Approved: April 1, 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 14, 1994 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: Senator Sandy Praeger
Dick Brock, Insurance Department
Chip Wheelen, Kansas Psychiatric Society
Sharon Huffman, Commission on Disability Concerns
Jim Schwartz, KECH
Sheryl Tatroe, Kansas Alliance for the Mentally Ill
Brenda Parker, citizen from Manhattan
Brad Smoot, BC/BS

Others attending: See attached list

HEARING ON SB 612: Insurance plans subject to group health and accident requirements

Senator Praeger explained that the bill expands portability of benefits by requiring that waiting periods for coverage be waived not only for movement from one group policy to another, but also for movement from an individual policy, a self-insured plan such as ERISA, a multiple employer welfare association, or a municipal funded pool (Attachment 1). Credit for waiting periods served under one policy would be portable for a period of 31 days from the date of termination of coverage under one type of policy to the beginning of coverage under a new policy.

The bill would also expand the size of a "small group" plan from no more than 25 employees to no more than 50 employees. Guaranteed access provisions and rating restrictions would be applicable to small employer groups with 50 or fewer employees as opposed to the current 25 or fewer employees.

Dick Brock, Insurance Department, explained that rating restrictions contained in the legislation will be applicable to more groups (Attachment 2). The rate compression as required by the bill is not always popular as the top end cost stays up for a while and the low end rate increases. The Insurance Commissioner could waive the rate increase under SB 561 (passed last year) when the rates on the low end started rising too fast. Eight waivers have been granted thus far. Many more have been applied for but the integrity of the group must be threatened before such a waiver is granted. Insurance companies are given a 3 year time period to reach the median rate. Companies have the right to call for up to a 12 month waiting period for those persons with a pre-existing condition and/or coming from no insurance company.

Chip Wheelen, Kansas Psychiatric Society, offered an amendment that any SEHC plan offered or delivered in this state shall include coverage for diagnosis and medically necessary treatment of mental illnesses (Attachment 3). Mr. Wheelen also presented a definition for mental illness: a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering death, pain or disability (Attachment 3A). Under this plan, mental illness would be treated with the same respect and attention as heart disease.

Brad Smoot, Blue Cross/Blue Shield, presented testimony supporting the bill which would increase group size from 25 to 50 (Attachment 4). Approximately 98% of Kansas businesses have 50 or fewer employees which involves about 36% of the population. Support was also given for the portability of the bill which assures immediate coverage for persons coming into a group program from a nongroup or self-insured

contract. He urged the legislature to make it difficult for small groups to opt out of the community pool through the mechanism of self-insurance with stop/loss coverage.

Sharon Huffman of the Kansas Commission on Disability Concerns read testimony prepared by Sharon Joseph, Chairman of the organization (Attachment 5). The support the applicability of the portability law to include groups not previously covered. Such a portability law would not be necessary if all insurance carriers were required to provide immediate and comprehensive coverage from the first day of enrollment.

Jim Schwartz, Kansas Employer Coalition on Health, Inc., presented testimony supporting the bill for its principles on health reform, particularly guaranteed issue, rate compression, and application for groups up to size 50 (Attachment 6).

Sheryl Tatroe, Kansas Alliance for the Mentally Ill and Kansas Mental Health Coalition, agreed with the amendment proposed by the Kansas Psychiatric Society (Attachment 7). The language in his amendment provides for treatment of mental illness as any other illness, subject to the same co-payments and deductibles. the amendment would remove the discrimination against the severe major mental illnesses and bring insurance coverage up to date with current scientific evidence.

HEARING ON SB 566: Kansas uninsurable health insurance plan

The bill provides that on and after May 1, 1994, the waiting period for pre-existing conditions for persons covered or making application for coverage under the Kansas uninsurable health insurance plan would be reduced from 12 months to 90 days. The Board of Directors of the plan would retain authority to reduce or increase the waiting period, however, the maximum waiting period could not exceed 180 days.

