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 8, 2001 in Room 519-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: Senator Sandy Praeger
Commissioner Kathleen Sebelius, Kansas Insurance Department
Ms. Chris Collins, Kansas Medical Society
Ms. Carla Mahany, Planned Parenthood
Mr. Terry Leatherman, Kansas Chamber of Commerce and Industry
Mr. Bob Corkin, Kansas Public Policy Institute

Others attending: See Attached Guest List

Chairman Tomlinson readdressed **HB 2209** - title insurance. The committee was back on the bill. Representative Huff made the motion to reduce the population from 50,000 to 40,000 and the motion was seconded by Representative Sharp. A sub-motion was made by Representative Edmonds and seconded by Representative Mayans to amend the bill marked for passage. There was a hand count of six yes to eight no, with absence of voting persons. A recount was asked for and the vote at that time was six yes and nine no, with still an absence of all votes. Motion fails. The committee was back on the original motion. Representative Vickery requested clarification of the motion. Clarification was made. Representative Grant made the motion to table the bill. Representative Grant then yielded the floor to Representative Mayans made a suggestion to raise the levels to 250,000 and offered this as a suggested motion. Representative Grant denied the suggestion and made the motion to table the bill to the first day of the January 2002 session. The vote was taken by the show of hands. The vote resulted in a tie of eight to eight, upon which a recount was requested. The Chairman honored the request and another show of hands resulted in a vote of nine yes and six no. The motion to table carried.

Chairman Tomlinson the opened public discussion on **HB 2247** - Kansas business health care partnership act, removal of sunset. The first conferee to come before the committee to present Proponent Testimony was Senator Sandy Praeger. A copy of Senator Praeger's testimony is (Attachment #1) attached hereto and incorporated into the Minutes by reference. Senator Praeger explained the bill would allow risk sharing among the larger groups of employers in the Partnership and provides small businesses the opportunity to pool their employees with other small business to offer health insurance and the choice of health plans to their employees. Senator Praeger explained the Children's Health Insurance Plan (CHIP) and subsidizing families when purchasing health insurance through their employer. This subsidy allows low-wage workers to afford coverage. She went on to explain that future money to support the bill and subsidies could come from the tobacco settlement, but this would need the recommended by the Children's Cabinet and approved by the Governor and the Legislature. The Senator explained how the bill was friendly for all involved. She encouraged the committee to support the bill, and stood for questions. Questions were asked by Representative Kirk, Boston and Chairman Tomlinson made comments toward mandates and self insuring companies, and that coverages with mandates are more expensive and cause people to drop their coverage.

The next conferee to come before the committee was Kansas Insurance Commissioner, Kathleen Sebelius. Commissioner Sebelius offered Proponent Testimony and a copy of her testimony is (Attachment #2) attached hereto and incorporated into the Minutes by reference.

Commissioner Sebelius confirmed the comments made by Senator Praeger and added, Kansas had made great strides in making insurance coverage more accessible to people living here. The Health Commission opened the state purchasing pool to school districts and is still seeking ways to expand the pool, as well as creating an enhanced tax credit for small employers as an incentive to small employers to offer coverage to their employees. While the children's program has offered the initiative to cover as many children in Kansas as possible, the adults are still not covered, and a serious dent has yet to be made. At least 80% of the parents are lacking coverage. They either do not have access to an affordable program or just simply cannot afford the coverage, even if it is offered. The passage of this bill helps to close those numbers. The Commissioner informed the committee that the Kansas Insurance Department received a $1.3 million grant from the U.S. Department of Health and Human Services. KID is hoping to develop a plan for covering all uninsured Kansans. The Commissioner urged the passage of the bill. Representative Boston directed a question to the Commissioner.

Ms. Marley Carpenter spoke on the behalf of Mr. Terry Leatherman, Kansas Chamber of Commerce and Industry. Both Mr. Leatherman and Ms. Chris Collins, Kansas Medical Association, gave Proponent Testimony to the committee. Their testimonies are (Attachment #'s3,4) attached hereto and incorporated into the Minutes by reference. Both Ms. Collins and Mr. Leatherman support the bill but had no new information to add to the previous testimonies.

Mr. Bob Corkins, Kansas Public Policy Institute, gave Neutral Testimony to the committee. A copy of the testimony is (Attachment #5) attached hereto and incorporated into the Minutes by reference. He informed the committee that for the last three years his Institute has researched the subject of defined-contribution pension programs and last year they found a promising field with the health insurance field. He continued on saying, "....idea that has hugely benefitted over 55 million Americans holding a 401 (k) pension account may provide the best path to greater availability and affordability of health insurance. Under the approach, employers would pay a set dollar amount to each employee that the employee then uses to purchase his or her own health insurance. The employee would select a policy that costs less than the amount of the employer's contribution and invest the difference in something like an MSA, or the employee would add her own money to the employer's in order to purchase a more extravagant health plan." Mr. Corkins continued on to let the committee know that this concept is crucial to the Kansas Business Health Partnership. He also explained that KPPI had health insurance expert Richard Teske look at this plan. He attached highlights from Mr. Teske's study. Mr. Corkins stood for questions. Representatives Hummerickhouse, Boston, and Huff posed questions to the conferee.

As there was no further testimony to the bill, the public hearing was closed and the Chairman open hearings on **SB 19** - Health Insurance; Classifying OB/GYN as a primary care provider.

The first conferee before the committee was Commissioner Kathleen Sebelius, Kansas Insurance Department. Commissioner Sebelius presented Proponent Testimony to the committee and a copy of the testimony is (Attachment #6) attached hereto and incorporated into the Minutes by reference. The issue before the committee is one that would allow women to have their OB/GYN's as their primary care providers. Commissioner Sebelius stated that this was particularly important to women who wanted to go for their annual pelvic examinations. At the moment approximately 56% of the 5,164 women surveyed stated they had seen their gynecologist for their last pelvic examination, while only 18% had seen their primary care physician for theirs. Also in the included in the study, 60 percent stated they preferred their gynecologist for this type of care, while only 13 percent preferred their PCP.

The Commissioner continued on to inform the committee that this movement to allow women access to their OB/GYN began in 1994. At that time Maryland became the first state to classify OB/GYN's as primary providers. Now 42 other states have followed the movement and also allow the same access to the women residing in their states. She also stated some of the laws require plans to permit qualified OB/GYN's as primary care physicians; others allow unlimited access or access for routine gynecological and pregnancy service only, without referral. She included a list of these states and the law they passed.

There were no questions.

There was written testimony supporting the bill submitted by Ms. Carla Mahany, Planned Parenthood, Ms. Chris Collins, Kansas Medical Society, Ms. Barbara Holzmark, National Council of Jewish Women, Greater Kansas City Section, Ms. Larry Ann Lower, Kansas Association of Health Plans, Ms. Barbara Duke, Kansas Choice Alliance and American Association of University Women-Kansas, and Ms. Sylvie Rueff, Lawrence< Kansas Chapter of NOW. Copies of their Proponent Testimonies are (Attachment #'s 7,8,9,10,11,12) attached hereto and incorporated into the Minutes by reference.

Public hearings on the bill were brought to a close.

The next item of business was to work **HB 2473** - Life Insurance Companies; replication transactions. The balloon and its' purpose was explained to the committee. The balloon inserts the word "Commissioner" and the meaning inserted as (3) under Section 1. Number changing for the rest of the definitions in this section then changes. Under (B) page 2, the word "financial instrument" is used in place of "derivative" carrying through to pace 3. Numbering changes continued through the bill, to (20). Page 4 brought the final insertion adding (4) the replication transaction is entered into in accordance with the requirements concerning replication transactions contained.....Page 5 of the bill (j) The commissioner shall have the authority to adopt rules and regulations necessary to implement this action. The balloon went to the committee. Representative Grant made the motion to adopt the balloon and Representative Dreher seconded the motion. Vote was taken and the balloon was adopted. Representative Hummerickhouse made the motion to pass the bill out favorably as amended. Representative Huff seconded the motion. The motion carried. A copy of the balloon is (Attachment #13) attached hereto and incorporated into the Minutes by reference.

The meeting was adjourned at 5:00 p.m. The next meeting will be held March 12, 2000.

HOUSE INSURANCE COMMITTEE GUEST LIST

DATE: March 8, 2001

NAME	REPRESENTING
PHILIP HURLEY	PAT HURLEY & Co / KAFP
Alison Ranson	Federico Consulting
Chuck Stones	KBIA
John Peterson	Ks Governmental Consulting
bill Brady	KLTA
Sondra McCauley	Ks Ins. Dept
Chris Collins	Ks Medical Society
Mollee Carpenter	KCCI
KAREN FRANCE	KAR
BILL YANEK	KAR
Erik Sartorius	K.C. Regional Assn of Realtors
Bob Corkins	Ks. Public Policy Institute
Rebecca Wempe	SBL
Tom Swank	SBL
Dan Mulle	Kathy Damron + MSSOC
Jeremy Anderson	KS Ins. Dept
Carrie Donovan	NAII
LARRY MAGILL	KAID
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LONG TERM CARE TASK FORCE
HEALTH CARE REFORM LEGISLATIVE OVERSIGHT COMMITTEE

MEMBER:
ASSESSMENT AND TAXATION
CONFIRMATIONS
INTERSTATE COOPERATION
ORGANIZATION, CALENDAR AND RULES
PUBLIC HEALTH AND WELFARE

SANDY PRAEGER

VICE PRESIDENT • KANSAS SENATE

TESTIMONY
on
HB 2247
March 8, 2001

By
Sandy Praeger

Thank you, Chairman Tomlinson, and members of the House Insurance Committee for this opportunity to appear in support of continuing the Kansas Business Health Partnership. Let me outline the key provisions of this legislation.

CHOICE

This legislation creates the Kansas Business Health Partnership. The Partnership provides the opportunity for small businesses to pool their employees with other small businesses to offer - not just health insurance - but a choice of health plans to their employees. It will also allow for risk-sharing among the larger group of employees from all of the companies participating in the Partnership. This doesn't just "level the playing field" for these companies; it lets them on the "playing field."

The Partnership will perform the following organizational functions:

1. Contract with two or more health plans to provide choice
2. Establish several benefit options
3. Receive subsidies from the state and link those funds with eligible families
4. Receive premiums from employer and employee, making this administratively simple for the participating employers

AFFORDABILITY

The Partnership provides a mechanism for subsidies to assist families in purchasing health insurance through their employer. The subsidy comes from the

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Attachment #1

Children's Health Insurance Program. The subsidy, along with the pooling of employees, creates the opportunity for small companies with low-wage workers to offer insurance. At some point in the future money from the tobacco settlement could also be used to subsidize the employees' share of the premium. This would, of course, need to be recommended by the Children's Cabinet and approved by the Governor and the Legislature.

EMPLOYER, EMPLOYEE AND FAMILY FRIENDLY

Instead of using the government-run program for the children, where they are insured separate from their parents, the family that qualifies can be covered by the same health plan offered through their place of employment. The employer that has not been able to afford to provide coverage for his/her employees may be motivated to do so with the availability of the subsidy. In this tight labor market, employers are increasingly looking for ways to attract and retain workers. This program can provide that incentive.

This approach builds on the concept of employer-based insurance coverage that, along with the government programs of Medicaid and Medicare, provides insurance for 85% of Americans. We could expand Medicaid (especially when one considers that our current eligibility level for non-pregnant adults is 43% of the federal poverty level); but instead, this is a private sector program that is both employee and employer friendly.

This Partnership also addresses the concern that the state is not enrolling enough children in the CHIP program (HealthWave). It creates another opportunity for outreach to get children enrolled while at the same time expanding coverage for their parents.

SUNSET PROVISION

I encourage the Committee to repeal this sunset provision and allow this program to continue to evolve. If it meets the needs of Kansas employees and employers, that process <u>will</u> continue. If not, there is nothing in this legislation that requires anything to happen. It only enables a process to continue.

One change that is occurring in the business community is consideration of "defined contribution" for health benefits instead of "defined benefits." If that trend does develop into individual employees shopping for their own health insurance, the market will need a mechanism for providing affordable choices. The Kansas Business Health Partnership could be a solution.

Thank you, Mr. Chairman. I would be happy to answer any questions.

The Wall Street Journal

Wednesday, February 21, 2001

Health & Medicine (A Special Report)

The Have-Nots: Can the problem of the uninsured be solved? Here are some of the proposed solutions

--

and their prospects

By Rhonda L. Rundle and Shailagh Murray

Hopes for a grand solution to the problem of the nation's uninsured died along with former President Clinton's health-overhaul package. But that failure has spawned a flourishing marketplace of small ideas coming not from Washington, but from the front lines of the health-care system.

For many in the health-care field, it has been a decade of hard lessons learned. The Clinton inauguration eight years ago signaled a revolution to reformers like Chris Jennings, the president's health-care adviser. But the dream of bold change died halfway through the first Clinton term. There's "a new world order . . . called incrementalism," Mr. Jennings says.

Government health-care policy got smaller scale and more focused, mainly on low-income populations. That opened the door to new forces: nonprofit think tanks, insurance companies, employers and other organizations, all with their own solutions to promote.

Diane Rowland, executive director of the Washington-based Kaiser Commission on Medicaid and the Uninsured, hails efforts from private groups to push the ball forward: "I don't think a proposal will ever work if it comes solely from political leaders." Certainly the Bush administration isn't expected to promote any global health-care solutions, says Ms. Rowland, whose group is part of the Henry J. Kaiser Family Foundation, a health-care philanthropy, and isn't associated with the California HMO Kaiser Permanente.

The nation's 43 million people without health insurance represent a huge problem. Doctors and hospitals are balking at the strains on their bottom lines. As managed-care companies clamp down on costs, indigent expenses stand out as a huge drag. Hospitals no longer have piles of cash to spend on free care. Doctors spend less time at inner-city clinics as they struggle to maintain their own practices. Drug companies are even getting stingier with the free samples that poor people rely on for prescriptions.

To be sure, recent labor shortages have forced employers to scrounge for ways to attract and retain good workers. This has spurred more of them to offer medical insurance, even to low-wage hourly employees. The uninsured population, which had been growing for decades, actually declined slightly in 1999, the latest year for which figures are available.

But the problem remains. And when lots of different protagonists -- ranging from doctors to small businesses -- have a stake in finding a solution, that's when you start to see movement on the policy front, says Ms. Rowland.

Groups ranging from the American Medical Association to the U.S. Chamber of Commerce have called meetings to brainstorm solutions. While most of the forums offer more talk than action, a consensus has emerged in favor of building on the employer-based system that already exists. That puts the spotlight on companies like Wal-Mart Stores Inc., which has liberalized its health plan to make it accessible to nearly all workers -- even those who punch in for only a few hours a week. The Bentonville, Ark., retailer's plan is outlined in more detail below.

Sometimes talk can inspire change. Sandy Praeger,a **Kansas** state senator, says she was galvanized by the **Health** Sector Assembly, a meeting of some 50 **health** -care organizations convened by the AMA in November 1999. Last year, her proposal for an innovative public-private **partnership** to expand coverage for small **businesses** and their low-income workers was enacted into law. She presented the plan, described below, at a second meeting of the assembly last fall.

Of course, there will always be people who choose not to buy such insurance, even if they can afford it. In fact, some health insurers are marketing directly to this group. Blue Cross of California, for example, is running television ads designed to scare people with the specter of financial ruin if they have an accident and don't have medical insurance.

Such people are the moral equivalent of "shoplifters," says Ken Abramowitz, a longtime Wall Street professional with a radical prescription for the uninsured problem. He advocates making health insurance mandatory for everyone living in the U.S., including illegal aliens.

That's the kind of talk rarely heard in Washington these days. Although a new survey by the nonprofit Robert Wood Johnson Foundation has found that the public overwhelmingly supports new aid to the uninsured, even if it costs them more in taxes, the political credo remains: one step at a time.

After the universal-coverage debacle, Mr. Clinton rolled out the Children's Health Insurance Program, a popular state-federal program that targets low-income kids. Sen. Ted Kennedy, a diehard health reformer, is another convert to incrementalism who drafted a 1996 bipartisan bill that allows people to keep their insurance when they move from job to job and also protects them from job discrimination due to pre-existing conditions. Next, Mr. Kennedy co-sponsored the CHIP bill with Sen. Orrin Hatch, a Utah Republican.

"His goal remains comprehensive health-insurance reform, but in the current political reality, he decided that this step-by-step approach is the best way to achieve that," says Jim Manley, Sen. Kennedy's spokesman.

Mr. Clinton wasn't the only president to have tried and failed at large-scale health-care reform. Franklin D. Roosevelt, Harry Truman, John F. Kennedy, Richard Nixon and Jimmy Carter all traveled that road, too. What went wrong? In each case, powerful health interests rose up in opposition, and supporters overreached and refused to compromise; all players stood by their convictions. Every time, the result was the status quo.

That's what history taught Ron Pollack and Charles N. "Chip" Kahn III. The two were opponents in many past health-care battles -- Mr. Pollack as a major Clinton supporter and Mr. Kahn as the Washington spokesman for the health-insurance industry. But even these two men are allies today, having tackled the uninsured problem in a new proposal that is as symbolic as it is substantive. "We've learned our lessons, too," Mr. Pollack says.

Here's a look at some plans for solving the problem of the uninsured:

Idea

-- employer-sponsored coverage for all workers, including part-timers

Example

-- Wal-Mart Stores Inc.

Obstacle

-- expensive to buy and administer

After two years at Wal-Mart, employees who work as few as three or four hours a week can participate in the same medical plan as the retailer's top executives. Nearly 40% of Wal-Mart's new hires lack health insurance before they join the company.

Wal-Mart's health-care coverage for its "associates," as employees are known, has made it a model for health-policy experts looking for practical ways to shrink the ranks of the uninsured. Many retailers, restaurants and other service businesses with sky-high employee turnover rates say they can't afford to provide medical benefits to such a transient population. Less than a quarter of companies offer health benefits to employees who work fewer than 20 hours a week, surveys show.

"We believe verystrongly that a good part-time associate is a very valuable employee -- especially longer-term part-timers because they know the store very well, our culture very well, our customers very well, and are willing to work flexible hours," says Thomas Emerick, vice president of benefits at Wal-Mart. The retailer estimates that fewer than 1% of its 900,000 associates are uninsured. Roughly 60% participate in Wal-Mart's plan, while others are

insured through another company, a spouse or a federal plan.

"We study very carefully who doesn't take our insurance," says Mr. Emerick. The main reasons turn out to be that some part-time associates, such as schoolteachers, work full time at other jobs. Many part-timers are women covered by their husbands' insurance, or people age 65 and older covered under Medicare.

To encourage participation, Wal-Mart keeps its associates' premium contributions low. Depending on the plan chosen, the cost ranges from $6.50 to $20 every two weeks for individual coverage, and from $27.50 to $60 for family coverage. Annual deductibles range from $350 to $1,000. Wal-Mart offers health- maintenance organizations in some locations, but its core plans provide traditional coverage that lets associates choose their own physicians.

That approach has won the praise of doctors like Tom Coburn, a family- practice physician in Muskogee, Okla. "Wal-Mart has a great policy. I'm happy as a physician to take care of their patients -- I don't get hassled or anything," says Dr. Coburn, who in January left Congress after serving six years as a Republican representative. In Washington, Wal-Mart stood out as a "hero on the health-care side of things," says Dr. Coburn, a managed-care critic who especially likes Wal-Mart's lack of reliance on HMOs.

Wal-Mart expects to pay out about $1 billion in claims for all employees this year, about double what it spent five years ago. Part of the increase reflects roughly a 50% increase in the number of associates at the fast-growing company, which now has about 3,000 U.S. stores. Wal-Mart pays about 70% of the total claims cost, while its employees pay 30%.

It's a lot of money, but it's worth it, Mr. Emerick says. Wal-Mart credits the policy with helping it attract and retain employees at a time of labor shortages. It's great to tell prospective recruits: "We have a **health** plan for you -- a good one that you can afford," Mr. Emerick says.

Idea

-- promote workplace coverage through subsidies to small employers

Example

-- **Kansas Business Health Partnership** , created by a new state law

Obstacle

-- daunting operational challenges and limited funding for subsidies

Studies show that roughly 85% of Americans get **health** insurance through their employers. Sandy Praeger, a **Kansas** state senator, says the percentage could be much higher if small employers had a way to offer more-affordable coverage.

"The working poor at these companies make enough money to survive, but not enough to buy **health** insurance," says Sen. Praeger, a Republican from Lawrence, **Kan** . Last year, she introduced a bill to create a nonprofit **partnership** that would pool state and federal funds with contributions from private employers and employees. Details are still to be worked out, but she hopes these combined funds will allow small **businesses** to offer workers a choice of at least two insurance plans. Her bill became law last year.

