Approved: March 22, 1994
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 March 10, 1994 in Room 527-S of the Capitol.

All members were present except: Representative George Teagarden, Excused

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
Chip Wheelen, Kansas Psychiatric Association
Larry Buening, KS Board of Healing Arts
John Peterson, KS Assoc. of Professional Psychologists
Joe Furjanic, Kansas Chiropractic Association
Ron Hein, Healthy Alliance Life Insurance Company

Others attending: See attached list

HEARING ON SB 486: Investments of insurance companies, health maintenance organizations

This bill would allow insurance companies to invest in stock in health maintenance organizations.

Dick Brock, Insurance Department, explained that the statutes regarding investment of insurance companies already permit investment in the stock of another insurance company but they contain no reference to the stock of health maintenance organizations (Attachment 1). It is somewhat inconsistent and confusing to permit domestic insurers to invest in insurance companies but not HMO's.

HEARING ON SB 487: Regulation of utilization review organizations

The bill directs the Insurance Commissioner, with the advice of an advisory committee, to establish standards governing the conduct of utilization review activities. Unless granted an exemption by the Commissioner, no utilization review organizations may conduct such review activities in Kansas, or affecting residents of Kansas, on or after May 1, 1995, without first obtaining a certificate from the Commissioner. The advisory committee would advise the Commissioner on the adoption of rules and regulations establishing utilization review standards and procedures.

Dick Brock, Insurance Department, reported that the bill is the product of a study conducted pursuant to 1993 SCR 1605 requiring the Insurance Department to conduct a study of utilization review activities and organizations and report to the 1994 legislation (Attachment 2). The legislation would establish a statutory regulatory structure that would serve to identify and guide the conduct of persons and firms performing utilization review services affecting Kansas citizens. The study was divided into two parts:

1. Development of standards which should be followed in the conduct of prospective and concurrent utilization review for admissions to hospitals, outpatient surgical center or other health care facilities such as skilled nursing or rehabilitation centers.

2. The enabling portion of the bill which would require that the Commissioner prepare and adopt regulations establishing standards to govern the conduct of utilization review activities.

The bill also provides for the creation of an advisory committee consisting of the Commissioner, a public member, four representatives of utilization review organizations and five representatives of health care providers including one hospital representative and two persons licensed to practice medicine and surgery.

Also addressed in the bill is the prohibition of compensation arrangements which would give a utilization review organization, its employees or agents any monetary incentive to deny certification or approval of medical care recommended by the attending physician. Confidentiality is also addressed.

Mr. Brock discussed the proposed balloon amendment which would more explicitly carry out the task force's intent. The first amendment would add duly licensed psychologists to the definition of health care provider. The second amendment identifies the types of utilization review activities that require more consideration and specifically exempts them from the certificate requirements until the necessary standards are developed and included in the administrative regulations.

Mr. Chip Wheelen, Kansas Medical Society and Kansas Psychiatric Society, expressed appreciation and support for the bill as KMS has been concerned about the lack of accountability in utilization review practices of some insurance companies or contractors for some years (Attachment 3).

Larry Buening, Jr., Executive Director of the Kansas Board of Healing Arts, expressed concern regarding the present language of the bill (Attachment 4). The Board suggests the following:

1. The effective date for the act be extended from July 1, 1995 as it would relate to utilization review which is not dealt with in the rules and regulations proposed by the task force.

2. Clear authorization for the Commissioner to suspend or revoke a URO's certificate if review determinations in an individual or multitude of cases are clearly incompetent, capricious and without foundation.

3. There is no provision which would require utilization review organizations to report instances of substandard care to the appropriate licensing agency for the profession involved.

4. The Board requests authority to issue certificates to utilization review organizations and to take action to revoke or suspend certificates.

5. The Board requests that a provision be added which would allow them to provide services to the Insurance Commissioner regarding medical necessity and appropriateness decisions.

6. Neither the bill nor the proposed rules and regulations requires involvement by an individual licensed by any state regulatory agency in the profession involved. The Board strongly feels than an individual who denies or recommends certain treatment to citizens of this state which services have been determined to be appropriate and necessary by an individual who is licensed in this state, should be required to also be licensed and accountable to the state licensing agency for their profession. This may prevent some turf battles.

John Peterson, Kansas Association of Professional Psychologists, said the bill does not deal with who will sign off on any particular problem. The terms "health care professional/health care provider/personnel require more detailed definition. He suggested the usage of one defined term throughout the bill.

Joe Furjanic, Kansas Chiropractic Association, requested an amendment be added to include chiropractors as health care providers if all are going to be reviewed.

Tom Bell, Kansas Hospital Association, presented written testimony (Attachment 4A).

HEARING ON SB 522: Insurance companies to report acquisition and disposition of assets

This bill requires every domestic insurance company to report to the Insurance Commissioner all transactions involving more than 5% of an insurer's total admitted assets, and all nonrenewals, cancellations or revisions of reinsurance contracts affecting more than 50% of the written premium for property and casualty insurance that has been transferred to another carrier, or more than 50% of the reserve credit taken with respect to life and accident and sickness insurance.

Dick Brock, Insurance Department, said this was another bill required by the National Association of Insurance Commissioners to maintain accreditation (Attachment 5). It will also provide regulators early information regarding transactions that can have a significant impact on an insurer's solvency. This is very sensitive information which could impact impressions regarding a company's financial strength and its policy holders. The proposal makes these reports confidential.

HEARING ON SB 563: Valuation for reserve requirements for life and accident and sickness insurance

The bill would require insurance companies to file actuarial opinion and supporting memorandum as to whether the reserves and related actuarial items held in support of the policies are computed appropriately and comply with Kansas law.

