Approved: April 2, 2008
Date

MINUTES OF THE SENATE HEALTH CARE STRATEGIES COMMITTEE

The meeting was called to order by Chairperson Susan Wagle at 1:30 P.M. on February 19, 2008 in Room 136-N of the Capitol.

Committee members absent:

Committee staff present: Ms. Emalene Correll, Kansas Legislative Research Department
Mrs. Terri Weber, Kansas Legislative Research Department
Ms. Nobuko Folmsbee, Revisor of Statutes Office
Ms. Renae Jefferies, Revisor of Statutes Office
Ms. Margaret Cianciarulo, Committee Secretary

Conferees appearing before the committee: Ms. Gina Maree, LSCWS, Director,
Health Care Finance and Organization, KHI
Mr. Tom Arnold, Deputy Secretary for Medicaid

Others in attendance: Please see attached Guest List

Continued hearing on SB541 - An act concerning the Kansas Health Policy Authority relating to powers and duties thereof regarding a medical home, and small business, wellness, grant programs; establishing the health reform fund.

Upon calling the meeting to order, Chairperson Wagle called upon Ms. Gina Maree, LSCWS, Director, Health Care Finance and Organization, Kansas Health Institute, who highlighted:

- the Florida Medicaid Reform made up of:
  - Mandatory Managed Care
  - Customized benefit packages
  - Choice counseling
  - Enhanced Benefit Accounts
  - Low income pool
  - Premium Assistance (Opt-out)

- the Florida Medicaid Reform 115 Waiver with Broward and Duval being the pilot counties

- Premium Assistance (Opt-out)
  - Opt out of Medicaid
  - Premiums paid for employer sponsored insurance and individual plans
  - Cost of the program
  - Administrative costs for the Opt-out Program & example premiums for 10 individuals

A copy of Ms. Maree's testimony is (Attachment 1) attached hereto and incorporated into the Minutes by reference..

Questions before Ms. Maree came from Senators Wagle, Barnett and Palmer including:

- are you saying that they also have the option to participate in Medicaid?

- on the 10 patients, are they guaranteed coverage or do they go into the underwriter's process for insurance products?

- I f we have a population that is not only sick but poor, would they be able to buy an individual plan or would they not? Would you contrast the Florida versus the Health Policy Authority proposal?

- If we get this kind of plan in Kansas, would someone with pre-existing conditions be excluded or actually end up in the high risk pool or would they be insured with a guaranteed offer?

The Chair then called on Mr. Tom Arnold, Deputy Secretary for Medicaid and asked for his opinion of the Florida program as well. Mr. Arnold said that Dr. Allison is correct if in fact they are talking about an individual who has hepatitis and wants to enter into the individual private market place (that person, like anyone else would have to qualify by going through a medical underwriting process and the insurance company would have the right to accept, decline, or write "quote/unquote" a particular illness on a individual bases. He is also right in the fact that the money allowed for the doctor may or may not be enough to purchase such policy depending what the underwriting findings are. However, if that same person with hepatitis worked for KBG Toys and was a stocker in the back and eligible for the group program at KGB Toys, because Kansas law says if they can't be underwritten, that they have to be accepted, especially if that group is between 2 & 55, then there are no underwriting or pre-existing requirements and that person could come into that group insurance program instantaneously at that particular point in time. Whether or not the dollar amount that is allowed is sufficient enough to pay for that group insurance premium would depend upon that particular groups insurance rates based upon what their demographics are.

He stated, after reviewing some additional information off of the KHP website, he did have a question, in looking at this Kansas Healthy Program, if you were already insured under the Medicaid system, does Medicaid count as credible coverage under the HIPPA regulations, that allow for their pre-existing conditions, applied to that particular group plan. If the answer is yes then than person comes in without any pre-existing conditions. So it is a yes and no at the same time? And if he understands the situation that was talked about was the Employer's Sponsored Plan, then that is an entirely different thing, but there are also ways to take the individual market place and open it up to a more competitive market place with the private sector that would meet the qualifications.

A copy of his testimony is (Attachment 2) attached hereto and incorporated into the Minutes by reference.

