Approved: March 30, 2001
Date

MINUTES OF THE HOUSE COMMITTEE ON INSURANCE.

The meeting was called to order by Chairperson Rep. Robert Tomlinson at 3:30 p.m. on March 6, 2001 in Room 527-S of the Capitol.

All members were present except:

Committee staff present:	Bill Wolff, Legislative Research Ken Wilke, Legislative Revisor Mary Best, Committee Secretary
Conferees appearing before the committee:	Ms. Linda DeCoursey, Kansas Insurance Department Ms. Josie Torrez, Developmental Disabilities Council Ms. Laura Howard, Health Care Policy (SRS) Mr. Gary Brunk, Kansas Action for Children
Others attending:	See Attached Guest List

SB 29 - Healthwave waiting period.

Upon the call to order the Chairman called for the approval of the Minutes from January 23, 25, 30, February 1, 6, 8, 13, 14, 15, 20, and March 1, with changes made on attendance for Representatives Huy and Vickery from excused to present or late. A motion was made by Representative Grant to accept the Minutes with the changes and was seconded by Representative Dreher. The motion was voted on and passed.

The Chairman then asked Dr. Wolff to give a brief overview of **SB 29** - HealthWave waiting period. Dr. Wolff explained that this bill would remove the six month waiting period for eligibility to get insurance coverage for children. The coverage would begin immediately upon being declared eligible. The bill strikes lines 28-32, on page 2 of the bill. With this information related to the committee, the Chairman recognized Ms. Josie Torrez, Developmental Disabilities Council. Ms. Torrez gave Proponent Testimony to the committee and a copy of the testimony is (Attachment #1) attached hereto and incorporated into the Minutes by reference. Ms. Torrez confirmed Dr. Wolff's explanation of the bill. She explained that in the present form the child must be "uninsured" for six months during which time a child would not be covered should they become ill or need any form of medical care. The options for parents, or caretakers are to either to pay cash from already straining budgets or try to treat the illness with over the counter drugs and hope for the best. Parents who find the need to change health insurance carriers, for what ever reason, cannot get coverage for children with "pre-existing " medical conditions. These children cannot get coverage under this bill until they "qualify and wait the six months." Ms. Torrez strongly urged the committee to pass this bill. She stood for questions. There were none.

Ms. Laura Howard, Assistant Secretary of Health Care Policy, SRS, was the Proponent of the bill. A copy of her testimony is (Attachment #2) attached hereto and incorporated into the Minutes by reference. She too agreed with the explanation given by Dr. Wolff. She then spoke of the Governor's recommendation, Health Care Financing Administration New Rules and Regulations, Transition Coverage, and "Crowd-Out". She explained to the committee that "crowd-out" is the substitution of HealthWave coverage for private group health plan coverage. She continued on "When the State Children's Health Insurance Program was initially enacted, there was concern that employers who ;make contributions to coverage for dependents of lower-wage employees cold potentially save money if they reduced or eliminated their contributions for such coverage and encouraged their employees to enroll their children in HealthWave." They also felt families making significant contributions toward their dependent group plan would have an incentive to drop that coverage and enroll their children in HealthWave, if the benefits were better or equal to what they have and decrease their out-of-pocket expenses. .

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

The new regulation of January 11, 2001, allows for states to eliminate the six month waiting period and monitors for crowd-out impact in their programs. Ms. Howard stood for questions. Questions were asked by Representatives Huy and Vickery .

Mr. Gary Brunk, Executive Director, Kansas Action for Children, Inc. was the last conferee to give Proponent Testimony to the committee. A copy of the testimony is (Attachment #3) attached hereto and incorporated into the Minutes by reference. Mr. Brunk agreed with all of the previous testimony and had nothing new to add. Questions were asked by Representatives Kirk, Huy and Boston. The public hearings on the bill were closed.

Commissioner Kathleen Sebelius, Kansas Insurance Department, submitted Proponent Testimony in writing only. A copy of the testimony is (Attachment #4) attached hereto and incorporated into the Minutes by reference.

SB 101 - Health insurance; HIPPA technical changes.