Now comes the hard part: translating the new law into a simple program that attracts small companies as well as their employees. Another challenge is to avoid paying subsidies to **businesses** and their workers who are already insured and don't qualify for help under the program rules. The state is still looking for funding. Having secured some through the existing Children's **Health** Insurance Program, some advocates hope to increase the budget by drawing a portion of the state's tobacco settlement. Then there's the job of creating a bureaucratic structure for the new plan, called the **Kansas Business Health Partnership**. v

If the **partnership** succeeds, **health**-policy experts say, it could be a model for other states trying to fashion their own solutions in an era when Washington doesn't call the shots. "It's a unique effort to blend something that is private and commercial with public subsidies in a way that reinforces job-based coverage," says Rick Curtis,

president of the Institute for **Health** Policy Solutions, a Washington nonprofit group. But he cautions that there are countless failed efforts by representatives of both the public and private sectors who don't speak the same language.

In Kansas, the approach is especially relevant because small employers play a more prominent role in the state's economy than in the U.S. as a whole. Nearly 95% of all establishments had fewer than 50 employees, according to a 1995 survey. These firms are far less likely to offer **health**-care coverage than larger firms. Premium increases, which typically hit small groups most severely, spur workers and employers to switch or drop coverage. Bill Riley, president of a committee that is setting up the **partnership**, hopes to create a **health** program that is stable enough to survive over the long term.

The committee is grappling with often competing views by the insurance industry, the medical community, employers and the public sector. Small employers don't want the hassle or responsibility of handling subsidies for individual employees. Insurance companies are worried that the partnership could compete with their private plans. The committee is trying to prepare a blueprint that will be used to solicit bids from nonprofit organizations interested in assuming management of the partnership. "We have a subcommittee working on the design of that request for proposal," Mr. Riley says.

Idea

-- target private medical plans to uninsured people

Example

-- Blue Cross of California's PPO saver campaign

Obstacle

-- even the cheapest insurance is still expensive for many

Blue Cross of California, that state's No. 2 health insurer, has an unconventional view of the uninsured population. Where others see an intractable problem, it sees a marketing opportunity.

Television spots in some cities show an accident victim being wheeled into an emergency room. The 28-year-old victim is going to survive. But the "tragedy" is that he has no health insurance "so he and his family will be paying the price for a long time," a narrator says. When the man's wife arrives, with their young son, the narrator declares: "A family like this can get coverage for only $66 per person a month."

Over the past two years, Blue Cross and its parent, WellPoint Health Networks Inc., have studied the uninsured population as an untapped market for their established line of individual and small-group insurance plans. If the company could crack the code for drawing in more of the uninsured, "we would be doing better as a business and this problem would be going away," says Mark Weinberg, president of the individual and small-group division of Blue Cross, based in Thousand Oaks, Calif.

Blue Cross was impressed by a survey by the California HealthCare Foundation, a nonprofit organization, which found that people think health insurance is much more expensive than it is. "Most of us can guess how much a tube of toothpaste or a dishwasher costs," says Mr. Weinberg. "But people at almost every age guessed that the monthly cost for a health-insurance policy is twice as much as it actually is." Other data from Los Angeles County showed a strong correlation between personal-bankruptcy filings and medical debts.

These findings inspired Blue Cross to design an advertising campaign that focuses on the affordability of insurance and its value in staving off financial disaster. Similar campaigns have cropped up in other cities. In Washington, D.C., for example, the George Washington University Health Plan posts witty ads on the Metro that depict yuppies who have to forgo vacations or house purchases because of an unexpected hospital bill.

The Blue Cross campaign touts a policy called PPO Saver, which costs $65 to $75 a month for an individual, and four times that for a family of four. While the plan offers basic coverage, it has some attractive features. The first four doctor visits each year for each child and the first two for each adult are covered with only a $20 payment to the doctor. These visits, as well as prescription drugs, aren't subject to the $500-a-member annual deductible. Blue Cross covers all expenses beyond a $5,000

annual out-of-pocket maximum per member.

Blue Cross says its advertising campaign is generating 7,000 to 9,000 phone calls a month. Many of the callers don't have medical insurance and are unfamiliar with its jargon and conventions. "This has created some challenges in terms of creating new scripts and training" for agents, who have to explain what words like "deductible" mean, Mr. Weinberg says. About 10,000 people have enrolled in the PPO Saver plan since it was introduced in April. So far, Mr. Weinberg concedes, "It hasn't been an explosive product for us."

Idea

-- make everyone buy health insurance

Example

-- health-care analyst Kenneth Abramowitz

Obstacle

-- lacks a political champion

Everyone living in the U.S. should be required to purchase health insurance unless they have employer-sponsored coverage, says Kenneth Abramowitz, a longtime health-care analyst. Such an "individual mandate" could solve the uninsured issue fairly simply, he maintains.

"We force people to send kids to school and to buy into a retirement system," says Mr. Abramowitz, who recently joined EGS Securities Inc. in New York as an investment manager. The government provides food stamps for poor people who can't afford to buy groceries. The uninsured problem should be approached using "similar principles to those we've adopted with Social Security and food stamps," he says.

Studies show that many people don't buy health insurance because they don't think they need it. Such people are "stealing" from society because when they get sick, they receive the treatment they need even when they can't pay for it, Mr. Abramowitz says. They receive care from hospitals and doctors who then seek to recoup their losses by charging higher prices to their paying customers.

If all the "freeloaders" who can afford coverage were required to buy it, the 43 million uninsured population would shrink by half, Mr. Abramowitz says. He proposes the creation of tax-subsidized vouchers, or "health-insurance stamps," to cover the remainder who truly can't afford coverage and to establish the principle that everyone must have health insurance.

To ease the transition, mandated health coverage should coincide with the next increase in the minimum wage. "That would make it easier to extract a portion of the increase for health insurance," Mr. Abramowitz says. He favors a "defined-contribution" approach, which would define the minimum amount to be set aside for insurance and let the marketplace determine what benefits that money could buy (as opposed to requiring specific benefits and then mandating whatever amount is needed to buy them). It would cost taxpayers about $22 billion a year to provide $1,000 of health-insurance stamps to each person in the poor half of the uninsured population. z

Critics on the left say such defined-contribution coverage would probably be skimpy. Conservatives, on the other hand, aren't likely to support a new entitlement program to distribute insurance stamps. Mr. Abramowitz maintains that entitlements already exist in the form of free care, and such handouts should be made more "honest and direct."

One big problem with mandates, as proponents in the past have discovered, is that the high cost of health care makes it almost impossible to design an affordable national benefits package. Mr. Abramowitz's $1,000 of stamps wouldn't come close to buying even the cheapest coverage under, say, the Federal Employees Health Benefits Program. Indeed, when former Sen. Bill Bradley ran for president last year, he was pilloried for offering an $1,800-a- year refundable tax credit -- nearly twice Mr. Abramowitz's stamp proposal -- to help uninsured adults buy coverage.

Mr. Abramowitz concedes that health-insurance stamps wouldn't buy first-class coverage. His response: So what? Food stamps don't pay for dinner at a fancy French restaurant, and "no one thinks they should."

Idea

-- target subsidies at kids and then try to include their families

Example

-- children's health program, paid for with matching state and federal funds

Obstacle

-- attracting enrollment -- even though the coverage is free

In 1994, even as his health plan was dying in Congress, President Clinton was plotting his next move: a smaller-scale program aimed at low-income kids.

Mr. Clinton rolled out the Children's Health Insurance Program in 1997, the largest expansion of government health care since Medicare and Medicaid. CHIP targets kids who are low income but don't qualify for Medicaid; mainly, they are the children of the working poor. Today, nearly every child with a family income below twice the poverty line, which comes to $28,300 for a family of three, is eligible for government health coverage, according to an analysis of census data by the Center on Budget and Policy Priorities, a Washington think tank.

The CHIP program represents the new, incremental approach of health-care legislation that has taken root in Washington. The final product was no one's definition of perfect. Health-care advocates thought CHIP didn't provide sufficient benefits. States, which administer the program, argued that the qualifications for participation were too stiff.

One big difference from the 1994 Clinton plan was that CHIP posed no threat to the private insurance sector. It also set up a competition between states that has proved to be an effective motivator. Under CHIP, the more money states committed to the program, the greater the federal match. But if states don't spend their minimum allotments, the money is redistributed elsewhere; this happened for many states for the first time this year.

Once it was enacted, the big challenge with CHIP became outreach. President and Mrs. Clinton and former Vice President Al Gore attended event after event to publicize the program. A national toll-free phone number was established so people could enroll from anywhere. States pitch CHIP like private insurance, not a handout, and promote it through catchy ad campaigns. Pediatricians and hospitals give CHIP literature to low-income patients. And in December, Congress opened up a new enrollment frontier -- school systems.

Government data released last year showed that the total number of uninsured children fell by more than one million in 1998 and 1999, in part because of increased enrollment in CHIP. Momentum is building in Washington for a major CHIP expansion, to include parents of eligible kids. And yet CHIP's numbers aren't growing as rapidly as advocates had hoped. Medicaid rolls have even slipped in recent years, as single mothers allow their health benefits to lapse when they move from welfare to work.

CHIP also shows that all government health programs -- no matter how successful or bipartisan -- have vulnerabilities. During the recent budget battle in Washington, GOP leaders bickered with the White House over the narrowest new CHIP provisions -- like whether kids can be enrolled through day- care centers. Republicans strongly objected, and the final bill mentions only elementary and secondary schools. But it does give states leeway to set their own enrollment standards.

"It's all about compromise," said the Clinton adviser Mr. Jennings after the deal was cut last December. "We'd have never gotten this far without it."

Idea

-- stop fighting, start compromising over health-care policy

Example

-- Health Insurance Association of America and Families USA

Obstacle

-- easier said than done

Even in health-care policy, opposites attract.

Washington's newest odd couple is an alliance between the Health Insurance Association of America and Families USA. HIAA is the health-care voice of Big Insurance whose members include Aetna Inc., Cigna Corp. and Mutual of Omaha Inc. Families USA is a nonpartisan but progressive public-policy organization that was a major booster of the Clinton health-care agenda.

From the Clinton administration's universal health plan in 1993 to the continuing debate over creating drug coverage for Medicare, "we have been diametrically opposed on every issue I can think of," says Charles N. "Chip" Kahn III, president of HIAA. But after a year of hard work, he and the Families USA president, Ron Pollack, have found common ground in a new proposal that is a mishmash of private and public initiatives to help low-income people. Their lesson for colleagues in Washington: The uninsured problem may not be as intractable as it seems.

The plan's three components have been around for a while -- they've just never appeared on the same page. For the private sector, there's a new tax credit to encourage companies to offer affordable health coverage to low-income workers. The federal government, meanwhile, would expand Medicaid funding to all families that earn less than the equivalent of $18,820 a year for a family of three -- up from the current cutoff at the poverty level, which is $14,150 for a family of three.

The government also would fund coverage, either through Medicaid or the Children's Health Insurance Program, for all adults with income levels up to twice that of the federal poverty level.

The two groups began their collaboration a year ago, when the Robert Wood Johnson Foundation asked them to co-sponsor a conference on the uninsured problem. Messrs. Kahn and Pollack scheduled a lunch to discuss the event. From the outset, they decided to put aside their policy differences and to focus only on principles they shared. To their surprise, it was a long list.

Those early sessions produced five common conclusions: It's impossible to do comprehensive reform that will cover everyone. There must be no threat to the current, employer-based system. It's best to build on successful existing programs, rather than to create new ones. There isn't enough money to cover everyone. And the low-income population should be targeted first.

The two men met three dozen times last year. Some days they would lobby against each other on managed-care reform, then meet for dinner to work on their uninsured draft. The proposal was unveiled in the January-February 2001 issue of Health Affairs, a public-policy journal. Mr. Pollack says the next step is finding the right combination of Democratic and Republican lawmakers to back it.

The big risk? That lots of people will like the proposal, but few will love it enough to fight the inevitable funding battles on Capitol Hill and with the White House. "If you look at the history of health reform," says Mr. Pollack, "all the stakeholders come in with their first-choice proposal. If they don't get it, they walk away -- their second choice being the status quo. It's that dynamic we want to change. We're trying to make a virtue out of second choice."

Ms. Rundle is a news editor in The Wall Street Journal's Los Angeles bureau. Ms. Murray is a staff reporter in The Wall Street Journal's Washington bureau.

Journal Link: Join a discussion on health-care reforms in the online Journal at WSJ.com/JournalLinks.

---- INDEX REFERENCES ----

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Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

TO: House Committee on Insurance

FROM: Kathleen Sebelius, Insurance Commissioner

RE: HB 2247 – Removal of sunset provision on Kansas business health partnership act

DATE: March 8, 2001

Mr. Chairman and members of the Committee:

Thank you for the opportunity to appear on HB 2247. Last year I appeared in support of the initiative (SB 668) to explore strategies to make comprehensive health insurance available to working Kansans who currently have no coverage.

We know that approximately 1500 owners of small businesses in Kansas offer no health insurance coverage to their employees. We also know that an estimated 250,000 Kansans have no health insurance coverage, and most of them are in the workforce. While the children of these workers may benefit from the new children's health initiative, the parents usually have no options for affordable health insurance.

As a reminder, we have made some efforts in the past few years to make affordable coverage more accessible to Kansans. The Legislature did create enhanced tax credits for small employers, and we have evidence that a number of firms who didn't previously offer health insurance are taking advantage of the new law. The Health Commission also opened the state purchasing pool to school districts, and is exploring expansion of the pool. The children's insurance initiative has enrolled thousands of Kansas children who previously had no health coverage.

House Committee on Ins.
March 8, 2001
Attachment #2

420 SW 9th Street
Topeka, Kansas 66612-1678

785 296-3071
Fax 785 296-2283

Consumer Assistance Hotline
1 800 432-2484 (Toll Free)

Even with these initiatives, we haven't made a serious dent in the problem of family coverage. We know that children are more likely to have coverage and access preventive health care, if their parents also have coverage. We know that 80% of parents of CHIP-eligible children are uninsured. They either have no access to employer-based coverage or can't afford the coverage that is offered. Proposed are higher subsidies to states which cover parents as well as children, and also a plan to assist families in affording private employer-based coverage. The passage of the Kansas Business Health Partnership Act furthers these goals.

In the Kansas Business Health Partnership act, a Health Policy Committee was established. As Insurance Commissioner, I serve on the Health Policy Committee by statutory designation. The Health Policy Committee met several times last year working towards its charge of developing a mechanism to combine federal and state subsidies with contributions from employers and employees to purchase health insurance for uninsured low wage employees of small employers. However, it became clear to us that in order to carry out our responsibilities, the Health Policy Committee needed technical assistance.

In October, 2000, the Kansas Insurance Department received news that they had been awarded a grant from the U.S. Department of Health and Human Services. The goal of the $1.3 million grant is to develop a plan for covering all uninsured Kansans.

Part of the grant funding is set aside for technical assistance to the Health Policy Committee. The Health Policy Committee, in January 2001, contracted with the Institute for Health Policy Solutions (IHPS) to assist us in developing creative and workable

solutions to health systems problems related to access, cost, and quality, and approaches that coordinate public and private sources for coverage of the uninsured.

With the information that is forth coming in the next year about the uninsured population in Kansas, I urge you to pass HB 2247 out favorably. Releasing the sunset on this statute, and working to find solutions to the serious problem of those without health insurance coverage, is the right thing to do for 250,000 Kansans.

LEGISLATIVE TESTIMONY

the Kansas Chamber of Commerce and Industry
The Unified Voice of Business

835 SW Topeka Blvd. • Topeka, KS 66612-1671 • 785-357-6321 • Fax: 785-357-4732 • E-mail: kcci@kansaschamber.org • www.kansaschamber.org

HB 2247

March 8, 2001

KANSAS CHAMBER OF COMMERCE AND INDUSTRY

Testimony Before the

House Committee on Insurance

by

Terry Leatherman
Vice President -- Legislative Affairs

Mr. Chairman and members of the Committee:

I am Terry Leatherman, with the Kansas Chamber of Commerce and Industry. Thank you for the opportunity to appear before you today in support of HB 2247.

The Kansas Chamber of Commerce and Industry (KCCI) is a statewide organization dedicated to the promotion of economic growth and job creation within Kansas, and to the protection and support of the private competitive enterprise system.

KCCI is comprised of more than 2,000 businesses which includes 200 local and regional chambers of commerce and trade organizations which represent over 161,000 business men and women. The organization represents both large and small employers in Kansas, with 48% of KCCI's members having less than 25 employees, and 78% having less than 100 employees. KCCI receives no government funding.

The KCCI Board of Directors establishes policies through the work of hundreds of the organization's members who make up its various committees. These policies are the guiding principles of the organization and translate into views such as those expressed here.

During the 2000 session of the Kansas Legislature, KCCI supported legislation to create the Kansas Business Health Partnership. It remains our hope that the Partnership structure will create an opportunity that is much needed in Kansas, affordable insurance alternatives for small employers.

House Comm on Ins.
March 8, 2001
Attachment # 2

9-1

cannot occur without legislation being approved to extend the current July, 2002 sunset in Act, which HB 2247 would lift if it is passed by the Legislature.

There are several reasons why KCCI has been encouraged by the Partnership structure. A major challenge for small employers in today's insurance market is their size offers no purchasing clout. By banding small business together in a purchasing cooperative, it is hoped their numbers will attract insurance options. The greater clout would be further increased by the opportunity the Health Partnership would have to utilize government subsidies for certain uninsured classes. Finally, insurance programs in the Partnership could be largely free of state insurance mandated coverage. As a result, the insurance options will be built around what the insurance purchaser demands, rather than what the government mandates be in an insurance policy.

Nearly a year after legislative passage, the Kansas Business Health Partnership remains mainly a promising idea, with much to still be determined before a policy is written. However, KCCI remains supportive of this innovative concept, and urges this Committee approve HB 2247. Thank you for the opportunity to comment on the legislation before you today. I would be happy to answer any questions.

3-2

TO: House Committee on Insurance

FROM: Chris Collins
Director of Government Affairs

DATE: March 8, 2001

RE: HB 2247: Kansas Business Health Partnership Sunset Removal

Chairman Tomlinson and Members of the Committee:

The Kansas Medical Society appreciates the opportunity to appear before you today in support of HB 2247. The Kansas Business Health Partnership provides an innovative means to address the persistent challenge of providing affordable health insurance to small businesses.

The members of the Kansas Business Health Policy Committee are to be applauded for the successes they have had thus far. The partnership has engaged in a truly ambitious undertaking, synthesizing federal and state aid programs with commerce and the insurance industry. In order for the Kansas Business Health Partnership to be successful, coalitions must be built where none presently exist and infrastructures must be created. Such processes take time. The partnership's present sunset clause does not afford the group adequate time to complete its charge. For these reasons, the Kansas Medical Society urges this committee to remove the sunset provision in the Business Health Partnership Act.

Thank you for the opportunity to appear today to testify in favor of HB 2247. I would pleased to respond to any questions.

Kansas Comm on Ins.
March 8, 2001
Attachment #4

4-1

KPPI

KANSAS PUBLIC POLICY INSTITUTE

P.O. Box 1946 • Topeka, KS 66601-1946
Ph: 785-357-7709 • Fax: 785-357-7524

March 8, 2001

Testimony before the Kansas Legislature
House Committee on Insurance
Re: Health partnership act (HB 2247)

by
Bob L. Corkins
KPPI President

Honorable Chair and Members of the Committee:

Thank you for the opportunity to appear today. KPPI is a nonpartisan, nonprofit research firm that educates people about free-market economic principles in the context of today's important public policy debates.

For almost three years, we've research the subject of defined-contribution pension programs (a terrific prospect for reforming KPERS). Last year, our pension research revealed a very promising application of this idea to the health insurance field.

The same idea that has hugely benefitted over 55 million Americans holding a 401(k) pension account may provide the best path to greater availability and affordability of health insurance. Under the approach, employers would pay a set dollar amount to each employee that the employee then uses to purchase his or her own health insurance. The employee would select a policy that costs less than the amount of the employer's contribution and invest the difference in something like an MSA, or the employee would add her own money to the employer's in order to purchase a more extravagant health plan.

Coincidentally, this concept is crucial to the Kansas Business Health Partnership. KPPI testified late in the 2000 legislative session at the Senate hearing for the Partnership project authorized by Senate Bill 668. Because there was no House hearing on the topic, this committee did not receive the following KPPI remarks about that proposal:

1. **The health partnership should be allowed to expand the scope of its participants**. If the partnership so chooses, every Kansan could participate; employers of more than 50 workers should be allowed in, just as individuals not affiliated with any business should be allowed in. All employees of participating employers, not just their subsidized workers, should be allowed to select from the partnership's array of coverage plans.

2. **Employees must have personal ownership of their partnership policy**. That is, employees should be allowed to maintain their partnership-acquired policy even after leaving employment.

3. **The state should not be allowed to coerce insurance carriers** into submitting bids to sell health insurance within the partnership. [This provision was later striken.]