Dick Brock, Insurance Department, reported that the bill would amend which is commonly known as the Standard Valuation Law (Attachment 6). This law stipulates the requirements that insurers must meet in calculating the reserves necessary to assure payment of insurer obligations to policyholders and beneficiaries. The bill incorporates a model NAIC provision to require an annual actuarial opinion that is much more comprehensive than the current requirement. The opinion would address whether the reserves are adequate based on the company's earnings, assets, premium charges , etc. It would also authorize the Commissioner to develop a transition period during which any higher reserves recommended by the actuary would have to be established. Materials used to support the actuarial opinion are not subject to public disclosure except for designated reasons.

DISCUSSION AND ACTION ON SB 485: Designating the secretary of health and environment, as administrator of the health care data base, as statistical agent for the statistical plan for premiums and loss and expense experience by accident and health insurers.

Representative King moved to report the bill favorably and place it on the Consent Calendar. Motion seconded by Representative Minor. Motion carried.

DISCUSSION AND ACTION ON SB 490: Authorizing additional insurance companies to issue homeowners' policies

Jeff Sonnich, Kansas Nebraska League of Savings and Loans, presented an amendment which would allow mortgage guaranty companies to offer mortgage guaranty insurance with a 97% loan to value ratio (Attachment 7). The current law only allows coverage of mortgages up to a 95% loan to value.

Representative Wagle moved to approve the amendment. The motion was seconded by Representative Neufeld. Motion carried.

Representative Cornfield moved that the bill be passed favorably as amended. Motion was seconded by Representative Gilbert. Motion carried.

DISCUSSION AND ACTION ON SB 491: Definition of managing general agents, persons exempt; penalties for violations

Representative Neufeld moved that the bill be passed out favorably and placed on the Consent Calendar. Motion was seconded by Representative Cornfield. Motion carried.

DISCUSSION AND ACTION ON SB 492: Insurance company annual report to be in electronically readable form in accordance with rules and regulations of commissioner.

Representative Dawson moved that the bill be passed favorably and placed on the Consent Calendar. Motion was seconded by Representative Neufeld. Motion carried.

DISCUSSION AND ACTION ON SB 506: Similarity of names prohibited for insurance companies or fraternal benefit societies.

Ron Hein, representing Health Alliance Life Insurance Company, asked that a letter and proposed amendment be made part of the record (Attachment 8). He has been assured by the Insurance Commissioner and a representative of the insurance company proposing the bill that such an amendment is not necessary.

Representative Dawson moved that the bill be passed favorably. The motion was seconded by Representative Crabb. Motion carried.

DISCUSSION AND ACTION ON SB 239: Uniform transfer on death security registration act

Representative Correll moved that the bill be reported favorably. Motion was seconded by Representative Cox. Motion carried.

DISCUSSION AND ACTION ON SB 677: Penalties for fraudulent insurance acts

Representative Cornfield moved that the bill be passed out favorably. Motion was seconded by Representative Dawson. Motion carried.

Representative King moved to accept the minutes of March 3 and 7, 1994. Motion was seconded by Representative Correll. Motion carried.

The meeting adjourned at 5: 25 p.m. The next meeting is scheduled for March 14, 1994.

GUEST LIST

COMMITTEE: _____ DATE: 3/10

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATIC
Dick Brock	Topeka	Ins. Dept.
TOM PALACE	TOPEKA	KNILSI
BOB HAYES	TOPEKA	INS. DEPT.
RAY SCHER	TOPEKA	SELF
[illegible]	Topeka	JRS
DAVID ROSS	TOPEKA	K. Assoc. of Life Underwriters
L M CORNISH	"	Ins. Dept P/C
Kathy Taylor	"	KS Bankers Assn.
[illegible]	[illegible]	KS. MEDICAL SOC.
Tom Bell	Topeka	KHA
SUSAN A. HAMILTON	"	KTA
Alan Steppat	TOPEKA	PETE McGill & Assoc.
Joe Furjanic	Topeka	KCA
[illegible]	Topeka	State Farm
Chip Wheelen	Topeka	KS Med. Soc.
Larry Buening	Topeka	Bd of Healing Arts
John Peterson	Topeka	KS Assn of Prof Psychologists
LARRY MAGILL	"	KAIA

Testimony on

Senate Bill No. 486

by

Dick Brock

Kansas Insurance Department

Senate Bill No. 486 amends the body of Kansas law which relates to the types of securities and other property in which a Kansas domestic insurance company may invest its funds. These statutes already permit such companies to invest in the stock of another insurance company but contain no reference to the stock of health maintenance organizations (HMOs).

Health maintenance organizations are not "insurance companies" yet, for investment purposes, it is somewhat inconsistent and confusing to permit domestic insurers to invest in insurance companies but not HMOs. This proposal will address these matters by specifically permitting such investments.

House F&A
Attachment 1
3-10-94

Testimony on
Senate Bill No. 487
by
Dick Brock
Kansas Insurance Department

Senate Bill No. 487 is the product developed as the result of a study conducted pursuant to the provisions of 1993 Senate Concurrent Resolution No. 1605. This resolution required the Insurance Department to conduct a study of utilization review activities and organizations and report our findings to the 1994 legislature. The study was conducted by a task force created for that purpose but significant input was also provided by a number of interested parties. A summary of the task force meetings, background documents, attendance rosters and so forth is available upon request. However, Senate Bill No. 487 is the core element of the task force findings. Specifically, this legislation would establish a statutory regulatory structure that would serve to identify and guide the conduct of persons and firms performing utilization review services affecting Kansas citizens.

