Approved: February 8, 2005
Date

MINUTES OF THE SENATE FINANCIAL INSTITUTIONS AND INSURANCE

The meeting was called to order by Chairman Ruth Teichman at 9:30 A.M. on January 26, 2005 in Room 234-N of the Capitol.

Committee members absent: Vicki Schmidt- excused

Committee staff present: Melissa Calderwood, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Ken Wilke, Office of Revisor of Statutes
Sandy Yingling, Committee Secretary

Conferees appearing before the committee: Dr. Richard Warner, KMS Second Vice President
Greg Scandlen, The Galen Institute

Others Attending: See attached list.

Madam Chair opened the meeting by taking bill introductions:

Larry McGill, representing The Kansas Association of Insurance Agents introduced an amendment to KSA 40-905 relating to fire insurance companies. Real Property shall not be issued for more than its replacement cost. (Attachment 1)

Senator Barnett moved the introduction of the bills, the motion was seconded by Senator Barone. The motion carried.

Madam Chair asked for other bill introductions, there were none.

Madam Chair turned the meeting over to Senator Barnett who arranged the speaker for the day. Senator Barnett introduced Dr. Richard Warner who spoke briefly giving a summary on his background stating he is the former president of the Johnson County Medical Society and First Vice President of the Kansas Medical Society. Dr. Warner brought an article that was published two years ago in the Kansas Position Newsletter on the subject of medical employee benefits. Dr. Warner then introduced Greg Scandlen, Director of the Center for Consumer Driven Healthcare at The Galen Institute who presented HSAs: The Progress of Consumer Driven Health. (Attachment 2)

Mr. Scandlen gave a brief introduction of himself and proceeded with his presentation. He began by defining HRA (Health Reimbursement Arrangements), a term explained by the IRS in June, 2002 and HSA (Health Savings Accounts) that passed as part of the Medicare Reform bill last year. HRA is employer money that can never be owned by the individual. It can be for any amount of money and go with any kind of health insurance plan. HSAs are aimed towards individuals and small groups. HSAs are required to go with a high deductible health plan. It is just a savings account that both the employer and employee puts monies into and draws money to pay for the workers share of coverage of the deductibles among other reasons. It is limited to the amount of the deductible and can build up year after year tax free. The funds belong to the employee who has total control over the money and how it is invested and set up his/her own account administrator. The employer has no control over the funds after the contribution, it is the worker's money and no one else. If the employer should withdraw the money and spend it on non-medical services a 10% penalty and taxes will be applied.

Upon conclusion of Mr. Scandlen's testimony, Madam Chair asked him to explain how HSAs worked in connection with financial institutions.

Mr. Scandlen explained in most cases the insurance company will provide the high deductible health plan and the financial institution will provide the savings account administration.

Madam Chair recognized Senator Barnett who inquired on how the plan could be maximized for state employees and Mr. Scandlen answered that the HSA plan could be maximized through state employee groups by setting the standard for other employees. They could have either HSA or HRA to help with

retirement expenses. Senator Barnett inquired as to the helpfulness to low wage earners, to which Mr. Scandlen answered the out of pocket expense to the individual is not that much different. The opportunity is that there is build-up money.

Senator Barnett inquired in regard to the Business Health Partnership in Kansas and the opportunity to target small business and the supplement fund from tobacco tax. Was there a way to marry that with HSA and Business Health partnership? Mr. Scandlen stated that he would discourage that because it would not be solving the problem of affordability and personal ownership. Senator Barnett explained that these were small businesses who cannot provide insurance and they would try to encourage them to provide a HSA option or some opportunity to encourage the employer to provide a HSA option and questioned if Mr. Scandlen would discourage that. Mr. Scandlen stated that he would discourage that, he stated he would rather spend that energy and money helping the individual workers to buy their own coverage. Dr. Warner disagreed with Mr. Scandlen he believes it would make perfect sense to wed them.

Senator Wysong questioned how the HSA works as a deductible on an individual's income tax and Mr. Scandlen pointedly answered no, it would not be a deduction.

Senator Steineger inquired what percent of GNP (Gross National Product) did this country spend on health care and Mr. Scandlen answered 14%. Senator Steineger asked what percent of health care costs are spent on administration and Mr. Scandlen answered approximately 25%. Senator Steineger asked what are the estimations on administrative fees per account on HSA and were the fees paid outside of the contribution or is it deducted from the HSA, Mr. Scandlen pointed out that there is no set amount. Some might be per transaction charge and other might be a set-up fee with small charges thereafter and typically it would be taken from the agency. Senator Steineger pointed out with this arrangement right away some of the health monies would be lost for administration. Senator Steineger asked if there were estimates for total revenue that would be generated to financial firms to manage these accounts? Mr. Scandlen said he had not seen any estimates and would depend on how many people sign up. Lastly, Senator Steineger wanted to know how would a HSA dissuade people from smoking, over eating and other health risk problems. Mr. Scandlen said that by having the individual more involved in their own health care decisions begins to help them understand better everything about health care.