(more)

House Commerce
March 8, 2001
Attachment #5

5-1

4. **Government should not subsidize the cost of health insurance.** The advantages of reducing the number of uninsured and making insurance premiums more competitive would be achieved without the subsidy components of this bill or other tax credits that may apply. The partnership could obtain market negotiating leverage that accompanies increased pool size while policies sold within the partnership would be free of much regulation -- such as mandated coverages -- that adds to insurance expense.

Product choice is limited in today's health care market because three out of every four people have insurance that is provided by either their employer or government. Escalating costs result because the consumers of health care are not the payers of health care. That is, employees ask the health benefits question "What do I get?" instead of "What do I get for my money?".

Managed care plans that kept medical inflation in check through most of the last decade have run their course. Such cost containment practices came at the expense of employee satisfaction and, many argue, quality of care. Political leaders from both major parties therefore continue their call for a "patients' bill of rights" that would bring greater regulation of, and recourse against, managed care administrators. Employers are tired of their role as the middle-man in these disputes between employees and insurance companies, a sentiment that is paving the way for DC health programs with a more consumer-oriented alternative.

When KPPI had health insurance expert Richard Teske take a look at the newly authorized Kansas Business Health Partnership, he concluded that a DC format is the only way to make it work. Highlights from his study (attached) include:

1. Health Purchasing Cooperatives (HPCs; such as the Kansas Partnership) have a terrible track record. In the few cases where they've survived, the reduce the number of uninsured by no more than 8%. They fail because they follow the outmoded defined-benefit model.
2. There are only two philosophical alternatives: a single-payer plan or market oriented consumer choice. Using a defined-benefits approach makes a single payer plan inevitable.
3. HPCs must have products insurance agents are willing to sell. Preventing agents from having any HPC role or allowing them only non-competitive commissions will doom the HPC.
4. Carriers must be allowed to more freely adjust for risk. Rating restrictions, standardized benefits, etc., will drive insurance carriers away from the HPC.
5. Catastrophic coverage coupled with a Medical Savings Account should be among the HPC choices provided. No HPC has tried it yet.
6. Employee choice rather than employer choice is preferable.

Again, thank you for this chance to share the Institute's findings.

The Emerging Market for Consumer-Owned Health Insurance

A one-day seminar detailing influences and options in the spread of consumer driven health insurance products, both individual and employer-based coverage.

Seminar presented by the

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and the

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This Seminar will be offered at two great locations for your convenience:

Thursday, October 5, 2000
Marriott Hotel
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Overland Park, Kansas

Thursday, November 9, 2000
Hilton Wichita Airport Hotel
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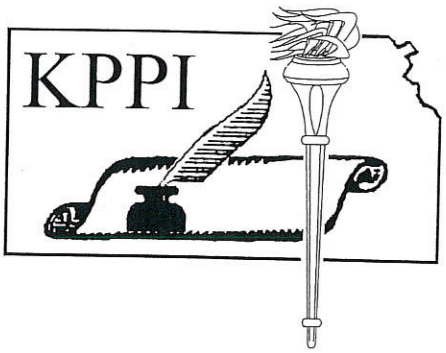
Kansas Chamber of Commerce and Industry
Kansas Medical Society
Medical Society of Johnson and Wyandotte Counties
Medical Society of Sedgwick County
National Federation of Independent Business
Wichita Area Chamber of Commerce



"A large-scale conversion of employer-sponsored health plans to defined contribution formats is inevitable...Employees will be placed in the "driver's seat" for selecting their own health plans in an open market, much as defined contribution has placed individuals center stage in the 401(k) world."

Booz-Allen & Hamilton
International management and technology consultants
New York, April 2000

While many continue their call for laws effecting a "patients' bill of rights", there are other reforms for bringing greater employee/consumer choice and control without the need for legislation. The marketplace is responding with a variety of these techniques to which attendees of these Seminars will be introduced.

As roughly three out of four healthcare consumers have their medical coverage provided by someone else — either their employer or government — they have little reason to ask "What do I get for my money?" and, instead, simply ask "What do I get?" When the former question prevails, market forces can begin bringing profound and positive change. Greater consumer control will mean a more rational determination of medical costs, a stronger bond between patients and healthcare providers in deciding questions of care, and a likely decrease in the number of uninsured.

There are several means by which this revolution is taking root. One promising approach is through *Health Insurance Purchasing Cooperatives*, sometimes referred to as *Alliances* or *HealthMarts*. Strategies derived from employee benefit *Cafeteria Plans* provide another route. Still others include *Medical Savings Accounts* or special *Health Trust Arrangements*. The options can in many cases be combined and all share the goal of consumer choice and empowerment.

A powerful concept borrowed from the success of 401(k) Retirement Plans provides a particularly innovative way thinking about healthcare. Employer-provided *Defined Contribution Health Insurance Plans* would create the conceptual framework for implementing many employee options. Major insurance marketers from around the country are now designing products based on this model.

"Amid a growing anxiety over their liability in health coverage decisions, companies of all sizes are increasingly wanting to end their role as the middle-man between their employees and insurance companies...The concept of defined contribution plans is one of the hottest topics in health care financing today."

Greg Scandlen
National Center for Policy Analysis
Washington, D.C., June 2000

Registration Form

The Emerging Market for Consumer-Owned Health Insurance

Please indicate your choice of dates and location and mail with your check made payable to the Kansas Public Policy Institute, P. O. Box 1946, Topeka, KS 66601-1946.

Alternately, you may fax your registration to KPPI at (785) 357-7524 and we will mail you an invoice upon which to pay.

KPPI will provide affidavits at each seminar site of Life and Health Continuing Education Credit, for qualifying Kansas Insurance Agents to verify their attendance. The Kansas Insurance Department Course Identification number is **958122LH.**

- Thursday, October 5, 2000.....Marriott Hotel in Overland Park
  8:30 a.m. - 4:00 p.m. 10800 Metcalf, Overland Park, KS 66210
  Phone: (913) 451-8000

- Thursday, November 9, 2000.....Hilton Wichita Airport Hotel
  8:30 a.m. - 4:00 p.m. 2098 Airport Road, Wichita, KS 67277
  Emerald Room
  (316) 945-5272

Registration Fee includes attendance of seminar, lunch and refreshments.....$115 per person .

A reduced rate of $103 is available for those securing their registrations before two weeks prior to each seminar date. Payment received by KPPI on or before September 20 for registrants to the Overland Park event, or on or before October 25 for registrants to the Wichita event, are entitled to the $103 per person rate.

Name: _____ Title: _____

Business: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Enclosed is my check # _____ for $115 for the above Seminar, or $103 for early registration.

The Kansas Public Policy Institute
P. O. Box 1946
Topeka, KS 66601-1946
or
112 S.W. 7th Street, Suite 300
Topeka, KS 66603

KPPI, based in Topeka, Kansas, is a nonprofit, nonpartisan 501(c)(3) organization performing research on a variety of free-market economic issues.

THE ONE-BY-ONE PROJECT, based in Overland Park, Kansas, is an association advocating consumer ownership of health insurance and the primacy of the doctor-patient relationship.

For questions call KPPI at (785) 357-7709.

Seminar Faculty, scheduled presentations*

Grace Marie Arnett

"Recent Developments in the Tax Implications for Consumer-owned Health Insurance"

Ms. Arnett is president of the Galen Institute, an Alexandria, Virginia, not-for-profit organization specializing in health and tax policy research. Arnett previously operated the consulting firm Arnett & Co., which specialized in public policy analysis. She served as executive director of the National Commission on Economic Growth and Tax Reform and is a frequent guest on radio and television programs, with articles appearing in the Washington Post, Wall Street Journal, and numerous other journals and newspapers.

Dr. Joel M. Karlin

"Reinforcing the Primacy of Doctor/Patient Care Decisions"

Dr. Karlin has been in the private practice of adult and pediatric allergy and asthma for 26 years in Metropolitan Denver, Colorado, with monthly rural outreach clinics in Syracuse, KS, and Limon and Salida, CO. He served as Chief of Allergy at the USAF Academy, and currently holds the position of Clinical Professor of Medicine and Pediatrics at the University of Colorado School of Medicine. A past president of the Colorado Medical Society, Dr. Karlin is very active in the American Medical Association, serving on the Council on Legislation since 1995, currently in the capacity of Vice Chair. He helped to move the AMA away from the position of support for employer mandate, and has spearheaded the AMA's policy efforts in supporting a move towards consumer ownership of health insurance. Dr. Karlin serves as Chairman of the Board of Health Insurance Select, a new company that provides the education and support services for large purchasers of health insurance and their employees that will enable individuals to become true health care consumers.

Craig Keohan

"Financially Empowering Healthcare Consumers"

Mr. Keohan is senior vice-president of MSAver Resources, an Overland Park, Kansas, firm which markets a variety of investment, insurance, and management services relating to Medical Savings Accounts.

Denise Mills and Howard Wizig

"*E-health and Personalized Healthcare Systems*"

Mr. Wizig is chairman of Vivius Inc. -- based in Minneapolis with offices in Overland Park -- and created the Vivius personalized healthcare system model. Wizig has more than 17 years of experience in the field of healthcare financing. Prior to forming Vivius, Inc. he was a nationally respected health care consultant with Towers Perin. Prior to consulting, he worked for Aetna Life and Casualty and Partners National Health Plans -- a joint venture between Aetna and VHA.

Ms. Mills is director of business development at Vivius, and has been involved in the insurance industry since 1976 with experience in both the carrier and insurance brokerage aspects of the industry. In the past 10 years she served as the manager of the employee benefits practices for an international brokerage organization and co-founded Corporate Benefits Consulting Group, an employee benefits consulting and brokerage firm.

Greg Scandlen

"*Defined Contribution Health: The Story So Far*"

Mr. Scandlen is a Senior Fellow in Health Policy for the National Center for Policy Analysis, Washington, D.C. Prior to joining NCPA he was a fellow in health policy at the Cato Institute and President of the Health Benefits Group, a consulting firm in Frederick, Maryland. The firm helped businesses establish medical savings account programs and published two newsletters on free market health care reform. Scandlen was the founder and CEO for five years of the Council for Affordable Health Insurance. He published the Health Benefits Letter and worked in the Blue Cross - Blue Shield system for 12 years, most recently as director of state research for the national association. He is an expert in medical savings accounts, insurance regulation and reform, employee benefits and ERISA, Medicare reform, and the uninsured. Scandlen has appeared on the NBC Nightly News, the O'Reilly Factor on Fox News, CNN, PBS, and C-SPAN.

Richard Teske (Overland Park only)

"*Lessons Learned from Health Insurance Purchasing Cooperatives Nationwide*"

Mr. Teske is the President of Strategic Advocacy, a Virginia-based firm that advises political, corporate, and association leaders in health care policy. Mr. Teske formerly headed the Washington office of Burroughs Wellcome Co. During the 1980s he was United Nations Delegate to the Conference on Economic and Social Policy, and was the official liaison to the White House for the U.S. Department of Health and Human Services (HHS). Teske also served as Deputy Assistant Secretary at HHS for Public Affairs, and as the Associate Administrator of the Health Care Financing Administration (HCFA).

David Uppinghouse (Wichita only)

"Successfully Managing a Health Insurance Purchasing Cooperative"

Mr. Uppinghouse is the Area Vice President for Gallagher Byerly, Inc., and has been employed in the health benefits field for more than 30 years. Gallagher Byerly administers several health insurance purchasing cooperatives. He is also a consultant for public and private sector clients, concentrating on managed care and alternate funding arrangements. Before joining Gallagher Byerly in 1988, Mr. Uppinghouse was with a major insurance company for twelve years, as well as holding consulting positions with two other national employee benefit firms.

Dr. Richard Warner

"A Prescription for What Ails Medicine: Encouraging Individual Responsibility"

Dr. Warner maintains a psychiatric practice in Overland Park, and heads up the One-by-One Project, a Kansas-based advocacy group promoting consumer ownership of health insurance. Warner is past chairman of the Johnson/Wyandotte County Medical Society.

***Unless otherwise specified, each speaker will appear at both seminars.**

5=6

The Emerging Market for Consumer-Owned Health Insurance

Your Choice of Two One-day Seminars
Overland Park, October 5, 2000
Wichita, November 9, 2000
presented by the **Kansas Public Policy Institute**
and the **One-by-One Project**

"The next stage of evolution in health insurance nationwide"

Program qualifies for six hours of continuing education for Kansas insurance agents.

Kansas Public Policy Institute
P.O. Box 1946
Topeka, KS 66601-1946

JOHNSON COUNTY
Business Times
Cover Story

NEW FRONTIER

story by Phil LaClerke, editor photos by Bob Johnson/JCBT staff

October 4 – October 10, 2000 Vol. 7, No. 39

Is Consumer-owned insurance the next evolution in Health care?

To the vast majority of Americans who get their health insurance through their employer, going to the doctor is a pocket-change expense - a mere $5 or $10 co-pay.

Because the bulk of the expense is picked up by a third-party - usually an HMO – consumers have no motivation to shop around to get the most health care bang for their buck. Therefore, doctors, pharmacists and hospitals are under no pressure to price their services and products competitively, and prices, consequently, escalate well beyond the rate of inflation.

"We've been seeing double digit medical inflation," says Bob Corkins, president and executive director of the Kansas Public Policy Institute. "Medical inflation happens when the consumer is not the payer of health care costs. Seventy-five percent of the American work force has insurance premiums paid by their employer or by the government. Only 15 percent buy on the open market. So there's a disconnect between who pays and who the consumer is."

Dr. Richard Warner, an Overland Park psychiatrist and founder of the One-By-One project, says the current HMO system has robbed consumers of their freedom of choice in health care matters. "And," he says, "it has been intrusive on the doctor/patient relationship, and we've seen a deterioration of medicine as a profession."

Greg Scandlen, senior fellow of health policy at the National Center for Policy Analysis in Frederick, Md., says his spouse's employer recently discontinued offering a prescription discount card as part of the coverage it offered.

"Now that she doesn't have the card, when she needs prescription drugs, she gets on the phone and calls OSCO and PharMor and HyVee, seeing where she can get the best deal. It has made her a better consumer."

On Thursday, Scandlen, Warner, Corkins and others will present alternatives to the current health care system, during an all-day seminar, "The Emerging Market for Consumer-Owned Health Insurance," at the Overland Park Marriott. A second seminar will be staged in Wichita Nov. 9.

The event, sponsored by Corkins' Kansas Public Policy Institute and Warner's One-by-One Project,,will present "a smorgasbord of ideas under the idea of consumer ownership," Corkins says.

Among topics will be insurance pools for small employers, Medical Savings Accounts, and "defined contribution" health care plans.

"All these avenues are designed to make people more mindful of what they're spending," Scandlen says.

Organizers admit their crusade to improve the health care delivery system is fueled by a mix of the political and the practical.

Howard Wizig, developer and chairman of Vivius Inc.

"Politically speaking, I'm a Constitutionalist," Warner says, "and I would like to see less government involvement in the delivery of heath care."

Corkins describes the Kansas Public Policy Institute as a "libertarian think tank."

"We espouse the free market approach to public policy issues," Corkins says. "We want to see government interference limited."

> *We shouldn't look for the political class to provide the leadership. Too many workers and employers will start finding ways to do it themselves, then politicians will rush to catch up.*
>
> -Bob Corkins
> president and executive director of the Kansas Public Policy Institute

Corkins and Warner agree that the Patients' Bill of Rights would represent an unhealthy intrusion by government into the free market, and would provide "a field day for trial lawyers."

"What we're fighting here is socialism," Corkins adds. "We're anti-statist. We look to other means to accomplish public policy goals. And, in the case of health care, we shouldn't look for the political class to provide the leadership. Too many workers and employers will start finding ways to do it themselves, then politicians will rush to catch up."

The business marketplace is beginning to express interest in the concept of consumer-owned health plans.

MSAs: Paying for our own 'bumps and bruises'

"Employers are paying $6,000 every year for every employee, and, premiums are getting more and more expensive," says Craig Keohan senior vice president of MSAvers in Overland Park. "They're saying there has to be a better way."

Keohan's better way comes in the form of Medical Savings Accounts, a health insurance vehicle established by Congress on a four-year trial basis in 1996.

For every employee who makes excessive visits to the doctor, there are scores who barely use their policies at all, Keohan says.

"Seventy-five percent of those who have insurance through an employer don't spend $500 a year on medical care," Keohan says. "Employers are buying these expensive policies for employees who seldom use them."

MSAs, Keohan says, lighten the financial load on an employer while still offering health care options to employees.

"The difference is, with MSAs, you pay for your own bumps and bruises."

Here's how MSAs work: "Basically it's two buckets," Keohan says. "One bucket has a safety net health plan with higher deductibles than a normal plan. Just like in auto insurance, when you have a higher deductible, you have a lower premium. You take the savings on the premiums and put them in a second bucket, an MSA."

The MSA fund, Keohan says, has several advantages.

"The money you put in is a tax deduction, it grows interest free, and it rolls over year after year. If you don't use your MSA for health care, you continue to accumulate that money, year after year, and, at age 65 you can take it out and use it as ordinary income or for long term care on a tax free basis. It's like setting aside an annuity for when you need it most."

And, the incentive of letting the fund accumulate says Warner "acts like a corporate wellness program."

"If an employee is paying from his own MSA fund, he is going to have an incentive to keep costs down. He is rewarded for healthy behaviors."

over →

ADDING OPTIONS

As employers continue coughing and wheezing their way to higher costs and more bureaucracy when it comes to health care, a Leawood entrepreneur is getting ready to launch a new virtual insurance prescription.

The remedy is designed to do nothing short of totally redefining the way health care is bought and sold, taking it out of the framework of limited choices and pre-set pricing and moving it into the realm of a much more genuine marketplace commodity.

"The assumption that's never challenged is health care is a flawed market," says Howard Wizig, developer and chairman of Vivius Inc. "We've created this illogical system."

Vivius is based in Minnesota with local offices in the former NCAA building in Leawood.

The current HMO system has catapulted health care costs to the point that they represent the largest percentage of the nation's gross national product. A good portion of this amount, between 18 percent and 22 percent, says Wizig, goes toward administrative costs.

"It's the amount of money not going to health care providers," says Wizig.

With the almost universal dissatisfaction with with the current state of affairs, Wizig's solution looks appealing to much of the business community. The company, which was started out of Wizig's basement, so far has a total investment of $16.5 million in "high-quality money" from venture capital firms.

Vivius expects to make much of its revenue from fees (about four percent) that doctors groups and other providers will pay to be in the network, says Wizig. Wizig says Vivius will be up and running for the "Christmas season" of the insurance industry, which begins with Jan. 1st open enrollment. From here, Vivius' plan is to methodically build business with a 30-city, 30-month rollout.

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At the crux of Vivius' business plan is the "defined contribution," as opposed to the "defined benefit" concept. The defined contribution model takes employers out of the role of health insurance gatekeeper, while maintaining their role as contributor.

For employees enrolled in a Vivius program, health care can be more specifically tailored to individual needs with cost repercussions affecting individual enrollees, not whole groups of employees. In other words, if an employee goes for premium coverage, a larger out-of-pocket expense will apply. If an employee is more moderate, leftover employer funds can be used to buy dental or vision insurance or placed in a medical savings account.

For providers, signing on with Vivius looks to be a near sure way of upping income at least by close to the amount of current administrative costs, which accounts for up to 22 percent of provider expenses. This is because the Vivius system uses no claim forms and doctors do not need to get approval for patient treatment procedures.

Software running the Vivius program tracks options into a kind of aggregate shopping basket where expenditures are tracked. Among the elements influencing total cost is doctor and hospital fees and the amount enrollees choose to make their deductible.

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— by Romona Paden, associate editor

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Keohan also is hopeful Congress will renew MSAs, and, open them to a wider audience.

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THE NEXT EVOLUTION: DEFINED CONTRIBUTION PLANS

Even if Congress does not extend MSAs, MSAvers has a potentially huge safety net waiting. The company was acquired in January by the Virginia-based Lumenos, which is intent, Keohan says, on exploring a new market: Defined contribution plans.

"MSAs will continue to be a niche market for us, but we'll be moving aggressively into the much broader defined contribution market," Keohan says.

They won't be alone. Vivius, a Leawood-based business that will wed its product with the world wide web, is preparing to test market a defined contribution plan in Kansas and other markets (see related story).

Scandlen, of the National Center for Policy Analysis, says defined contribution plans "have a lot of sex appeal now."

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One study, by the McLean, Va.-based consulting firm Booz-Allen & Hamilton, flatly predicted: "A large-scale conversion of employer-sponsored health plans to defined-contribution formats is inevitable."

Essentially, defined-contribution plans work like 401-Ks. Rather than paying all or some of an employee's premiums, employers would place contributions in a fund, from which an employee could buy insurance on the open market, or from among a menu of plans that employers would make available.

"That leaves it up to the employee to pick the plan that's most appealing to them. It's a portable plan that you can take from job to job. And, importantly, it allows the employee to be the policyholder. The employer's role is limited to the contribution," Scandlen says.

Under the defined contribution model, employers would make available a variety of plans with widely different features and costs. By offering more tailored coverage, Corkins says, "premium costs can be cut by 20 to 30 percent."