In previous efforts to measure the need for some sort of legislation relating to utilization review, attention has focused on the voluntary program established by the national Utilization Review Accreditation Commission (URAC) and have found it to be acceptable. The task force reached the same conclusion and relied heavily upon their work. Therefore, we too believed that the Commission's program is a responsible, credible effort that serves the public interest. However, in 1992, the General Accounting Office identified 294 organizations that were or seemed to be conducting some sort of utilization review -- another source puts this number at 350. Of course, not all of these operate in Kansas -- probably only a small fraction. Nevertheless, the sheer number of unknown, unregulated entities performing these services is a concern. In comparison to this number of identified UROs -- and bear in mind that since there is no registration or regulation in most states there are probably more than the GAO or other researchers have discovered. But even using the 300-350 number

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-- URAC, as of July of 1993, has accredited 89 organizations representing 162 sites where utilization review activities are conducted. In addition to URAC, a voluntary effort coordinated by the Kansas City Area Hospital Association and called the Kansas City Private Review Group has developed a licensing arrangement with URAC under which they have developed their own standards for utilization review but which use the URAC standards as a foundation. So in the Kansas City area, there are additional entities conducting utilization review in accordance with credible guidelines. As laudable as these efforts are, they still reach only a fraction of the UROs that may be providing review services that affect Kansans. Equally important, experience tells us that those who are either accredited by URAC or participate in the Kansas City Private Review Group probably don't include the UROs that are most in need of oversight.

Consequently, it didn't take the task force very much time to determine that we need to get a handle on utilization review activities. We did this in two parts and really in reverse of what the actual process will entail. First, we developed the standards we believe should be followed in the conduct of prospective and concurrent utilization review for admissions to hospitals, outpatient surgical centers or other health care facilities such as skilled nursing or rehabilitation centers. I won't go into detail with regard to these standards because if Senate Bill No. 487 is enacted, they will be incorporated in an administrative regulation and therefore be open to public review and comment during the process of adoption. Nevertheless, the standards developed can be summarized by telling you that we used the URAC standards as a base, modified them with what we believe are some enhancements taken from the Kansas City Private Review Group's efforts and sprinkled throughout are some task force initiatives that we believe materially strengthen the existing criteria particularly in the area of physician involvement and oversight. I should also add that URAC is in the process of revising its standards. Therefore, if enabling legislation is enacted, the standards derived through the task force efforts will need to be revisited prior to or during the course of development of the implementing regulation.

Senate Bill No. 487 itself is, of course, basically enabling legislation. However, it does contain the all-important ingredient of establishing the basic requirement that utilization review organizations must hold a certificate issued by the Commissioner if they perform utilization review services in Kansas or which affect Kansas citizens. The other fundamental provision is the enabling part -- a requirement that the Commissioner prepare and adopt regulations establishing standards to govern the conduct of utilization review activities. Beyond that, most of the details are fairly standard in terms of requirements, documentation and so forth. For example, those seeking a certificate would be required to submit an application, a certified copy of its charter or articles of incorporation and bylaws, location of the offices where utilization review activities affecting Kansas citizens are located and a summary of the experience and qualifications of the persons actually performing utilization review activities.

In addition to these requirements, Senate Bill No. 487 provides for the creation of an advisory committee consisting of the Commissioner, a public member, 4 representatives of utilization review organizations and 5 representatives of health care providers including 1 hospital representative and 2 persons licensed to practice medicine and surgery. This advisory committee would assist the Commissioner with respect to development of the implementing regulations and would also advise the Commissioner with regard to the suspension or revocation of a utilization review organization's certificate.

We have also tried to accommodate the problems that may arise in areas such as Kansas City where if, this legislation is enacted, two states -- Missouri and Kansas -- will have similar but not the same requirements. We propose to do this by taking advantage of the voluntary programs established by URAC and the Kansas City Private Review Group. Specifically, the task force proposal would require all utilization review organizations to have a Kansas certificate but the proposal would then exempt UROs accredited by URAC or actively participating in the Kansas City Private Review Group from adherence to the Kansas specific standards as well as the filing of documentation and information otherwise required for a certificate. Under

this arrangement, utilization review organizations have a choice. They can adhere to what we believe are somewhat stronger standards and submit numerous documents in support of their certificate but pay an initial fee of only $100 and an annual continuation fee of $50 or they may be accredited by URAC at a much, much higher cost but which will allow them to conduct utilization review in a number of states or they may agree to participate in the Kansas City program. We believe adherence to any of the three programs will result in utilization review being conducted by and under the supervision of competent personnel in a responsible and constructive manner.

The proposed enabling legislation addresses two other situations which we believe are important, perhaps even essential, ingredients in any system of utilization review regulation. The first appears in Section 7, subsection (a), paragraph (2) of the bill. This paragraph would prohibit compensation arrangements which would give a utilization review organization, its employees or agents any monetary incentive to deny certification or approval of medical care recommended by the attending physician. The second provision appears in Sections 9 and 10 of the bill where the ever-present issue of confidentiality of medical records is addressed.

Again summaries of the task force meetings including a copy of the utilization review standards envisioned by the task force and various other information underlying this proposal is available to the committee if desired.

The Senate Committee amendments consisted of 2 editorial corrections and 1 of greater substance. The editorial amendments appear on line 21, page 2 where the word "property" was changed to "properly" and on line 3, page 6 where the word "of" was corrected to "or". The more substantive amendment appears on page 1, line 33 where the approval authority of the advisory committee created under Section 5 was deleted. During the Senate Committee discussion, it was recalled that the lack of approval by the advisory committee having similar responsibility and authority with respect to a workers compensation medical fee schedule had substantially delayed implementation of that legislative directive. Therefore, the advisory

committee created by Senate Bill 487 should be advisory only thereby avoiding a similar situation.

