Approved: February 3, 1993
Date

MINUTES OF THE HOUSE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by Chairperson William Bryant at 3:30 p.m. on January 25, 1993 in Room 527-S of the Capitol.

All members were present except:

Committee staff present: William Wolff, Legislative Research Department
Bruce Kinzie, Revisor of Statutes
Nikki Feuerborn, Committee Secretary

Conferees appearing before the committee:

Dick Brock, Insurance Department
Bud Cornish , Kansas Association of Property and Casualty Companies
Bill Mitchell, Alliance Insurance Company

Hearing on HB 2078:

Dick Brock of the Insurance Department presented testimony on the bill which contains the procedures to follow regarding impaired or insolvent Kansas domiciled insurance companies. The law currently requires the dissolution of such a corporation. The law currently fails to recognize that the corporate shell of an insurance company may have value based upon the number of states in which the company is licensed. The bill would rectify this by making it permissive for the court to order dissolution but allowing the insurance commissioner (receivership) to request the sale of the corporate shell of a domestic insurer. The proceeds of the sale would be added to other assets of the estate. If legitimate claims are outstanding and the company cannot pay, the Kansas Guaranty Fund becomes responsible with a $100 deductible for the debts (Attachment 1).

Hearing on HB 2079:

Dick Brock of the Insurance Department stated that the bill applies to the merger and consolidation of mutual property and casualty insurance companies and would eliminate a requirement for a policy holder vote under certain circumstances (Attachment 2). This bill applies only to domestic mutual and casualty companies in financial difficulty. The company agreeing to consolidate with the financially stressed company would not be required to have the policy holders of the impaired company's approval for the merger. Absorption of the company and its business would have little impact on the surviving company so its policy holders would have little interest in voting. The need for such approval would delay the process and be very costly for the acquiring company. The merger must have the approval of management of both companies involved as well as the approval of the Insurance Commissioner so adequate oversight would exist.

Hearing on HB 2076:

Dick Brock of the Insurance Department stated that the bill is intended to remove a significant economic obstacle regarding mergers or consolidations of financially sound mutual property and casualty insurance companies. Policy holder vote would not be required if the surplus of the surviving company is 25 or more times greater than that of the nonsurvivor. The policy holders of the company that is going to disappear as a result of the merger or consolidation will be required to vote (Attachment 3).

Bud Cornish, Kansas Association of Property and Casualty Companies, stated his organization's support of the bill.

Bill Mitchell, appearing as counsel for Alliance Insurance Company, stated that the mailing and merger costs would be exorbitant if policy holders in the large companies would be required to vote on the proposed merger or consolidation.

Dick Brock asked that legislation be introduced which would allow insurance-educated but not licensed lay individuals to present information on the Kansas Healthy Kids Program to schools and individuals (Attachment 4). In order to comply with current legislation, three pilot projects must be in place by July of 1993.

Representative Allen moved that the bill draft be introduced into legislation. Representative Helgerson seconded the motion. Motion carried.

Dick Brock asked that an amendment be introduced to change municipalities who have entered into an agreement to pool their liabilities for Kansas workers' compensation benefits and employers' liability from Chapter 44 to Chapter 12. At this point there is no way to transfer all assets without legislation (Attachment 5).

Representative Helgerson moved that the amendment be introduced into legislation. Representative Minor seconded the motion. Motion carried.

Representative Helgerson moved that the minutes of January 19 and 20, 1993, be approved. Representative Correll seconded the motion. Motion carried.

Bill Wolff gave Committee members copies of a November 4, 1992, memo on issues considered by the Joint Committee on Health Care Decisions for the 1900's (Attachment 6).

The meeting was adjourned by the Chair at 4:20 p.m.

The next meeting is scheduled for January 26, 1993.

GUEST LIST

COMMITTEE: Financial Institutions & Insurance

DATE: Jan. 25, 1993

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Bill Sneed	Topeka	State Farm
David A. Ross	Topeka	Ks. Assn. of Life Underwriters
L M (Bud) Cordish	"	Ksassn P/C Cos
James L Ketchersside	McPherson, Ks	Farmers Alliance Mutual Ins. Co.
[illegible]	Hutchinson KS.	Allianz Ins-
Dick Brea	Tipt-	Ins Dept
Joe Fugazzi	Topeka	KCA
Danielle Noe	Topeka	Conlee Consulting
Dorothy Taylor	Topeka	Prof. Ind. Ins. Agents

Testimony on
House Bill No. 2078
by
Dick Brock
Kansas Insurance Department

House Bill No. 2078 amends the statutes which contain the procedures to be followed with respect to impaired or insolvent Kansas domiciled insurance companies.

Currently, as the language in subsection (a), section 1 of House Bill No. 2078 reveals, the dissolution of the insolvent corporation is required either by order of the court or by operation of law depending on the circumstances of the particular liquidation. This requirement fails to recognize that the corporate shell of an insurance company may itself have value and this value increases depending upon the number of states in which the company is licensed. As a result, the requirement to dissolve the corporation is sometimes counterproductive in terms of maximizing the value of an insolvent insurance company's estate.

House Bill No. 2078 would rectify this statutory shortcoming by making it permissive for the court to order dissolution of the corporation and inserting specific language permitting the insurance commissioner to request and the court to permit the sale of the corporate shell of a domestic insurer including any of its licenses to do business. The proceeds from any such sale would, of course, be added to other assets of the estate.

Since such corporation would continue to exist if this option was exercised, it is also necessary to immunize it from claims of creditors and others which arose when the corporation was the insurance company placed in liquidation. Language to this effect is contained in lines 31 through 33 of the bill.

Financial Institutions
Insurance
Attachment 1
January 25, 1975

Testimony on
House Bill No. 2079
by
Dick Brock
Kansas Insurance Department

House Bill No. 2079 applies to the merger and consolidation of mutual property and casualty insurance companies and would eliminate a requirement for a policyholder vote under certain circumstances.

While none of us like to think about it and even though Kansas has been fortunate having experienced the situation with respect to a domestic insurer only twice in my 33 years of regulation and I'm aware of none before that, the fact remains that domestic insurance companies can become financially hazardous or actually be financially impaired to the extent that their surplus falls below the statutory minimum surplus required or worse. When this happens, the policyholders of the financially distressed company are best served if the Commissioner has ready access to every available means of protecting their interests. Kansas, like most states, has a safety net for insolvencies in the form of a guaranty association. However, reliance on this vehicle is not be the best, easiest or quickest way to address the situation in some instances. One of those instances would be where the financially distressed insurer is relatively small, operates only in Kansas or a very limited number of states, is not involved in the sale of any exotic or unusual insurance products but, for whatever reason, finds itself -- or more likely the Commissioner finds it to be -- in financial difficulty.