Written testimony - Senator Sandy Praeger (Attachment #8)

Dick Brock, Insurance Department, reviewed the history of the current legislation and status of the 269 participants in the plan as of February 1 of this year (Attachment 9). It is questionable if the 90 day waiting period is sufficient to prevent excessive abuse but it will certainly require some increase in premium by virtue of the fact that claims for pre-existing conditions will enter the system nine months earlier than originally prescribed. The Department supports the bill but they do so without knowing what the actuarial impact might be.

Brenda Parker, Manhattan, Kansas, reiterated the story of her child being born with numerous physical birth defects, and the magnitude of the medical bills (Attachment 10). The child will not be technology dependent much longer but will not have access to medical coverage due to the year waiting period for pre-existing conditions. Such a plan defeats the purpose. 90 days without coverage may be a challenge but Mrs. Parker believes the plan is workable and urged the bills passage and implementation.

Sharon Huffman, Kansas Commission on Disability Concerns, urged the Committee to eliminate entirely any waiting period in the proposed legislation (Attachment 11). Many of the individuals who would benefit from this plan would not be allowed to receive coverage for the very condition that made it necessary for them to enroll in the first place.

DISCUSSION AND ACTION ON SB 522: Insurance companies to report acquisition and disposition of assets

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

DISCUSSION AND ACTION ON SB 486: Investments of insurance companies; health maintenance organizations

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

The meeting adjourned at 4:55 p.m. The next meeting is scheduled for March 15, 1994.

GUEST LIST

COMMITTEE: _____ DATE: 3-14-94

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATIC
Dick Brock	Topeka	Ins Dept
Bill Curtis	Topeka	Ks Assoc of School Bds
Bill Sneed	TOPEKA	HIAA
William Patton	Topeka	KDHE
Sherry SANDERS TATRO	TOPEKA	KS MENTAL HEALTH COALITION
Christy Walker	Topeka	KCDC
Brad Smoot	"	BCBS
Sharon Huffman	"	KCDC
Rhonda Parker	Manhattan	Parent
Jena McFarland	Overland Park	OPChamber
Jacqueline Gordon	Topeka	KPCDD
JP Schwartz	Topeka	KECH
Brent Drake	Wichita	WH / B Denker
Danielle Noe	Topeka	HIAA

STATE OF KANSAS

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TOPEKA

COMMITTEE ASSIGNMENTS
CHAIR PUBLIC HEALTH AND WELFARE
JOINT COMMITTEE HEALTH CARE DECISIONS FOR THE 90's
MEMBER FEDERAL AND STATE AFFAIRS
FINANCIAL INSTITUTIONS AND INSURANCE
CORPORATION FOR CHANGE
KANSAS HEALTHY KIDS CORPORATION
JOINT COMMITTEE ON CHILDREN AND FAMILIES

SENATE CHAMBER

Testimony On SB 612

By
Senator Sandy Praeger

Mr. Chairman and members of the House Financial Institutions and Insurance Committee:

SB 612 concerns group accident and health insurance and was amended by the Senate Financial Institutions and Insurance Committee. The bill would expand portability of benefits by requiring that waiting periods for coverage be waived not only for movement from one group policy to another, but for movement from an individual policy, from a self-insured plan such as ERISA, from a multiple employer welfare association specifically authorized by Kansas law, or from a municipal funded pool. Credit for waiting periods served under one policy would be portable for a period of 31 days from the date of termination of coverage under one type of policy to the beginning of coverage under a new policy. The bill would also expand portability of insurance coverage and the size of "small group" plan from no more than 25 employees to no more than 50 employees. Portability of insurance policies is a key element of health security. Portability eliminates "job lock" which occurs when a person is afraid to leave one place of employment for fear they could not get health insurance coverage at their next job.

Thank you for this opportunity to comment on SB 612, and I would be happy to answer any questions.

Attachment 1
March 14, 1994

Testimony on
Senate Bill No. 612
by
Dick Brock
Kansas Insurance Department

Senate Bill No. 612 as amended by the Senate Committee would amend the group health insurance reforms incorporated in 1991 House Bill No. 2001 and 1992 Senate Bill No. 561 by expanding the "portability" provisions and by making the guaranteed access provisions and rating restrictions applicable to small employer groups with 50 or fewer employees as opposed to the current 25 or fewer.