Finally, attached to my testimony is a balloon amendment that will more explicitly carry out the task force's intent. During the course of the task force efforts, it was ultimately determined that the prospective and concurrent review activities normally performed with respect to medical, surgical, hospital treatment are substantially different than the reviews conducted with respect to mental health, substance abuse, chiropractic and other services. As a result, it was agreed that the standards relating to those latter types of utilization review activities should be developed separately and that input from providers not on the then current task force would be necessary. It was intended, however, that the enabling legislation should be designed to accommodate this additional ingredient. The proposed amendment is intended to more clearly meet this objective.

The first amendment would simply add duly licensed psychologists to the definition of health care provider. This was always intended and it was not known that K.S.A. 60-513d did not encompass this discipline until it was brought to my attention. Page 4 Line 17 The second proposed amendment simply identifies the types of utilization review activities that require more consideration and specifically exempts them from the certificate requirements until the necessary standards are developed and included in the administrative regulations.

As Amended by Senate Committee

Session of 1994

SENATE BILL No. 487

By Committee on Financial Institutions and Insurance

1-12

AN ACT relating to health care services; regulation of utilization review organizations.

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

Section 1. This act shall be known and may be cited as the utilization review organization act.

Sec. 2. The legislature finds that in order to promote the delivery of quality health care services in a cost effective manner, it is necessary to encourage greater coordination between health care providers and those agencies performing utilization review of health care services. Effective standards for utilization review activities will protect patients while reducing administrative costs associated with the review and approval of health care services provided to patients.

Sec. 3. For the purposes of this act:

(a) "Commissioner" means the commissioner of insurance.

(b) "Utilization review" means the evaluation of the necessity, appropriateness and efficiency of the use of health care services, procedures and facilities.

(c) "Utilization review organization" means any entity which conducts utilization review and determines certification of an admission, extension of stay or other health care service.

(d) "Health care provider" has the meaning provided in K.S.A. 60-513d and amendments thereto and shall also include a duly licensed psychologist

Sec. 4. (a) The commissioner shall adopt rules and regulations, with the advice ~~and approval~~ of the advisory committee created by section 5, establishing standards governing the conduct of utilization review activities performed in this state or affecting residents of this state by utilization review organizations. Unless granted an exemption under section 6, no utilization review organization may conduct utilization review services in this state or affecting residents of this state on or after May 1, 1995, without first obtaining a certificate from the commissioner.

(b) The commissioner shall not issue a certificate to a utilization review organization until the applicant:

(1) Files a formal application for certification in such form and

detail as required by the commissioner and such application has been executed under oath by the chief executive officer of the applicant;

(2) files with the commissioner a certified copy of its charter or articles of incorporation and bylaws, if any;

(3) states the location of the office or offices of the utilization review organization where utilization review affecting residents or health care providers of this state will be principally performed;

(4) provides a summary of the qualifications and experience of persons performing utilization review affecting the persons and at the locations identified pursuant to paragraph (3);

(5) makes payment of a certification fee of $100 to the commission; and

(6) provides such other information or documentation as the commissioner requires.

(c) Certificates issued by the commissioner pursuant to this act shall remain effective until suspended, surrendered or revoked subject to payment of an annual continuation fee of $50.

(d) The commissioner with the advice of the advisory committee may suspend or revoke the certificate or any exemption from certification requirements upon determination that the interests of Kansas insureds are not being ~~property~~ *properly* served under such certificate or exemption. Any such action shall be taken only after a hearing conducted in accordance with the provisions of the Kansas administrative procedure act.

Sec. 5. (a) There is hereby created an advisory committee which shall assist the commissioner in the adoption of rules and regulations to implement the provisions of this act. The advisory committee shall consist of 11 persons appointed by the commissioner as follows:

(1) The commissioner, or the designee of the commissioner, who shall be the chairperson;

(2) one member appointed from the public at large;

(3) four members who are representatives of utilization review organizations; and

(4) five members who are representatives of health care providers, one of which shall be a representative of a Kansas hospital, and two of which shall be persons licensed to practice medicine and surgery in Kansas.

(b) Members of the advisory committee shall be appointed for a term of three years, except that the first term of office of two members representing utilization review organizations and two members representing health care providers shall be for a term of two years, and the first term for two members representing health care pro-

viders and one member representing utilization review organizations shall be for a term of one year.

(c) The advisory committee shall be attached to the insurance department, and all administrative functions of the advisory committee shall be under the direction and supervision of the commissioner. Within available appropriations therefor, members of the advisory committee shall be paid subsistence allowances, mileage and other expenses as provided in subsection (e) of K.S.A. 75-3223 and amendments thereto.

(d) Before adopting rules and regulations to carry out the provisions of this act, the commissioner with the advice of the advisory committee shall:

(1) Establish utilization review standards which provide for uniformity in the procedures for interaction between utilization review organizations and health care providers, payors and consumers of health care;

(2) establish utilization review procedures that prevent unnecessary and inappropriate disruption to the health care delivery system;

(3) strive to achieve an efficient process for the certification of utilization review organizations; and

(4) specify the kinds of insurance or types of insurance products to which the standards apply and the scope of such application.

(e) This act shall not apply to:

(1) Utilization review of health care services provided to patients under the authority of the Kansas workers compensation act (K.S.A. 44-501 *et seq.*, and amendments thereto); or 3 any medical programs offered under

(2) reviews conducted by any insurance company, health maintenance organization, prepaid service plan, group-funded self-insured plan or similar entity solely for the purpose of determining compliance with the specific terms and conditions of an insurance policy, agreement or contract as a part of the normal claim settlement process.