It is at this point that the reason for House Bill No. 2079 parallels those I will shortly discuss with respect to House Bill No. 2076. In this case we are talking about an insurance company that is already in financial difficulty so there is little reason for a financially sound company to be interested in a merger or consolidation except to accommodate policyholder interests if the distressed company's agency force, book of business or some other attribute is of little value to

Financial Institutions & Insurance
Attachment 2
Jan 25, 1993

other insurers. As a result, a healthy insurance company would have no incentive to expend the funds necessary to acquire policyholder approval. House Bill No. 2079 would remove the need for such approval in this instance and it would do so for both companies. In this case, the nonsurviving company is in a hazardous financial condition or financially impaired so its inconceivable that its policyholders would disapprove the opportunity to move their policy to a company that is financially sound. Therefore, approval by the policyholders of the impaired company would seem to be totally unnecessary and unproductive. Absorption of the company and its business would have little impact on the surviving company so its policyholders would have little interest in voting. And, probably more important, the need for such approval would only delay the process and the Commissioner really must make decisions of this sort rather quickly.

Consequently, complete elimination of the policyholder voting requirements as proposed by House Bill No. 2079 would not only remove one deterrent to the possible attraction of an insurance company that is willing to assume the business of a financially distressed insurer but it would also permit the Commissioner to consider this option at any time because he or she would not have to await a policyholder vote that would almost certainly be a foregone conclusion prior to moving decisively toward the objective of a merger or consolidation.

Again, the agreement would have to be reached by the management and boards of directors of the companies involved and the Commissioner's approval would be required the same as any other merger or consolidation so adequate oversight would continue to exist.

Testimony on
House Bill No. 2076
by
Dick Brock
Kansas Insurance Department

House Bill No. 2076 was introduced at the request of the Insurance Department and, like House Bill No. 2079, is intended to not only simplify but remove a significant economic obstacle with respect to mergers or consolidations of mutual property and casualty insurance companies.

Under current law, as you will note from subsection (a) of the bill any agreement of consolidation or merger must be submitted to a vote of the policyholders of each company. When the companies involved in the merger or consolidation are reasonably equal in size, market share or similar measurement, this is a reasonable and logical requirement. However, when one of the companies is much larger than the other, the merger or consolidation is almost always prompted by a concern of the management and board of the smaller company about its future financial viability. The interest of the larger company is more one of accommodation and a public relations type of concern about the impact on other Kansas insurers if a domestic competitor becomes insolvent or impaired and the policyholders become an innocent victim. Rarely, if ever, does the larger insurer have much to gain from acquisition of the assets, agency force or other elements of the smaller company. Therefore, the very significant expense involved in preparing, sending and processing the instruments required to conduct a vote of all policyholders is just that -- an expense. It cannot be construed as an investment because there is little opportunity for gain by the larger company either in the short or the long run. As a result, this single consideration can discourage what, from the public's perspective, would be desirable mergers and consolidations. When it does, it is the policyholders of the small insurer that will be affected.

Financial Institutions & Insurance
Attachment 3
January 25, 1993

House Bill No. 2076 removes this obstacle by excluding the policyholder vote otherwise required if the surplus of the surviving company is 25 or more times greater than that of the nonsurvivor.

By doing so, we are by no means removing all protections and oversight. First, the management and boards of directors would both have to agree to the merger or consolidation and the conditions attached to it. The board of directors of a mutual insurer is elected by policyholders and management is controlled by the board so, in effect, the policyholders have a voice in all decisions. Second, House Bill No. 2076 only removes the need for a policyholder vote with respect to the surviving company. The policyholders of the company that is going to disappear as a result of the merger or consolidation would have greater reason to be concerned but they will still be required to vote. Finally, although it doesn't appear in the bill, a related section of the law governing mergers and consolidations requires the approval of the Commissioner of Insurance and one of the statutory conditions of his or her approval is that the merger or consolidation is not injurious to the interests of the policyholders and creditors of the companies involved.

Consequently, we believe House Bill No. 2076 will remove an unnecessary and expensive requirement of the merger or consolidation process in this narrowly defined situation without endangering the interests of any affected policyholders.

As indicated at the time I requested introduction of this measure a potential merger is already being considered that would be affected by enactment of this bill. Therefore, I not only hope it will receive a favorable recommendation by this committee but also that action on the bill can be expedited.

LEGISLATIVE PROPOSAL

AN ACT relating to the Kansas healthy kids program act; exemption from insurance laws; amending Section 3 of 1992 House Bill No. 2913 and repealing the existing section. (K.S.A. 1992 Supp. citation not available at time of preparation.)

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF KANSAS:

Section 1. Sec. 3. of 1992 House Bill No. 2913 is hereby amended to read as follows: Sec. 3. (a) There is hereby created a body politic and corporate to be known as the Kansas healthy kids corporation. The Kansas healthy kids corporation is hereby constituted a public instrumentality and the exercise of the authority and powers conferred by this act shall be deemed and held to be the performance of an essential governmental function. The corporation shall be governed by a board of directors who shall be residents of this state.

(b) The Kansas healthy kids corporation board of directors shall:

(1) Develop a program which will provide, based on ability to pay, health insurance benefits, including preventive and primary care services and basic dental care to all Kansas school aged children who are not otherwise covered by public or private insurance programs, grades kindergarten through 12, and their nonschool siblings younger than 18 years of age, such program to have children enrolled and be providing services in at least three pilot school districts on or before July 1, 1994, and

Financial Institutions & Insurance
Attachment 4
January 25, 1993

subsequent to the establishment of such pilot programs provide for the expansion of the program to other school districts as appropriate;

(2) establish, with consultation from experts, appropriate professional organizations and others, a list of benefits appropriate to children which will be included in the insurance program and, except as provided in this act, such insurance program shall not be subject to any law requiring the coverage or the offer of coverage of a health care service or benefit;

(3) establish eligibility criteria which children and their families must meet in order to participate in the program;

(4) develop and implement a plan to publicize the Kansas healthy kids program, the eligibility requirements of the program and the procedures for enrollment in the program;

(5) accept and receive grants, loans, gifts or donations from any public or private entity in support of the Kansas healthy kids program;

(6) develop funding sources for the Kansas healthy kids program;

(7) employ staff necessary to administer the Kansas healthy kids program;

(8) establish the administrative and accounting procedures for the operation of the corporation;

(9) enter into contracts as may be necessary under the Kansas healthy kids program act including contracts, as the board deems appropriate, with corporations or other entities for administrative and other services for the corporation;

(10) coordinate the development of the Kansas healthy kids program with other public or private initiatives in order to promote efficiency and coordination and to avoid duplication of effort; and

(11) report on its activities to the governor and to the legislature on or before February 1 of each year.