SB 101 - Health Insurance; HIPPA technical changes, was brought before the committee. Ms. Linda DeCoursey was the only conferee to offer testimony. A copy of the Proponent Testimony is (Attachment #5) attached hereto and incorporated into the Minutes by reference. Ms. DeCoursey explained the bill was technical in nature and designed to bring Kansas accident and sickness insurance for groups into compliance with HIPPA Act of 1996. HCFA has implemented various regulations, rulings to further clarify the federal laws and when this is done, Kansas laws become non-compliant with HIPPA. The department feels the changes are necessary to "...change our law to state that the succeeding carrier cannot eliminate its legal obligation to enroll an individual who is disabled at the time that the original health is terminated. In other words, the succeeding carrier must enroll all employees at the same time, even if one is in the hospital." Comments were made to Ms. DeCoursey by Chairman Tomlinson. Public hearings were over.

The Chairman called for the pleasure of the committee regarding **SB 101**. Representative Sharp made the motion, as the bill was of non-controversial nature, to place the bill on consent calendar. Representative Toelkes seconded the motion. The vote was taken and passed.

HB 2209 - Title insurance; requiring certain disclosures and prohibiting certain actions.

The next bill to be worked was **HB 2209**. A copy of the amendment is (Attachment #6) atanced hereto and incorporated into the Minutes by reference. Representative Edmonds made the motion to exempt bankers, Representative Huff seconded the motion. A show of hands vote was ten for and six opposed. There was discussion on the motion before the vote. There was an Amendment offered inserting 50,000 population instead of 10,000. Representative Edmonds made the motion to consider the amendment with Representative Mayans seconding the motion. Discussion was held with Representatives Huff and Hummerickhouse. Hand count nine for and seven opposed. Motion passes. The committee returned to the bill twice amended. Representative Hummerickhouse made the motion to table the bill. The vote was taken and was a tie vote, eight for and eight against. The Chairman cast the breaking vote to defeat the motion. The motion to move the bill out favorably was made by Representative Edmonds and was seconded by Representative Mayans. Representative Kirk requested a sub-motion which left county population at 200,000, and Representative seconded. A vote was taken and the motion was defeated. Representative Edmonds renewed his motion to move the bill out. Discussion was held with Representative Grant on Graham, Leach, Bliley. He made a sub-motion to table the bill, which was amended as it was out of order. There was a discussion with Representatives Kirk, Mayans and Representative requested the bill be explained again. Again a vote was taken and the meeting was adjourned before the results were announced. The time was 4:25 p.m.

The next meeting will be held March 8, 2001.

HOUSE INSURANCE COMMITTEE GUEST LIST

DATE: March 6, 2001

NAME	REPRESENTING
Chuck Stones	KBA
Bill Sneed	HIAA
Erik Sartorius	K.C. Regional Association of Realtors
Linda McClaysel	KS Ins. Dept
Jeremy Anderson	KS Ins Dept
Laura Howard	SRS
Josie Totter	KCDD
Gary Brunk	Kansas Action for Children
Karen Francis	KAR
Bill Yanek	KAR
Larry Magill	KAIA
Jim Pelton	SBC
Rebecca Wempe	SBC
Allen Miller	Kathy Damrow Assoc
Bill Brady	KLTA
Barb Conard	KTLA
Jennifer Gross	Federico Consulting
Kathy Olsen	KS Bankers Assn.
Lonnie Cox Rowe	KAHP

Kansas Council on Developmental Disabilities

BILL GRAVES, Governor
DAVE HEDERSTEDT, Chairperson
JANE RHYS, Ph. D., Executive Director

Docking State Off. Bldg., Room 141, 915 Harrison
Topeka, KS 66612-1570
Phone (785) 296-2608, FAX (785) 296-2861

"To ensure the opportunity to make choices regarding participation in society and quality of life for individuals with developmental disabilities"

House Committee on Insurance
March 6, 2001

Testimony in Regard to SB 29 – Health Wave waiting period

To ensure the opportunity to make choices regarding participation in society and quality of life for individuals with developmental disabilities.