Senator Brownlee questioned what percent of buyers of HSAs are uninsured, and Mr. Scandlen answered approximately 30%. Senator Brownlee pointed out that the allowable amount compared to the amount the healthcare provider charges differs considerably and her question was how would she be charged if she had an HSAs, the higher or lesser amount? Mr. Scandlen said the way individuals are billed is shocking and changes need to be made. Lastly, Senator Brownlee asked Mr. Scandlen to comment on AHP (Associate Health Plan), Mr. Scandlen said they get the highest risk, because the healthiest groups can go out of the association and buy coverage on their own at a more favorable rate. The advantage of AHPs is it would allow the federal government to preempt some of the state regulations. He does believe there is a need for deregulation in insurance.

Senator Brungardt's curiosity about the roll of the uninsured and if they would have a car wreck and incur a huge medical expense prompted him to ask how important are they to the big picture and how do you include them economically? Mr. Scandlen believes the 45 million uninsured most of which are full time working, intelligent people is a market of opportunity not a crisis. He stated the uninsured is a very attractive population without a lot of money that should be targeted with health care product that would be of value and at least up until HSAs came along, that it has not been done. Senator Brungardt pointed out that it is often said that when the uninsured seek care it is the least efficient and highest priced and that this is a big drag on the system. Mr. Scandlen believes that is an overstatement. He quoted an article in Health Affairs that tried to quantify that fact. They published that uninsured used approximately 90 billion dollars in health care services and out of that the individual paid directly from their own pocket about 1/3 of that amount, 1/3 was paid by government qualifying programs and 1/3 was paid through uncompensated care, i.e. the hospitals, etc. About 35 million dollars was hospital uncompensation which represented approximately 3 ½ % of total health spending in the country.

Senator Wilson questioned if America was ready for a major shift and change in saying we are ready to

take personal responsibility of and start eating and exercising better. Mr. Scandlen stated he has no data on this, but quoted a study by Harvard done over five countries with different systems and summarized that it is time for policy to catch up to the people.

Senator Barnett asked Mr. Scandlen's thoughts on policy proposals to expand the Medicaid system. Mr. Scandlen simply stated that Medicaid was a "lousy program" and why would anyone want to expand it, that money would be better spent by helping individuals find coverage of their own.

Madam Chair thanked Mr. Scandlen and Dr. Warner for testifying.

Meeting was adjourned at 10:32 a.m.

FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST
DATE: January 26, 2025

NAME	REPRESENTING
Bill Snead	State Farm
MATT HANSON	Sen. Dennis Wilson
Katie Gonzales	Federico Consulting
[illegible]	KID
LARRY MAGILL	KAIA
DANIEL MAGILL	KAIA
Hal Hudson	NFIB/KS – Topeka
Ron Gaches	GBBA
Linda McCarthy	Health Care Cmsn.
Chris Ballard	County Health Care
Akiko Motegi	Intern
Rebecca Bailey	KMS
Jerry Slaughter	KMS

40-905

Chapter 40.--INSURANCE
Article 9.--GENERAL PROVISIONS
RELATING TO FIRE INSURANCE COMPANIES

40-905. Statement of value in policy; evidence of ownership of property; exceptions. (a) Whenever any policy of insurance or an increase in the amount of coverage in an existing policy of insurance shall be written to insure any improvements upon real property in this state against loss by fire, tornado, windstorm or lightning, and the property insured shall be wholly destroyed, without criminal fault on the part of the insured or the insured's assigns, the amount of insurance written in such policy shall be taken conclusively to be the true value of the property insured, and the true amount of loss and measure of damages, and the payment of money as a premium for insurance shall be prima facie evidence that the party paying for such insurance is the owner of the property insured. _____

(b) The provisions of subsection (a) shall not apply to:

(1) New policies of fire insurance or existing policies of fire insurance where there has been an increase in the amount of coverage of 25% or more, until such policies have been in effect for at least 60 days. If there is a total loss by fire within the sixty-day period and the insurer pays less than the face value of the policy, the insurer shall refund the difference in premium between the amount of insurance purchased and the premium applicable for the amount of the loss actually paid. This paragraph shall not apply to a loss by fire caused by lightning.

(2) Builder's risk policies of insurance covering property in the process of being constructed. The value of the property insured shall be the actual value of the property at the time of the loss.

History: L. 1927, ch. 231, 40-905; L. 1981, ch. 192, § 1; July 1.

Real property shall not be insured for more than its replacement cost as determined by recognized appraisal method or service. Nothing herein shall prohibit as insurer from offering an inflation guard endorsement on a replacement cost policy.

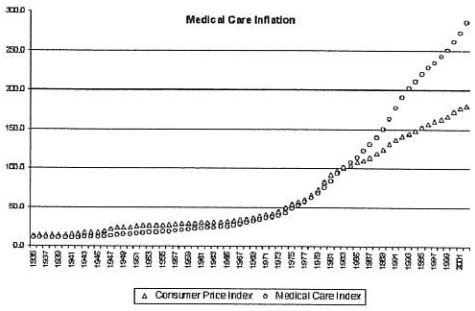
Attachment 1
1-26-05
FII

Medical care inflation

Richard Warner, MD: KMS Second Vice President

The number of American people who do not have health insurance coverage is a matter of great concern to policymakers. We hear increasing calls for adoption of some plan for universal health coverage. Last winter the American Medical Association adopted a resolution calling for health coverage for all Americans by 2009. Politicians at both the presidential and the congressional levels are offering variations on the same theme.