The change from 25 to 50 in the definition of small employer group will, of course, make the guaranteed access provisions of Senate Bill 561 available to more groups. It will also make the rating restrictions contained in that legislation applicable to more groups. In some cases, this is not a desirable experience but it does move the concept of rate compression to an expanded population of insureds and the waiver provision is still available if a particular group is uniquely and adversely affected.

With regard to portability, Senate Bill No. 612 would require that credit be given for waiting periods served under not only a group policy in effect prior to the effective date of coverage under a new group contract but would also require that credit be given for prior coverage under a prior individual policy, group-funded or self-insured plan or multiple employer welfare association (MEWA) specifically authorized by Kansas law.

In addition, Senate Bill No. 612 would require such credit to be given if the "new" group coverage becomes effective within 31 days of the termination of coverage under a prior group, individual, self-insured or MEWA plan.

These refinements to the group health insurance reforms enacted in 1991 and 1992 represent practical changes that probably should have been incorporated in the original legislation. They are not substantive policy changes but simply reveal once again the benefit of hindsight.

Senate F&D
Attachment 2
3-14-94

a converted policy had the group policy been issued in that jurisdiction.

(21) The insurer shall give the employee or member and such employee's or member's covered dependents reasonable notice of the right to convert at least once during the six-month continuation period in accordance with rules and regulations adopted by the commissioner of insurance.

(E) (1) No policy issued by an insurer to which this section applies shall contain a provision which excludes, limits or otherwise restricts coverage because medicaid benefits as permitted by title XIX of the social security act of 1965 are or may be available for the same accident or illness.

(2) Violation of this subsection shall be subject to the penalties prescribed by K.S.A. 40-2407 and 40-2411, and amendments thereto.

Sec. 2. K.S.A. 40-2209e is hereby amended to read as follows: 40-2209e. (a) Any individual or group health benefit plan issued to a group authorized by subsection (A) of K.S.A. 40-2209 and amendments thereto shall be subject to the provisions of this act if it provides health care benefits covering employees of a small employer and if it meets any one of the following conditions:

(1) Any portion of the premium is paid by a small employer, or any covered individual, whether through wage adjustments, reimbursement, withholding or otherwise;

(2) the health benefit plan is treated by the employer or any of the covered individuals as part of a plan or program for the purposes of section 106 or section 162 of the United States internal revenue code; or

(3) with the permission of the board, the carrier elects to renew or continue a health benefit plan covering employees of an employer who no longer meets the definition of a "small employer."

(b) For purposes of this act an aggregation of two or more small employers covered under a trust arrangement or a policy issued to an association of small employers pursuant to subsection (A)(3) or (5) of K.S.A. 40-2209 and amendments thereto shall permit employee or member units of more than two but less than ~~26~~ *51* employees or members and their dependents to participate in any health benefit plan to which this act applies. Any group which includes employee or member units of ~~25~~ *50* or fewer employees shall be subject to the provisions of this act notwithstanding its inclusion of employee or member units with more than ~~25~~ *50* employees or members.

(c) Except as expressly provided for in this act, no law requiring the coverage or the offer of coverage of a health care service or benefit shall apply to any SEHC plan offered or delivered to a small

employer.

(d) Except as expressly provided in this act, no health benefit plan offered to a small employer shall be subject to:

(1) Any law that would inhibit any carrier from contracting with providers or groups of providers with respect to health care services or benefits;

(2) any law that would impose any restriction on the ability to negotiate with providers regarding the level or method of reimbursing care or services provided under the health benefit plan.

(e) Individual policies of accident and sickness insurance issued to individuals and their dependents totally independent of any group, association or trust arrangement permitted under K.S.A. 40-2209 and amendments thereto shall not be subject to the provisions of this act.

(f) Notwithstanding the provisions of subsection (c) of this section or K.S.A. 40-2,105 and amendments thereto, any SEHC plan offered or delivered in this state shall include coverage for diagnosis and medically necessary treatment of mental illnesses.