(c) In establishing the program under subsection (b), the corporation shall construct the program so that coverage is secondary to any other available coverage, and the corporation may establish procedures for coordinating benefits under this program with benefits under other public and private coverage. The insurance benefits part of the program under subsection (b) and the location of the three pilot school districts shall be established by the board of directors on or before July 1, 1993.

(d) No law affecting insurance shall apply to the Kansas healthy kids program, the Kansas healthy kids corporation or its board of directors and no such law shall be construed to prevent or restrict the ability of any insurance company, health maintenance organization, nonprofit medical and hospital service corporation or other nonprofit service corporation authorized to do business in Kansas from entering into or administering any contract of or with the Kansas healthy kids corporation. Notwithstanding the foregoing, the provisions of Chapter 40, Article 24 of the Kansas Statutes Annotated shall continue to apply to the extent they are not inconsistent with the intent of the Kansas healthy kids program act.

Sec. 2. Section 3 of 1992 House Bill No. 2913 is hereby repealed.

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

AMENDMENT TO CHAPTER 44

Any municipalities, as defined by K.S.A. 75-6102 as amended, who have entered into an agreement to pool their liabilities for Kansas workers' compensation benefits and employers' liability under the provisions of K.S.A. 44-581, et seq. and amendments thereto, prior to January 1, 1987, may seek to reorganize the pooling agreement under K.S.A. 12-2616, et seq. All assets, liabilities, and the fund balance of each group-funded workers' compensation pool shall be transferred to the pool seeking a certificate of authority under K.S.A. 12-2616, et seq. upon authorization by the Commissioner of Insurance.

House Financial Institutions & Insurance
Attachment 5
January 25, 1993

KANSAS EASTERN REGION INSURANCE TRUST (KERIT) MUNICIPALITIES

Atchison County

Gardner

Lansing

City of Leavenworth

Leavenworth County

Leawood

Lenexa

Merriam

Olathe

Shawnee

Fairway

Ottawa

Junction City

Chanute

MEMORANDUM

Kansas Legislative Research Department

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Telephone (913) 296-3181 FAX (913) 296-3824

November 4, 1992

ISSUES CONSIDERED BY THE JOINT COMMITTEE ON HEALTH CARE DECISIONS FOR THE 1990S

I. Changes in the Health Care Delivery System – National Proposals

The Joint Committee on Health Care Decisions for the 1990s has reviewed a number of different proposals for reform or restructuring of the system through which health care is provided and financed in the United States. The following represent the major variations that the Committee has considered that are being considered at the national level.

Centralized – Government Controlled Financing and Provision of Care

The most extreme proposals for centralization of both health care delivery and financing are modeled on the British National Health Service under which health care services are delivered by providers who are employees of the National Health Service in clinic and hospital settings that are also managed and owned by the National Health Service. All individuals are covered by the National Health Service although there are also providers in private practice and institutional providers in the private sector that provide services for individuals who choose to seek and pay for their services. Thus, the British National Health Service does not fund or deliver total health care services although public funding in believed to represent slightly over 90 percent of expenditures.

Although the British National Health Service was the model for national health insurance plans that were proposed in earlier decades, there are no current proposals that are either widely advocated or supported by a group with national scope that embody the total government role that would result from adoption of a health benefits plan modeled on the National Health Service. Descriptions of the British National Health Service have been included in written material reviewed by the Joint Committee.

Publicly Funded

Over the past several years there have been proposals introduced in Congress that would replace the current private-public system of financing health care in the United States with a

Attachment 6
House Financial Institutions
& Insurance
January 25, 1993

universal access, publicly funded model. Examples of such proposals before Congress are H.R.16 introduced by Congressman Dingell *et al.* that would provide universal health insurance through the establishment of a national single-payer health insurance program funded in part by a National Health Care Trust Fund that, in turn, would be partially funded by a value added tax. H.R. 1300 introduced by Congressman Russo and others would create a universal single-payer health insurance plan funded through a National Health Trust Fund financed by a number of specified new federal taxes. Other examples were provided the Committee in the testimony offered by Janet Murgia.

There are currently proposals before Congress in which the government would replace the insurance industry and finance all health care. These proposals differ from the British National Health Care System in that the government would not provide care. Some proposals differ from the Canadian system in that all funding would be federal rather than a combination of federal, provincial, and private funding.

Single Payer – Multiple Funding Sources

The Canadian model of a single-payor system that the Joint Committee heard described in a January, 1991 meeting is an example of a health care system that is pluralistic in funding although largely dependent on federal and local taxes for the financing of about 75 percent of all health care. However, the Canadian system includes a privately financed component in the form of employer based insurance that covers services not included in the provincial plans, donations for capital projects, and the private purchase of services. Under the Canadian system, universal access to health care is largely underwritten by the federal and provincial governments with funding raised from taxes. [Two of the provinces also charge residents an annual health insurance premium.] Under the Canadian system, the federal government contributes federal funding to each province, which in turn, raises the provincial share of funding through taxes of various types. Each provincial government is responsible for setting operating budgets for hospitals and the negotiation of fees with professional provider associations.

Several of the proposals reviewed by the Committee would retain the employer-employee based health insurance funded through employer and employee contributions as in the current system, but would expand publicly funded coverage to include those who are not now covered by employment based health insurance. Even though there would be a continued reliance on a pluralistic funded health care system there would be payment for services concentrated in one entity that would be responsible for the negotiation of budgets or capitated payments for institutional care and negotiated fee schedules for individual providers that would apply to all payers. The AFL-CIO proposal presented to the Committee recommends that a federal agency negotiate uniform reimbursement rates for hospitals, physicians, and other providers. The UNY-Care proposal of the New York Department of Health would rely on a single statewide billing and claim processing system operated by the state and applicable to all reimbursement for health services.