As health care has become so expensive, people have come to rely as much as possible on insurance to finance their care. As universal coverage is made into an absolute value, attention is focused on questions of who would provide the insurance. Would it be a government monopolized "single payer" system? Or would all employers be mandated to provide health insurance for their employees with the federal government providing insurance for people who are not employed? Or might we encourage more individual ownership of health insurance through the use of tax credits? Unfortunately, framing the issue in terms of the urgency of achieving universal coverage distracts attention from what is a more fundamental question: How have the prices of both medical care and the insurance that would pay for it gotten as expensive as they have?



The accompanying graph of sixty-eight years of price data drawn from the Bureau of Labor Statistics illustrates two facts. First is that we live in a constantly inflationary environment with the Consumer Price Index rising dramatically and steadily since the early 1970's. That was when President Nixon ended the last vestiges of linkage of the U.S. dollar to our gold reserves and allowed the only limit on dollar creation to be the wisdom of the Federal Reserve Board of Governors. The second fact is that medical care price increases have been in the vanguard of that inflation since the early 1980's.

If we would construct an index of health insurance premiums, we would find that it rises even more precipitously than the CPI and the Medical Care Index. All of this should make us wonder, what is this inflation and what policies aggravate it?

A helpful perspective on inflation could be gained by graphing these indices in a different way, which would illustrate the loss of dollar buying power in relation to the goods and services purchased. To do so we would merely need to invert the graphs to see that the overall value of a dollar is 23% of what it was in 1972 and for medical purchases it has held only 14% of its value.

To look at the matter in terms of the value of a dollar, it is further helpful to think of the various ways in which dollars are experienced. When I make a purchase, I will use some combination of three kinds of money. For most items I will spend MH, money I have. For some purchases I will spend MEH, money I expect to have (credit). Finally, I might be able to spend ME, money to which I am entitled (insurance or government entitlement).

If I am spending MH, I will likely exercise more discretion in my purchase than I will if I am spending ME. I will search out the best value for my MH, and I will be more conscious of the price of the purchase. I will demand that I get my money's worth, and I will not continue spending on something that does not offer enough value. If I am spending ME, I might exercise more discretion if I know that I will have to pay more MH (in taxes or health insurance premiums) in the future to have access to the ME. But since my own MH contribution to the ME pool is relatively diluted, I am not nearly so motivated to shop wisely. In fact, if I think I am already paying a high price in MH to have access to the ME, then I may feel entitled to get my fair share of the ME and be motivated to spend more freely.

Too often we think of prices, particularly for medical goods and services, as simply set by the sellers. We pay too little attention to the role of the buyers in agreeing to pay the prices asked by the sellers. When individual patients are using mostly insurance or entitlement benefits to pay for prescriptions and services, their role in restraining the rise of prices is diminished. The key to restraining medical inflation is having patients participate with their own MH in some significant part of the price of each medical transaction.

Based on this way of thinking, here are some policies that can contribute to the effort to contain medical inflation:

- Make prescription benefits percentage-based coinsurance rather than fixed dollar co-payments. Even tiered co-payments only influence the choice of whether to get a prescription. They do not encourage the patient to shop for the best total price. If everyone were doing so, the collective effect would be to hold down pricing.
- Use percentage-based coinsurance for physician services for the same reason.
- Indemnity benefits that pay a certain amount toward a provider's fee but allow discretion in the setting of charges above that amount would allow more flexibility in how providers set their charges. That would allow them to offer individualized discounts to patients in need.
- Open up the market for personal savings accounts, tax advantaged accounts that encourage saving money to use for coinsurance, deductibles and discretionary medical purchases. This would allow people to rely less on health insurance, and they would be able spend less on insurance premiums.
- Encourage employers to make defined contributions toward their employees' health insurance premiums and saving accounts. Allow the employees to choose from a variety of plans and pay with their own money the marginal dollars above the employer's contribution for the premium. This will bring more realism to peoples' expectations of their insurance.
- Encourage incentives for individuals and insurance companies to achieve more longitudinal relationships, rather than changing after a few years to other plans. In this way insurance plans would be able to reward younger and healthier customers to build up credits that could offset premiums later in life. Also, there would be more incentive to take prudent preventative measures.

The thrust of this analysis is to suggest that an important factor in health care and health insurance both becoming so costly has been our reliance on health insurance plans that have sought to spare people all but the least costs of their health care. To place the highest priority simply on achieving universality of health insurance coverage may only aggravate that inflation further. Whatever financing plans are developed, if they do not sufficiently consider the role of individuals in containing inflation, they will likely bring about more inflation. Our goal should be to achieve health insurance coverage that is both equitable and sustainable. ▲

Attachment 2
1-26-05
FII