Mr. Chairman, Members of the Committee, I am appearing today on behalf of the Kansas Council on Developmental Disabilities regarding the waiting period to qualify for Heath Wave.

The Kansas Council is a federally mandated, federally funded council composed of individuals who are appointed by the Governor, include representatives of the major agencies who provide services for individuals with developmental disabilities, and at least half of the membership is composed of individuals who are persons with developmental disabilities or their immediate relatives. Our mission is to advocate for individuals with developmental disabilities, to see that they have choices in life about where they wish to live, work, and what leisure activities they wish to participate in.

Health Wave now requires a child to be "uninsured" for six months before qualifying for Health Wave. During the six month waiting period children can, and do get sick. What are parents to do at that point? They can either take the child to the doctor and pay for the doctor visit and any prescription medication out of pocket, or try to treat the illness with over-the-counter medication.

House Comm on Ins.
March 6, 2001
Attachment #1

Ten years ago when I stayed home with my children and did not work, my husband was laid off from his job. At that time, the employer allowed six months of health insurance as part of the "lay-off package" to all those laid off. While my husband was looking for another job, our youngest son, Joey had many ear infections that were treated by his doctor. Once my husband found a job, five months later, we all had health insurance except for Joey due to his "pre-existing" condition. This meant no health insurance for our son, who was constantly having ear infections. The rest of us were insured. Joey continued to have ear infections and we could not afford a doctor's visit and the $50 prescription medication it took to clear up the infections. Thus, Joey suffered and now has a 20% hearing loss in his left ear and 25% hearing loss in his right ear.

The Council believes the State of Kansas must to do the "Right Thing" for Kansas children. There are many children today waiting for health insurance through Health Wave. By eliminating the 6 month waiting period to apply for Healthwave, this will be a long-term benefit to the State and Kansas children as a step to prevent life impacting illnesses. This is a wonderful program that benefits many children in Kansas. Let's give them all a chance to lead healthy and happy lives.

We ask that you provide all uninsured children the opportunity to apply for Health Wave as soon as they become uninsured. We appreciate the opportunity of appearing before you.

Josie Torrez
Kansas Council on Developmental Disabilities
Partners in Policymaking, Coordinator
915 SW Harrison, Room 141
Topeka, Kansas 66612
785-296-2608 (V & TDD)

Kansas Department of Social and Rehabilitation Services

Janet Schalansky, Secretary

For additional information contact:

Diane Duffy, Deputy Secretary of Operations

J.G. Scott, Budget Director;

Trudy Racine, Director of Planning and Policy Coordination;

Phone: (785) 296-3271 **Fax:** (785) 296-4685

House Insurance Committee
March 6, 2001

Senate Bill 29

Health Care Policy
Laura Howard, Assistant Secretary
785.296.3773

House Comm on Insurance
March 6, 2001
Attachment # 2

2-1

Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

House Insurance Committee
March 6, 2001

Chairman Tomlinson and members of the Committee, thank you for the opportunity to appear before you today in support of Senate Bill 29. My name is Laura Howard, the Assistant Secretary for Health Care Policy for SRS. S.B. 29 deletes the requirement that children be without health insurance coverage for six months before becoming eligible for coverage under HealthWave, the State Children's Health Insurance Program.

Governor Graves' Recommendation

In his FY 2002 budget recommendation, the Governor proposed a legislative change to eliminate the waiting period for obtaining Title XXI, HealthWave coverage in Kansas. Currently, K.S.A. §38-2001 precludes HealthWave eligibility to children who were covered, during the prior six months, by employer-sponsored health insurance. S.B. 29 eliminates this requirement. Each month, approximately 35 children are denied coverage under the HealthWave program because they had existing health insurance sometime in the preceding six months. Passage of ths bill would provide coverage to 420 children annually for this six month period during which they are currently ineligible for services. Passage of S.B. 29 will result in an additional annual cost of of $299,174 all funds ($83,978 SGF), which is included in the Governor's Budget recommendations for SRS.