The Chair recognized Mr. Ron Gaches who asked, if the only reason we were talking about the Florida Medicaid Reform Model was those ten folks that Ms. Maree described, then we wouldn't waste the Committee's time. We are talking about the entire reform package for Medicaid reform in Florida. It is the ability of Florida to design a reform package that lets the market place respond to the opportunity. They are not issuing RFP's in Florida for insurance companies or HMO's to come forward to serve parts of the Medicaid program. They have an open process that allows any firm to come forward, complete an application that meets the criteria of the state, and compete in the market place for those constituencies. That is not the kind of program that is being discussed as premium assistance in Kansas. They are suggesting that before you invest that money you look at the possible program designs to see what options are out there that actually invigorate the private market and let them respond to the problems that we are trying to address, not only for the 11% that do not have insurance but for the 89% who do.

The Chair then asked for other questions from the Committee. Questions came from Senators Palmer, Wagle, Barnett including:

- follow-up on the RFP's, are they not open to all companies, why isn't this a free market, and why not contract?

- regarding last year's premium assistance legislated without being funded, concerns at to why Medicaid was not expanded; the providers saying, if they enact this program, is it possible they would be asked to cut their rates lower than what Medicaid pays; and what is your enforcement mechanism for making sure that once you contract, these people actually do what they are contracting to do? Now we are asking future legislation to be bound by **SB11.** What is our assurance that when you contract with these companies, that they are going to pay providers as intended and if we are looking at an $86M shortfall and it's highly unlikely that the cigarette tax will pay this off, and we are enticing people to buy into this with the hope someday we will expand and have a larger pool of people to insure, what if we don't get there

and have to start pinching pennies and ask providers to take less? Beyond that, there is concern that the KHPA does have contracts with two companies for children's Healthwave & you want to bring them into this, someone will have to break the existing contracts.

- in looking at the population that is uninsured and poor and will never have insurance, we are all paying for it now in other ways, we shouldn't be going into this worried about how much we are going to pay, because right now we are paying zero, so if this is a starting point, is there a way for premium assistance to work and to open opportunities for others?

- Dr. Nielsen was asked if she was open to listening to Medicaid reform issues that have been discussed in Florida ?

The Chair then called on with Mr. Mike Gross, President of Association of Health Underwriters in Kansas, who stated he had talked this am with two of the analysts in Florida that helped put the program together who said they went to the managed care organization and said here is how much money we have what can you do for us? They started out at the beginning of the first year with one managed care operations, they now have 11, so the free system works. On the other side, you go into a defined contribution then you are into a negotiating fee schedule having no control over how many services are provided only the cost of each service as it is provided. He stated he encourages the Committee to look at all states (more than just Florida, there is S. Carolina, Ohio, etc. Idaho) lots of plans that started out like this (all having free enterprise ideas) and they are going back to a defined contribution. He stated he was not here to defend the Florida plan, but to defend the choices that their method has given them to pick from.

The Chair recognized Mr. Arnold again, who referenced a handout listing 12 points their ideas and a discussion ensued regarding how and why the Health Underwriters were not involved in any of the discussions or committees and were not included in the council and is there a desire to become involved. A copy of the handout is (Attachment 3) attached hereto and incorporated into the Minutes by reference.

The Chair then referred the Committee to written neutral testimony offered by Dr. Ira Stamm who offered facts regarding uninsured Kansans, proposed solutions and uninsurable medical conditions due to the high cost of treatment and medications (when such conditions are listed on the application, many health insurance companies will decline coverage without further review of medical records. And lastly, he offered two charts entitled (2007" Individual Health Insurance Underwriting Guidelines," and one entitled "Action Taken by the Insurance Companies for Selected Conditions." A copy of his testimony and attachments are (Attachment 4) attached hereto and incorporated into the Minutes by reference.

Adjournment

As it was going on Senate session time, the Chair said that she would like to give the Committee time to digest the information before them then hear from them where they want to go from here. The meeting was adjourned. The time was 2:31 p.m.

The next meeting is scheduled for February 25, 2008.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

GUEST LIST

DATE: Tuesday, February 19, 2008

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NAME	REPRESENTING
Daniel Morin	KS Medical Society
Jerry Slaughter	" " "
Richard Sampaio	Kearney & Assoc
Ira Stamm	SCLF
Lindsey Douglas	Hein Law Firm
Cheryl Allard	Coventry Health Care
Todd Deutsch	Ks Optometric Assoc.
TONY Wellener	KS Assn. for Med Underservd
Cathy Harding	" " " " "
LARRY MAGILL	KAIA
Cynthia Smith	SCL Health System
Beth Langvis	KHPA
Dallas Polen	Children's Mercy Hospital
James Giese	Children's Mercy Family Hlth Partners
Reagan Cussimanio	KHPA
Mike Gross	KAHU
Jon Gaches	KAHU
Larry Ann Rowen	KAHP
	KDHE