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New coverage idea gains favor with employers, workers

By Anna Jaffe
Staff Writer

As frustration with managed care has grown, so has the push to find reasonable health insurance alternatives.

Many employers are scrambling to find ways to combat managed-care premium increases and the growing paper nightmare associated with administering benefits.

During the past year, an increasing number of people in Kansas City and throughout the country are looking to defined-contribution health benefits as a possible solution. Employers contribute a specific amount of money toward employees' health insurance premiums. Employees choose the type of coverage, who will provide it and how much they will contribute out of pocket.

> 'Managed care is terminally ill.'
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> Vivius Inc.

Recent surveys show broad-based support from employers and employees for defined-contribution plans. A study conducted by PricewaterhouseCoopers found that about 60 percent of employers expect to shift to a defined-contribution system in the next 10 years.

And a survey of 14,000 employees conducted by KPMG found that nearly 73 percent expressed an interest in defined-contribution plans.

At least eight companies nationwide have jumped on the defined-contribution bandwagon. Minneapolis-based Vivius Inc. already is test-marketing its product in the Kansas City area. The company is signing up physicians and hospitals and plans to roll out its system on Jan. 1.

INSURANCE: *Cost appeals to employers, but some experts are skeptical*

From Page 3

"Managed care is terminally ill," Vivius Chairman L. Howard Wizig said. "We're giving people what they're asking for."

Companies such as Vivius aren't the only ones taking notice.

Bob Corkins, executive director of the Kansas Public Policy Institute, said he became interested in defined-contribution coverage last fall as he was researching defined-contribution pension plans. KPPI serves as an independent source of information on public policy issues, focusing specifically on issues related to limited government, open markets and individual freedom.

"It sounded to us like it was the wave of the future and that more people ought to be aware of it," he said.

Ready for change

Corkins sees defined-contribution health benefits spreading rapidly, much as 401(k) plans have.

"It's all a question of personal control," he said. "Now, people are stuck with whatever plan their employer has negotiated."

Defined-contribution coverage would solve this problem, he said.

"Defined contribution is a way to get consumers in the loop," said Dr. Deborah Jantsch, past president of the Metropolitan Medical Society. "They start making choices about the health care they want and how their benefit dollars are spent."

Employers are showing a growing interest in the defined-contribution concept largely because of increasing health care costs.

"Managed care, like most strategies for cost containment, worked for a while," said Greg Scandlen, a senior fellow with the National Center for Policy Analysis. "But it's worn off, and costs are going up."

Corkins thinks defined-contribution coverage ultimately could help stem the tide of health care inflation.

The current system completely disconnects consumers from the cost of care, and in most cases, employers absorb insurance premium rate increases, Corkins said. Defined-contribution plans put consumers in the driver's seat. In this system, if employees choose a plan that costs more than an employer contributes, employees pay.

Increasing costs coupled with the difficult task of administering benefits has opened the door for employers to consider other insurance options.

"Employers are looking to get out of the health care business," Scandlen said, and increasingly they are looking at defined-contribution plans as the possible answer.

If defined-contribution health coverage takes hold, it will be because employers demand it, Scandlen said.

"Employers have to come to the conclusion that their work force is better off making their own health care decisions, and I think they're increasingly getting there," he said.

Health care providers, many reeling from reductions in reimbursements and a loss of decision-making power due to managed care, see defined-contribution plans as a step in the right direction.

Jantsch thinks physicians are willing to give this coverage a try.

"We are interested in making sure that there are protections for the consumer, that they have every opportunity to make good choices and that they have access to quality care," she said.

Potential pitfalls

If defined-contribution plans are so appealing, why are they only now gaining momentum?

"Sometimes the most brilliant ideas are the ones where people slap themselves on the head and say, 'Why didn't I think of that before?'" said Wizig of Vivius.

Not everyone in the industry agrees. The sudden interest in defined contributions has received a cautious response from many observers.

"There is no perfect way to handle health insurance," said Richard Coorsh, a spokesman for the Health Insurance Association of America. "If there were, it would have been discovered by now."

Coorsh said the HIAA has not taken an official position on defined-contribution coverage. But he said it will not be the health care panacea everyone seeks.

"The current system is not perfect, but it works for the majority of people," he said.

Although Coorsh admits that the health system needs to work for even more people, he worries that defined-contribution plans could cause health care costs to skyrocket further, a sentiment echoed by Randy McConnell, a spokesman for the Missouri Department of Insurance.

"Defined-contribution coverage is one of those things people talk about because it would get companies out of the paperwork business and would create more choice," McConnell said.

But he thinks it would create even more problems than exist now, including increasing costs and the number of uninsured.

"The pool averages out cost," he said. "When you set many people out in their own individual boats, many are going to sink."

Corkins said he is not surprised that the insurance industry has been reluctant to jump aboard.

"This is a change in the way of doing business," he said. "People are reluctant to change. ... It could undermine their current industry advantages."

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BUSINESS

Michael Hooper, Business Editor 295-1293; e-mail biz@cjonline.com

Friday, October 6, 2000 THE TOPEKA CAPITAL-JOURNAL

SMALL-BUSINESS OWNERS AND INSURANCE

Third party may be solution

Strategic experts: Combining groups may lower rates.

By MICHAEL HOOPER
The Capital-Journal

Politics — not markets — have hindered small businesses from providing affordable health insurance to their employees, a health-care policy consultant said.

"To the extent that you permit markets to work and not politics to work, you will succeed," said Richard Teske, president of Strategic Advocacy, a Virginia-based firm that advises political, corporate and association leaders in health-care policy.

He spoke Thursday at a seminar called "The Emerging Market for Consumer-Owned Health Insurance" in Overland Park at the Marriott Hotel. The program was sponsored by the Kansas Public Policy Institute and the One-by-One Project, both nonprofit agencies.

In the spring, the Kansas Legislature approved the creation of the Kansas Business Health Partnership, which works to help small employers provide health insurance to their employees.

Sen. Sandy Praeger, R-Lawrence, a member of the Kansas Business Health Partnership Policy committee, said the group will be taking requests for proposals later this year or early next year for an organization to serve as a third party between small employers and health insurance companies.

The selected third-party group would negotiate with insurance companies to find affordable health insurance for the employees of small businesses. The theory is that by combining employee groups, they can get better rates, she said.

The planning for the partnership is funded by a $1.3 million grant from the Health Resources and Services Administration. The grant is to be used to help reduce the number of uninsured people in Kansas, currently at about 250,000.

Teske said Kansas has the opportunity to develop a Health Purchasing Cooperative for businesses with 50 or fewer employees.

See SOLUTION, page 3-C

Solution

Continued from page 1-C

Essentially, the cooperative would create a pool of premium dollars shared by employees and insurance companies.

To the employee, the cooperative would work much like a 401(k), which provides choices for investing retirement funds.

Teske's vision is a free market approach that would give employees a sense of ownership in their health insurance program.

With ownership, they would lobby for better rates, he said. He acknowledged, however, that only the state of Connecticut has had mild success with a Health Purchasing Cooperative. That is because it has a defined benefits approach, he said.

In order for such a cooperative to be successful, Teske said, the Kansas Legislature should use a "defined contribution" approach.

Under the defined contribution approach, he said, employers would offer employees a defined amount for their health insurance premium. The employee would have the option to take a health insurance program with a low deductible and a high premium or a high deductible and a lower premium, or somewhere in the middle.

The only way the program would work, Teske said, is to get dozens of insurance providers and many employees involved.

"You can't attract plans with good benefits and low prices unless you promise a certain level of membership," Teske said.

Praeger said that while Teske's idea is "a lofty goal, it has lots of problems."

A person with a pre-existing condition would have trouble getting into a health insurance program under a defined contribution approach.

Teske said a separate pool should be developed for high-risk individuals.

But Praeger said the idea of insurance is to pool everybody together to share risk.

Under the defined contribution model, she said, there is no guarantee employees will use the money for health insurance, unless the state mandated that everybody have health insurance just as the state requires everybody to have car insurance.

"I don't see us mandating it," Praeger said Thursday.

The challenge for these small employers, she said, is that they don't provide enough money for a premium. She said the state may have to provide a subsidy for the premium.

"We don't have a market that could let this happen unless you legislate rates," Praeger said.

However, she supported the concept of pooling insurance premium money together from small businesses. She said she just wants to make sure employees have a choice in what types of plans to join.

Teske said small employers can't get health insurance for their employees is because they can't negotiate as good a rate as large employers.

He said 95 percent of employers with more than 100 employees offer health insurance; only 29 percent of businesses with three to nine employees offer health insurance.

Michael Hooper can be reached at (785) 295-1293 or mhooper@cjonline.com.

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The Wichita Eagle

Saturday, November 4, 2000

Of insurance, yard signs and KTN

By Phillip Brownlee

If you work for a good-sized company, you're likely in the midst of reviewing your benefit options for next year. But in the not-so-distant future, the number of health-insurance plans employees can choose from may dramatically increase, as a seminar next week in Wichita will examine.

Experts from across the country will gather Thursday at the Airport Hilton Hotel to discuss what could be the next wave of reform: consumer-owned health insurance.

"It's going to be a smorgasbord of ideas," said Bob Corkins, executive director of the Kansas Public Policy Institute, a libertarian think tank that is one of the seminar's organizers.

Here's the basic concept: Instead of providing prepackaged health-insurance plans, employers offer their employees a fixed sum of money to buy their own insurance.

Besides helping companies control their costs and liabilities, benefits to employees of a "defined-contribution" system include:

• More options.

• Increased portability, as employees could keep the same plan, regardless of whether they change employers.

• More say and control in personal health-insurance plans.

Also, if people had a greater personal stake in their health insurance -- such as they do now with auto insurance -- they likely would be more careful consumers, which could help hold down health-care costs.

I'm still concerned about whether people with serious health conditions would face sky-high premiums. But Richard Warner, an Overland Park psychiatrist and a presenter at the seminar, said that there are ways to avoid that, such as spreading high-risk costs across an entire purchasing pool.

It's an intriguing idea. And given the rising cost of health care nationwide, it's a strategy that more and more companies are likely to embrace.

KPPI

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October 5, 2000

HOW THE KANSAS BUSINESS HEALTH PARTNERSHIP CAN LEARN FROM OTHER HEALTH PURCHASING COOPERATIVES (HPC's)

By
Richard Teske

About the Author

Richard Teske is president of Strategic Advocacy, a Virginia based firm that advises political, corporate, and association leaders in health care policy. He previously served as Official Liaison to the White House for the U.S. Department of Health and Human Services and also as HHS Deputy Assistant Secretary for Public Affairs. Other notable capacities in which he served include that as Associate Administrator of the Health Care Financing Administration and as United Nations Delegate to the Conference on Economic and Social Policy.

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EXECUTIVE SUMMARY

Late in the Kansas Legislative session of 2000, a new health insurance marketing organization for small employers was authorized by statute. The explicit objectives behind this measure were to decrease the number of uninsured Kansans and create a new delivery mechanism for existing federal insurance aid for the children of lower income workers.

Although the large majority of other states' experiments with similar purchasing cooperatives have met with dismal results, that experience could serve Kansas well. Much depends on the manner in which a specially appointed committee chooses to implement the program and how some parts of the authorizing new law are interpreted.

Rather than installing this cooperative with blind allegiance to the traditional "defined benefits" approach for employer sponsored health insurance, a modern "defined contribution" approach would be superior. By setting up such market-oriented health benefits similar to defined contribution, 401(k)-styled retirement plans, then the quality, cost, and accessibility of health insurance can be improved.

INTRODUCTION

The purpose of this paper is to help advise the Kansas Business Health Partnership[1] on how to best establish a defined contribution consumer choice program. This will be done by analyzing the lessons learned by other state health purchasing cooperatives (HPC). More than any organizational or administrative element, setting realistic expectations from the start seems to be the key to success.

The use of state HPC's to provide coverage for small employers and individuals has cooled since the early 1990's. There are four reasons: 1) the failure of President Clinton's health reform in 1994 (based on a national HPC); 2) other federal laws passed since 1994 that address some of the same health problems that HPCs seek to address; 3) the change from the 15-20% yearly price increases in the 80's and early 90's to as little as 2-3% within the last few years; and, 4) the inability of almost any state HPC to attain its initial goals because of changing market and political conditions. If Kansas ignores the established track record of other HPCs it will guarantee the failure of the Business Health Partnership. Even if it avoids the many pitfalls of other programs, it will still be problematic for the Partnership to meet expectations.

Setting realistic expectations from the start seems to be the key to success of any Health Purchasing Cooperative (HPC).

[1] Sen. Sub. HB 2005, enacted 5/15/00, effective date 7/1/00.

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The theory behind a HPC is simple: the state pools small employers and/or individuals (small market reform) so they can negotiate lower health insurance rates as large employers can do. HPCs also resemble the Federal Health Employees Health Benefit Program (FEHBP) in that they offer an alleged market oriented defined contribution consumer choice of competing health plans.

In reality, the HPC record proves almost the opposite. A HPC can succeed only if it conforms to market economics rather than political expediency. This is extremely rare since almost every HPC was established because of a political response to the growing number of uninsured and the believed loss of accessibility to affordable health insurance in the individual and small group market. Secondly, when they ignore basic market economics, the HPC will fail to attract enough plans to have true market oriented consumer choice competition.

A HPC can succeed only if it conforms to market economics rather than political expediency. This is extremely rare since almost every HPC was established as a political creation.

The HPC then enters a death spiral. Politicians demand tighter controls and lower prices. Plans then withdraw or refuse to participate since the rates or benefit packages demanded aren't economically feasible. With fewer choice of plans, employers and employees don't find the HPC attractive and don't see any advantage to join. With fewer consumers joining, insurers can't attain the "economics of scale" (or market share) that the pooling initially promised. Plans then seek to cut benefits and/or raise rates to survive. We thereby return to the beginning with politicians again demanding controls and lower prices.

This death spiral also explains why the FEHBP is only a partial example for HPCs. The federal government essentially delivers millions of employees and dependants as a captive market. HPCs, however, rely on voluntary participation of plans and voluntary membership of employers and employees. You can't attract plans with good benefits and low prices unless you promise a certain level of membership. But you can't attract membership unless you have a large number of plans offering good benefits and low prices.[2]

You can't attract plans with good benefits and low prices unless you promise a certain level of membership. But you can't attract membership unless you have a large number of plans offering good benefits and low prices.

To solve this "chicken or egg" problem means entering the complex and arcane world of insurance, not health care. It is helpful to know how health care is delivered but it is imperative to understand how the insurance market works. The terms in the "small market reform" area are often alien to health policy experts. Even when the terms are understood, it is the

[2] Managed Care Week, *Health Purchasing Coalitions Felled by Inadequate Size, Lack of Buy-in,* April 24, 2000, (referencing an Alpha Center Study)

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synergy of the various elements that will mean success or failure of the HPC. Even if unintended consequences can be avoided by understanding this synergy, there is no single state HPC that can be used as an example for Kansas.

The reason that it is difficult to advise on the Kansas program is that much of the available HPC literature dates from the 1993-94 federal health care debate. There is little comparative state data, in part the result of the "cooling" of interest in HPCs.

There are other small group approaches not addressed by this paper because Kansas' program follows the HPC approach. There are Association Health Plans that permit trade organizations to be small business purchasing agencies. There are also Health Marts that have a board of directors consisting of all stakeholders. Both Association Health Plans and Health Marts are free of state mandates on coverage and providers offered in other insurance. HPCs, conversely, must meet most state mandates.

Even with this additional administrative flexibility these approaches have over HPCs, they still are not very successful at lowering the number of uninsured. Studies have shown that neither approach is "likely to reduce health costs enough to significantly entice most firms not now offering coverage to buy health insurance. In addition, benefit packages that are significantly less comprehensive than typical do not seem to have broad appeal, and still may be too costly for most small business"[3]. Although these approaches differ somewhat from HPCs, their outcomes still apply.

Connecticut's program, possibly the most successful statewide HPC, has mustered an insurance market share of only 8%.

These studies more ominously concluded that even if the federal government provides tax credits, funds feasibility studies and start-up activities, or requires purchasing insurance through a collective purchasing agency, it *still* wouldn't result in a large decrease of uninsured. They estimated at best 80-90% of those currently uninsured would remain uninsured.

California, with 148,000 lives represents less than 5% of the formerly uninsured and has attracted only 2% of the small employers. Connecticut, possibly the most successful HPC, only has 8% market share.[4] In fact, Kentucky and Washington have repealed their group purchasing laws because of disappointing results.[5]

It is within this sobering context that Kansas must frame its initial expectations. The Kansas Business Health Partnership will never be the single solution to small group purchasing. It can, if properly designed, be part of the solution.

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[3] Eliot K Wicks and Jack A. Meyer, "Small Employer Health Insurance Purchasing Arrangements: Can They Expand Coverage?", National Coalition on Health Care, May, 1999

[4] *Ibid*

[5] Health Insurance Association of America, *Group Purchasing Position Paper,* Washington, D.C., February 1999

I. DEFINING THE NEED FOR SMALL MARKET REFORM

The need for small market reform is connected to the rise in the numbers of the uninsured. This is especially true for firms with less than 50 employees -- the so-called "small market".

In 1998, in the last year with official statistics, the U.S. Census Bureau estimated that there were 44.3 million uninsured, or 16.3% of the population.[6] In the same study about 47.5% of poor workers were uninsured. Thirty percent of people 18-24 years old were without insurance. In the intervening two years since the study, some estimates of the uninsured have grown to 48 million, so the numbers above may also be assumed to have increased.

More importantly for this paper, of the 146.3 million workers, 53.3% had policies in their own name.[7] In firms of 1,000 or more employees, 66.2% own employment based insurance. In firms with less than 25 employees, only 29.3% have insurance. Consequently, most small market reforms are targeted to firms from 2-50 employees.

A realistic expectation is that, at best, only 5-10% of the uncovered employed are likely to get health insurance through the Kansas Partnership.

The U.S. Government Accounting Office (GAO) found that only half of all employers with 3-9 employees offer health insurance. This compares to 95% of employers with over 50 employees.[8]

In 1998 Kansas had 10.3% without insurance compared to the national average of 16.3%. Kansas had 2,346,000 persons covered and 270,000 not covered.[9]

What may be the most important finding is what causes people to be uninsured. The key factors determining uninsured status were: 1) age, with those aged 18-24 leading the group; 2) race, with the highest being persons of Hispanic origin at 35.3% versus 11.9% of non-Hispanic whites; 3) education; 4) work experience; and, 5) national origin, with 34.1% of foreign born persons uninsured versus 14.4% for natives.[10]

What is crucial for policy makers to understand is that small market reforms only address only one of the five causes: work experience...and that only partially. Work experience includes not only size of firms but also age (younger workers may correctly choose to forego coverage in favor of higher wages). This may explain better than anything else the failure of purchasing cooperatives to meet expectations.

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[6] U.S. Bureau of the Census, *"Health Insurance Coverage: 1998"*, www.census.gov/hhes/hlthins/hlthin98/hlt98asc.html, 1999

[7] *Ibid.*

[8] US General Accounting Office, *Private Health Insurance: Cooperatives Offer Small Employers Plan Choices and Market Prices,* HEHS-00-49, March 31, 2000

[9] United States Census Bureau, *Health Insurance Coverage, 1998*

[10] *Ibid.*

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The lesson: smart policy makers will not exaggerate the potential of the Kansas Partnership, but will work to make the public's expectations realistic. This means that, at best, only 5-10% of the uncovered employed are likely to get health insurance through the Partnership.

This disappointing record is somewhat counterintuitive during a period of record prosperity and higher wages. It should mean employers and employees could more easily afford insurance. With record low numbers of unemployed coupled with small market reforms, more people than ever should have access to employer based coverage. Furthermore, employers have had relative price stability. Yet, the number of uninsured has risen from 34 to 44 million during the last eight years.

The reason for the counterintuitive result is that there is a major mistake in the two basic assumptions that under gird the rationale for HPCs.

First, there are not savings from pooling employers that result in lower costs to the employee. According to Wicks and Meyer, the costs of marketing result in high diseconomies such as small-scale agent commissions, high advertising costs, greater administrative costs and high turnover. The variation of risk from employer to employer is much greater in the small group market than in, say, Fortune 500 companies. This means fewer employers and participants are attracted to participate, and this reinforces the difficulty of insurers enjoying any economies of scale.

Second, HPCs haven't kept pace with the realities of the health care market nor the global economic change. It's as though they were designed in a vacuum ignoring the rest of the health care marketplace. They were conceived at a time of huge cost increases in indemnity plans in the late 1980's and early 1990s. Employers chose to turn massively from fee-for-service to HMOs to save money. They did not turn to group purchasing. The result is that the HPC cost savings based on indemnity calculations is greatly reduced when compared to HMOs. Although employer HMO coverage limits choice, the lack of HPCs to attract many plans made the consumer choice element less determinative. Also, the federal laws passed in the mid-1990s (detailed below) addressed many of the problems HPCs were designed to address.