Mandated Employer Coverage

Several of the health care system reform proposals reviewed by the Joint Committee would rely on a continuation and expansion of the existing employment based health insurance

system, along with an expanded role for publicly financed coverage for those who do not qualify for such coverage.

In several of the proposals reviewed by the Committee, employers would be mandated to provide a basic level of health insurance for all full-time employees, with the unemployed and others who do not obtain insurance through employment to be covered by an expanded Medicaid program or a similar program financed by the federal government and the states. The Hawaiian employer mandated coverage, along with the SHIP program, and subsidies for certain employers is an example. Other employer mandates reviewed by the Committee are exemplified by the Kennedy-Waxman bills introduced over the last several years and the Pepper Commission proposal.

There are variations on the employer mandate solution to universal access such as employer "pay or play" exemplified by the Massachusetts legislation and the Employer Coalition proposal as well as several others reviewed by the Commission. Under these proposals, an employer who chose not to offer health insurance would pay a tax for the support of public coverage that would be available to his employees. Many of the employer mandate plans would exempt small employers, as that term is defined in the individual proposal, from the mandate. Others would subsidize small employer coverage with public funds or phase-in coverage by small employers. Some proposals would utilize tax incentives to encourage small employer participation. Some would require the employer to pay a percentage of the cost of the health insurance or to pay for the cost of certain defined basic benefits. One proposal would allow small businesses to purchase coverage through the public program in order to benefit from the cost savings engendered from large programs. The most publicized of the "pay or play" proposal, the Massachusetts Universal Health Access Plan, has not been implemented although it was originally scheduled for implementation one year after enactment of the legislation. The Massachusetts Legislature has three times delayed the implementation date and come close on two occasions to repealing this provision of the law.

The most publicized of the "pay or play" proposals is Health America (S. 1227) introduced last June by Senate Majority Leader George Mitchell. In addition to imposing a "pay or play" scheme, the bill would create a federal expenditures review board charged with setting rates for medical care, require standardized claim forms, provide for outcomes research, allow states to experiment with alternatives to the current litigation-based malpractice system through grants to the states, increase federal funding for community health centers, give the states flexibility to design their own health care systems, and set federal standards for small group health insurance.

All the employer mandate proposals reviewed by the Committee include an expanded publicly funded program to cover those not eligible for work-related coverage or existing public coverage. Several would include either all persons with incomes below the federal poverty level or persons with income below a specified percentage above the federal poverty level. One would make publicly funded coverage available as a buy-in for anyone who is self employed, uninsurable, or otherwise not covered by an employer based plan.

Employment based proposals also vary in whether they would require coverage of specified benefits, would require or reward managed care systems, limit the out-of-pocket costs of employees, etc.

Individual Mandated Coverage

Less common than an employment based mandate, are proposals that would redirect mandates from the work site to the individual by mandating that all individuals secure private health coverage. In terms of presentations heard by the Joint Committee, these proposals are similar to the German health benefit system in which all individuals are required to participate in a privately operated health benefit plan. In general, such systems would rely on tax incentives to encourage the individual to be responsible for his or her own health benefits coverage. A proposal by Professor Uwe Reinhardt that was reviewed by the Committee would exempt individuals who participate in private coverage from a tax that would be imposed on an income-related basis to pay for a government sponsored basic benefit package.

From press reports, it appears that the proposal that Senator Kassebaum has introduced is based on the concept of requiring everyone to carry a single, nationally uniform BasiCare insurance that every insurer would have to offer. Insurance companies would be barred from offering any plans that would duplicate BasiCare, but could offer supplemental policies. BasiCare would be subject to strict regulation in terms of denial of coverage, rates, and discrimination on the basis of health status. Government would set broad annual limits on allowable rate increases, and the private sector would be responsible for finding ways to keep health care costs within the government prescribed budget.

Tax Strategies and Voucher Systems

The proposals that would least disrupt the current health care delivery and funding system would guarantee access to insurance coverage for low-income individuals and families through the issuance of vouchers that could be used to purchase insurance or offset the cost of employer-sponsored health benefit plans. Implicit in several of the voucher proposals is a corresponding tax credit or other tax strategy that would ameliorate the cost of health insurance for other than low-income individuals and families.

The most publicized of the tax related reform proposals is that proposed by President Bush which would allow low and moderate-income families to be eligible for a transferable tax deduction to cover health insurance costs up to specified maximums. Individuals could take either a tax deduction or a tax credit, whichever was most advantageous. Low-income families that do not earn enough to pay taxes could receive a tax credit in the form of a voucher that they could use to purchase insurance (transfer of a voucher could only be to a private insurer or HMO for the purchase of health benefits.) Vouchers would be administered by the states, and the states would be responsible for working with private insurers to develop basic benefit packages that correspond in terms of cost with the tax credit. Health insurance reforms are also included in the Administration proposal, including required coverage for all groups that request insurance, guaranteed renewability, the barring of pre-existing condition exclusions when transferring from one group to another, a ban on state laws requiring mandated benefits, premium price restrictions, health risk adjustment across all insurers, and the establishment of networks of small business groups to reduce the cost of administering health insurance policies. Other proposals relate to malpractice reform, then use of a single claim form, and increased federal spending on primary and preventive care services. In terms of funding, the Administration proposal depends on savings from cost containment provisions and some changes in Medicare and Medicaid.

II. Changes in the Health Care Delivery System – Kansas Proposals

Bills have been before the Kansas Legislature that would create changes in the manner in which health care is financed and delivered in Kansas. Many of the proposals before the Legislature would build on one or more of the proposals that are being considered at the national level.

Senate Bill No. 179

S.B. 179 was introduced in 1992 and primarily related to health insurance reform, some of which was accomplished by enactment of H.B. 2001 in 1992. However, Section 6 of the bill was similar to a bill considered the previous year that was drafted by and introduced at the request of the Commission on Access to Services for the Medically Indigent and Homeless. The previous bill was amended by the Senate Committee on Financial Institutions and Insurance, and the amendments were reflected in Section 6 of S.B. 179.

Under the provisions of S.B. 179, the Kansas Health Benefits Program would have been created and the Secretary of Social and Rehabilitation Services directed to establish a statewide program under which qualified individuals and their dependents would have access to limited medical and health benefits through the payment of monthly premiums established by the Secretary. The Secretary would have administered the program through the structure used to administer Medicaid. During the first two years of operation of the program authorized by the bill, the benefits would have been limited to the services of persons licensed to practice medicine and surgery, pharmacy services, and limited hospital services, not including organ transplants and emergency hospital services. Copayments would have been required for the services offered under the program. Following the first two years, the Secretary would have reported to the Governor and Legislature any recommended changes in benefits.