please pass on thank you mjd

39 in att.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

GUEST LIST

DATE: Tuesday, February 19, 2008

NAME	REPRESENTING
Susan Kenney	KDHE
Marci Nielsen	KHPA
Tracy Russell	"
Tom Bryon	Ks Ass of Health Underwriters
Mike Shields	KHI News
Rachel Smith	KHI
Carolyn Smith	VCHS
Dodie Wellshear	Ks Academy of Family Physicians
Bruce Witt	Reformed Health Systems
Lana Forbes	VHG
Kathleen Outlaw	KSNA
Cindy Allison	KSHPA
Bob Williams	Ks. Assoc. Osteopathic Medicine

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Florida Medicaid Reform:

Topeka, Kansas • February 19, 2008

Gina C. Maree LSCSW
Director of Health Care Finance and Organization
Kansas Health Institute

Florida Medicaid Reform 1115 Waiver

- In October 2005, under leadership of the Governor Jeb Bush
- Approximately 2 weeks to approve
- May be the most significant Medicaid Reform in recent history
- Requires budget neutrality
- Pilot Counties (Broward, Duval) and to expand statewide

Florida Medicaid Reform

- Mandatory Managed Care
- Customized benefit packages
- Choice counseling
- Enhanced Benefit Accounts
- Low Income Pool
- Premium Assistance (Opt-out)

Premium Assistance (Opt-out)

- September 2006
- Opt out of Medicaid
- Premiums paid for employer sponsored Insurance and individual plans
- Choice Counseling

Premium Assistance (Opt-out) continued

- Program funded for 66 individuals
- As of September 2007, highest enrollment equals 10
- Costs of the program
  - Premiums paid
  - Set Administrative costs
  - Administrative costs for each enrollee

Administrative costs for Florida's Opt-out Program

Number of Enrollees	Annual Administrative costs	Annual Administrative costs per enrollee
66	$99,600	$1,509
10	$66,000	$6,600
8	$64,800	$8,100

Example Premiums for 10 Individuals

Annual Medicaid Premiums	Annual ESI Premiums	Medicaid Annual Premium Savings	Medicaid Annual Loss incorporating Administrative Costs
$13,254.72	$10,438.20	$2,816.52	- $ 3,783.48

Florida Medicaid Reform beyond premium assistance

- Mandatory Managed Care
- Customized benefit packages
- Choice counseling
- Enhanced Benefit Accounts
- Low Income Pool

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Mandatory Managed Care

- HMO (As of September 2007)
  - 11 plans
  - Capped premiums based on risk adjustment for individuals
  - HMO holds risk
  - 143,776 enrolled
  - Most enrollees are low income families with children

Mandatory Managed Care continued

- Provider Service Networks (PSN)
  (As of September 2007)
  - Typically hospital systems and physician groups
  - 6 plans
  - First 3 years no financial risk
  - FFS Payment for actual costs
  - 53,664 enrolled
  - Disproportionate enrollment of persons who are disabled

Customized benefit packages

- Capitated plans have flexibility for non-pregnant adults
  - Certain services covered
  - Cost sharing
  - Providing additional services

Customized benefit packages continued

- Covered at the State Plan limit
  - No flexibility for amount, duration or scope of services
- Covered at the sufficiency threshold
  - Could vary services up to pre-established limit for coverage based on historical use by a target population
- Flexible
  - Some coverage but can vary amount, duration or scope of services

Customized benefit packages continued

- As of September 2007,
  - 30 customized benefit packages for HMO
  - 13 expanded benefits for PSN
- Physician Concerns Expressed
  - Decrease in Specialist
  - Providing needed services
  - Administrative Burden

Georgetown University Study of 28 Plans

- A study by Georgetown University reviewed 28 plans comparing them to previous year
  - 58 eliminations or decrease in benefits
  - 16 additional or increasing benefits
- Co payment changes in the 28 plans
  - 58 added or increased co pays
  - 1 eliminated or decreased

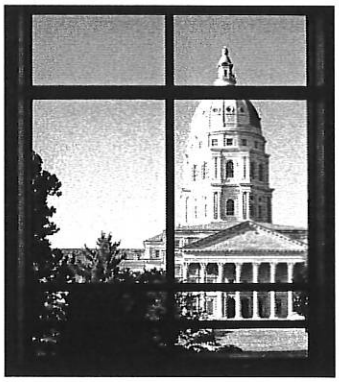
Choice Counseling

- Provided by a contractor
- Helps beneficiaries choose between plans
- Auto assignment if no choice
- Beneficiary satisfaction is good

Enhanced Benefit Accounts

- $125 credit per State Fiscal Year
- Can be used to purchase health related products and supplies
- Initial administrative costs are $1.1 Million
- As of October 2007, 4 percent or $260,691 of $ 6 million earned credits are redeemed

Kansas Health Institute



Information for policy makers. Health for Kansans.