Sec. 6. (a) No certificate shall be required for utilization review activities conducted by or on behalf of:

(1) An agency of the federal government;

(2) a person, agency or utilization review organization acting on behalf of the federal government, but only to the extent such person, agency or organization is providing services under federal regulation;

(3) a federally qualified health maintenance organization authorized to transact business in Kansas which is administering a quality assurance program and performing utilization review activities for its own members as required by 42 U.S.C. 300e(c)(8) and 42 U.S.C.

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300e(c)(6) respectively;

(4) a person employed or used by a utilization review organization authorized to perform utilization review in Kansas, including, but not limited to, individual nurses and other health care providers. This exemption shall not apply with respect to individual persons performing utilization review activities in conjunction with any insurance contract or health benefit plan pursuant to a direct contractual relationship with a health maintenance organization, group-funded self-insurance plan or insurance company;

(5) a health benefit plan that is self-insured and qualified under the federal employee retirement income security act of 1974 as amended; or

(6) hospitals, home health agencies, clinics, private health care provider offices or any other authorized health care facility or entity conducting general, in-house utilization review unless such review is for the purpose of approving or denying payment for hospital or medical services in a particular case.

(b) The provisions of section 4 (b)(2), (3), (4), (5), (6) and subsection (c) shall not apply to:

(1) Utilization review organizations accredited by and adhering to the national utilization review standards approved by the utilization review accreditation commission (URAC); or

(2) utilization review organizations presenting evidence satisfactory to the commissioner that they subscribe and are adhering to the voluntary guidelines established by the Kansas City private review group. This exemption shall apply only to Kansas City private review group participants located within the Kansas City, Missouri, and Kansas Metropolitan Statistical Area established by the federal Office of Management and Budget as of June 30, 1993; and

(3) such other utilization review organizations as the advisory committee may recommend and the commissioner approves.

Sec. 7. (a) (1) It is unlawful for any person or utilization review organization to perform utilization review activities in this state except in accordance with this act.

(2) No utilization review organization nor any individual performing utilization review activities may agree to be compensated or receive compensation which is contingent in any way upon frequency of certification denials, costs avoided by denial or reduction in payment of claims or other results which may be adverse to the needs of the patient as determined by the attending health care provider.

(b) When the commissioner has reason to believe a utilization review organization subject to this act has been or is engaged in

(7) utilization review organizations conducting utilization review only with respect to psychiatric and chemical dependency, chiropractic, optometric, podiatry or dental services until utilization review standards governing such treatment or service are incorporated in rules and regulations adopted pursuant to section 4 of this act.

KANSAS MEDICAL SOCIETY
623 SW 10th Ave. • Topeka, Kansas 66612 • (913) 235-2383
WATS 800-332-0156 FAX 913-235-5114

March 10, 1994

TO: House Financial Institutions and Insurance Committee

FROM: Chip Wheelen, KMS Director of Public Affairs

SUBJECT: Senate Bill 487; Accountability of Utilization Review

The Kansas Medical Society enthusiastically supports the provisions of SB487 which require professional standards and establish accountability of organizations that engage in utilization review of health care services. For several years now the KMS has been concerned about the lack of accountability in utilization review practices of some insurance companies or contractors. When utilization review organizations are not accountable for determinations they make as to the medical necessity of recommended services or procedures, the ability of the treating physician to provide the appropriate medical care can be adversely affected.

We asked the Legislature to address this problem in 1990 but at that time, the Utilization Review Accreditation Commission had just initiated a voluntary program for UR organizations which were interested in developing and implementing professional standards in their industry. The Legislature chose not to take action at that time but instead to monitor voluntary accreditation. In the meantime, many responsible UR organizations have become accredited and other good UR entities have established similar standards of professionalism in their operations.

Unfortunately, there remain some UR organizations which fail to be accountable to the insured patients or the treating physicians. We again approached the Legislature about this problem during the 1992 interim and SCR1605 resulted, which created the study process that developed SB487. We are grateful to the 1993 Legislature for initiating this effort.

We also want to publicly extend our appreciation to Commissioner Todd and Mr. Brock for the resources which the Insurance Department devoted to the study of utilization review practices in Kansas. As Chairman of the Utilization Review Task Force, Mr. Brock managed to achieve consensus among the major interest groups as to the fair and appropriate way of establishing much needed standards of professionalism throughout the UR industry. In order to implement that plan, the Insurance Commissioner needs additional statutory authority and that is why SB487 is before you today.

We respectfully urge you to recommend passage of SB487. Thank you for considering this important matter.

House F.I.&I.
Attachment 3
3-10-94

KANSAS BOARD OF HEALING ARTS

JOAN FINNEY
Governor

LAWRENCE T. BUENING, JR.
Executive Director

235 S. Topeka Blvd.
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(913) 296-7413
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M E M O R A N D U M

TO: House Committee on Financial Institutions and Insurance

FROM: Lawrence T. Buening, Jr.
Executive Director

DATE: March 10, 1994

RE: **SENATE BILL NO. 487**
REGULATION OF UTILIZATION REVIEW ORGANIZATIONS

Mr. Chair, Members of the Committee:

Thank you very much for the opportunity to appear before you and to submit testimony on SB No. 487 on behalf of the State Board of Healing Arts.

The Board has concerns regarding the quality of evaluations of medical care services which determine the cost, necessity and appropriateness of medical care provided in the State of Kansas. These concerns deal not only with the lack of accountability of persons who conduct the review, but also the qualifications of the individuals who do this review. Therefore, the Board is supportive of Legislation which would better regulate and control utilization review organizations. However, the Board has some concerns regarding the present language of SB No. 487.

