Assn.
Kathy Damron	Shawnee Mission - St. Luke's
Steve Montgomery	United Healthcare
Kevin Barone	Hein/Weir Chrtd.

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

TO: Senate Financial Institutions & Insurance Committee

FROM: Kathy Greenlee, General Counsel

RE: Senate Bill 619 (HMO Solvency)

DATE: March 22, 2000

Since I addressed you earlier this week, we have made three changes to this bill.

1. Page 9. New confidentiality balloon.
   Industry asked us to add stronger language to this section of the bill. Subsections (2)(B) and (3) are new.

2. Page 11. Risk-based capital phase-in balloon.
   We were asked by industry to delay implementation of risk-based capital beyond the one-year phase-in period. In compromise, we agreed to a two year phase-in period. Thus, for year 2000 and 2001 annual reports, we will use the phase-in regulatory response. This allows companies more time to meet the capital requirements but gives us close regulatory oversight for that extended period.

   Additionally, we made some technical changes to the phase-in balloon to make it more closely mirror the NAIC model.

3. Page 19. Strike the word "health" from the definition of uncovered expenditures. This is a technical clean-up resulting from our earlier definition changes.

We are not aware of any further issues which need to be resolved.

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Senate Financial Institutions & Insurance
Date 3/22/00
Attachment 1

1 pose of enforcement actions taken by the commissioner pursuant to this
2 act or any other provision of the insurance laws of this state.
3 (b) RBC instructions, RBC reports, adjusted RBC reports, RBC
4 plans and revised RBC plans are intended solely for use by the commis-
5 sioner in monitoring the solvency of health organizations and the need
6 for possible corrective action with respect to health organizations and shall
7 not be used by the commissioner for ratemaking nor considered or intro-
8 duced as evidence in any rate proceeding nor used by the commissioner
9 to calculate or derive any elements of an appropriate premium level or
10 rate of return for any line of insurance which an health organization or
11 any affiliate is authorized to write.

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

(B) No waiver of an existing privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized by subsection (c)(1).

(3) The commissioner of insurance is hereby authorized to adopt such rules and regulations establishing protocols governing the exchange of information as may be necessary to implement and carry out the provisions of this act.

12 New Sec. 21. The comparison of a health organization's total ad-
13 justed capital to any of its RBC levels is a regulatory tool, and shall not
14 be used to rank health organizations generally. Therefore, except as oth-
15 erwise required under the provisions of this act, the making, publishing,
16 disseminating, circulating or placing before the public, or causing, directly
17 or indirectly to be made, published, disseminated, circulated or placed
18 before the public, in a newspaper, magazine or other publication, or in
19 the form of a notice, circular, pamphlet, letter or poster, or over any radio
20 or television station, or in any other way, an advertisement, announce-
21 ment or statement containing an assertion, representation or statement
22 with regard to the RBC levels of any health organization, or of any com-
23 ponent derived in the calculation, by any health organization, agent, bro-
24 ker or other person engaged in any manner in the insurance business is
25 prohibited. Notwithstanding the foregoing, if any materially false state-
26 ment with respect to the comparison regarding a health organization's
27 total adjusted capital to any of its RBC levels or an inappropriate com-
28 parison of any other amount to the health organization's RBC levels is
29 published in any written publication and the health organization is able
30 to demonstrate to the commissioner with substantial proof the falsity or
31 misrepresentative nature of such statement, the health organization may
32 publish a rebuttal if the sole purpose of such publication is to rebut the
33 materially false or improper statement.
34 New Sec. 22. The provisions of this act are supplemental to any other
35 provisions of the laws of this state, and shall not preclude nor limit any
36 other powers or duties of the commissioner under such laws, including
37 but not limited to K.S.A. 40-3605 *et seq.* and amendments thereto.
38 New Sec. 23. Any foreign health organization, upon the written re-
39 quest of the commissioner, shall submit to the commissioner an RBC
40 report as of the end of the calendar year just ended the later of:
41 (a) The date an RBC report would be required to be filed by a do-
42 mestic health organization under this act; or
43 (b) 15 days after the request is received by the foreign health