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Florida Medicaid Reform

Thomas W. Arnold

Deputy Secretary for Medicaid

Presented to the Senate Health Policy Committee

October 2, 2007

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Goals of Medicaid Reform

- Improve access to health care services.
- Provide more choices (plans and services) for Medicaid beneficiaries.
- Provide opportunities for beneficiaries to take a more active role in their health care decisions.
- Reduce the administrative complexity of managing the Florida Medicaid Program.
- Slow the rate of growth of expenditures:
  - Better care coordination
  - Reduction of over-utilization
  - Reduction of fraud

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Reform Timeline

- **May 2005:** Reform authorized by Florida Legislature in SB 838.
- **December 2005:** Waiver approved by the Legislature in HB 3-B.
- **September 2006:** Enrollment began for Duval and Broward Counties.
- **September 2007:** Enrollment began for Baker, Clay and Nassau Counties.

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Key Elements of Reform

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- Outreach Efforts.
- Choice Counseling.
- Delivery System:
  - Coordinated Systems of Care (Health Maintenance Organizations and Provider Service Networks).
- New Options / Choice:
  - Customized Plans.
  - Enhanced Benefits.
  - Opt-Out.
- Financing:
  - Premium Based.
  - Risk-Adjusted Premium.
  - Comprehensive and Catastrophic Component.
- Low Income Pool (LIP).

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Choice Counseling

- A free service to help beneficiaries understand their plan choices and make a choice that best fits their health care needs.
- Certified Choice Counselors.
  - Specially Trained.
  - Diverse.
  - Multiple Languages.
- Services for the Disabled and Medically Complex.
  - Sign-language Interpreters.
  - Braille, CD, and Large Print.
  - Special Needs Unit Staffed by Registered Nurses.

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Choice Counseling

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- Contract Standard: 65 percent voluntary choice (calculated quarterly)

October 2006:	68%
November 2006:	59%
December 2006:	57%
Quarter:	**62%**
January 2007:	65%
February 2007:	56%
March 2007:	81%
Quarter:	**66%**
April 2007:	82%
May 2007:	73%
June 2007:	67%
Quarter:	**75%**
July 2007:	81%
August 2007:	74%
September 2007:	80%
Quarter:	**78%**

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Choice Counseling

➤ Total Calls received:	209,035
➤ Total outbound calls:	54,239
➤ Average talk time:	7 minutes
➤ Average speed to answer all calls:	28 seconds
➤ Percent of calls answered within 15 seconds:	71.48%
➤ Percent of calls answered within 60 seconds:	82.52%
➤ Percent of calls answered within 180 seconds:	96.72%

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New Options / Choice

- Plans participating in Reform:
  - Broward:
    - 10 Health Maintenance Organizations
    - 5 Provider Service Networks
  - Duval:
    - 4 Health Maintenance Organizations
    - 3 Provider Service Networks
  - Baker, Clay and Nassau:
    - 1 Health Maintenance Organization
    - 1 Provider Service Network

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Customized Benefit Packages

- Customized Benefit Packages:
  - Reform health plans create benefits to meet beneficiaries' needs so that they can choose the right package.
  - Benefit packages include all Federally required benefits – and may include some services not currently covered by Medicaid.
  - Benefit packages must have the same value as the current Medicaid benefit package.
  - Benefits must meet State defined standards of "sufficiency" – based on the health plan's target population – not just the "average" member.

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Enhanced Benefits

- The goal of the Enhanced Benefits program is to promote self involvement in one's health care needs.
- To achieve this, participation in healthy behaviors that have positive outcomes and can improve one's health status will be rewarded.
- Rewards are in the form of credit dollars that may be used to purchase health related products and supplies.
- Beneficiaries may earn up to a maximum of $125 per year in credit dollars.