In order to qualify to participate in the health benefits program authorized by S.B. 179, an individual would have to have been a resident of Kansas, have an income not in excess of 150 percent of the federal poverty level, not have an employer who offered health benefits, and not be eligible for governmental programs or insurance. As an alternative, a resident who was unable to purchase health insurance because of health conditions and not covered by Medicaid or Medicare could have qualified for participation.

The Secretary of Social and Rehabilitation Services would have been required by S.B. 179 to apply for waivers to operate the Kansas Health Benefits program as a demonstration program, and the program would have been in lieu of MediKan.

Senate Bill No. 205

S.B. 205 was introduced in 1991 and referred separately to the Senate Committees on Public Health and Welfare and Financial Institutions and Insurance. The bill would have created a Kansas Health Care Commission as a corporate entity and charged the Commission with providing

a single, publicly financed statewide insurance program that provided comprehensive coverage for health care services for all Kansas residents. The bill also directed the board of governors of the Commission to establish a Kansas Health Care Trust Fund within which would have been established (1) a prevention account that was to be used solely for the purpose of establishing and maintaining primary community prevention programs, and (2) a health services account from which participating providers were to be reimbursed for services provided to insureds. A Health Professional Education and Training Fund also would have been established within the State Treasury by S.B. 205.

Under the provisions of S.B. 205, any Kansas resident would have been eligible for coverage under the state-administered health insurance program created pursuant to the bill; covered and noncovered services would have been defined in the law; providers would have been prohibited from refusing to provide services to eligible insureds; payment and reimbursement for providers would have been negotiated annually; and Social and Rehabilitation Services would have been required to request specified waivers from federal Medicaid laws and regulations. The universal, single-payor health insurance that would have been provided pursuant to S.B. 205 would be funded by

1. employer paid health premium surcharges equal to 8 percent of the total amount each employer paid in wages for all persons employed by such employer,

2. quarterly estimated payments by self-employed persons and independent contractors equal to 8 percent of such person's Kansas adjusted gross income,

3. a surcharge on each Kansas resident who received interest in an amount over $1,000 a year at the rate of 2 percent of the interest received,

4. a surcharge on each resident who received over $1,000 a year from dividends at the rate of 2 percent of the dividends received,

5. a surcharge added to the state income tax at a varying percentage set out in the bill,

6. a surcharge on cereal malt beverages equal to 10 percent of the retail price, and

7. a surcharge on cigarette and tobacco products equal to 10 percent of the retail price.

S.B. 205 died at the end of the 1992 Session.

Senate Bill No. 553

S.B. 553, introduced in 1992, was referred to the Senate Committee on Public Health and Welfare which held hearings on the bill.

The bill would have created the Kansas Health Care Reform Act under which a corporate entity to be known as the Kansas Health Care Commission would have been created and

governed by an appointed board of directors. The Commission would have been responsible for administering a single-payor, publicly financed, statewide health insurance plan that would cover all Kansas residents. The bill established a copayment schedule based on Kansas taxable income, itemized noncovered services, barred participating providers from refusing services to eligible insureds based on reasons set out in the bill, provided that eligible residents were to receive services regardless of preexisting conditions, and required Social and Rehabilitation Services to apply for certain Medicaid waivers.

Under the provisions of the bill, a Kansas Health Care Trust Fund would have been created in the State Treasury, and the Legislature would have been required to appropriate all revenue resulting from surcharges established by the bill to the Trust Fund. Within the Commission itself, there would have been established an Education, Training, and Research Board, an Evaluation Board, a Health Planning Board, and a Health Services Payment Board. An account within the Health Care Trust Fund would have been established corresponding with the individual boards, and the responsibilities of the boards and purposes of the accounts were as specified in the bill.

Under the terms of S.B. 553, each health facility would have negotiated an annual budget with the Health Services Payment Board to cover the services to be provided in the following year. The annual budget would have been based on past services provided and projected changes in prices and service levels. Individual health service providers would have been required to make an annual election of a choice of reimbursement mechanisms set out in the bill. Participating providers could not have a financial interest or professional association with a facility where tests or procedures ordered by the provider are carried out.

S.B. 553 would have established a procedure for the issuing of facility permits by the Health Planning Board prior to undertaking projects of the type specified in the bill and made the securing of a review and permit a condition of application for a new license. Procedures and guidelines for review and issuing of facility permits and the revocation of permits were set out in the bill. Certain facility projects were exempt from review under the bill.

The publicly funded health insurance made available to all Kansas residents under S.B. 553 would have been paid for through

1. employer paid health premium surcharges equal to 8 percent of the total amount of wages paid by such employer,

2. a health premium surcharge paid by self-employed persons and independent contractors at the rate of 8 percent of quarterly estimated Kansas adjusted gross income,

3. a surcharge at the rate of 2 percent on all interest received by a Kansas resident on amounts exceeding $1,000 a year,

4. a surcharge at the rate of 2 percent on each resident who receives dividends in an amount exceeding $1,000 per year,

5. a surcharge on the state income tax based on various percentages set out in the bill,

6. a surcharge on cereal malt beverages at the rate of 10 percent of the retail price, and

7. a surcharge at the rate of 10 percent of the retail price of cigarette and tobacco products.

S.B. 553 died at the end of the 1992 Session.

Senate Bill No. 647

S.B. 647, introduced in 1992, was referred to the Senate Committee on Public Health and Welfare which held hearings on the bill.

The bill would have created the KanCare Comprehensive Health Act under which a nine-member, appointed board would have appointed a Secretary of Health Care to administer the act under the direction of the board. The bill also would have created the KanCare Fund to receive all money received under the act and appropriated by the Legislature from which expenditures for KanCare would have been made. Tax increases prescribed by the bill would have been transferred from the State General Fund to the KanCare Fund.