"Crowd-Out"

The six-month provision was originally included in law to address federal concerns regarding the potential of "crowd-out," that is, the substitution of HealthWave coverage for private group health plan coverage. When the State Children's Health Insurance Program was initially enacted, there was concern that employers who make contributions to coverage for dependents of lower-wage employees could potentially save money if they reduced or eliminated their contributions for such coverage and encouraged their employees to enroll their children in HealthWave. In addition, it was believed that families that make significant contributions towards dependent group health plan coverage could have an incentive to drop that coverage and enroll their children in HealthWave if the benefits would be comparable, or better, and their out-of-pocket costs would be reduced.

Health Care Financing Administration New Rules and Regulations

On January 11, 2001, HCFA issued new rules and regulations which specifically address the issue of "crowd-out" in State children's health insurance programs. HCFA determined that there is little evidence from states that "crowd-out" is occurring. The new regulations allow states to eliminate the six-month waiting period, and instead monitor for "crowd-out" impacts in their programs.

Kansas' Efforts to Monitor "Crowd-Out"

In Kansas, there has also been little evidence of "crowd-out." We will continue to monitor for "crowd-out" by retaining on all HealthWave applications questions about private group health insurance coverage. SRS will review the applications to identify whether families are substituting private group health insurance for HealthWave.

Transition Coverage

Although not included in S.B. 29, I would also note another recommendation of the Governor which can be done administratively by the Department. Specifically, the Governor recommends that coverage for children under HealthWave begin at the time of eligibility determination. Currently, there is a lag of 30-45 days until actual enrollment in a managed care plan occurs. The Governor's budget recommendation also includes $641,844 all funds ($180,186 SGF) to provide coverage beginning when the child has been found eligible for the program.

In closing, I would urge the passage of S.B. 29, to eliminate the six-month waiting period and provide vital health insurance coverage to additional children under the HealthWave program.

Kansas kids Action For count Children, Inc

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Gary L. Brunk
Executive Director

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Kansas Action for Children
Testimony: Senate Bill 29

♦

House Insurance Committee
March 6, 2001

♦

Submitted by: Gary Brunk, Executive Director

Kansas Action for Children supports the elimination of the six-month waiting period for HealthWave coverage.

In the past couple years we have made significant progress toward a goal I am sure we all share: health insurance coverage for all Kansas children.

The creation of HealthWave not only provides insurance coverage for thousands of previously uninsured children, it has also brought thousands of children into the Medicaid program. It is true that we still have not met the goal of covering all children; nevertheless, the fact that 39,000 more children have health insurance since the inception of HealthWave is an important achievement.

We can now focus on eliminating some of the remaining barriers to coverage for all children, including covering the children of state employees who meet the income guidelines and developing a more seamless system. Kansas Action for Children supports enactment of Senate Bill No. 29 because it would remove another important barrier, the requirement that children previously covered by health insurance must wait six months for HealthWave coverage. We urge this Committee to support this bill.

House Commerce Ins.
March 6, 2001
Attachment #3

Our Work

Kansas Action for Children is an independent, not-for-profit, citizen-based corporation founded in 1979. We work on behalf of all children to ensure that their physical and emotional needs are met and that they become healthy and contributing adults.

- We *paint the picture* of Kansas children by gathering and publicizing information on child well-being through the *Kansas Children's Report Card*, the *Kansas KIDS COUNT Data Book*, and special reports.

- We *advance alternatives* by developing state policy that is family and child friendly. Over the years, programs related to early childhood development, teen pregnancy, preventive health care, citizens review boards, and services to children in troubled families have stemmed from our work.

- We *build the base* of citizen advocacy for children by working with citizens and organizations across the state. We believe that hundreds of citizens speaking out for children can help create communities that support families and children.

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

TO: House Committee on Insurance

FROM: Kathleen Sebelius, Insurance Commissioner

RE: SB 29 – Kansas Insurance Coverage for Children (HealthWave)

DATE: March 6, 2001

Mr. Chairman and members of the Committee:

Thank you for the opportunity to discuss with you SB 29, which relates to the very important topic of children's health insurance plan.