Pursuant to Senate Concurrent Resolution 1605, the Commissioner of Insurance created a task force which met from June through November, 1993. That task force, in addition to preparing the initial draft of SB No. 487, also has proposed rules and regulations to implement the bill should it be enacted and become law. As a member of this task force, I can advise that the Insurance Department and the task force worked very hard and diligently to arrive at the proposed rules and regulations. However, after 4 meetings spanning 6 months, the rules and regulations presently proposed are limited only to utilization review which applies to inpatient admission to hospitals and other

Attachment 2
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inpatient facilities as well as to outpatient admissions surgical facilities. SB No. 487 as set forth in Section 3(b) would require a certificate to be issued to **any** review organization which conducts utilization review of **any** health care service. The Board questions whether time would permit proposed rules and regulations to be prepared and adopted in order to issue certificates for other than inpatient hospital services and outpatient surgical facilities prior to the effective date of this act on July 1, 1994. Therefore, the Board would suggest that the effective date for the act be extended as it would relate to utilization review which is not dealt with in the rules and regulations proposed by the task force.

The Board questions whether the existing language of SB No. 487 provides the Commissioner of Insurance with adequate authority to suspend or revoke a URO's certificate if review determinations in an individual or multitude of cases are clearly incompetent, capricious and without foundation.

The Board is also concerned that Section 10 of the Bill would conflict with the existing language of K.S.A. 65-4923(f). K.S.A. 65-4923(f) provides that the reporting requirements imposed upon health care providers relating to instances below the standard of care and which have a reasonable probability of causing injury to a patient do not apply to health care providers acting solely as a consultant or providing review. While Section 10 of SB No. 487 may allow for the exchange of information, there is no provision that would require utilization review organizations to report instances of substandard care to the appropriate licensing agency. The Board believes this is a source of valuable information and proposes that utilization review organizations should be required to make reports to the appropriate licensing Board when there is evidence reflecting incompetency or other violations of the licensure laws for the profession involved.

SB No. 487 vests authority in the Commissioner of Insurance to issue the certificates to utilization review organizations and to take action to revoke or suspend certificates. Complaints alleging erroneous determinations will require the Commissioner of Insurance to make judgements relating to medical necessity and appropriateness. The Board feels it is better equipped to serve this function.

The State Board of Healing Arts regulates 10 health care professions. As a result, it is constantly receiving and reviewing information and making determinations on whether an appropriate standard of care has been met. In so doing, it has a great deal of expertise and broad-based experience and knowledge in evaluating necessity and appropriateness of health care services. The Board is willing to provide services to the Insurance Commissioner whenever questions of medical necessity and appropriateness must be

addressed. However, there is no provision in SB No. 487 for this to be accomplished.

Finally, the Board is concerned that neither the Bill nor the proposed rules and regulations would require involvement by an individual licensed by any state regulatory agency in the profession involved. As far as back as October, 1988, the State Board of Healing Arts has taken the position that utilization review may constitute the practice of the healing arts in this State since it serves to make a diagnosis and recommend treatment whether that be by denying admission or denying services which have been recommended by a Kansas licensee. The Board is cognizant of Attorney General Opinion 90-130 in which the Attorney General opined that "An insured who is denied benefits by utilization review, on the grounds that the treatment sought is not 'medically necessary' for example, is not prevented from obtaining medical care; such person would merely be in the same position as one without any insurance coverage at all". As justification for the opinion, the Attorney General derived legislative intent that utilization review does not fall within the scope of the healing arts as defined in K.S.A. 65-2802 from the fact that the Legislature failed to adopt 1990 Senate Bill 760. The Board strongly feels that an individual who denies or recommends certain treatment to citizens of this State which services have been determined to be appropriate and necessary by an individual who is licensed in this State should be required to also be licensed and accountable to the state licensing agency for their profession. This is in accordance with the American Medical Association's Principles of Medical Review which states that "Any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of services should be licensed to practice to medicine and actively practicing in the same jurisdiction as the practitioner who is proposing or providing the reviewed service, and should be professionally and individually accountable for his or her decisions".

In conclusion, the Board is supportive of SB No. 487, but would request that this Committee consider amending the Bill to effectuate the changes above noted. Thank you very much for allowing me to appear on behalf of the Board. I would be happy to respond to any questions.

KANSAS HOSPITAL ASSOCIATION

Memorandum

Donald A. Wilson
President

March 10, 1994

TO: House Financial Institutions and Insurance Committee

FROM: Kansas Hospital Association

RE: **SENATE BILL 487**

The Kansas Hospital Association appreciates the opportunity to comment in support of Senate Bill 487. This bill directs the Commissioner of Insurance to adopt rules and regulations establishing standards for utilization review.

Many issues led to the unanimous adoption by both the House and the Senate of 1993 Senate Concurrent Resolution No. 1605, which required the Commissioner of Insurance to conduct "... a study of utilization review practices affecting consumers and providers of health care services in this state and report to the 1994 Legislature ..." For instance, a 1992 study by the General Accounting Office identified 294 utilization review organizations, but Kansas has no way of determining how many of those organizations' decisions impact Kansas health care consumers. There is currently no standardization among utilization review procedures, and review may be performed by anyone, regardless of qualifications or experience. The lack of standardized procedures often raises questions about patient privacy and creates administrative burdens for entities asked to supply data. In addition, utilization review organizations have not been required to disclose the criteria they use in making decisions about the appropriateness and necessity of the procedures performed.