Any person who had been a resident of Kansas for five years and in good standing with the Department of Revenue by filing an income tax return, if required to file, would have been eligible to subscribe to KanCare. Any person who wished to subscribe to KanCare for coverage of health-related services would have been required to pay an amount equal to one dollar per day for the subscriber and a dollar a day for each family member covered by KanCare. Payments would have been collected in conjunction with the subscriber's income tax payment, either through quarterly or annual payments or withholding from wages or other compensation. A subscriber would have been entitled to receive basic health care services under KanCare, not including the exclusions listed in the bill. The subscriber would have been responsible for a $100 annual deductible and a 50 percent copayment on drugs furnished through KanCare. Maximum lifetime expenses were also prescribed by the bill as was a maximum malpractice recovery limit. Subscribers could have elected to receive services from among the health care providers who agreed to participate in KanCare. Health care providers who agreed to participate could do so on the condition they agreed to accept fees for services according to a fee schedule established by the KanCare board.

In addition to subscriber fees, KanCare would have been funded through an increase of $.01 per gallon of beer; $.02 per gallon on wine containing 14 percent or less alcohol; $.04 per gallon on wine containing more than 14 percent alcohol by volume; and $.13 per gallon on alcohol and spirits. The tax on cigarettes would have been increased by $.20 on each pack of cigarettes containing 20 cigarettes and $.31 on each 25-cigarette package. The bill would have imposed an inventory tax of $.25 on each 20-cigarette pack and $.31 cents on each 25-cigarette package. A tax increase of $.28 on cereal malt beverage barrels of 31 gallons would have been imposed.

S.B. 647 died at the end of the 1992 Session

House Bill No. 3026

H.B. 3026 was introduced in 1992 and assigned to the House Committee on Insurance which held hearings on the bill. The bill would have created the Kansas Universal Health Care Access Act and initiated small group insurance reforms, including community rating. The portion of the bill that created the Kansas Universal Health Care Access Act would not have become effective until the Insurance Commissioner had received an exemption from ERISA.

Under the provisions of H.B. 3026 that would have created the Kansas Universal Health Care Access Act, any eligible person, defined as an individual who resided in Kansas for 24 months and who was not covered by a third-party payor, Medicaid, or Medicare, or was not eligible to be covered by a qualifying health benefits plan, could receive a voucher from the Insurance Commissioner who was directed by the bill to develop and administer a health care voucher program. The voucher could be exchanged for an accident and health policy or HMO coverage and would have been required to be accepted as full payment for such coverage. The Commissioner was directed by the bill to develop a sliding fee scale based on income for cost sharing for vouchers issued under the plan. The maximum value of a voucher would have been equal to the lowest annual premium for accident and health insurance or HMO. Vouchers would have been redeemed by the insurer or HMO from the Kansas Health Care Services Trust Fund created by the bill. The Trust Fund would have been the depository for all monies appropriated by the Legislature to the Commissioner and all money received from copayments and other dedicated revenue sources. The Legislature would have been required by H.B. 3026 to make an annual appropriation to the Trust Fund in an amount equal to revenue collected from surcharges imposed pursuant to the provisions of the bill.

The health benefit coverage available through vouchers authorized by H.B. 3026 would have been funded in part through

1. an employer contribution tax equal to 4 percent of wages paid by an employer who does not offer a qualifying health benefit plan to such employer's employees,

2. a health premium tax equal to 4 percent of Kansas adjusted gross income tax imposed on independent contractors or self-employed individuals,

3. a premium tax surcharge of 2 percent of total health benefits premiums collected by insurers or health service corporations selling accident and health insurance, including union and welfare funds and self insurers, and

4. a surcharge on Kansas taxable income of 4 percent levied on every <u>eligible</u> person in the state.

An employer could agree to pay all or part of the employee's surcharge and such payment would not be considered income for Kansas income tax purposes.

H.B. 3026 also included provisions identical to S.B. 561 as introduced, placed strict limits on health insurance rate increases based on a percentage increase above the CPI for the previous year, included the provisions relating to community rating deleted from 1991 H.B. 2001, and required

the Insurance Commissioner to seek a waiver from the application of the Federal Employees Income Security Act of 1974 (ERISA) in Kansas.

H.B. 3026 died at the end of the 1992 Legislative Session.

III. Increased Access to Health Insurance – Kansas Actions

One manner of increasing access to health care is to improve the availability of health insurance for Kansas residents, particularly those who are employed by small employers that have had difficulty in obtaining group health insurance at all or who have been forced by market practices to discontinue group health benefits because of increased cost. Other Kansans have faced exclusion from group coverage because of existing illness, disease, or health conditions that make them high risks and are unable to secure individual coverage in the market due to uninsurability or high cost resulting from the risk they represent. The Kansas Legislature has been addressing the insurance issues since 1988.

1988

S.B. 539 amended K.S.A. 40-2209, which related to group accident and health insurance, to prohibit any policy providing benefits to any member of a single employer group from containing any provision preventing any employee from insurance coverage, with some exceptions. An employee or dependent who did not enroll by the end of an open enrollment period could be subject to a waiting period, not to exceed one year, for any preexisting condition and any hospitalization in progress at the time of enrollment need not be covered. The group plan could provide for participation requirements and define "full-time" employee for the purposes of participation.

1990

H.B. 2010 created the Small Employer Health Benefit Act under which any two or more employers who qualify under the act may establish a small employer health benefit plan and contract with carriers for health insurance as described in the act. To qualify as small employer under the act the employer must employ no more than 25 employees, not have contributed to any health insurance premium on behalf of any employee in the preceding two years and make a minimum contribution as set by the plan toward the premium incurred on behalf of a covered employee. In order to encourage small employers to enter into a plan created under the act, any insurance provided under a small employer health benefit plan is exempt from mandates and is exempt from premium tax. In addition, the employer who provides insurance under a plan created pursuant to the act may be eligible for a tax credit and any contribution made by the employer toward the premium is not to be counted as income to the employee for purposes of Kansas income tax. The Small Employer Health Benefit Act was amended by the 1992 Legislature to any employer with 50 or fewer employees.

Also in 1990, the Legislature amended the Municipal Group-Funded Pool Act that allows municipalities to pool their workers' compensation liability. The Act was expanded to allow

the pooling of liability for health and accident insurance and life insurance. The effect of the 1990 action was to make health insurance coverage available and, perhaps, at a rate less than the rate at which the individual municipality could purchase coverage for employees.