In 1998, SB 424 was passed which outlined the current HealthWave program and included many of the recommendations made by two task forces which studied this issue – SRS Kansas Insurance Coverage for Kids committee chaired by Senator Praeger, and the Children's Health Insurance Action Group, established through the Kansas Insurance Department.

One of the key points of that bill was to establish a federally required "crowd out" prohibition. Kansas chose to use a 6-month exclusion stating that if a child had insurance coverage during the prior six months, then her or she was not eligible for coverage under the new program. It is my understanding that the federal government has now relaxed that prohibition, and that this bill seeks to strike the language from Kansas law.

It is a well-known fact that access to health care coverage is crucial to the well-being of Kansas children. Uninsured children are at risk of preventable illness, and the solution is getting more children insurance coverage. I would certainly ask your favorable support of SB 29.

House Committee on Ins.
Attachment #4
March 6, 2001

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Topeka, Kansas 66612-1678

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Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

TO: House Committee on Insurance

FROM: Linda J. De Coursey, Director of Government Affairs

RE: SB 101 (Technical changes to law; HIPAA)

DATE: March 6, 2001

Mr. Chairman and members of the committee:

I am appearing in support of Senate Bill 101, which was introduced at the request of the Kansas Department of Insurance. The bill is technical in nature and brings Kansas group accident and sickness insurance law into compliance with HIPAA (Health Insurance Portability and Accountability Act of 1996). Please find attached a recent bulletin from Health Care Financing Administration (HCFA) about the "succeeding-carrier" or "extension of benefits" laws and an insurer's obligation under HIPAA.

In 1997, the Kansas Legislature passed SB 204, which implemented HIPAA in our state law. Since that time, HCFA has issued various regulations, rulings, and bulletins to further clarify the federal law. Sometimes their determinations cause our laws to become non-compliant with HIPAA.

The attached Bulletin addresses the situation in which an employer with a disabled employee or dependent switches the group health plan coverage from one insurer (prior carrier) to another (succeeding carrier). We need to change our law to state that the succeeding carrier cannot eliminate its legal obligation to enroll an individual who is disabled at the time that the original

House Comm on Ins.
March 6, 2001
Attachment #5

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health insurance coverage is terminated. In other words, the succeeding carrier must enroll all employees at the same time, even if one is in the hospital.

We believe that the language in this bill accomplishes that directive. I respectfully ask that when the committee considers SB 101, to please consider it favorably for passage.

ADVANCE COPY OF FINAL ISSUANCE

PROGRAM MEMORANDUM
INSURANCE COMMISSIONERS
INSURANCE ISSUERS

Department of Health and Human Services

Health Care Financing Administration

Transmittal No. 00-04 **Date** August 2000

Title: Insurance Standards Bulletin Series -- INFORMATION

Subject: State "succeeding-carrier" or "extension of benefits" laws and an issuer's obligation under HIPAA to enroll an eligible individual who is disabled[1].

Markets: Group

I. Purpose

This bulletin conveys the position of the Health Care Financing Administration (HCFA) on the relationship between State "succeeding-carrier" laws and the insurance reform provisions of Title XXVII of the Public Health Service Act (PHS Act), as added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

A number of States enacted these laws prior to HIPAA to address the situation in which an employer with a disabled employee or dependent switches its group health plan coverage from one issuer (the "prior carrier") to another (the "succeeding carrier"). This bulletin explains why a State succeeding-carrier law cannot eliminate the succeeding carrier's legal obligation under federal law to enroll an individual who is disabled at the time that the original health insurance coverage is terminated. However, as discussed below, this does not preclude State laws from promoting better outcomes by imposing obligations over and above the federal law requirements, or by providing rules for which carrier will actually make payment in a particular situation.[2]

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[1]The term "disabled individual," is used in this bulletin to include an individual who is receiving inpatient hospital services on the date of replacement coverage or is covered under an extension of benefits provision. Similarly, the term "disability" is used herein to refer to the state of being hospitalized on the date of replacement coverage or covered under an extension of benefits provision.