Under the directive of SCR 1605, the Commissioner of Insurance created a task force to study and attempt to remedy the concerns surrounding utilization review. The group was comprised of highly qualified individuals with diverse backgrounds and interests. Collectively, they were able to propose legislation in Senate Bill 487 that will provide effective standards for utilization review and will alleviate some of the problems that prompted the 1993 Legislature to call for a study.

Senate Bill 487 will help protect patients and reduce unnecessary administrative costs as it promotes the delivery of quality health care. Thank you for your consideration of our comments.

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1263 Topeka Avenue • P.O. Box 2308 • Topeka, Kansas 66601 • (913) 233-7436 • FAX (913) 233-6955

Testimony on
Senate Bill No. 522
by
Dick Brock
Kansas Insurance Department

Senate Bill No. 522 requires every domestic insurance company to report to the Commissioner all transactions involving more than 5% of an insurer's total admitted assets and all nonrenewals, cancellations or revisions of reinsurance contracts affecting more than 50% of the written premium for property and casualty insurance that has been ceded (transferred) to another carrier or more than 50% of the reserve credit taken with respect to life and accident and sickness insurance.

This is another bill required by the National Association of Insurance Commissioners to maintain accreditation but, more important, it will provide regulators early information regarding transactions that can have a significant impact on an insurer's solvency.

Reports on these transactions are to be made within 15 days after the end of the calendar month in which the reportable transactions occur. A copy of the report is also to be provided the NAIC so that it will be accessible by insurance departments of other states in which the insurer does business. Because this is a model law and is included in the financial regulatory standards applicable to NAIC accreditation, this legislation will be enacted in most states which means Kansas will also benefit from having access to the reports of insurance companies not domiciled in Kansas but which hold a Kansas certificate of authority.

Needless to say, this is sensitive information which could adversely affect an insurance company's operations and ultimately perhaps even its solvency if such information was accessible to its competitors. Furthermore, the information contained on such reports in and of itself would not be useful in any attempt to gauge a particular insurer's financial strength. Yet such information could be misused to produce erroneous impressions to the

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detriment of not only the insurer involved but its policyholders. Therefore, this proposal also contains an amendment to the Kansas Open Records Act which would have the effect of making these reports confidential.

The amendments by the Senate Committee of the Whole appear on page 2, lines 29 and 31 of the bill. As you can see, the amendments are purely editorial in nature and have no substantive impact on the bill's provisions.

Testimony on
Senate Bill No. 563
by
Dick Brock
Kansas Insurance Department

Senate Bill No. 563 amends what is commonly known as the Standard Valuation Law. All states have laws that stipulate the requirements that insurers must meet in calculating the reserves necessary to assure payment of insurer obligations to policyholders and beneficiaries. The elements necessary to calculate these reserves are an interest rate, a mortality table and a method of valuation. All of these ingredients are contained in the Standard Valuation Law in some form. However, the type and issue date of the life insurance policies determines the particular application of these ingredients to the specific amount of reserve that must be established and how long it must be maintained. The same process and requirements apply to annuities and endowment contracts. Consequently, the bulk of this rather lengthy set of statutory provisions is devoted to designating the various types of life insurance products and, with respect to each, the mortality table, maximum interest rate that may be assumed as the rate of return on the assets held as reserves and the method of valuation which must be used to calculate the minimum reserves. In most cases, the method of valuation is the standard actuarial formula appearing in lines 41 through 43 on page 13 and 1 through 6 on page 14 of the bill and identified as the Commissioner's reserve valuation method.

The last amendment to the Standard Valuation Law was in 1982 when the legislature enacted NAIC changes to recognize updated mortality tables and interest rates. These changes included authority for the Commissioner to adopt new mortality tables by regulation and a formula based on Moody's corporate bond yield average as the basis for updating the maximum presumed interest rate.

Needless to say, the policy reserves are an extremely important consumer protection tool. In fact, they are so important that domestic life insurers

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are required to maintain a deposit with the State Treasurer and Insurance Commissioner cash, securities, mortgages or other acceptable assets in an amount equal to the net reserves of policies and annuity contracts in force. However, with or without the deposit requirement and whether or not the reserves conform to the statutory requirements for establishing the minimum reserves the real test is whether the reserves are and will be adequate to meet a company's obligations. For a number of years, state statute has required an annual valuation and actuarial certification of the reserves. In addition, a standard procedure in an on-site examination of most domestic life insurers is to acquire an independent actuarial valuation of the reserves. Senate Bill No. 563 takes this a step farther.

Senate Bill No. 563 incorporates a model NAIC provision to require an annual actuarial opinion that is much more comprehensive than the current requirement. Even more important, this amendment would require the actuary to include an opinion as to whether the reserves are adequate based on the company's earnings, assets, premium charges and so forth. Finally, the amendment would authorize the Commissioner to develop a transition period during which any higher reserves recommended by the actuary would have to be established.

Obviously, the information to be included in the actuarial memorandum required to support the opinion will be quite sensitive. Therefore, Senate Bill No. 563 also includes an amendment to the Kansas statutes governing public records to provide that the memoranda and other material used to support the actuarial opinion are not subject to public disclosure except for the reasons stated in subsection (b)(5)(G) of the bill.

~~40-3501.~~ Title of act. This act may ~~be~~ cited as the "mortgage ~~guaranty insurance~~ act."

History: ~~L. 1977, ch. 154, § 1;~~ Jan. 1, ~~1978.~~ 7

40-3502. Definitions. As used in this act the following terms shall have the meanings respectively ascribed to them herein:

(a) "Mortgage guaranty insurance company" shall mean any corporation, company, association, reciprocal exchange, persons or partnerships writing contracts of mortgage guaranty insurance and shall be governed by the provisions of this act and the other provisions of chapter 40 of the Kansas Statutes Annotated applicable to companies organized or operating under the provisions of K.S.A. 40-1101 *et seq.* to the extent such other provisions are not inconsistent with the requirements of this act.