HPCs haven't kept pace with the realities of the health care market nor the global economic change. It's as though they were designed in a vacuum ignoring the rest of the health care marketplace.

More importantly in the long run may be the change from an industrial to an information based economy. Tying health insurance to the employer may have made sense in 1940s industrial America when you held a single job for 40 years. It makes no sense to do this in an information economy when the average person will change jobs 8 times. This makes portability as important as the old triangle of cost, quality and access.

HPCs have been constructed on the industrial model. It is the employer that decides to join. It is the employer, in some cases, who decides which of the HPC plans will be offered to their employees. Most importantly, unless the state makes it explicit, the chosen plan won't be portable to the next employer.

This may mean that there will be more pressure to establish effective individual association plans rather than small group reform or purchasing groups. But these have been even more unsuccessful than HPCs because the above assumptions (and results) are magnified in the individual market.

The lesson: Make your HPC as individual friendly as possible, but grafting "individual" reforms onto an industrial era entitlement structure dooms its prospects.

II. REVIEW OF RECENT PAST HEALTH AND REGULATORY REFORMS

In addition to the two great changes in the health care and global information economies discussed above, federal and state governments passed many laws that impacted the small group market directly. These reforms undermined the need to establish HPCs as conceived in the early 1990's.

Dominating all health reform debates was the defeat of President Clinton's national proposal in 1994. It combined the emerging solution *de jure*, managed care, with a concern for providing universal coverage. The result was "managed competition". Its failure has affected all reforms considered and passed since. It has had a great effect on group purchasing plans.

First, the Clinton plan would have been comprehensive reform of the entire health care system. Afterward, only incremental reforms have been considered rather than risk one-seventh of the nation's economy on an untried theory. Although incremental reforms lessen the risk, they also lock in the existing defined benefits entitlement structure that function best in an industrial economy. A consumer choice defined contribution approach is more consistent with an information economy. The underlying structure, defined benefits or defined contribution, affects every element of health care delivery. It is crucial for the Kansas Partnership to understand the differences.

All health plans (be they indemnity, HMO, Medicare or Medicaid) consist of three elements: eligibility, benefits and cost. In a defined benefits plan, eligibility and benefits are fixed while costs are variable. This means that if you are eligible, you are "entitled" to all the benefits regardless of the cost to employer, insurer or taxpayer.

This is important because of the regulatory structure that defined benefits program need. Government always regulates the variable and

Although incremental reforms lessen the risk, they also lock in the existing defined benefits entitlement structure that functions best in an industrial economy.

A consumer choice, defined contribution approach is more consistent with today's information economy.

that means *cost*. Consequently, most past regulations pertain to cost containment and reimbursement cuts. The entitlement approach demands an intrusive bureaucracy to ferret out waste, fraud and abuse. This has been the history of health insurance reform since World War II.

In a defined contribution plan, however, it is eligibility and costs that are constant while benefits are the variable. This means that the regulatory focus is on quality of care and patient satisfaction. But HPCs that mandate basic or standard benefit packages defeat this approach. Rather than make adverse selection (described below) a positive characteristic by allowing flexible benefits, HPCs error by believing standard benefits make it easier to compare plans. However, there won't be comparisons if no plans participate!

HPCs error by believing standard benefits make it easier to compare plans. However, there won't be comparisons if no plans participate!

The second thing that changed in 1994 was the discrediting of "managed competition". This essentially was a HPC approach applied nationally. It allegedly borrowed "managed" from HMOs and "competition" from the private sector. In reality it was neither managed nor competitive. It was centrally planned universal coverage that was more corporatist than socialist. By not changing the underlying defined benefits entitlement structure, it couldn't have been anything else.

At the state level, smaller versions of the Clinton proposal were adopted. Tennessee's Tenncare led the way in 1993 by trying to cover all uninsured and uninsurables through a revised Medicaid program. It proved to be a disaster. Unfairly or not, this was another blemish on statewide "HPC" approaches.

The lesson for Kansas is clear because the public's desire for universal coverage remains high. In reality, there are only two philosophical alternatives: a single payer plan or market oriented consumer choice. Using a defined benefits structure makes a single payer plan inevitable. A defined contribution structure makes market oriented consumer choice possible.

The failure of comprehensive reform also led to incremental reforms that addressed the issues that HPCs were designed to solve. The 1996 Health Insurance Portability and Accountability Act (HIPAA) addressed portability, denial because of pre-existing conditions, and mandated guaranteed issue to any employer who applies to the plan. These are three major elements of any HPC plan.

The 1997 Balanced Budget Act did a number of things. It created Medicare+Choice and permitted states to institute Medicaid Mandatory Managed Care Programs without federal approval. Welfare reform cut the tie between categorical Medicaid eligibility and cash assistance, permitting states to cover uninsured. These included previously uninsured.

The 1997 Children's Health Insurance Program (CHIP) provided coverage for uncovered children of working poor. It also provided access to coverage for the children's parents. This means that HPCs

greatest target audiences, working poor families, were addressed (at least somewhat) through direct subsidies.

States passed many new regulations and proposals too numerous to review. To the extent they passed intrusive regulatory schemes to protect patients or provide coverage, costs exploded. This made private sector competition seem even more costly and less attractive.[11]

Lesson: No matter what reforms are contemplated, Kansas must consider the competitive impact of these reforms on HPC design.

III. THE SYNERGY OF HPC POLICY ELEMENTS

When designing a HPC it is crucial to understand the different elements and how they interact in the marketplace -- not politically. The key to everything is risk. The way insurers are able to risk adjust will determine the degree to which adverse selection will affect the plan's success.

This is where many HPCs fail at the starting line. Politicians seek to have everyone treated equally. This is good in politics, but it is fatal in markets. If states desire egalitarian health care that promises equal access at the same cost, then a single payer approach should be pursued. Remember, however, the health care triangle. If you want open access at low cost, quality will suffer.

If a state wants equal health care access at a uniform cost, then the proper mechanism is a single-payer approach...but quality will suffer.

Markets provide the best quality to the most people at the lowest realistic cost.

Markets don't promise equal treatment. Markets have proven to provide the best quality to the most people at the lowest realistic cost. Every one of the policy choices poses this political versus market dichotomy.

It is helpful for policy makers to remember that indemnity companies and HMOs, by definition, are risk pools. When you design a HPC, you are pooling other risk pools into a larger one. Regardless of the size, a risk pool responds to the limitations placed upon it. There is another way of saying this: if you duplicate all the conditions in the private marketplace in the HPC, the result will be a plan with benefits, access and costs identical to the private sector.

[11] Grace-Marie Arnett and Melinda Schriver, *Uninsured Rates Rise Dramatically in States with The Strictest Health Insurance Regulation,* Heritage Foundation Publication No. 1211, August 14, 1998

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The element(s) that you select to be different than the private sector will have an impact on all other elements and determine if it is attractive to participate. This is the synergy between elements.

Agents play the key role in the success of a HPC.[12] Many group-purchasing plans initially thought that they didn't need to use agents to reach small businesses. It is extremely important that the Partnership have a product agents want to sell. This is the reason the Illinois plan failed after only one year.[13] They learned that just a good product at a low price isn't enough. Initially HPCs sought to eliminate the agents entirely, believing that they could eliminate the "overhead" commissions. They were wrong and agents remain skeptical to this day. Competitive commissions must be paid by the Partnership.

Insurers, or as Kansas calls them, **Carriers**. The most important thing is that they believe there is a "level playing field".[14] This means that they do not want the rules for the HPC carriers to be more favorable than other insurers operating in the state. This means rate reforms, marketing rules, guaranteed issue and all other laws should be the same. They are initially suspicious of employers who join a HPC. They believe they join only when one employee is at high risk. Guarantee issue could tip the balance. They also may believe that the HPC competes with their existing business.

Conversely, if carriers perceive that the rules are stricter in the HPC or the benefits too rich, they will be able to drain off the low risk people to their regular business and leave the high risk for the HPC. Whole group, renewability and portability are very popular with insurers and agents.

Risk Adjustment and Adverse Selection drives all carrier decisions and is the key to profitability. It is crucial to remember that competition depends on risk selection strategies and product differentiation. This isn't accomplished if carriers can't deny coverage for pre-existing conditions, have provisions for guaranteed issue, have rating restrictions or community based rating, and have standardized benefits packages. There is no way for the carrier to adjust for risk and no way to differentiate product. That means that adverse selection may imperil the carrier. This threat will discourage small carriers from participating. The reason is best explained mathematically.

The risk adjustment rule of thumb is that 10% of any large population accounts for 70% of costs.[15] Let's assume 100 people in a plan. Only 10 will be high risk. If, by risk adjustment, the plan can remove just one of these people it will save 7% (if five people, then 35%). If the rules don't permit any flexibility, the addition of a very few high-risk persons could threaten the existence of small carriers. What would happen to a small carrier that has an attractive plan that attracts all AIDS patients? Rather than take that risk, they won't participate.

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[12] Mark A. Hall, *'An Evaluation of Health Insurance Market Reforms"*, Wake Forest University School of Medicine, February 1999

[13] Managed Care Week, *op.cit.*

[14] HIAA, *Group Purchasing Policy Paper, op.cit.*

[15] Wicks and Meyer, *op.cit.*

High Risk Pools and Reinsurance are two ways of handling risk adjustment. Reinsurance works similar to how Lloyds of London operates by selling off portions of risk. Carriers generally don't like linking reinsurance and group purchasing. Twenty-seven states have high-risk pools that seem to operate well, but I have not found any state that uses a high-risk pool with a HPC. Costs could be apportioned to the carriers on market share. The state could subsidize certain populations. The carriers could refer supposed high risks to the pool and the Partnership could evaluate the referral with medical review. If states implement the types of restrictions discussed below, they must solve the issue of high risk and adverse selection.

Rating Restrictions vary state to state. If no rating differences are tolerated, a high risk pool must be considered. Some states allow rates to fluctuate by plus-or-minus 25% of the rates of the usual enrollee. Rates can be adjusted by age or health status, but each additional subjective judgment requires additional administrative overhead to provide oversight. In states with standard benefit packages and rating flexibility, some companies set the rate at 75% rather than at 100% so they could charge 125% for high risk.[16] This could provide an additional 67% of revenues. Again, this is an example of synergy. HPCs should accept all applicants and limit premium differences to some rate range.

Rate Negotiation by the HPC could threaten rating reform rules that pertain to carriers outside of the HPC.[17] California has done some negotiation and it has been cited as one of the crucial reasons that their HPC hasn't been more successful. Colorado permits rate variation only on the administrative portion of the premium, not the medical portion,[18] with savings passed along to the consumer. Colorado's HPC happens to be one of the fastest growing in the country.

Community Based Rating is very controversial. Allegedly it provides the same rates for the same class of people regardless of any other factors. Because carriers can't risk adjust, there is a trade off. To assure that high risk persons don't overwhelm their plan, they will set the premiums higher. The result is that community rating results in higher marketwide price increases. It also, through adverse selection, drives all non-HMO options out of the HPC.[19] Carriers will try to avoid adverse selection by offering fewer benefits or less attractive pricing.[20] If community rating is pursued, then a minimum benefits package must be adopted, and some rating approval limits or system established. This, however, raises all the problems with standardized benefits (below) and the need for an intrusive bureaucracy to monitor rates that borders on price controls. This is the clearest example of market action versus political goals.

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[16] Mark A. Hall, *op.cit.*
[17] Wicks and Meyer, *op.cit*
[18] *Ibid.*
[19] Mark A. Hall, *op.cit.*
[20] *Ibid.*

Finally, with increased costs passed on to the consumer, premiums must rise. More employees are declining coverage because of increased cost sharing -- some estimates indicating as high as 67% of all uninsured are people who decline insurance for this reason![21]

Mandated/Defined Benefits or **Basic and Standardized Benefit Plans** have many of the same effects. First, once benefits can be mandated, then every special interest will lobby for their particular provision. This will lead to a rich benefit program that is very costly. Standard benefit plans have not succeeded in HPCs.[22] Insurance agents don't like them and are reluctant to market them. If HPCs mandate an inferior *or* superior product *vis a vis* the private sector, it is ripe for adverse selection. Some states that have designated standard benefits only for guaranteed issue have attracted high-risk participants. The most important point is that consumer choice is impossible with community rating. If you don't compete by offering different benefit packages, it really is a defined benefits approach and there is little consumer choice.

If the plans have standardized benefits (especially if coupled by rating restrictions), indemnity plans may not participate and only HMOs may be able to compete.

What carriers want is to use the same plans that they use in the non-HPC sector, not to devise new plans. If benefits are the same, indemnity companies won't join or will be driven out.[23]

States like standard benefits because they believe it's easier for participants to compare plan prices and quality and they discourage adverse selection.[24] It is up to whom you believe and if you favor defined contribution or defined benefits approaches.

Catastrophic Coverage coupled with a **Medical Savings Account** would be an interesting alternative to the usual mandated benefits plans above. I know of no HPC that has followed this course, but if it competed with standard plans there is the possibility for adverse selection.

Guaranteed Issue removes another tool from carriers to avoid adverse selection. Guaranteed issue usually means that every employer wanting to participate and every employee choosing coverage must be permitted to join. In return, carriers want some type of medical underwriting, but states are wary of any system that is subjective. Most find adjustments for health status to be the most subjective and in need of heavy regulation. Again, it returns to the issue of how to handle high risks.

Employee Choice rather than employer choice is preferable for a market oriented plan. Carriers, however, claim individual policies are more costly to administer than group plans. Employers may also wish to restrict the choice of plans, which should be prohibited.

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[21] Mark A. Hall, *op.cit.*
[22] *Ibid.*
[23] *Ibid.*
[24] Wicks and Meyer, *op.cit.*

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A more important issue is helping employees to choose. Since they are uninsured, they may not know how to access the health system. They may not have experience choosing a health plan. That's why the use of an independent broker (in this case the Partnership) needs to be responsible for approval of marketing materials. They serve as the umpire between the states' political goals and carriers' profit motive. They also need some control over enrollment -- especially if there is a high-risk pool.

IV. COMPARISON OF KANSAS PARTNERSHIP AND OTHER STATE HPCs

The Elliot Wicks and Jack Meyer study "Small Employer Health Insurance Purchasing Arrangements: Can They Expand Coverage?" provided a useful chart to compare the elements of different state approaches. In a somewhat modified form, we will use their chart and compare the characteristics to Kansas' plan.

Political Oversight Committee
Other State HPCs: No
Kansas: Yes

This, potentially, could be the worst part of Kansas plan since it introduces political control for market judgment. The Committee is the body who must certify that 70% of the employer's employees are covered by the program. How is this certified? When is this determined? This is another "chicken or egg" question: How do you know the percentage unless you proceed with enrollment, but how do you proceed without certification? Most importantly, what are the powers of this committee to intervene with the contracted Partnership if it is displeased? Doesn't this politicize the entire process?

Partnership Board Represents Purchasers
Other State HPCs: Yes
Kansas: Possibly,
minimum of one employee and one employer

This should be a requirement in the contracting of the Partnership

Must Accept All Willing Plans
Other State HPCs: Yes
Kansas: Yes

Can Negotiate With Plans Over Premiums
Other State HPCs: Usually
Kansas: Presumably

This is extremely delicate since most other types of risk adjustment have been removed from carriers. The temptation, especially when influenced politically, is to continually cut rates and premiums to meet political goals. This is especially true of a defined benefits approach (which Kansas essentially is).

Offers Multiple Health Plans
Other State HPCs: Yes
Kansas: Not necessarily

Kansas mandates two health plans but has no provision for multiple competing carriers.

Employee Choice
Other State HPCs: Usually
Kansas: Yes

This is good. A prohibition on employers limiting the employee's choice to a subset of carrier plans should be considered.

Standardized Benefits
Other State HPCs: Usually
Kansas: Yes

Kansas will determine the two low cost benefits packages that all carriers must offer. That means they will not compete on the basis of benefits, but on price. This is defined benefits, not defined contribution. It also means indemnity carriers probably won't participate; being driven out by HMOs -- thus limiting employee choice.

Subject to State Mandated Benefits Laws
Other State HPCs: Yes
Kansas: Yes

Carriers who profess to want a level playing field should greet this favorably.

Group Size Limits
Other State HPCs: Usually 2-50 employees
Kansas: 2-50 employees

Must Take All Employers that Apply,
Regardless of Health Status or Underwriting
Other State HPCs: Yes
Kansas: Partnership to Develop Minimum Rating Policies

Rates Based on Health Status or Claims Experience
Other State HPCs: No
Kansas: Perhaps (see above)

With little to risk-adjust or differentiate their products (the two keys to competition) carriers will somehow press to medically underwrite. Kansas needs to think how this can be done. I believe a High Risk pool is the best way to answer this need.

Accepts Only Groups, Not Individuals
Other State HPCs: Yes
Kansas: Yes

Geographic Service Area
Other State HPCs: Usually Statewide
Kansas: Unclear

For a rural state, "statewideness" is important. The FEHBP usually offers plans statewide, but sometimes in limited areas. Kansas FEHBP participants have dozens of fee-for service, Point of Service and HMO plans.[25] The Partnership should talk with the FEHBP people before they lock into rates, premiums, benefits or statewideness requirements.

CONCLUSION

The desire to form state HPCs has cooled since the early 1990's for four reasons. First, the defeat of the Clinton "comprehensive" reform based on a HPC-like plan. Second, the rate of health cost increases has lessened. Third, "incremental" laws have addressed problems HPCs were supposed to address. Finally, HPCs haven't kept pace with the changing health care and global marketplace.

The Kansas Business Health Partnership can only succeed to the degree it permits market forces to prevail over political expediency. If it doesn't, it will enter an economic death spiral leaving it without carriers, agents, employers or employees. Even if it succeeds it should keep its expectations small. The highest market share attained by any state HPC is only 8%.

The possible reason for HPCs lackluster record is that the basic assumption was wrong. Pooling of employers didn't save money. The high cost of marketing to small groups wipes out any savings.

To design a HPC, you need to understand the synergy between the programs policy elements. Kansas' design is more like a defined benefit than a defined contribution approach. But by comparing how other states have met these policy challenges, Kansas may be able to avoid some of their mistakes.

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[25] U.S. Office of Personal Management, www.opm.gov/insure/00/states

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July 12, 2000

The Real Consumer Revolution in Healthcare:

Defined-Contribution Health Plans

by

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David Knott
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forward by

Dr. Richard Warner
Overland Park, Kansas

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Forward

Who Decides?

By Dr. Richard B. Warner

The most basic of all decision is who shall decide.
- Thomas Sowell

The idea of employers providing support for their employees' health insurance by way of a defined contribution toward the premium, leaving it to the employees to select their own insurance, is gaining wider attention. Indeed, the accompanying article from the firm of Booz-Allen and Hamilton speaks of the inevitability of the idea.

Yet one cannot speak for long about the idea of promoting individual ownership of health insurance without encountering the objection that people cannot be trusted to make good decisions about such complicated and important matters. As Dr. Stormy Johnson put it in his talk at the Kickoff Meeting of the One By One Project, "Some would say that people are just too stupid to make their own decisions and want someone else to do it."

The appearance of peoples' passivity is largely an artifact of current practice, in which employers or the federal government provide health insurance to three-quarters of the American public. Of the people who are provided insurance as an employment benefit, sixty percent of them have only one plan offered to them, usually an HMO. Since people are so insulated from the true costs of the insurance and the care that it would purchase, they are not able personally to save money by exercising their discretion. Consequently, there is little reason for these people to concern themselves with the details of their health plans. That fact can lead to the impression that people will always prefer to have someone else choose their benefits for them.

Have you noticed anyone asking their employer to select a home mortgage for them? A homebuyer is faced with a number of options in choosing the type of mortgage that fits their financial plans. Size of the down payment, length of the loan, adjustable versus fixed rate, and lending source all have advantages and disadvantages to consider, and it can all seem pretty complicated. Yet people gather the necessary information and make the selection without their employer having to do it for them. The same could be said in the area of retirement planning, as people increasingly control the allocation of their 401(k) assets.

Perhaps the best place to look for how people would take to the idea of selecting and owning their own health insurance is not the current arrangement in which people find their own decisions having so little impact. Instead we should look at such markets as life insurance, auto insurance, homeowner's insurance, and investments to see that people are quite capable of weighing options and picking the plans and instruments that best fit their own situations. And they would greatly object if someone presumed to make their choices for them.

The reason for that objection is that people know they can best judge for themselves the details that are important to their own needs, risks, and goals. The details they would emphasize for themselves are likely different from what an employer picking a one-size-fits-all plan would think important. While anyone can use some guidance and education in these matters, being able to make the decision for one's self is going to yield the greatest likelihood of a person getting the plan best suited to his or her individual and family needs. It is also the most likely to lead to people better understanding and working with the philosophy that underlies the insurance plan, whether that is a managed care plan or a high deductible, catastrophic plan that maximizes individual responsibility.