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

31

6 New Sec. 29. (a) If uncovered expenditures exceed ~~eight~~ ten percent of
7 total health care expenditures for two consecutive months, a health main-
8 tenance organization shall place an uncovered expenditure insolvency de-
9 posit with the commissioner, with an organization or trustee acceptable
10 to the commissioner through which a custodial or controlled account is
11 maintained, cash or securities that are acceptable to the commissioner.
12 The deposit at all times shall have a fair market value in an amount 120%
13 of the health maintenance organization's outstanding liability for uncov-
14 ered expenditures for enrollees in this state, including incurred but not
15 reported claims, and shall be calculated as of the first day of the month
16 and maintained for the remainder of the month. If a health maintenance
17 organization is not otherwise required to file a quarterly report, such
18 health maintenance organization shall file a report within 45 days of the
19 end of the calendar quarter with information sufficient to demonstrate
20 compliance with this section.
21 (b) The deposit required under this section shall be in addition to the
22 deposit required under K.S.A. 40-3227, and amendments thereto, and
23 shall be deemed to be an admitted asset of the health maintenance or-
24 ganization in the determination of such health maintenance organization's
25 net worth. All income from deposits or trust accounts shall be deemed
26 to be assets of the health maintenance organization and may be withdrawn
27 from the deposit or account quarterly with the approval of the
28 commissioner.
29 (c) A health maintenance organization that has made a deposit may
30 withdraw that deposit or any part of the deposit if: (1) A substitute deposit
31 of cash or securities of equal amount and value is made; (2) the fair
32 market value of such substitute deposit exceeds the amount of the re-
33 quired deposit; or (3) the deposit required under subsection (a) is re-
34 duced or eliminated. Deposits, substitutions or withdrawals may be made
35 only with the prior written approval of the commissioner.
36 (d) The deposit required under this section shall be held in trust and
37 may be used only as provided under this section. The commissioner may
38 use all or any portion of the deposit of an insolvent health maintenance
39 organization for administrative costs associated with administering such
40 deposit and the payment of any claim of an enrollee of this state for
41 uncovered expenditures in this state. Each claim for uncovered expend-
42 itures shall be paid on a pro rata basis based on assets available to pay
43 the ultimate liability for incurred expenditures. A partial distribution may

(a) Any regulatory action based upon any RBC report required to be filed by a health organization for such health organization's operations during calendar years 2000 and 2001 shall be subject to the following:

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

(2) In the event of a regulatory action level event with respect to any health organization under either subsection (a) or (b) of section 11, the commissioner shall take such action with respect to such health organization under section 5 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 (c), (d), (e) or (f) of section 11 or an authorized control level event, the commissioner shall take such action with respect to such health organization under sections 11 though 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 sections 15 and 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 or the Kansas statutes annotated, and amendments thereto or any rule and regulation adopted thereunder.

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.

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1 ~~(v)~~ *(w)* "Provider" means any physician, hospital or other person
2 which is licensed or otherwise authorized in this state to furnish health
3 care services.
4 ~~(w)~~ *(x)* "Uncovered expenditures" means the costs of health care
5 services that are covered by a health maintenance organization for which
6 an enrollee would also be liable in the event of the organization's insol-
7 vency as determined by the commissioner from the latest annual state-
8 ment filed pursuant to K.S.A. 40-3220 and amendments thereto *and*
9 *which are not guaranteed, insured or assumed by any person or organi-*
10 *zation other than the ~~health~~ carrier.*

Strike word "health"

11 Sec. 38. K.S.A. 1999 Supp. 40-3209 is hereby amended to read as
12 follows: 40-3209. (a) All forms of group and individual certificates of cov-
13 erage and contracts issued by the organization to enrollees or other mar-
14 keting documents purporting to describe the organization's health care
15 services shall contain as a minimum:
16 (1) A complete description of the health care services and other ben-
17 efits to which the enrollee is entitled;
18 (2) The locations of all facilities, the hours of operation and the serv-
19 ices which are provided in each facility in the case of individual practice
20 associations or medical staff and group practices, and, in all other cases,
21 a list of providers by specialty with a list of addresses and telephone
22 numbers;
23 (3) the financial responsibilities of the enrollee and the amount of
24 any deductible, copayment or coinsurance required;
25 (4) all exclusions and limitations on services or any other benefits to
26 be provided including any deductible or copayment feature and all re-
27 strictions relating to pre-existing conditions;
28 (5) all criteria by which an enrollee may be disenrolled or denied re-
29 enrollment;
30 (6) service priorities in case of epidemic, or other emergency condi-
31 tions affecting demand for medical services;
32 (7) in the case of a health maintenance organization, a provision that
33 an enrollee or a covered dependent of an enrollee whose coverage under
34 a health maintenance organization group contract has been terminated
35 for any reason but who remains in the service area and who has been
36 continuously covered by the health maintenance organization for at least
37 three months shall be entitled to obtain a converted contract or have such
38 coverage continued under the group contract for a period of six months
39 following which such enrollee or dependent shall be entitled to obtain a
40 converted contract in accordance with the provisions of this section. The
41 converted contract shall provide coverage at least equal to the conversion
42 coverage options generally available from insurers or mutual nonprofit
43 hospital and medical service corporations in the service area at the ap-

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