1991

The 1991 Legislature enacted H.B. 2001 which made a number of changes in the regulation of group accident and sickness policies, including prohibiting the exclusion of any person eligible for coverage under a group; providing that eligibility applies to all Kansas insureds regardless of the place of issuance of the policy; prohibiting any limitation or exclusion of benefits for specific conditions existing at or prior to the date of coverage; allowing up to a one-year waiting period for conditions diagnosed, treated, or for which medical advise was sought or received in the 90 days prior to the effective date of the coverage; requiring that, to the extent any waiting period is served under a "replaced" policy, it shall be considered served under a new policy with no gap in coverage (portability); requiring that all forms, risk classifications, and premium rates be filed with the Commissioner of Insurance prior to putting them into effect (file and use); prohibiting rate increases in excess of 75 percent in one year unless the insurer can document a material and significant change in the risk characteristics of the group; prohibiting rate classifications, rates, etc. that are unreasonable, excessive, or unfairly discriminatory; and prohibiting rate classifications within a group that are based on medical conditions.

The 1991 Legislature also directed the Insurance Commissioner to devise universal accident and sickness insurance claim forms that must be utilized by all insurers, HMOs, and nonprofit health-care related service corporations. Such forms have been developed.

1992

H.B. 2511 creates a new act to be known as the Kansas Uninsurable Health Insurance Plan Act, under which a nonprofit legal entity that will be named the Kansas Health Insurance Association is created to make limited health insurance available for eligible persons who are unable to secure health insurance in the market or are unable to secure such insurance at a premium rate that is less than that set for participants in the limited coverage to be marketed by the Association. Insurers and fraternal benefit societies providing "health insurance" as that term is defined in the bill; health maintenance organizations; Blue Cross-Blue Shield and dental and optometric nonprofit health care service plans; multiple employer trusts; associations or other organizations that provide members health care services or benefits; group funded pools; and certain self insured health benefit plans are required to participate in the Association. Association members share the risks and costs of the insurance that is to be made available through the Kansas Uninsurable Health Insurance Plan developed by a board of directors selected by members of the Association and approved by the Commissioner of Insurance.

Among other requirements, the operating plan developed by the Kansas Health Insurance Association must provide for appropriate cost control measures, including preadmission review, case management, utilization review, and exclusions and limitations on the treatments and services covered under the plan; for assessments against members of the Association; and for a program to publicize the availability of insurance under the plan. The insurance to be offered may

cover only those health care expenses enumerated in the bill, including such limitations and optional benefits levels as prescribed by the plan. The laws mandating coverage of specific services or benefits are not applicable to insurance offered under the plan, but the mandates relating to coverage of the services of specific health care providers are to apply. The plan may, however, incorporate provisions that direct covered insureds to the most appropriate, lowest cost health care provider and, subject to the approval of the Commissioner of Insurance, the board of directors must review and recommend the inclusion of coverage for mental health services and such other primary and preventive health services as it determines will not materially impair affordability of the plan. All coverage is to be subject to copayments and deductibles as set by the board of directors, subject to limitations set out in the legislation. At least one option must provide for a minimum annual deductible of $5,000, and any coverage under the plan is to be subject to a maximum lifetime benefit of $500,000 per individual. In the first two years of operation of the plan, coverage must exclude any charges or expenses incurred for a preexisting condition for 12 months following the effective date of the coverage. In succeeding years exclusion of preexisting conditions is to be determined by the board, but may not exceed 12 months. Any applicant for insurance provided under the plan is to be provided with a form for making a declaration directing the withholding or withdrawal of life-sustaining procedures in a terminal condition that is in substantial conformance with the form in the Kansas Natural Death Act.

In the first two years of the plan's operation, rates are required to be set in an amount that is estimated by the board to cover the cost of all claims and the expense of operating the plan. In subsequent years, the premium rate must be reasonable in terms of the benefits provided. Premium rates and rate schedules may reflect appropriate risk factors such as sex, age, and geographic location and take into consideration appropriate risk factors in accordance with accepted actuarial and underwriting practices. Rates may not be based on the health conditions or illness of the applicant for insurance. All members required to participate in the Association are subject to an annual assessment to pay a proportionate share of losses incurred by the plan during the previous year. Any net gains would be held to offset future losses or reduce future premiums. In addition to any losses to be offset by assessments, all members of the Association can be assessed for the initial costs of developing and implementing the insurance plan to the extent that funds authorized to be loaned from the Pooled Money Investment Board in the first four years are insufficient to pay such initial costs. Eighty percent of the assessment made against a member, except for those made during the first four years of operation, can be claimed as a credit against the member's premium or privilege tax. In order to be eligible for insurance under the plan created by the Kansas Health Insurance Association, an individual must have been a Kansas resident for at least six months prior to applying for insurance and meet one of the following criteria:

- had health insurance coverage involuntarily terminated other than for nonpayment of a premium; or
- applied for health insurance and been rejected by two carriers because of health conditions; or
- applied for health insurance and been quoted a premium that is more than 150 percent of the premium set by the plan in the first two years of the plan's operation or, in succeeding years, is in excess of the plan's premium rate in an amount set by the board; or

- been accepted for health insurance subject to a permanent exclusion of a preexisting condition.

No person is eligible for coverage under the plan who is a recipient of Medicaid, eligible for Medicare, or for any other public or private program that provides or indemnifies for health services, or if such person has access to health insurance through an employer-sponsored group or self-insured plan, has had coverage under the Association plan terminated within the preceding 12 months, or has received accumulated benefits in excess of the lifetime limit established under the law.

Providers of health services that are to be indemnified through the insurance offered under the plan would have to enter into provider agreements with the plan under which rates of reimbursement for covered services would be set by the board, and no provider of health care services could collect an additional fee or charge from the insured except authorized copayments and deductibles and fees for noncovered services if the insured has been informed in advance that the service is not covered.

H.B. 2511 authorizes loans in the amount of $500,000 annually for four years from the Pooled Money Investment Board to an Uninsurable Health Insurance Plan Fund created by the legislation in order to assist with the start-up costs and expenses of the plan. Moneys loaned under this provision are required to be repaid over a ten-year period. Other provisions of the bill relate to audits and reports required to be made to the Joint Committee on Health Care Decisions for the 1990s.

S.B. 561 requires, on and after May 1, 1993, every carrier issuing or maintaining health benefits plans covering small employers, as a condition of transacting such business in Kansas, to offer at least a basic and a standard small employer health care plan to any small employer group seeking such coverage (guarantee issue). For the purposes of S.B. 561, a "small employer" generally is defined as one with 25 or fewer employees; however, a group covered under the plan may continue in the plan even though the group may have grown beyond the cap of 25 if the board and the carrier agree to its continuation. "Carrier" is defined to include insurance companies, nonprofit medical and hospital service corporations, and health maintenance organizations.