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Enhanced Benefits

- To date, over 111,000 beneficiaries have received credits for healthy behaviors, totaling $5,997,201 in credit dollars.
- As of August 3, almost 9,000 unique beneficiaries have used $260,691 in credits.
- 4,475 recipients have earned the annual cap of $125.

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The Opt-Out Program

- Employed Medicaid beneficiaries are offered the choice to opt-out of Medicaid and direct their premium paid by Medicaid to an employer-sponsored plan.
- If a beneficiary chooses to opt-out, the state pays up to the amount it would have paid a Medicaid Plan towards the employee's share of the premium.
- Families can combine premiums to purchase family coverage through their employer.

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Risk Adjusted Rates

- Risk Adjusted Rates:
  - A process to predict health care expenses based on chronic diagnoses.
  - Distributes capitation payments across health plans based on the health risk of the members enrolled in each health plan.
  - Captures adverse selection without using experience rating.
  - Rate allocation, not rate setting.
- Risk Adjustment Process:
  - Better matches payment to risk.
  - Pay for the risk associated with each plan's enrolled population.

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Current Enrollment

- Enrollment ~ Phase One: 175,786
  - Broward: 107,317
  - Duval: 67,888

- Total Projected Enrollment ~ Phase Two: 17,913
- Current Enrollment ~ Phase Two:
  - Baker: 423
  - Clay: 2,710
  - Nassau: 1,283

- Current Total Enrollment: 179,903

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Enrollment by Plan
(for October 2007)
Broward: 10 HMOs + 5 PSNs

HMOs	Enrollment	PSNs	Enrollment
Amerigroup	11,088	Access Health Solutions	3,205
Healthease	14,684	CMS (Children's Medical Services)	2,045
Humana	9,721	Florida NetPASS	4,262
Preferred Medical Plan	1,812	Pediatric Associates	9,008
Staywell	27,651	South Florida Community Care Network	6,314
Total Health Choice	1,323		
United Healthcare	6,463		
Universal	84		
Vista dba Buena Vista	6,139		
Vista Healthplan of South Florida	3,518		
HMO enrollment	**82,483**	**PSN Enrollment**	**24,834**

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Enrollment by Plan
(for October 2007)
Duval: 4 HMOs + 3 PSNs

HMOs	Enrollment	PSNs	Enrollment
Healthease	34,779	Access Health Solutions	5,893
Staywell	2,754	CMS (Children's Medical Services)	1,318
United Healthcare	8,157	Shands/Jax dba First Coast Advantage	14,883
Universal	104		
HMO Enrollment	**45,794**	**PSN Enrollment**	**22,094**

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Enrollment by Plan
(for October 2007)

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Baker: 1 HMO + 1 PSN

United Healthcare	282	Access Health Solutions	423
		Total Enrollment Baker	**705**

Clay 1 HMO + 1 PSN

United Healthcare	1,428	Access Health Solutions	1,282
		Total Enrollment Clay	**2,710**

Nassau: 1 HMO + 1 PSN

United Healthcare	539	Access Health Solutions	744
		Total Enrollment Nassau	**1,283**

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Next Steps

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Guiding Principles for Possible Expansion of Reform

- Review current service referral and delivery patterns that cross counties, including Primary Care Provider selection.
- Target reform waiver implementation in counties with capitated managed care experience.
- Include counties with larger Medicaid mandatory populations sooner rather than later to help ensure waiver budget neutrality.
- Consider recipient access to choice counseling help-line and the potential impact of waiver implementation on the choice counseling contract.

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Guiding Principles for Reform Expansion Options

- Consider other Agency initiatives affecting either recipients or providers in potential waiver implementation counties
- Consider Fiscal Agent transition from ACS to EDS (March 2008).
- Consider and incorporate lessons learned from prior reform county implementations as we expand into new counties.

Kansas Association of Health Underwriters - Health Care Reform Agenda

KAHU supports the following policy initiatives to address Accessibility, Affordability and Portability of health insurance for all Kansans.

1. Affordability – Low income Kansans who are not eligible for other public health care programs should receive state premium assistance to purchase affordable, private health care insurance.

2. Affordability and Portability – Employers should be allowed to use pretax dollars to assist employees in purchasing their own health insurance policies.

3. Affordability – All Kansans should be encouraged to live healthy lifestyles to extend their productive lives and reduce the demand for expensive health care.

4. Affordability – Kansas should enact a comprehensive Reinsurance Plan to spread the risk for individuals with expensive medical bills.

5. Affordability – Consumers should have available information about health care provider quality of care and the true costs of health care.