The reliance on employers to choose the details of health benefit plans has arisen largely from the simple fact that it has been tax advantageous for people to do so over the past five decades. But the fact that people have remained ignorant of the economic realties behind these plans has resulted in complicated schemes of claim processing and bureaucratic oversight that are frustrating and intimidating. If we will move to a world in which employers provide a defined financial contribution and as much information as their employees want, people will likely find that they can choose for themselves the most helpful forms of health insurance.

• *Dr. Warner maintains a psychiatric practice in Overland Park, Kansas, and directs the One-by-One Project which advocates consumer ownership of health insurance.*

The Real Consumer Revolution in Healthcare:

Defined-Contribution Health Plans

A large-scale conversion of employer-sponsored health plans to defined-contribution formats is inevitable. This shift is the key ingredient in finally and irrevocably creating a consumer-driven healthcare system in the United States. Employees will be placed in the "driver's seat" for selecting their own health plans in an open market, much as defined contribution has placed individuals center stage in the 401(k) world. Employees will not lead the defined-contribution revolution, but will find much to like once the concept takes hold.

The idea is simple; the implications are profound. The supply side of the healthcare industry will experience nothing short of the emergence of new business models (e.g., "HMOs'R'Us.com" power retailers) and the need for existing industry participants to deploy new, consumer-focused capabilities.

The emergence of e-commerce will fuel the shift at a dizzying pace. As in any revolution, the magnitude of the change brought about by defined contribution in health benefits will ultimately create new winners and losers in the industry.

The issues that should most concern executives of health plans, delivery systems and other key players are these: when will the shift happen? How? And what can I do—now—to win? This article explores each of these issues. The following is a summary of the structure and rationale of the conversion.

Defined Contribution Meets "HMOs'R'Us.com"

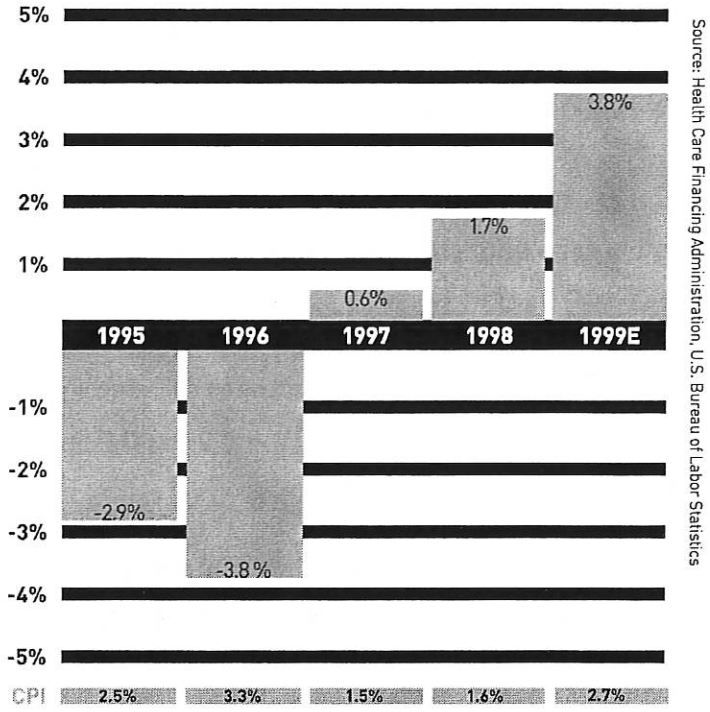
Even beyond the vagaries of rising healthcare costs in general and structural inefficiencies in health plan design, sales and administration are sufficient to fuel a massive change to a new funding and distribution model. The duplicative, complex and highly intermediated world of health plan sales, selection and administration is ripe for change. We estimate that about $18 billion of value added (and an implied market capitalization of $200 to $400 billion) is potentially in play:

- Health plans incur about $5 billion per year in selling costs.

- Benefits consultants are paid an estimated $3 billion per year for design, selection and other services.

- Employers' internal administrative costs, an often-overlooked category of spending, add up to an estimated $10 billion per year—roughly a 10% hidden burden in addition to premium/claims expense.

Exhibit 1: **Real Health-Care Premium Inflation**



The economic rewards for rationalizing these distributions, channel and complexity costs will be enormous for those who own pieces of the answer. For their part, employers should be anxious to limit their future risk (cost increases), eliminate much of today's imbedded infrastructure costs and get out of the thankless role of de facto intermediary between patients and healthcare providers.

The emergence of e-commerce and the success of defined-contributions pension plans provide the capabilities and template for the coming revolution in health benefits. The transformation will include the following features:

- Employers will take the logical next step of deeming their annual health benefits budget as essentially a defined contribution. This will become more likely as employers realize that funding a benefit need not imply that they must go into the market, find appropriate products, run through an annual selection/retailing process and operate ongoing expediter and ombudsman functions.

- Today's Web-based healthcare benefits sites will evolve into true e-tailers of healthcare plans. Today, these sites offer individual sales (in some states), but primarily serve as platforms for selecting between a limited number of pre-approved plan options and then providing enrollment and other front-end services. Ultimately, true e-tailing will likely resemble the early days of Schwab and Fidelity in the investment world—retailers who offer a wide variety of (other people's) products, lots of information and a very low-cost transactions environment.

- The convergence of defined-contribution approaches and Web-based healthcare retailing will transform the health benefits world. An employee, armed with defined-contribution dollars from his/her employer, would access an on-line retailer (an "HMOs'R'Us.com," say) and would make his/her plan selection based on the features, risks and pricing that best meet his/her needs (see Exhibit 2). If married, the employee might combine benefit dollars with his/her spouse and select one plan—potentially freeing up some money for other benefits (or a contribution to a medical savings account). Enrollment, card issuance, provider selection and other front-end services would also be provided.

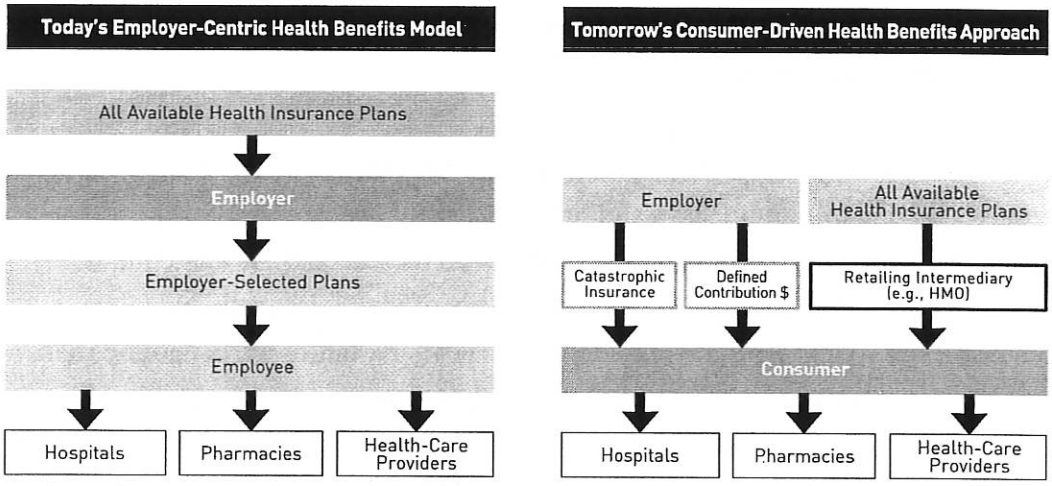


Exhibit 2: **Evolution of Health Benefits Models**

The transition to defined-contribution health plans will be more complex than the conversion of pension programs over the past decade or so. The information requirements (e.g., provider panels, coverages, family structure complexities, quality data) are staggering. In addition, the whole concept of risk and group-identity structure will challenge traditional underwriting approaches.

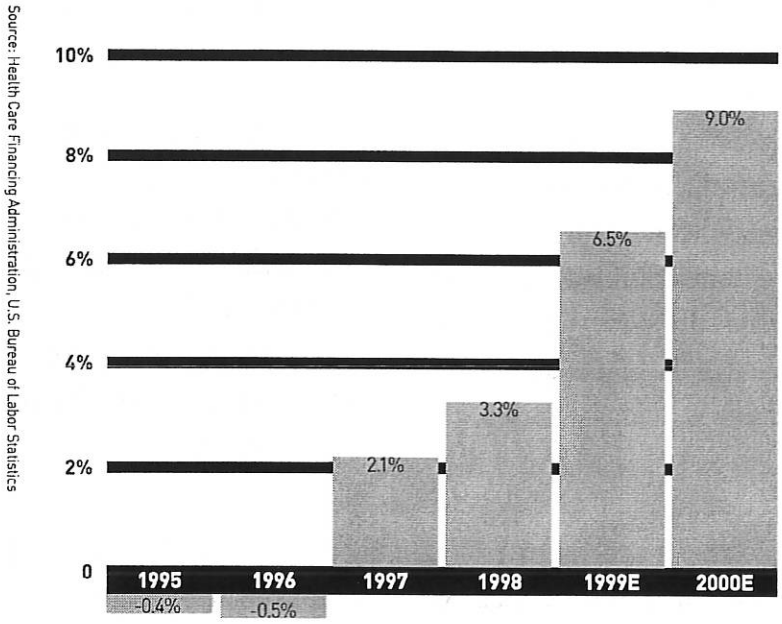
The forces affecting the timing of the transition and potential models for risk are the subjects of the remainder of this article. The winds of change are slowly swirling for the next healthcare revolution—when consumers take control of their own destinies, whether by choice or necessity. Growing frustration with restrictions on choice, continued fragmentation of service providers and confusion over options, costs and quality will provide a robust demand for information; therefore, the Internet and e-commerce capabilities will be the enablers of the revolution. Employers' eventual move to defined contribution approaches will be the catalyst that changes the healthcare benefits world forever. Since the first shots of the healthcare revolution will be coming from the employers' direction, let's examine that side of the equation first.

Defined Contribution- A Breaking Wave, Not a Trend

For most Americans, healthcare coverage and employment are inextricably linked. Major medical coverage became commonplace in the 1950s and 1960s. By the 1980s, the crippling cost increases required a new approach to manage the skyrocketing costs of healthcare. The solution was managed care, with its utilization controls, preferred providers and increased emphasis on prevention. Managed care seemed to be an answer that worked, resulting in several years of significant reductions in the rate of cost increases. However, it came at the price of health consumer choice with overtones of a Big Brother hovering over the patient-provider relationship.

Enter the new managed care—with its opt-outs, point-of-service features, state-mandated minimum stays and other variants. The new managed care looks an awful lot like the old indemnity system, with increased costs and complexity. The new prosperity with historically low levels of unemployment and a buoyant economy has focused employers' attention elsewhere, but in the economic road, we are only a bump away from confronting these issues. To understand some of these issues from the employer's point of view, we conducted a qualitative survey of employers drawn from Fortune magazine's listing of the country's best 100 companies to work for. We spoke to 31 firms ranging in size from 60 to over 200,000 employees. The survey included not-for-profits, manufacturing firms, service companies and high-tech players. A telling indicator of the potency of the subject, especially in a tight labor market, was an unwillingness to permit their names to be used. They did not seem to be alarmed at the rising healthcare costs: the 5% to 9% expected increases for the coming year were described as "modest" by most of those surveyed. Economic times are indeed good—for now.

Exhibit 3: **Nominal Health-Care Premium Increase**



A clear picture emerges from the survey of the economic and political dynamics at play. In terms of knowledge, attitudes and readiness, the companies fall fairly neatly into three groups. Borrowing some military jargon, we see three general categories of readiness for defined-contribution approaches:

- DefCon III—Several very large companies in the survey are aware of defined-contribution approaches but have no intention of ever moving to them. These employers could be characterized as paternalistic (or, perhaps, communitarian), believing the issues are too important and complex to leave to their employees.

- DefCon II—About two-thirds of the respondents fall into this category: aware of defined-contribution features, convinced it will happen some day, but absolutely unwilling to be a first mover because of the risk of alienating their employees (who are viewed as having many other employment opportunities).

- DefCon I—Three respondents (all large employers) can be characterized as champing at the bit. They are ready and willing to make the transition to defined contribution, but see little value (and big risks) in being first movers—until something changes.

Our conclusion from the survey is that defined-contribution plans will emerging rapidly, but only after a major shock to the economic system, or perhaps a cumulative effect of more modest changes across the spectrum of employer concerns cited below. In a robust, high-employment economy, employer conversion to a defined-contribution plan is viewed as risky. The status quo is reinforced by an entrenched employee benefits bureaucracy, which will have a diminished role within a defined-contribution paradigm. However, the survey discovered that certain changes in the status quo could send the fence-sitters in search of new approaches:

"The status quo is reinforced by an entrenched employee benefits bureaucracy, which will have a diminished role within a defined-contribution paradigm."

- The "R" Word—a general recession in the economy could quickly change employers' attitudes toward their work forces from "we're lucky to have these folks" to "these folks are lucky to have jobs." In an environment of layoffs and limited re-employment opportunities, companies would be much more willing to entertain changes and even reductions in their benefit plans.

- Intractable Cost Increases—although seemingly sanguine about "moderate" recent annual increases of 5% to 9%, employers are unlikely to be comfortable with many more years of medical inflation at two or three times the growth rate of the CPI.

- Onerous Additional ERISA Mandates or Loss of ERISA Protections—significant changes to the exemptions or mandates under ERISA could send many of the nation's largest employers back to the benefits drawing board.

The change will occur like a wave that builds and then breaks. Therefore, the absence of any gradual proliferation of defined-contribution plans should not be taken as a sign that the issue is dormant. Exactly when these forces will meet and propel us forward is impossible to say, but it's a risky gamble to bet that it is more than three to five years away.

Consumers Will Rule—Once They Understand

Consumers have shown themselves to be capable of far greater responsibility and independence than many once thought. The rapid acceptance of defined-contribution retirement plans and the increasingly sophisticated use of e-commerce and information providers is stunning.

Translating the health benefits arena through the defined-contribution paradigm is not as straightforward as might be hoped. At the most basic level, the supply side is far more complicated, requiring the tracking of a vast array of products, household permutations, providers, geographies, etc., not to mention the staggering volume of transactions to be processed. Furthermore, there are few, if any, reliable and accepted performance and quality standards that can guide consumers at a higher level, the consequences of consumers' decisions are more immediate and potentially more profound. For these reasons alone, we should approach the new world with some caution.

Perhaps the biggest barrier to overcome is one of conceptualization and expectation. The changes in the healthcare system over the past two decades have left most people, even many industry executives, confused about the very nature of health benefits. The difference between *health insurance* and a *health services* plan must be recognized and understood.

"The upshot is that today we have health insurance products masquerading as health services plans, resulting in confusion and misperceptions on the part of healthcare consumers."

Prior to the managed care revolution of the late 1980s-1990s, the majority of people who received employment-based health benefits knew exactly what they were getting: health insurance commonly in the form of a major medical policy that indemnified the employee for expenses above a deductible threshold. Simple. Managed care ushered in an era of different expectations. Managed care was marketed as a health services plan, where consumers pay a fixed amount and receive an enhanced bundle of services, usually including routine checkups and preventive care not typically covered under major medical plans.

Employees didn't like the restrictions imposed by managed care very much and pressured employers and insurers for options, creating an alphabet soup of hybrid arrangements (PPOs, EPOs, POS plans, etc.), most of which lack the very features that made managed care an economically attractive conception in the first place. The upshot is that today we have health insurance products masquerading as health services plans, resulting in confusion and misperceptions on the part of healthcare consumers.

True, many employees' real costs have increased, but their perceived costs are even greater, amplified as they tried restricted-panel HMOs (with few out-of-pockets) and switched back to less restrictive but more expensive plans where deductibles and co-pays are significant features. Furthermore, employees' experience and beliefs about managed care have created an expectation that their health benefits will be in the form of a health services plan, rather than health insurance, and they are beginning to experience sticker shock when looking at the costs of high-choice products. This situation is analogous to expecting your car insurance policy to include coverage for washing, waxing and oil changes, and being surprised when your premium skyrockets.

The confusion won't disappear with the onset of the defined-contribution revolution, but consumers will be better able to sort through the chaos and select products best suited to their circumstances. The underwriting structure of defined-contribution retailing will create a rational marketplace.

Risk Structure and Consumer Choice

We envision a three-tiered risk structure as a conceptual model of purchasing decisions under defined-contribution approaches. Under this scheme, the roles of the players (employers, consumers, insurers and intermediaries) are much clearer and product arrays sort out into a more clearly understandable set of choices. We see risk sorting into three levels:

- Catastrophic/Extraordinary—stop-loss coverage is a feature virtually everyone needs, regardless of product or plan type. Given sufficient group size (about 200 is the minimum) for a $50,000 stop-loss policy coverage is pretty inexpensive-about $30 to $50 per month in most cases. We see most employers purchasing this for their employees even under a defined-contribution approach. This is only a small amount more per month than many large employers currently spend simply to administer their health benefits plans.

- "Normal" Risk—employees would enter the retail marketplace (almost certainly via e-commerce) already covered for catastrophic loss and armed with defined-contribution dollars from their employers (which could be combined with a working spouse's defined-contribution dollars). At the highest level, their decisions will revolve around their appetite for risk—essentially where to "draw the line" on deductibles and co-pays. The more risk they assume, the smaller their premiums.

- Out-of-Pockets—costs and risks that would be borne by the employee are the final tier of the model. Consumers will discover that there is very limited leverage at the low end of the deductible scale. For example, doubling one's deductible from $250 to $500 would produce only about a 6% premium savings, whereas increasing the deductible to $2,000 would have about a 25% impact. These factors will not only drive consumers to consider higher deductibles, but are also likely to reinvigorate the demand for limited-panel HMOs as a mechanism for reducing one's risk for out-of-pocket expenses.

While some harsh realities may be exposed in the early days of the transition, the overall effect will be to clarify and simplify products, risks, choices and costs:

- **Two major product categories will emerge**. For those who see themselves at low risk ("immortal" single males in their 20s, for example), high-deductible, high-choice insurance products will dominate (see Exhibit 4). People with families (or starting one) will likely trade some choice for limited-panel health services plans (HMOs). Medicare, already experimenting with vouchers (an implicit defined contribution), could also fit into the system by allowing beneficiaries to choose between insurance and health services plans on a community-rated basis.

- **Product innovation and mass customization will eventually take hold**. Once freed from offering a limited product set to a given group, insurers can design new products tailored to specific needs. For example, one could envision a low-cost insurance plan that would require preventive care and "healthy" behaviors in exchange for enhanced benefits and lower costs. One can also envision health services plans that rely heavily on nurse practioners for routine care to reduce costs—a difficult product to mandate for one's employees today, but one with great potential attraction in a more customized, consumer-driven market.

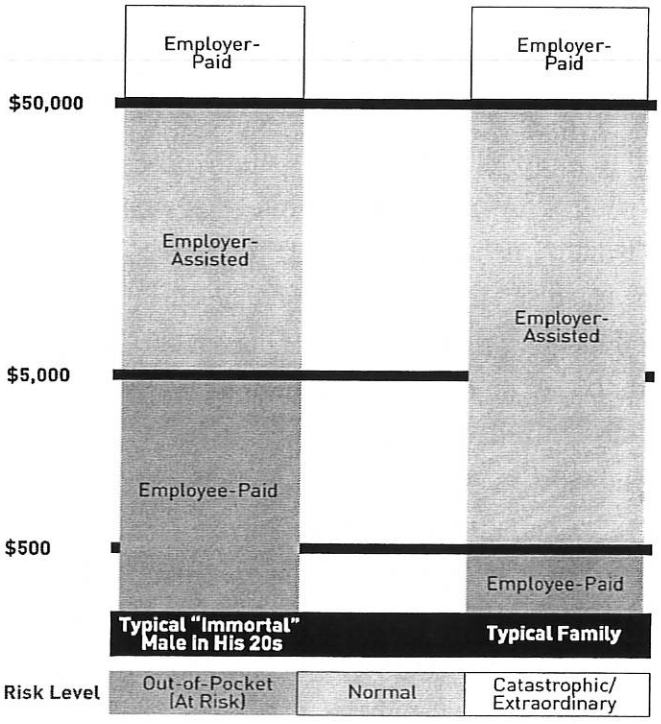
- **Customer service will rise** as insurers move from a wholesale to a retail mentality in their relationship with policyholders. Customer service and clinical data will be readily available to consumers. In a market with low switching costs, transparency of products and performance will foster intense competition for customers.

- **Employers may innovate**, purchasing certain specific types of coverage for their employees (beyond the defined contribution) based on enlightened self-interest. For example, some employers might see substance abuse services coverage as a valuable mechanism for reducing absenteeism, turnover and accidents. Purchasing special-purpose coverages based on business needs could become common.