[2]For example, while under the PHS Act the legal obligation of the succeeding carrier to enroll the individual for benefits is absolute, State law might provide that another carrier has the obligation to pay for the services, so that there is no cost (or a reduced cost) to the succeeding carrier for the benefits it would otherwise be legally obligated to cover.

Because many State laws are based on the "Group Coverage Discontinuance and Replacement Model Regulation" adopted by the National Association of Insurance Commissioners (NAIC Model), this bulletin will set forth general principles based on the NAIC Model. A number of issuers and State regulators have inquired whether a State law based upon the Model is consistent with an issuer's duties to provide coverage under the PHS Act. Even if a State's law is not identical to the Model, the principles discussed here should provide useful guidance. For the reader's convenience, a copy of the NAIC's Group Coverage Discontinuance and Replacement Model Regulation is attached to this bulletin. The Model is published and copyrighted by the NAIC. Permission to reprint it here has been graciously given by the NAIC.

II. Background

A. NAIC Model.

Under the NAIC Model, when group health coverage is discontinued, the prior carrier must continue to provide benefits for a specified period of time for covered individuals who are totally disabled.[3] This obligation is the same whether or not the group health plan purchases replacement coverage.

However, if the plan obtains replacement coverage that is similar to the old coverage, section 7.B describes the extent to which the prior carrier remains liable for any extension of benefits, while section 7.C addresses the obligations of the succeeding carrier. In particular, the Model addresses the situation in which an individual was disabled at the time the plan changed carriers, and the succeeding carrier has an "actively-at-work" or "nonconfinement" clause that would preclude coverage for the disabled individual.

B. Public Health Service Act

The following provisions of the Public Health Service Act control the interaction between that federal statute and any succeeding carrier provisions that apply under State law.

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[3] Under Section 6.A of the Model, every policy or contract must provide "a reasonable provision for extension of benefits in the event of total disability at the date of the discontinuance of the group policy or contract." Section 6.D specifies that for hospital or medical expense coverages other than dental and maternity, the requirement is satisfied by an extension of at least twelve months under comprehensive or "major medical"coverages, and at least 90 days under other types of hospital or medical expense coverages. This bulletin in only concerned with the types of coverages described in Section 6.D.

5-K

1. Section 2702 of the PHS Act, 42 U.S.C. §300gg-1, states that issuers that offer coverage to group health plans "may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan" based on any of the listed "health status-related factors." The statute makes clear that disability is one of these health factors. (Section 2702(a)(1)(H).)

2. Section 2701, 42 U.S.C. §300gg, permits an issuer to impose preexisting condition exclusions for group health insurance coverage, but places substantial restrictions on that ability. In general, the exclusion:

- cannot be based on a medical condition if medical advice, etc. was not received during the six-month period before the individual became covered under the group health plan, or began a waiting period for coverage.
- cannot last longer than 12 months (or 18 months for late enrollees)
- must be reduced by creditable coverage

3. Section 2723(a) of the PHS Act, 42 U.S.C. §300gg-23(a), specifies that State laws will only be preempted under certain limited circumstances, which are discussed below.

C. Preemption – In General

"Preemption" is a term of art that refers to the situation in which Federal law supersedes State law. The courts have established guidelines for determining whether, and to what extent, State laws are preempted. The clearest indication of preemption is through the inclusion by Congress of an express preemption provision in a statute, such as in section 2723(a) of the PHS Act. That section specifies that State law will generally be preempted only if it "prevents the application of" a provision or requirement of Part A of Title XXVII. The legislative history indicates that this is intended to be the "narrowest" preemption of State laws.[4]

General case law on preemption provides additional guidance in determining what constitutes the scope of the preemption. One basis on which courts have found preemption is if compliance with both Federal and State law is, in effect, physically impossible. See Louisiana Public Service Commission v. Federal Communications Commission, 476 U.S. 355 (1986). In light of the statutory language that State law will not be preempted unless it "prevents" compliance with the

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[4] See House Conf. Rep. No. 104-736, at 205 (1996), reprinted in 1996 U.S. Code Cong. & Admin. News 2018.