6. Accessibility – Kansas should provide financial incentives to support primary care physicians in underserved areas.

7. Affordability – Controlling the total cost of health care requires continued tort reform efforts and elimination of expensive health care mandates.

8. Affordability and Accessibility – Individuals should receive an immediate tax reduction at the time they enrollment in an individual or family insurance policy.

9. Accessibility and Affordability – Insurance companies should be allowed to offer plans without all of the current health care mandates, at least for those unable to afford more comprehensive plans.

10. Accessibility and Affordability – Kansas should expand the small business tax credits for all health insurance plans.

11. Accessibility and Affordability – All Kansas taxpayers should help subsidize the cost of insurance available from the State High Risk Pool.

12. Portability – Kansas should require continuation of coverage for employees of small employers (under 20 employees) for at least 18 months following termination of employment matching the federally required 18 months under COBRA.

Senate Health Care Strategies
Committee
Date: February 19, 2008
Attachment 3

Written Testimony for SB 540 and SB 541
Senate Committee on Financial Institutions and Insurance
Senate Committee on Health Care Strategies
February 18, 2008

Uninsured Kansans

The Kansas Health Policy Authority has documented that there are 300,000 Kansans without health insurance.

The Institute of Medicine has estimated that in 2006 22,000 Americans died because of the lack of health insurance.

This means that in 2006 –198 Kansans died because of the lack of health insurance.

Approximately 198 Kansans without health insurance died in 2007 and another 198 Kansans will die in 2008.

Over 400+ Kansans without health insurance will have died in Kansan since Kansas initiated its program of health care reform.

Uninsurable Kansans

- At any point in time 10% of the population have a medical condition that renders them uninsurable (see attached list). Kansas has a population of 2.7 million. This means that any point in time there are **270,000** Kansans that have medical conditions that make them uninsurable.

- Individuals with these medical conditions cannot obtain individual health insurance at affordable prices.

- Individuals with these medical conditions who currently have insurance – cannot obtain individual insurance should their current insurance be terminated for any reason.

- The Kansas High Risk Pool requires that the individual show two letters of rejection from insurance companies in order to be eligible for the high risk pool. Premiums for this high risk coverage are beyond the reach of most Kansans.

Assuming that 10% of the 300,000 uninsured also have uninsurable medical conditions, about **540,000** Kansans or 20% of the population of Kansas either have no insurance or have medical conditions that make them uninsurable.

Underinsured Kansans

A Commonwealth Fund study estimated that in 2003 16 million Americans were underinsured. This means that in 2003 **144,000** Kansans were underinsured.

Adding together 300,000 Kansas who are uninsured, 270,000 Kansans with medical conditions that make them uninsurable, and 144,000 Kansans who are uninsured – means that altogether **714,000** Kansas have problems with health insurance. This is

Senate Health Care Strategies Committee
Date: February 19, 2008
Attachment 4

26.4% of the population of Kansas. This does not include the tens of thousands of Kansans who struggle daily with their insurance companies around problems of access to care, utilization review, etc.

Proposed Solution

To remedy this situation – SB 540 and SB 541 should be amended as follows:

Amendment A – The Kansas Health Policy Authority is directed to produce a plan to offer affordable health insurance to all those Kansans who are currently uninsured.

Amendment B – The Kansas Health Policy Authority and the Kansas Insurance Department will develop rules and regulations that

- prevent insurance companies from denying any Kansan health insurance because of a pre-existing medical condition and
- allows the individual to retain his/her insurance coverage from the employer at the group rate even when the employee is no longer employed by the company. The former employee would pay the group rate the employer offers to current employees.
- simplify the insurance process by requiring insurance companies to offer three basic levels of coverage to all Kansans.

Amendment C – Insurance companies doing business in Kansas would pool all insureds for that company into one risk pool for the company. Individuals, small companies, and larger companies would be in the same risk pool.

- This will bring health insurance in Kansas closer to its original concept as social insurance than the actuarial insurance model that it has become. The social insurance model of health insurance benefits the consumer; the actuarial insurance model of insurance benefits the insurance company and shareholder.