- **Employee consumers may begin to make trade-offs** that will address the problem of infinite demand for healthcare services. By making up-front decisions about risks, features and prices, healthcare consumers will have an incentive to compare different treatment options (e.g., surgery versus medicine/lifestyle approaches to disease, real versus perceived differences between generic and branded pharmaceuticals, the value of so-called alternative medicine). Dictating or mandating these choices is a hopeless endeavor, but empowering consumers to make these choices for themselves could be a positive force for real change.

As with any new approach, it is easy to envision a new paradigm fully formed but the problem is that transitions don't occur magically from one mature concept to the next mature concept. The messiness in the middle is why change is hard—and some guidance in anticipation of the coming messiness seems in order.

Exhibit 4: **Risk Structure and Consumer Choice**



5-42

Implications and Counsel

Defined-contribution health benefits have structural, social and political challenges to surmount. The new paradigm will create enormous opportunities for existing and emerging players on the supply side of the equation. Even at this early stage, some of these challenges and opportunities can be anticipated:

- **Today's employment-based group underwriting approach may survive the first wave of the transition**. That is, a consumer would access a Web-based plan retailer (an "HMOs'R'Us.com," say) as a member of a specific employer or affinity group. This vestige of the old world may be necessary to avoid Darwinian underwriting that would penalize those genetically at risk and those with pre-existing conditions. Further in the future, though, assigned risk pools, non-employment-based groupings, or other innovations could be used to ensure fairness to the individual.

- **Medical savings accounts or another tax-advantaged approach may be necessary** to permit consumers to expand their risk horizons beyond a single plan year. This could, for example, permit "immortal" single males in their 20s to advance-fund their higher risk years (parenthood, middle age, etc.) with today's "excess" defined contribution.

- **Supply-side players who wait for a defined-contribution trend risk missing the boat**. The wave will crash over them and benefit the first movers, who will establish defensible long-term positions. Furthermore, those insurers who fail to prepare for a more informed, Web-savvy and health-conscious consumer will fail not only in the future world of defined contribution but in today's world as well.

- **It is not too early for insurers to begin strategizing** about their roles and value propositions in the emerging world of defined-contribution health benefits. Value chain roles (and potential niches) in manufacturing (product design/underwriting), distribution/sales, information aggregation, transactions processing, e-commerce infrastructure, etc., are all up for grabs.

- **Defined-contribution health benefits plans may lend added momentum to the existing trend toward benefits outsourcing**. Total benefits outsourcers (TBOs) are poised for further growth as companies seek ways to reduce cost. It is not too radical to think that some large

insurers may seek to forward-integrate by acquiring (or allying with) major benefits managers and/or outsourcers.

- **Large insurers may soon see the value of approaching major accounts with attractive propositions** for prototype products tailored to the new defined-contribution paradigm.

- **E-commerce players also need to begin staking out their distinctive roles**. Who will become the "HMOs'R'us.coms" of the future—the sites consumers will review to make their decisions and health benefits purchases? Will this be a pure e-tailing play, or will it require a standardized transactions platform and engine to deliver sufficient value added and a sustainable role in the new industry?

- **Healthcare providers (hospital systems, physician groups, etc.) may become bigger players in the game**, if limited-panel HMO products regain popularity and can be locally or regionally branded. E-commerce would level the playing field for these scale-disadvantaged competitors.

Conclusion

In hindsight, all revolutions appear to have been inevitable. Before they occur, though, only insurmountable obstacles can be seen. Who in 1970 would have predicted that before the end of the century tens of millions of Americans would be actively managing their retirement portfolios with home computers? We believe that employer-managed, defined-benefit health plans will be largely gone within 15 to 20 years, perhaps sooner. Their demise will seem inevitable—to winners and losers alike—in the coming transition to defined-contribution, consumer-driven health benefits. The winners, though, will be celebrating.

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

TO: House Committee on Insurance
FROM: Kathleen Sebelius, Insurance Commissioner
RE: SB 19 – Insured Woman's Access to OB/GYN care
DATE: March 8, 2001

Mr. Chairman and members of the Committee:

Thank you for the opportunity to discuss with you SB 19, which allows the health insurer to permit an insured woman to receive an annual visit to an in-network OB/GYN for routine gynecological care without requiring the insured woman to first visit to her primary care provider.

A survey completed in 1999 in Northern California revealed that of the responses from 5,164 women (age 35 years, plus) over half--56 percent--had seen a gynecologist for the last pelvic examination, only 18 percent had seen their primary care physician for the exam. In that same study, 60 percent of the women stated they preferred a gynecologist for basic gynecology care. Only 13 percent preferred their own PCP.

Yet, many women cannot easily go to an OB/GYN. Women who prefer to go to their OB/GYN, instead of their PCP for their annual pelvic examination, first have to go to their PCP, which means an extra appointment and more time. Why should women be forced to see two doctors when the only need one doctor.

The legislative movement for women to obtain direct access to OB/GYNs began in 1994 when Maryland became the first state to classify an OB/GYN as a primary care physician (PCP), and allow direct access. Since that time 42 other states have enacted OB/GYN direct access laws. While the laws vary, each gives women direct access to OB/GYNs or other women's health providers for their annual visit. Some of the laws require plans to permit qualified OB/GYNs as primary care physicians; others allow

House Comm on Ins.
March 8, 2001
Attachment # 6

420 SW 9th Street
Topeka, Kansas 66612-1678

785 296-3071
Fax 785 296-2283

Consumer Assistance Hotline
1 800 432-2484 (Toll Free)

unlimited access, or access for routine gynecological and pregnancy service only, without a referral. I have attached a list of those states passing laws or regulations allowing women direct access to OB/GYNs.

Mr. Chairman and members of the committee, there really isn't a good reason why some women should be forced to see two doctors when they only need one. This is an issue that affects the lives of the female population of Kansas. Women want the option to see a specialist in women's health throughout their lifetime. It's time to put a law on the books to insure Kansas women have access to the best health care available to them. This proposed legislation affords the opportunity to promote primary and preventive health care. I respectfully urge you to favorably pass SB 19 out of committee.

STATE INSURANCE MANDATES FOR OB-GYN PRIMARY CARE/DIRECT ACCESS, 1994-2001

[Current as of January 2001]

STATE LAWS/RULES/REGS (1994-2000) - #42	2001 ACTIONS
Laws: Alabama, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin **Department of Health and/or Insurance Rule:** New Jersey, New Mexico, Vermont, West Virginia **Implementing/Enforcement Regs:** Colorado, New York, Pennsylvania, Texas, Washington	**Pending Bills:** Kansas, Missouri, Virginia

GENERAL DESCRIPTION AND INTENT OF LAWS/ REGS (These are broad categorizations. For actual language, see individual laws, rules, or regulations.)	STATE
PRIMARY CARE *Insurers* must permit eligible ob-gyns to contract as primary care physicians thereby allowing female enrollees to select such an ob-gyn in their insurance plan as their primary care physician. Women do not have direct access unless they select an ob-gyn as their primary care physician.	CA, FL, IN, KY, NE, NJ, UT, WV
DIRECT ACCESS *Insurers* must permit female enrollees to self-refer (i.e., direct access) to a participating ob-gyn in their insurance plan for certain specified obstetric and gynecologic services without a gatekeeper's preapproval or preauthorization. Insurers are not required to permit ob-gyns to contract as primary care physicians.	AR, CA, CO, CT, FL, GA, IL, KY, LA, MD, MA, MI, MN, MO, NV, NH, NY, NC, OH, PA, RI, SC, TN, TX, UT, VA, VT, WA, WV, WI
BOTH PRIMARY CARE AND DIRECT ACCESS *Insurers* must (1) permit eligible ob-gyns to contract as primary care physicians (PCPs) thereby allowing female enrollees to select such an ob-gyn in their insurance plan as their PCP; and also (2) permit female enrollees to self-refer for their obstetric and gynecologic care. This means that women have maximum choice: They can either select an eligible ob-gyn as their PCP or, if they select a non-ob/gyn as their PCP, they can still self-refer to an ob-gyn within their plan without having to go thru a gatekeeper (although services typically are more restricted with the self-referral option). This also means that ob-gyns have maximum choice: They will not lose patient access if they choose not to contract as PCPs because women are permitted to self-refer for their obstetric and gynecologic care.	AL, DE, DC, ID, KY, ME, MS, MT, NM, OR but see also CA, FL, KY, UT and WV above; CA, FL, KY and UT have passed 2 distinct laws; WV has passed a law and a rule
STATE INSURER OPTION *Insurers* have the option under the law of permitting eligible ob-gyns to contract as primary care physicians. This means that ob-gyns may contract as primary care physicians only at the option of individual insurers; and women may select a participating ob-gyn as their primary care physician only at the option of their insurer.	CT, LA*, MD * insurer option applies to HMOs only

Planned Parenthood®
of Kansas and Mid-Missouri

TESTIMONY
in Support of Senate Bill 19

by Carla Mahany, Kansas Public Affairs Director
Planned Parenthood of Kansas and Mid-Missouri
913.312.5100, Ext. 227

House Committee on Insurance

Honorable Bob Tomlinson, Chair

Thursday, March 08, 2001

House Committee on Ins.
March 8, 2001
Attachment # 7

4401 W. 109th St., Suite 200 • Overland Park, KS 66211 • (913) 312-5100

7-1

Testimony in support of SB 19
PPKM, March 8, 2001

Thank you for this opportunity to speak to you about Senate Bill 19, which would require health insurance providers to permit women participating in their plan to visit an in-network gynecologist or obstetrician for routine gynecological care without visiting a primary care provider first. We support the amendment of the Senate Committee clarifying that an annual routine visit needs no referral by a primary care physician, and the amendment by the Senate Committee of the Whole regarding inclusion of state health plan participants.

As one of the largest providers of routine OB/GYN care in this state, and as one of the leading advocates for quality reproductive health services and better access to these services in this country, Planned Parenthood of Kansas and Mid-Missouri fully supports this legislation. Nationally, the Planned Parenthood Federation of America includes "expanded access to obstetric and gynecological care" as part of the Responsible Choices Action Agenda, our program to advocate for new policies at the federal and state levels that will advance reproductive health and decisions.

In 1999, Planned Parenthood of Kansas and Mid-Missouri had 27, 288 unduplicated family planning visits by women. These numbers include our health centers in Missouri as well as Overland Park, Lawrence, Hays, and Wichita. Nationally, our health centers saw 1,883,374 unduplicated family planning clients who were women. An initial gynecological exam at Planned Parenthood includes at least a Pap test, a pelvic and breast exam, and a blood pressure check. The care provider also listens to the heart and lungs and palpates the thyroid. A variety of health problems can be detected during this exam. Other testing and treatment available at this time include testing for vaginal and sexually transmitted infections (such as HIV), hematocrit, urinalysis, and screening for sickle cell anemia, diabetes, cholesterol and anemia. This exam can be very important, perhaps even to the point of being life-saving, for a woman who may see no other physician. That's why Planned Parenthood keeps the cost of these exams as low as possible, and requires such an exam before birth control pills or other contraceptives can be dispensed.

Another reason people come to Planned Parenthood is that we have as few barriers as possible – women can obtain an appointment for an annual gynecological exam in a matter of days. Our experience from seeing so many of these women – those with insurance and without – is that providing quick and easy access to routine gynecological exams is the best way to ensure as many women as possible get yearly preventative care. Women who have insurance plans that do set up barriers to access, such as primary care provider referral, may not ever get around to it.

There may indeed be a trend in the insurance industry to allow access to routine OB/GYN preventative health care without the extra step of gaining a referral from a primary care physician. In the case of other insurance providers, however, SB 19 is probably needed to ensure a commensurate level of access. And of course, some providers may offer easier access to routine care in some but not all of the plans they offer to employers.

The American College of Obstetricians and Gynecologists has issued a number of documents supporting legislation such as SB 19, and can make it available to any of you if you wish. We hope you will support this bill. Thank you for your consideration.

Direct Access to OB-GYNS for Women in Managed Care Plans*

Today's rapidly changing health care delivery system has, in many cases, moved too quickly to reduce costs at the expense of quality of care. As the largest consumers of health care, women often are affected disproportionately by inappropriate changes. One of the most critical issues for women continues to be access to obstetricians and gynecologists for their primary and specialty care. This issue should be considered in light of the following facts.

- **Primary-Preventive Health Care is Integral to Services Provided by OB-GYNs**
  These services include periodic health screening, evaluation and counseling about health and lifestyle risks behaviors, immunization, family planning, instruction in breast self-examination, hypertension and cardiovascular surveillance, osteoporosis counseling, smoking cessation counseling, sexually transmissible diseases counseling, risk assessment before and during pregnancy, and identification of domestic violence.

- **Women See OB-GYNs as Primary Care Physicians**
  For many women, an ob-gyn is often the only physicians they see regularly during their reproductive years. According to a 1993 Gallup poll, 54% of women aged 15-44 consider their ob-gyn to be their primary care physician, and women are more likely to have had a physical examination within the last two years from an ob-gyn than from any other type of doctor (72% vs. 57%). Because of the often unique relationship a woman may have with her ob-gyn, disruption in this important doctor-patient relationship can be a problem for many women. So much so that, in a survey of employee attitudes toward health plan design, 68% of women responded that they would be unwilling to change their ob-gyn to save money.

- **1990 ACOG/Princeton Survey Shows Plans are Keeping Women From Needed Health Care**
  Sixty percent of all ob-gyns in managed care plans reported that their gynecologic patients are limited or barred from seeing their ob-gyns without getting permission from another physician. 28% reported that their pregnant patients must first receive another physician's permission before seeing their ob-gyns. Nearly 75% of ob-gyns surveyed reported that their patients have to return to their primary care physicians for permission before they can provide necessary follow-up care.

- **OB-GYNs Provide More Preventive Services for Women**
  According to the Commonwealth Fund, "preventive care is better when women have access to ob-gyns." The Fund's 1993 Survey of Women's Health found that the number of preventive services received by women, including complete physical exam, blood pressure reading, blood cholesterol test, clinical breast exam, mammogram, pelvic exam, and pap smear, is higher for women whose regular doctor is an ob-gyn versus other primary care physicians.

- **Americans Overwhelmingly Support Passage of Direct Access Legislation**
  A 1998 survey conducted by the Kaiser Family Foundation and Harvard University found that 82% of Americans support direct access legislation—63% even if their health insurance costs increase.

- **Requiring All HMOs to Allow Women Direct Access Costs Just Pennies Per Year**
  An April 1998 cost analysis conducted by Coopers & Lybrand found that requiring all HMOs to allow direct access to ob-gyns for routine and preventive services will raise an individual's health insurance premium by only 12 cents a year. This analysis, based on interviews with health plan representatives, concludes that there is "little expected cost of this provision." The Congressional Budget Office estimated the cost of direct access and primary care by ob-gyns as only 0.1% of the premiums, or $1 million in the first year.

*Compiled from materials prepared by the American College of Obstetricians and Gynecologists.

KANSAS MEDICAL SOCIETY

TO: House Committee on Insurance

FROM: Chris Collins
Director of Government Affairs

DATE: March 8, 2001

RE: SB 19: Direct Access to OB/GYN

Chairman Tomlinson and Members of the Committee:

The Kansas Medical Society appreciates the opportunity to appear before you today in support of SB19. KMS supports this measure primarily because it encourages the efficient use of health care resources without sacrificing the quality of patient care.

SB19 codifies the already fairly common practice of permitting a woman to directly access care by her OB/GYN without the need for prior authorization from her primary care provider. OB/GYN services are those most frequently sought by women in good health in their child-bearing years. Without the protection afforded by SB19, health plans have the ability to require that a woman attend two office visits -- first, to her primary care physician, and then to her OB/GYN. This can be a time-consuming and frustrating process for patients, presenting an impediment to receiving the health care they desire. SB19 streamlines the health care delivery process by eliminating the need for the first, often unnecessary, office visit. Even if an office visit to the primary care physician is not mandatory, health plans frequently require a written referral from the primary care provider to the OB/GYN. This bill also contains a provision to eliminate that requirement, which means that medical office staff no longer need to devote their time and resources to writing a referral. A woman will no longer need to run a gauntlet of formalities before accessing her health care provider of preference.

SB19 achieves the goal of increased access in a reasonable manner. The bill permits direct access only to an in-network OB/GYN and limits such visits to one per year. Furthermore, it requires that an OB/GYN confer with a patient's primary care provider prior to performing a diagnostic procedure that is not routinely undertaken in a gynecological exam. This ensures communication between the providers about other health care concerns and allows the primary care provider to follow up and/or treat accordingly.

SB19 simply codifies a practice that is routinely done in the health care insurance industry. It ensures that health care resources are efficiently utilized and does not sacrifice the quality of care that patients receive. For these reasons, KMS respectfully urges this committee to recommend SB 19 favorable for passage. Thank you for the opportunity to testify today. I would be pleased to answer any questions.

Kansas Association of Insurance Agents

623 SW 10th Ave. • Topeka KS 66612–1627 • 785.235.2383 • 800.332.0156 • FAX 785.235.5114
Western Kansas office • PO Box 354 • Hays KS 67601 • 785.625.8215 • FAX 785.625.8234

March 8, 2001
Attachment #8

.0National Council
Of Jewish Women

NCJW
Greater Kansas City Section

March 8, 2001

Testimony of Barbara Holzmark, Kansas Public Affairs Chair
National Council of Jewish Women, Greater Kansas City Section
8504 Reinhardt Lane, Leawood, Kansas 66206
(913)381-8222, Fax: (913)381-8224, E-Mail: bjbagels@aol.com

Re: SB 19

Representative Tomlinson and Members of the House Insurance Committee,

My name is Barbara Holzmark and I am the Kansas Public Affairs Chair for the Greater Kansas City Section of the National Council of Jewish Women (NCJW). We are nearly 1000 members strong in the metropolitan Kansas Ctiy area with 200 sections across the United States and 90,000 members nationwide.

I write to you in favor of SB 19.

The mission of NCJW, a volunteer organization inspired by Jewish values, is to work through a program of research, education, advocacy and community service to improve the quality of life for women, children and families and strives to ensure individual rights and freedoms for all.

To accomplish our mission NCJW works to advance the well-being and status of women, children and families and to ensure individual and civil rights. We believe in equal rights and equal opportunities for women, human rights and dignity, and quality, comprehensive, nondiscriminatory health care coverage and services which are accessible and affordable for all. These are principles that must be guaranteed for all individuals. In order to ensure individual and civil rights, we advocate for the protection of every individual's right to privacy, and every female's right to reproductive choice and reproductive freedom.

The position of NCJW is that any woman should be allowed to visit an obstetrician or gynecologist, without a referral first, for the basic reason that it is **routine** to her health. She is allowed to visit a dentist for this same reason without a primary care provider referral. As basic as it is, an Ob-gyn **is** the primary care provider for a woman! Personally, this is the first doctor my mother took me to see when I outgrew my pediatrician, while another routine visit was to my dentist. Once I married, it was the Ob-gyn that I was concerned with, not my "primary care provider." My concern was that my insurance covered this particular doctor and that all I had to do was call and set an appointment. It is not unheard of for a young woman to be diagnosed with "female" cancers and through easy access and annual routine exams, women have confidential, quality, comprehensive reproductive freedom and reproductive health care. This is the only doctor a woman sees on a regular basis, and she must have accessibility and be covered in an insurance plan that is available to her without any barriers. All women should have the right to privacy through laws that provide for annual obstetrical and gynecological care. I urge you to vote favorably on SB 19. Thank you for considering my testimony.

House Insurance Committee
March 8, 2001
Attachment # 9

Kansas Association of Health Plans

1206 SW 10th Street
Topeka, KS 66604

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

Written Testimony prepared for the House Insurance Committee

Hearing on SB 19
March 8, 2001

Chairman Tomlinson and members of the Committee. Thank you for allowing me to submit testimony 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 who support managed care. KAHP members serve all of the Kansans enrolled in a Kansas licensed HMO. KAHP members also serve the Kansans enrolled in HealthWave and medicaid HMO's and also many of the Kansans enrolled in PPO's and self insured plans. We appreciate the opportunity to provide written comment on Senate Bill 19.

The KAHP is opposed to SB 19. This bill mandates that a health insurer allow a woman to visit an in-network obstetrician or gynecologist for routine gynecological care, once a year without a referral.

As we stated last year, all Kansas HMO's currently allow a woman to visit an OB-Gyn for routine gynecological care once a year without a referral. This routine visit is a covered benefit not because the government has demanded that we allow the visit, but because this is what the marketplace has demanded of us. Please find attached an example of how some managed care plans actually encourage insureds to seek a routine gynecological exam once a year.

The KAHP would request that you continue to allow us to meet the demands of the marketplace rather than enacting an unnecessary piece of legislation.

Finally, for policy and procedural reasons, if you feel this is a necessary mandate then we would strongly suggest that this legislation first be subject to the provisions of K.S.A. 40-2249a. This statute which was passed two years ago, requires the testing of any new mandate first on the state employees health plan.