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5-X

PHS Act, the legislative history that indicates that preemption will be limited to the "narrowest" of circumstances, and the general case law on preemption, HCFA takes the position that State law "prevents the application" of a PHS Act provision if the State law makes it impossible for a party to comply with the PHS Act. If a State law simply permits but does not require an issuer to do something that is prohibited under the PHS Act, the State law would not be applicable. The issuer simply could not take advantage of the State law provision.

This result is also consistent with Executive Order 13132 of August 4, 1999 (See 64 Fed. Reg. 43, 255 (August 10, 1999)), which states that "Agencies shall construe... a Federal statute to preempt State law only where the statute contains an express preemption provision or there is some other clear evidence that the Congress intended preemption of State law, or where the exercise of State authority conflicts with the exercise of Federal authority under the Federal statute."

III. Analysis

Section 7 of the NAIC Model appears to address the situation in which the succeeding carrier has an actively-at-work or nonconfinement clause that would permit the carrier to refuse to enroll a disabled individual who had been covered by the prior carrier. This provision predated the HIPAA amendments to the PHS Act, and these clauses are no longer permitted to the extent that they would deny enrollment of an individual because of a health factor. We have explained this analysis in Bulletin 00-01, with respect to nonconfinement clauses.[5] We expect future regulations to address the issue of actively-at-work provisions. However, while such provisions may be permissible in some situations, an actively-at-work provision that is used to discriminate against an individual based on a health factor, such as disability, is not permitted.[6]

Section 7.C.(1) of the NAIC Model currently states:

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[5] A nonconfinement clause generally is a plan or policy provision that delays an individual's effective date of coverage based on whether the individual is either: (1) confined to a hospital; (2) disabled; or (3) eligible for benefits under another plan's or policy's extension of benefits provision which is based on hospitalization or disability.

[6] This would include, for example, actively-at-work provisions that treat individuals on sick leave or disability leave less favorably than individuals on other types of leave.

> "Each person who is eligible for coverage in accordance with the succeeding carrier's plan of benefits (in respect of classes eligible and actively at work and non-confinement rules) shall be covered by that carrier's plan of benefits."

(Emphasis added.) If the underlined words are deleted, because nonconfinement clauses and certain actively-at-work clauses are impermissible under the PHS Act, then section 7.C.(1) of the Model would appear simply to require the succeeding carrier to enroll the disabled individual and provide coverage under the regular terms of the replacement policy. This would be consistent with the PHS Act, assuming the prior carrier covered the disabling condition. It would also seem to make section 7.C.(2) inapplicable, since that section addresses the responsibilities of the prior and succeeding carriers with respect to a disabled individual who cannot satisfy an actively-at-work or nonconfinement clause.

As noted above, §2702 of the PHS Act contains an absolute legal prohibition against a carrier's refusing to enroll an otherwise eligible individual based on a disability or other health factor. As also explained above, if a State law simply permits but does not require an issuer to do something that is prohibited under the PHS Act, the State law would not be applicable. Thus if the State law purported to relieve a succeeding carrier of legal responsibility for enrolling an individual, on the basis that the individual was covered by a prior carrier under a State extension of benefits requirement, the State law would not apply.[7]

However, to the extent the State law requires coverage more extensive than required under the PHS Act, the State law could still apply. For example, in a situation that involves replacement coverage, the nondiscrimination provision of the PHS Act only applies to the succeeding carrier. Therefore, the State law obligation of the prior carrier is unaffected by the PHS Act requirement. If, for example, section 2701 of the PHS Act permitted the succeeding carrier to impose a preexisting condition exclusion on an individual's disabling condition, the prior carrier's extension of benefits obligation would presumably require it to provide coverage under State law.[8]

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[7]We believe the State law would be preempted if it prohibited the succeeding carrier from covering the individual.