Respectfully,

Ira Stamm, Ph.D., ABPP

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Topeka, KS 66611
913 706-8831
istamm@cox.net

Attachments:

Uninsurable Medical Conditions (OPIC) – (www.opic.state.tx.us)
2007 Individual Health Insurance Underwriting Guidelines (OPIC)
Actions Taken by the Insurance Companies for Selected Conditions (OPIC)

UNINSURABLE MEDICAL CONDITIONS

Many health conditions are considered uninsurable due to the high cost of treatment and medications. When such conditions are listed on the application, many health insurance companies will decline coverage without further review of medical records. These conditions include but may not be limited to the following: [1]

[1] List of medical conditions taken from Texas Health Insurance Risk Pool Qualifying Medical/Health Conditions.

Cancer
- Malignant Tumor within 4 Years (except skin cancer)
- Metastatic

Cardiovascular
- Artificial Heart Valve
- Cardiomyopathy
- Coronary Artery Disease
- Polyarteritis Nodosa
- Peripheral Vascular Disease

Endocrine/Exocrine
- Diabetes Mellitus
- Cystic Fibrosis
- Addison's Disease

Gastrointestinal
- Intestinal
  - Crohn's Disease
  - Ulcerative Colitis
- Liver
  - Cirrhosis (non-alcoholic)
  - Wilson's Disease
  - Hepatitis

Hematopoietic
- Anemia
  - Sickle Cell
  - Splenic (True Banti's Syndrome)
- Hemophilia
- Leukemia
- Thalassemia

Hodgkin's Disease

Immunological
- AIDS or HIV Positive
- Lupus

Musculoskeletal
- Dermatomyositis or Polymyositis
- Muscular Atrophy or Dystrophy
- Myotonia
- Rheumatoid Arthritis
- Still's Disease
- Legge-Perthes Disease

Neurological - Central Nervous System
- Cerebral Palsy
- Cerebral Vascular Accident (CVA)
- Epilepsy
- Gullian-Barre Syndrome
- Huntington's Chorea
- Hydrocephalus
- Lead Poisoning with Cerebral Involvement
- Lobotomy
- Parkinson's Disease (if treatment within 3 years)

Neurological - Periphal Nervous System
- Amyotrophic Lateral Sclerosis
- Friedrich's Ataxia
- Myasthenia Gravis
- Paraplegia or Quadriplegia
- Sclerosis, Multiple
- Syringomyelia
- Tabes Dorsalis (Locomotor Ataxia)

Psychotic Disorders

Pulmonary
- Silicosis (Black Lung)

Renal
- Polycystic Kidney

Other
- Brain Tumor
- Down's Syndrome
- Scleroderma
- Transplants

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2007 Individual Health Insurance Underwriting Guidelines

UNDERWRITING GUIDELINE	USED TO DENY COVERAGE	USED TO CHARGE A HIGHER RATE	USED TO OFFER LESS COVERAGE	TOTAL PERCENT OF MARKET SURVEYED USING GUIDELINE FOR UNDERWRITING PURPOSES
MEDICAL CONDITION The company examines the medical history of each applicant, using questions on the application, follow-up phone calls, and a review of medical records. Applicants with certain medical conditions are considered uninsurable and are routinely denied coverage. Click here for a list of uninsurable diseases and conditions as compiled by the Texas Health Insurance Risk Pool. For many common health conditions, applicants may be accepted, denied, charged a higher rate, or offered less coverage. For a breakdown of the actions taken by the insurance companies for selected conditions, click here.	100%	100%	100%	100%
HEIGHT/WEIGHT The company increases premiums or deductibles based on Body Mass Index (BMI). Premium increases can be between 25-50% of the standard (acceptable) rate. If applicant's BMI is higher than 35, the company will reject the applicant According to the National Institutes of Health: 18.5 – 24.9 NORMAL 25.0 – 29.5 OVERWEIGHT 30.0 – 39.9 OBESE 40.0 and higher – MORBIDLY OBESE	100%	86%	14%	100%
MORALS/LIFESTYLE The company asks if the applicant has had any convictions including DWI/DUI, number of speeding tickets, and whether the applicant has used illegal substances/drugs or abused prescription medications. In most cases, if an applicant answers "yes", a further investigation is done, and most likely the applicant will be declined.	76%			76%
AVOCATIONS The company underwrites based on the hobbies of the applicant and considers whether the hobby is professional or amateur. Some examples include SCUBA, Sky Diving, Parachuting, and Rodeo.	52%	24%	48%	67%
INFORMATION FROM CONSUMER REPORTING AGENCIES The company must ask applicant for permission to obtain these reports.				
MEDICAL INFORMATION BUREAU (MIB) REPORT- These reports provide data that is collected by approximately 500 member insurance companies. Information on medical conditions, driving records, criminal activity, and participation in hazardous sports, and aviation activity is contained in these reports.	67%	67%	67%	67%
CREDIT REPORT – A record of an individual's past borrowing and repaying history, including information about late payments and bankruptcy	67%	67%	67%	67%