I would also like to point out a question we had in analyzing this bill:

1. Section 1(a)(2) requires the obstetrician or gynecologist to confer with the woman's primary care provider before performing any non routine diagnostic procedure. We question how that provision would be enforced, and what relevance it would have to indemnity coverage which is also subject to this mandate.

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Therefore, should the Committee decide to pass this legislation, we would like to offer the attached amendment. The amendment simply deletes the section regarding the unenforceable requirement that the OB-Gyn confer with the primary care provider before performing any non-routine care.

Thank you for your time in considering this issue. I'll be happy to try to answer any questions the Committee may have.

10-3

[As Amended by Senate Committee of the Whole]

As Amended by Senate Committee

Session of 2001

SENATE BILL No. 19

By Committee on Financial Institutions and Insurance

1-10

AN ACT concerning health insurance; relating to gynecological care.

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

Section 1. (a) Each health insurer ***[and the state health care benefits program]*** shall permit a woman insured by the health insurer ***[or such program]*** to visit an in-network obstetrician or gynecologist for routine gynecological care from an in-network obstetrician or gynecologist ~~at least~~ one time each calendar year without requiring such woman to first visit ***or receive a referral from*** a primary care provider, so long as ~~[~~ the ~~(1) The]~~ care is medically necessary, including, but not limited to, care that is routine ~~[and~~

~~(2) the obstetrician or gynecologist confers with such woman's primary care provider before performing any diagnostic procedure that is not routine gynecological care rendered during any such visit.]~~

. (b) This section shall be part of and supplemental to the patient protection act, cited at K.S.A. 40-4601 *et seq.*, and amendments thereto.

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

Postcard
#1

HUMANA Health
Improving the health of our members.

Understanding your needs.

We understand that women have unique needs. The following information addresses preventive care and health issues relating only to women. Schedule a visit with your doctor and ask how you can make preventive care a part of your healthy lifestyle.

Entendiendo sus necesidades.

Nosotros comprendemos que las mujeres tienen necesidades únicas. La siguiente información se refiere al cuidado preventivo y asuntos de salud que atañen sólo a las mujeres. Programe una visita a su médico y pregúntele cómo puede hacer del cuidado preventivo una parte integral de su estilo de vida saludable.

Regular PAP smears are key to good health.

Having a PAP smear is one of the most successful ways to detect conditions affecting women only. Your doctor can identify certain problems even before you have symptoms - and offer the appropriate treatment. Ask your doctor if you are due for a PAP smear.

Un cuidado regular de los pies le puede manten.

Una prueba de Papanicolau es una de las más exitosas maneras de detectar condiciones médicas que afectan a las mujeres solamente. Su médico puede identificar ciertos problemas - y ofrecerle el tratamiento apropiado. Pregúntele a su médico si ya es hora de que le hagan una prueba de Papanicolau.

A mammogram could save your life.

A yearly mammogram is very important to your health. In fact, this simple test can reveal breast cancer at the earliest stages, when it is most successfully treated.

Una mamografía puede salvarle la vida.

Una mamografía anual es muy importante para su salud. De hecho, esta sencilla prueba puede detectar el cáncer de seno en sus primeras etapas, cuando se le puede tratar con mayor éxito.

Call your doctor today and schedule your preventive care exams.

Llame a su médico hoy mismo y haga citas para sus exámenes de cuidado preventivo.

Simple changes bring great rewards.

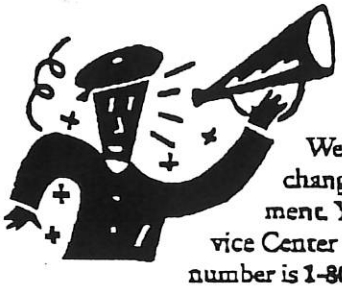
A few changes in your daily routine can improve your quality of life. When you eat a nutritious diet and exercise regularly, you can reduce your risk for many major diseases. Exercise, such as walking or dancing, may also lower your risk for developing osteoporosis. Other ways to prevent osteoporosis are to take calcium supplements and avoid smoking. Your doctor may also suggest hormone replacement therapy. Ask your doctor to help you create a diet and exercise program that's best suited to your total health needs.

Cambios sencillos le pueden recompensar en grande.

Unos cuantos cambios en su rutina diaria pueden mejorar su calidad de vida. Cuando usted lleva una dieta nutritiva y hace ejercicio con regularidad, puede reducir su riesgo de contraer muchas enfermedades graves. El ejercicio como caminar o bailar también puede reducir su riesgo de desarrollar osteoporosis. Otras maneras de prevenir la osteoporosis son tomar suplementos de calcio y evitar fumar. Su médico también podría sugerirle terapia de reemplazo hormonal. Pídale a su médico que le ayude a diseñar el programa de dieta y ejercicio más apropiado para todas sus necesidades de salud.

HUMANA.

Summer 1997



New Number and Hours for Customer Service

We are pleased to announce a big change in our Customer Service department. You can now call our Customer Service Center at our new, centralized location. The number is **1-800-4-HUMANA (1-800-448-6262)**.

With our new Customer Service Center, we expand our hours and provide more staff to better serve your needs. We will also be able to solve problems faster, since the new service center is also responsible for processing your claims. Customer Service representatives will be able to enter corrections or additional information into your records. The new Customer Service hours are Monday through Friday, from 8 A.M. to 9 P.M., and Saturday, from 8 A.M. to 1 P.M.

For your convenience, we have provided you with two cards with the new Customer Service number and hours, and the mailing address for claims. The cards are on the insert between pages 16 and 17 of this issue of *Health Journal*. Simply cut the cards out and place one in your wallet and one near your telephone at home.

Our new Customer Service Center is just one of the ways that we are working to improve service to you. We will continue to work hard to provide improved health plan products and services so that we may continue to earn your support.

Your Well-Woman Benefits

If you are a female HMO member, you can now schedule your annual well-woman examination with either your primary care physician (PCP) or a participating Humana gynecologist. You do not need a referral to see a gynecologist for this exam, as long as he or she participates with Humana. Your gynecologist will report his or her findings and recommendation to your Humana PCP. The well-woman exam may include a Pap smear and a mammogram.

As part of your well-woman benefit, we also send you a birthday card to remind you to get your annual well-woman checkup. This special greeting is our way of reminding you of the importance of these screenings. You also receive an educational pamphlet on breast self-examination in the mail. Remember, most women should have a Pap test every three years and a mammogram every two years.

We hope that this expanded benefit will make it easier for you to schedule your well-woman examination. These examinations play an important part in detecting cancers and diseases early, when they are easiest to treat.

Health Journal is published four times a year (March, June, September, and December) by Humana Health Care Plans, with executive offices at Suite 200, 10450 Holmes, Kansas City, MO 64131, in cooperation with Mosby Consumer Health, 283 Summer St., Boston, MA 02210.

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Kansas City, MO 64131-3471

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Members newsletter

The Kansas Choice Alliance

Aid for Women
American Association of University Women - Baldwin Branch
American Association of University Women - Kansas
American Association of University Women - Shawnee Mission Branch
American Civil Liberties Union of Kansas and Western Missouri
Jewish Community Relations Bureau/American Jewish Committee
Jewish Women International
Kansas Religious Leaders for Choice
KU Pro-Choice Coalition
League of Women Voters of Johnson County
League of Women Voters of Kansas
League of Women Voters of Wichita-Metro
MAINstream Coalition
MO-KAN Choice Coalition
National Council of Jewish Women, Greater Kansas City Section
National Organization for Women, Johnson/Wyandotte County Chapter
National Organization for Women, Kansas Chapter
National Organization for Women, Kansas City Urban Chapter
National Organization for Women, Lawrence Chapter
National Organization for Women, Manhattan Chapter
National Organization for Women, Wichita Chapter
Planned Parenthood of Kansas & Mid-Missouri
Pro-Family Catholics for Choice
Wichita Family Planning
Women's Health Care Services
YWCA of Wichita

Testimony in Support of Senate Bill 19

House Insurance Committee

The Honorable Bob Tomlinson, Chair
Thursday, March 8, 2001

Thank you for the opportunity to submit this testimony in support of SB 19. This legislation facilitates a woman's routine gynecological care by allowing her to visit an approved obstetrician or gynecologist annually without a referral from her primary care doctor. It also requires that the primary care doctor be consulted before any non-routine gynecological care is given.

I had hoped that this legislation would allow a woman to visit her OB/GYN for other care without a referral – for example, in the case of possible exposure to a sexually transmitted disease when a delay could be serious.

Nevertheless, this legislation would make it easier and less expensive for women to obtain routine health care. We strongly support SB 19 because would save women time and money and is efficient for doctors and insurers as well. We urge passage of SB 19.

Submitted by Barbara Duke
President, Kansas Choice Alliance

On behalf of the Kansas Choice Alliance
and American Association of University Women - Kansas

The Kansas Choice Alliance
902 Pamela Lane - Lawrence, KS 66049-3020

Louise Cowan on behalf of Barbara Duke
March 8, 2001
Attachment #11

National Organization for Women
KANSAS Chapters
Lawrence Manhattan/KSU Wichita JO/Wy Counties
PO Box 15531 Lenexa, KS 66285 913 384 7900

March 8, 2001

Testimony in Support of SB 19

Dear Chair Tomlinson and Committee Members:

The Lawrence Chapter of the National Organization for Women, along with the other state chapters of Kansas NOW, recognizes the need for women to have primary access to their Obstetrician/Gynecologist (OB/GYN) as they would their primary care generalist or internist. We hope that the legislature will provide a mandate for insurers to provide for immediate access to OB/GYN care without needing to obtain referral by another health care professional.

A woman who seeks birth control should not be made to wait through the lengthy referral process. Nor is the family practitioner the doctor best able to determine her specific birth control needs.

From the commencement of sexual activity, or by the age of 18, whichever is earlier, the AMA has proscribed that women need to get regular pelvic examinations, pap smears and medical history appropriate breast cancer checks, from OB/GYNs who are best able to treat their reproductive system conditions.

With the availability of today's over-the-counter pregnancy tests, a woman can determine in her home in a matter of minutes whether or not she is pregnant. When she has direct access to her OB/GYN, she can begin a pregnancy regime, which will optimize the chances for a safe pregnancy and healthy child. To delay the beginning of pregnancy support by the month or more that the referral appointment, examination process policy of some insurers, would preclude the early pregnancy support that current medical science understands reduces the incident of birth defects, high risk infants, complications and maternal fatality.

Women who suspect they have contracted a sexually transmitted disease, or who are having irregular or difficult menses or other reproductive system symptoms are best served by direct access to their OB/GYN, so they can receive the fastest and most effective treatment possible.

Allowing a woman to have primary contact with an OB/GYN without referral increases the probability of a higher likelihood of developing a relationship with a single doctor who will understand her history and particular health circumstances when she becomes pregnant or another condition needs need immediate treatment. In this way women can be given the fastest and most appropriate treatment possible.

The conditions women experience through their reproductive systems are no more important than the conditions of any other system of the body. The difference is that they are predictable occurrences in every woman's life. And, while women support the responsibility for family planning more than men, they require the medical access to this specialty where a similar need is not predictable in men's lives.

Most insurers wisely recognize the benefit of allowing women access to OB/GYNs in the same direct way they access their primary care physicians. Preliminary examinations and/or the referral process are time consuming, bothersome, and costly in health and dollars for all involved.

That any woman should face unnecessary delays that might cost her health and the health of her future children and/or sexual partners because of the frustrations of a burden-some healthcare policy of mandated referrals seems ridiculous. We feel ensuring availability of direct access to OB/GYNs by women is good public health policy that needs to be reinforced, in the age of managed care, by good law.

Thank you for your efforts to serve women's health.

House Committee on Ins
March 8, 2001
Attachment # 12

Submitted by Sylvie Rueff
Lawrence Chapter NOW

Session of 2001

HOUSE BILL No. 2473

By Committee on Federal and State Affairs

2-9

AN ACT concerning life insurance companies; relating to replication transactions; amending K.S.A. 40-2b25 and repealing the existing section.

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

Section 1. K.S.A. 40-2b25 is hereby amended to read as follows: 40-2b25. (a) Any life insurance company heretofore or hereafter organized under any law of this state may use financial instruments under this section to engage in hedging transactions , *replication transactions* and certain income generation transactions or as these terms may be further defined in regulations promulgated by the commissioner. ~~The~~ *For each hedging transaction in which a life insurance company engages, such* life insurance company shall be able to demonstrate to the commissioner the intended hedging characteristics and the ongoing effectiveness of the financial instrument transaction or combination of the transactions through cash flow testing or other appropriate analysis.

(b) As used in this section:

(1) "Cap" means an agreement obligating the seller to make payments to the buyer, each payment based on the amount by which a reference price or level or the performance or value of one or more underlying interest exceeds a predetermined number, sometimes called the strike rate or price.

(2) "Collar" means an agreement to receive payments as the buyer of an option, cap or floor and to make payments as the seller of a different option, cap or floor.

(3) "Counterparty" means the business entity with which a life insurance company enters into financial instrument transactions.

(5) [(4)] "Crediting basis amount" means the amount of interest credited to an insured's account value for the percentage of change on an underlying index.

(6) [(5)] (A) "Financial instrument" means an agreement, option, instrument or any series or combination thereof:

(i) To make or take delivery of, or assume or relinquish, a specified amount of one or more underlying interests, or to make a cash settlement in lieu thereof; or

"Commissioner" means the commissioner of insurance as defined in K.S.A. 40-102 and amendments thereto.
(4)

Senate Comm. INS
March 8, 2001
Attachment #13
13-1

(ii) which has a price, performance, value or cash flow based primarily upon the actual or expected price, level, performance, value or cash flow of one or more underlying interests.

(B) Financial instruments include options, warrants, caps, floors, collars, swaps, forwards, future and any other agreements, options or instruments substantially similar thereto, or any series or combination thereof.

[(6)] "Financial instrument transaction" means a transaction involving the use of one or more financial instruments.

[(7)] "Floor" means an agreement obligating the seller to make payments to the buyer in which each payment is based on the amount that a predetermined number, sometimes called the floor rate or price, exceeds a reference price, level, performance or value of one or more underlying interests.

[(8)] "Forward" means an agreement (other than a future) to make or take delivery of, or effect a cash settlement based on the actual or expected price, level, performance or value of one or more underlying interests.

[(9)] "Future" means an agreement traded on a qualified exchange, to make or take delivery of, or effect a cash settlement based on the actual or expected price, level, performance or value of one or more underlying interests.

[(10)] "Hedging transaction" means a financial instrument transaction which is entered into and maintained to reduce:

(A) The risk of a change in the value, yield, price, cash flow or quantity of assets or liabilities which the insurer has acquired or incurred or anticipates acquiring or incurring; or

(B) the currency exchange-rate risk or the degree of exposure as to assets or liabilities which an insurer has acquired or incurred or anticipates acquiring or incurring.

[(11)] "Income generation transaction" means a financial instrument transaction involving the writing of covered call options which is intended to generate income or enhance return.

[(12)] "Option" means an agreement giving the buyer the right to buy or receive, sell or deliver, enter into, extend or terminate, or effect a cash settlement based on the actual or expected price, level, performance or value of one or more underlying interests.

[(13)] "Potential exposure" means:

(A) As to a futures position, the amount of the initial margin required for that position; or

(B) as to swaps, collars and forwards, .5% times the notional amount times the square root of the remaining years to maturity.

[(14)] *"Replication transaction" means a [derivative] transaction or combination of [derivative] transactions effected either separately or in con-*

financial instrument

financial instrument

junction with cash market investments included in a life insurance company's investment portfolio in order to replicate the investment characteristic of another authorized transaction, investment or instrument or operate as a substitute for cash market transactions. A [derivative] transaction entered into by a life insurance company as a hedging transaction, as defined in paragraph [10] or income generation transaction, as defined in paragraph [11], authorized pursuant to this section shall not be considered a replication transaction.

[(15)] "SVO" means the securities valuation office of the national association of insurance commissioners or any successor office established by the national association of insurance commissioners.

~~(15)~~ [(16)] "Swap" means an agreement to exchange for net payments at one or more times based on the actual or expected price, level, performance or value of one or more underlying interests.

~~(16)~~ [(17)] "Underlying index" means the index, market or financial futures contract used to determine the crediting basis amount.

~~(17)~~ [(18)] "Underlying interest" means the assets, other interests, or a combination thereof, underlying a financial instrument, such as any one or more securities, currencies, rates, indices, commodities or financial instruments.

~~(18)~~ [(19)] "Warrants" means an option to purchase or sell the underlying securities or investments at a given price and time or at a series of prices and times outlined in the warrant agreement. Warrants may be issued alone or in connection with the sale of other securities, as part of a merger or recapitalization agreement, or to facilitate divestiture of the securities of another corporation.

(c) A life insurance company may enter into financial instrument transactions for the purpose of hedging except that the transaction shall not cause any of the following limits to be exceeded:

(1) The aggregate statement value of options, caps, floors and warrants not attached to any other security or investment purchase in hedging transactions may not exceed 110% of the excess of such insurer's capital and surplus as shown on the company's last annual or quarterly report filed with the commissioner [of insurance] over the minimum requirements of a new stock or mutual company to qualify for a certificate of authority to write the kind of insurance which the insurer is authorized to write;

(2) the aggregate statement value of options, caps and floors written in hedging transactions may not exceed 3% of the life insurance company's admitted assets; and

(3) the aggregate potential exposure of collars, swaps, forwards and futures used in hedging transactions may not exceed 5% of the life insurance company's admitted assets.

(d) A life insurance company may enter into the following types of

(11) → [financial instrument

(12)

(16) (17) (18) (19) (20)

income generation transactions if:

(1) Selling covered call options on noncallable fixed income securities or financial instruments based on fixed income securities, but the aggregate statement value of assets subject to call during the complete term of the call options sold, plus the face value of fixed income securities underlying any financial instrument subject to call, may not exceed 10% of the life insurance company's admitted assets; and

(2) selling covered call options on equity securities, if the life insurance company holds in its portfolio the equity securities subject to call during the complete term of the call option sold.

(e) *A life insurance company may enter into replication transactions if:*

(1) Such life insurance company would otherwise be authorized to invest its funds under this article in the asset being replicated;

(2) the asset being replicated is subject to all provisions and limitation (including quantitative limits) on the making thereof specified in this article with respect to investments by such life insurance company, as if the transaction constituted a direct investment by such life insurance company in the asset being replicated; [and]

(3) as a result of giving effect to the replication transaction, the aggregate statement value of all assets being replicated does not exceed 10% of such life insurance company's admitted assets;

; and

(4) the replication transaction is entered into in accordance with the requirements concerning replication transactions contained in the SVO purposes and procedures manual of the SVO entitled "Purposes and procedures manual of the securities valuation office of the national association of insurance commissioners" as published on December 31, 1999, or any later version as established in rules and regulations adopted by the commissioner.

(f) The limitations set forth in subsection (c) regarding financial instrument transactions for the purpose of hedging and in subsection (d) regarding income generation transactions shall not apply to any investments made by a life insurance company where such investments are used only to hedge the crediting basis amount an insured receives on a particular insurance policy which is determined by an underlying index, provided, however, that such investments shall not in the aggregate amount exceed 10% of the life insurance company's admitted assets as shown on the company's last annual or quarterly report, without the prior written approval of the commissioner [of insurance]. All investments made pursuant to this subsection shall only be made with counterparties that have a rating designated as "1" by the national association of insurance commissioners (NAIC) in its most recently published valuations of securities manual or supplement thereto, or its equivalent rating by a nationally recognized statistical rating organization recognized by the SVO.

~~(f)~~ *(g)* Upon request of the life insurance company, the commissioner may approve additional transactions involving the use of financial instruments in excess of the limits of subsection (c) or for other risk management purposes~~, excluding replication transactions~~, pursuant to regulations promulgated by the commissioner.

~~(g)~~ *(h)* For the purposes of this section, the value or amount of an

investment acquired or held under this section, unless otherwise specified in this code, shall be the value at which assets of an insurer are required to be reported for statutory accounting purposes as determined in accordance with procedures prescribed in published accounting and valuation standards of the national association of insurance commissioners (NAIC), including the purposes and procedures of the securities valuation office, the valuation of securities manual, the accounting practices and procedures manual, the annual statement instructions or any successor valuation procedures officially adopted by the NAIC.

~~(h)~~ *(i)* Prior to engaging in transactions in financial instruments, an insurer shall develop and adequately document policies and procedures regarding investment strategies and objectives, recordkeeping needs and reporting matters. Such policies and procedures shall address authorized investments, investment limitations, authorization and approval procedures, accounting and reporting procedures and controls and shall provide for review of activity in financial instruments by the insurer's board of directors or such board's designee.

Recordkeeping systems must be sufficiently detailed to permit internal auditors and insurance department examiners to determine whether operating personnel have acted in accordance with established policies and procedures, as provided in this section. Insurer records must identify for each transaction the related financial instruments contracts.

Sec. 2. K.S.A. 40-2b25 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

(j) The commissioner shall have the authority to adopt rules and regulations necessary to implement this section.