Health benefit plans made available to small employers will be designed by an 11-member board of directors created pursuant to S.B. 561 and will identify benefits levels to be provided as well as any deductibles, coinsurance factors, and exclusions and limitations. The board of directors also is to serve as the governing body of the reinsurance program that will be created pursuant to the bill.

S.B. 561 applies the existing statutory mandates relating to providers to both the basic and standard health benefits plans that are required to be offered and sold to small employers. Further, the board of directors shall review and recommend the inclusion of specified benefits set out and other health services in both the basic and standard plans, subject to the approval of the Insurance Commissioner and subject to the development of a plan that is cost effective and meets the most critical needs of small employers and their employees. The board is permitted but not required to incorporate provisions in the plans that direct insureds to the most appropriate and cost effective available service provider.

Since carriers are required to offer health care plans to any small group soliciting such coverage, the bill allows the carrier to classify the groups for purposes of establishing premium rates. However, the health status or past claims experience of the small group may not be used in determining the classifications. Carriers may establish not more than a one-year waiting period for a pre-existing condition, *i.e.*, is a condition for which diagnosis, treatment, or advice was sought or received within six months immediately preceding the effective date of coverage. The bill allows carriers to adjust premium rates based on specific formulae set out and subject to annual actuarial certification of compliance to the Insurance Commissioner. In no case, however, can an annual premium increase more the 75 percent over the previous rate.

Further, because of the guarantee issue provision of the bill, S.B. 561 authorizes reinsurance of certain risks through the Kansas Small Employer Health Reinsurance Program. The Program is authorized to reinsure only group risks with the original carrier being required to retain specific amounts of liability for the group reinsured. If the Program should have insufficient funds to cover losses, assessments would be made first upon carriers with risks in the Program and, secondly, to all writers of accident and sickness insurance policies or contracts in Kansas. Maximum assessments would be established that might be levied upon the carriers and a second tier of assessments will exclude from the assessment ratio any premium earned by a small employer carrier from small employer plans that are mandated by the bill.

IV. Health Care Provider Access

The Joint Committee heard several presentations relating to providers of health care, including credentialing issues, crosstraining, increased charity care, expanded use of alternate care providers, and the shortage of primary care physicians.

Credentialing

The issues raised in the discussion of credentialing include whether new health care provider groups should be credentialed by the state in some manner. Another issue is whether the credentialing review process should be continued and supported by the Committee or changed in some manner. Additionally, the issue of whether current laws impede the most efficient and effective use of health care providers who are not credentialed was raised, *i.e.*, are there blocks raised by licensing or registration that prevent the use of noncredentialed or nonacademically trained providers in health care services that may be qualified to provide through on-the-job or other training. Who should be responsible for decisions relating to the qualifications of ancillary health providers -- the employer or a state board that licenses or registers certain providers?

Crosstraining

The Joint Committee heard a presentation on the use of individuals who are trained for a particular health care service to provide other services for which their training qualifies them or to be trained in such manner as to be qualified to provide more than one health care service. There

are a number of issues that arise from this concept, among them the need to review existing laws to determine whether they inhibit the use of individuals who are crosstrained and the need to revamp health care provider education to allow a mix of skills to be included rather than increasing the amount and duration of training for a specific health care provider skill. In addition, state rules and regulations may inhibit the use of an individual provider in more than one role. The issue of who determines the appropriate role of a health care provider also applies in this area. Should decisions relating to the use of individuals in dual roles be left up to the employer or rest with state licensing boards?

Charity Care

Several issues have been raised in regard to charity care. Among them is the issue of what is necessary to encourage additional charity care on the part of licensees in medicine and surgery. Suggestions have been made that the Kansas Tort Claims Act be further amended to include coverage for the care of Medicaid clients and in settings other than local health departments when reimbursement for the care is provided. Constitutional issues are raised by any further attempts to extend the definition of state employees under this Act.

Questions have been raised about the role of the state-funded health care provider education programs in the provision of expanded charity care.

Alternate Care Providers

There appears to be agreement that increased access to primary and preventive care services will be dependent, in part, on the increased use of mid-level providers, particularly nurse practitioners and physician assistants. Several previous interim committees and the Commission on Access to Services for the Medically Indigent and Homeless have recommended state assistance or support for the development of training programs that qualify registered professional nurses to be certified as advanced registered nurse practitioners without securing a masters' degree in nursing. A study done for an interim committee several years ago indicated that the recent masters' graduates in nursing were not entering direct patient care services on graduation in great numbers, but were going into administration, teaching, and other nonpatient care positions. On the other hand, the nurses who had completed the now defunct Wichita State program for nurse clinicians that did not require a graduate degree for completion had primarily returned to practice in less populated areas to engage in direct patient care services following completion of the nurse clinician training program and had tended to remain in this type of practice. The only training program for physician assistants in Kansas at Wichita State has recently changed to a four-year program leading to a degree even though the Kansas law does not require this level of training to be placed on the register of qualified physician assistants.

Primary Care Physicians

The Joint Committee heard presentations on the shortage of primary care physicians (family practice, general internal medicine, pediatrics, and ob/gyn specialties) both in rural areas and in urban areas. In addition, the Committee heard of the difficulty that the Medicaid program is

experiencing in some areas of the state in access to primary care providers for Medicaid clients. Presentations were made by the Medical School and by representatives of family practice specialists on efforts to persuade more medical students to enter primary care. The Committee has initiatives proposed by the Medical School to increase the number of students who enter primary care specialties.

V. Cost Containment

In setting the agenda for 1991-1992, the Committee included a study of cost containment measures -- specifically certificate of need or other regulation of facility, equipment, or service expansion; provider caps; mandatory charity care; and other regulatory measures. At the present time only one of these issues has been addressed by the Joint Committee, the issue of a modified certificate of need or other means of controlling unnecessary expansion or development of facilities, services, or equipment. The Committee has received testimony in regard to local and statewide concerns about the development of duplicative facilities and services.

VI. Rural Health

The other issue that is has been addressed by the Committee is that of encouraging the development of rural health clinics and community health centers. One issue that impacts on community health center designation for some local health departments that might otherwise be able to qualify is that of the board of health. Outside of joint city-county or multi-county health departments, the board of health is, by statute, the board of county commissioners. Federal law requires that the board of a community health center be composed of at least 50 percent consumers of health care.

See also Memorandum entitled "Health and Health Related Legislation Enacted in 1992."