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UNDERWRITING GUIDELINE	USED TO DENY COVERAGE	USED TO CHARGE A HIGHER RATE	USED TO OFFER LESS COVERAGE	TOTAL PERCENT OF MARKET SURVEYED USING GUIDELINE FOR UNDERWRITING PURPOSES
PRESCRIPTION DRUG HISTORY Each company has a separate list of declinable medications. Some examples include: regular insulin for diabetes treatment, Plavix for treatment of clots, and Aricept for Alzheimer's Disease. If a patient is currently taking medications on the unacceptable drug list, the company may decline the applicant. An insurer can also increase premiums or deductibles based on certain medication usage. Also, some insurers require the applicant to purchase endorsements excluding or limiting coverage.	52%	24%	24%	67%
RESIDENCY Some insurers require United States residency of 12–24 months before an applicant can apply for coverage. Other insurers will decline an applicant who is on Visa status.	67%			67%
OCCUPATION The insurer will have a list of occupations that will result in declining the applicant or will ask the applicant to purchase endorsements excluding or limiting coverage based on his/her occupation.	48%		19%	52%
REPUTATION The company asks an insurance agent and in some instances, conducts personal interviews with friends, neighbors, and associates, regarding the general reputation and characteristics of the applicant. A sample question for an agent is, "Are you aware of any information not disclosed on this application relating to the health, habits or reputation of any person listed on this application which might have a bearing on the risk?"	38%	38%	38%	38%
BLOOD TEST OR ATTENDING PHYSICIAN STATEMENT (APS)				
BLOOD TEST - In order to process an application, the company requires a blood test.	5%	5%	5%	5%
APS- In order to process an application, the company requires an Attending Physician Statement regarding the applicant's health. In most cases, this is the insured's physician.	33%	33%	33%	33%
DOMESTIC VIOLENCE The company underwrites impairments caused by domestic violence.	10%	10%	10%	10%

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ACTIONS TAKEN BY THE INSURANCE COMPANIES FOR SELECTED CONDITIONS

	ACTIONS				DETERMINING FACTORS			
MEDICAL CONDITION	**USED TO DENY COVERAGE**	**USED TO CHARGE A HIGHER RATE**	**USED TO OFFER LESS COVERAGE**	**TOTAL PERCENT OF MARKET SURVEYED USING GUIDELINE FOR UNDERWRITING PURPOSES**	**SEVERITY**	**TIME SINCE DIAGNOSED OR LAST EPISODE**	**CONTROLLED WITH MEDICATIONS**	**OTHER**
Breast Cancer Survivor	38%	62%	48%	100%	10%	90%	14%	24% [i]
Drug/Alcohol Abuse	100%	38%		100%		29%		10% [ii]
Maternity	86%		14%	100% [iii]				
Prostate Cancer Survivor	48%	52%	57%	100%	14%	81%		57% [iv]
Back Injury	38%	48%	62%	90%	62%	57%	19%	10% [v]
Arthritis	38%	62%	43%	86%	43%	14%	24%	
Asthma	43%	48%	52%	86%	38%	33%	67%	10% [vi]
High Cholesterol	29%	62%	33%	86%			33%	52% [vii]
Ulcers	33%	48%	48%	81%		43%	29%	
Depression	33%	43%	24%	76%	29%	14%	67%	
Osteoporosis	38%	57%	38%	76%	19%	14%	29%	24% [viii]
Hypertension	48%	57%	67%	71%	5%	24%	52%	33% [ix]
Thyroid	24%	38%	43%	67%		19%	52%	
Allergies		43%	24%	62%	24%	29%	52%	10% [x]
Fibrocystic Breast Changes	10%	29%	24%	48%	10%	19%		14% [xi]

[i] Medical records, lab reports, and mammograms
[ii] Blood test required.
[iii] 33% of the companies decline the entire family if one applicant is pregnant.
[iv] Prostate-Specific Antigen (PSA) test results.
[v] Medical records are required for further underwriting.
[vi] Age of applicant when last episode of asthma occurred is considered.
[vii] HDL/LDL lab results are needed for consideration.
[viii] Bone Density test results.
[ix] Current blood pressure reading is required for underwriting.
[x] Allergy testing results.
[xi] Medical records

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