(b) "Mortgage guaranty insurance" shall mean and include: (1) Insurance against financial loss by reason of nonpayment of principal, interest or other sums agreed to be paid under the terms of any note or bond or other evidence of indebtedness secured by a mortgage, deed of trust, or other instrument constituting a lien or charge on real estate, when the improvement on such real estate is a residential building or a condominium or townhouse unit or buildings designed for occupancy by not more than four (4) families;

(2) Insurance against financial loss by reason of nonpayment of principal, interest or other sums agreed to be paid under the terms of any note or bond or other evidence of indebtedness secured by a mortgage, deed of trust or other instrument constituting a lien or charge on real estate, when the improvement on such real estate is a building or buildings designed for occupancy by five (5) or more families or designed to be occupied for industrial or commercial purposes; or

(3) Insurance against financial loss by reason of nonpayment of rent or other sums agreed to be paid under the terms of a written lease for the possession, use or occupancy of real estate, when the improvement on such real estate is a building or buildings designed to be occupied for industrial or commercial purposes.

(c) "Authorized real estate security" shall mean an amortized note, bond or other evi-

add:

ninety-seven percent (97%)

dence of indebtedness, not exceeding ~~ninety-five percent (95%)~~ of the fair market value of the real estate, secured by a mortgage, deed of trust, or other instrument which constitutes, or is equivalent to, a first lien or charge on real estate, when: (1) The real estate loan secured in such manner is one of a type which a bank, savings and loan association, or an insurance company, which is supervised and regulated by a department of this state or an agency of the federal government, is authorized to make, or would be authorized to make, disregarding any requirement applicable to such an institution that the amount of the loan not exceed a certain percentage of the value of the real estate;

(2) The improvement on such real estate is a building or buildings designed for occupancy as specified by K.S.A. 40-3502(b)(1) or (2); and

(3) The lien on such real estate may be subject to and subordinate to the following:

(i) The lien of any public bond, assessment or tax, when no installment, call or payment of or under such bond, assessment or tax is delinquent; and

(ii) Outstanding mineral, oil, water or timber rights, rights-of-way, easements or rights-of-way of support, sewer rights, building restrictions or other restrictions or covenants, conditions or regulations of use, or outstanding leases upon such real property under which rents or profits are reserved to the owner thereof.

(d) "Contingency reserve" shall mean an additional premium reserve established to protect policyholders against the effect of adverse economic cycles.

(e) "Single risk" shall mean the insurance provided with respect to each separate loan or lease covered by an individual policy of mortgage guaranty insurance or an individual certificate issued pursuant to K.S.A. 40-3511.

History: L. 1977, ch. 154, § 2; Jan. 1, 1978.

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Ronald R. Hein
William F. Ebert
Stephen P. Weir

HOUSE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE
TESTIMONY RE: SB 506
Presented by Ronald R. Hein
on behalf of
HEALTHY ALLIANCE LIFE INSURANCE COMPANY
March 10, 1994

Mr. Chairman, Members of the Committee:

My name is Ron Hein, and I am legislative counsel for Healthy Alliance Life Insurance Company.

I previously advised the Chairman that I would be out of town on the day you held the hearing on SB 506, and had requested permission to appear at a later date to present an amendment. The amendment that Healthy Alliance was going to propose to SB 506 is attached to my testimony. This amendment was designed to insure that SB 506 was deemed to be prospective only, and to make clear legislative intent that the provisions of SB 506 would not force any existing licensed entity to change their name or to otherwise impede the ability of any such existing entity to transact business in the state utilizing an existing name.

After having presented this proposed amendment to a representative of the insurance company proposing SB 506, and to the Insurance Commissioner's Office, I have been advised by both that such amendment is unnecessary. The Insurance Commissioner's Office has indicated that SB 506 would not have such an impact on companies licensed prior to the enactment of SB 506.

With this expression of legislative intent by the sponsors and by the Insurance Commissioner's Office, we feel comfortable that nothing in the provisions of SB 506 could be construed to require Healthy Alliance Life Insurance Company to change its name or to impede its ability to transact business utilizing that name.

Therefore, relying upon the expressed legislative intent of the authors of this legislation, we are submitting this testimony for the record and see no need to adopt the proposed amendment.

Thank you very much for permitting me to make this statement, and to have this statement reflecting our understanding of legislative intent spread upon the minutes of the Committee.

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SENATE BILL No. 506

By Committee on Financial Institutions and Insurance

1-14

AN ACT relating to insurance; similarity of names of insurance companies or fraternal benefit societies; amending K.S.A. 40-203 and repealing the existing section.

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

Section 1. K.S.A. 40-203 is hereby amended to read as follows: 40-203. (a) No insurance company or fraternal benefit society organized under the laws of this state shall adopt the name of any existing company or society ~~transacting a similar business in this state~~, or any name so similar as to mislead the public; ~~nor shall any~~. *No* foreign insurance company or society *shall* be licensed in this state which bears the name of any company or society already licensed in this state, *or of any insurance company or fraternal benefit society organized under the laws of this state,* or any name so similar as to mislead the public. The commissioner shall require the name of every domestic insurer to be submitted to him prior to commencement of business and may reject any name so submitted when it is so similar to that of any other corporation as to mislead or tend to mislead the public.

Sec. 2. K.S.A. 40-203 is hereby repealed.

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

(b) Nothing in subsection (a) shall be construed to require any insurance company or fraternal benefit society licensed in this state as of January 1, 1994, to change its name or to cease transacting business using such name.