[8]We are providing this example for illustration, although this situation would only occur in the unlikely event that the succeeding carrier's preexisting condition exclusion would meet all of the requirements of section 2701 of the PHS Act. (i.e., the disabling event occurred prior to the individual's enrollment date in the group health plan; the individual had been covered under the prior carrier for less than the maximum 12 months (18 months for a late enrollee); and the individual did not have enough other creditable coverage to completely eliminate the preexisting

Some States have taken the position that succeeding carrier laws simply operate as coordination of benefits provisions. We believe that this may, as a practical matter, be true when all that is at stake is which carrier pays for particular services. However, in a managed care environment we cannot agree that this is true as a legal matter. If, for example, a disabled individual was eager to switch to a provider that is only available through the succeeding carrier's network of providers, we do not believe that a State law could deny the individual the right granted by HIPAA to enroll in the succeeding carrier's coverage. We are sensitive to the fact that some States may view succeeding carrier laws as a way to protect certain disabled individuals from being suddenly required to change medical providers because of a change in carriers, where the carriers have limited provider networks. States are free to implement State requirements in a way that protects the interests of the disabled individuals without preventing the application of the federal requirement. Since 1997, the PHS Act has clearly left it within the States' authority to enforce the nondiscrimination and pre-existing condition exclusion provisions under their own laws. Therefore in the event there is any dispute about which carrier is required to provide coverage, States have the authority to enforce the various provisions in a way that guarantees that the individual is protected.

Where to get more information:

The regulations cited in this bulletin are found in Part 146 of Title 45 of the Code of Federal Regulations (45 CFR §146). Information about the PHS Act is also available on HCFA's website at http://hipaa.hcfa.gov.

If you have any questions regarding this Bulletin, call the HIPAA Insurance Reform Help Line at (410) 786-1565 or your local HCFA Regional Office.

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condition exclusion.)

~~(e) No title insurer or title agent may accept any order for, issue a title insurance policy to, or provide services to, an applicant if it knows or has reason to believe that the applicant was referred to it by any producer of title business or by any associate of such producer, where the producer, the associate, or both, have a financial interest in the title insurer or title agent to which business is referred unless the producer has disclosed to the buyer, seller and lender the financial interest of the producer of title business or associate referring the title insurance business.~~

~~(f) No title insurer or title agent may accept an order for title insurance business, issue a title insurance policy, or receive or retain any premium, or charge in connection with any transaction if: (i) The title insurer or title agent knows or has reason to believe that the transaction will constitute controlled business for that title insurer or title agent, and (ii) 20% or more of the gross operating revenue of that title insurer or title agent during the six full calendar months immediately preceding the month in which the transaction takes place is derived from controlled business. The prohibitions contained in this subparagraph shall not apply to transactions involving real estate located in a county that has a population, as shown by the last preceding decennial census, of 10,000 or less.~~

~~(g)~~ The commissioner shall adopt any regulations necessary to carry out the provisions of this act.

(15) *Disclosure of nonpublic personal information.* No person shall disclose any nonpublic personal information to a nonaffiliated third party contrary to the provisions of title V of the Gramm-Leach-Bliley act of 1999 (public law 106-102). The commissioner may adopt rules and regulations necessary to carry out this section. Such rules and regulations shall be consistent with and not more restrictive than standards contained in regulations promulgated under title V of the Gramm-Leach-Bliley act of 1999 (public law 106-102) by federal regulatory agencies governing financial institutions doing business in Kansas.

Sec. 7. K.S.A. 40-2404 is hereby repealed.

Sec. 8. This act shall take effect and be in force from and after its publication in the statute book.

(e) No title insurer or title agent may accept an order for title insurance business, issue a title insurance policy, or receive or retain any premium, or charge in connection with any transaction if: (i) The title insurer or title agent knows or has reason to believe that the transaction will constitute controlled business for that title insurer or title agent, and (ii) 20% or more of the gross operating revenue of that title insurer or title agent during the six full calendar months immediately preceding the month in which the transaction takes place is derived from controlled business. The prohibitions contained in this subparagraph shall not apply to transactions involving real estate located in a county that has a population, as shown by the last preceding decennial census, of 10,000 or less or 50,000 or greater.

Attachment #6
House Commerce
March 6, 2001
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