Sec. 3. K.S.A. 40-2209f is hereby amended to read as follows: 40-2209f. Health benefit plans covering small employers that are issued or renewed within this state or outside this state covering persons residing in this state shall be subject to the following provisions, as applicable:

(a) Provisions of preexisting conditions shall not exclude or limit coverage for a period beyond 12 months following the individual's effective date of coverage and may only relate to conditions or related conditions for which diagnosis, advice or treatment was sought, during the six months immediately preceding the effective date of coverage.

(b) Such policy may impose a waiting period, not to exceed one year for benefits for conditions, including related conditions, for which diagnosis, treatment or advice was sought or received in the six months prior to the effective date of coverage. *On and after May 1, 1994,* such policy shall waive such a waiting period to the extent the employee or member or individual dependent or family member was covered by a group *or individual* sickness and accident policy, *coverage under section 607(1) of the employees retirement income act of 1974 (ERISA), a group specified in K.S.A. 40-2222 and amendments thereto or a group subject to K.S.A. 12-2616 et seq. and amendments thereto which provided hospital, medical and surgical expense benefits within 31 days* prior to the effective date of coverage *under a health benefit plan* with no gap in coverage.

(c) Any health benefit plan issued, delivered or renewed within this state and subject to ~~the provisions of~~ this act, shall be renewable with respect to all eligible employees or dependents at the option of the policyholder, contractholder, or small employer, except for:

amendment requested by Chip Wheelen on behalf of Kansas Psychiatric Society

3-14-94 Attachment 3

Health Insurance Mandates Under Kansas Law

Provider Reimbursement Mandates

40-2,101
physicians and chiropractors

40-2,100
dentists, optometrists, and podiatrists

40-2,104
Ph.D. psychologists

40-2,114
clinical social workers

40-2250
advanced registered nurse practitioners

Coverage Mandates

40-2,102
newborn infants including adoption

40-2229 and 2230
mammograms and pap smears

40-2,105
mental illness, alcoholism, and drug addiction

optional definition for SB612 re' KPS amendment

For purposes of this act "mental illness" means a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering death, pain or disability.

drafted by Chip Wheelen
Kansas Psychiatric Society

Human Res.
Attachment 3A
March 14, 1994

BRAD SMOOT
ATTORNEY AT LAW

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STATEMENT OF BRAD SMOOT, LEGISLATIVE COUNSEL FOR BLUE CROSS BLUE SHIELD OF KANSAS

PRESENTED TO THE KANSAS HOUSE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE REGARDING 1994 SENATE BILL 612, MARCH 14, 1994

Mr. Chairman and Members of the Committee:

I am Brad Smoot, Legislative Counsel for Blue Cross and Blue Shield of Kansas, a not-for-profit domestic mutual insurance company serving thousands of Kansans.

Blue Cross and Blue Shield of Kansas strongly supports the concept of community rating. Our company continued to community rate small groups until less than six years ago, and was driven to experience rating only as a last resort in the face of intense competitive pressure.

That pressure, familiar to most by now, caused insurers to cease to compete based upon service and to compete based largely on who could avoid insuring those groups needing insurance the most.

The Kansas Legislature took a big step toward restoring equity in health insurance rates and access for small employers in its passage of SB 561 in 1992, providing for rate compression among small groups of from 3 to 25 employees. We supported that bill, although we also pointed out that for every employer whose rates go down because of rate compression, another employer's rates would go up - that is, that we could not restore good public policy without causing some dissatisfaction.

We support SB 612 as well. Increasing group size from 25 to 50 for employers subject to this act will bring even more employer groups within the guaranteed issue requirements and also the rate compression (community rating) features of S 561. Our research suggests that 98% of Kansas businesses have 50 or fewer employees, involving about 36% of the population.

House FI&I
Attachment 4
3-14-94

We also applaud the portability objective of the bill. Assuring immediate coverage for persons coming into a group program from a nongroup contract or a self-insured contract is accomplished in the bill's amendment of K.S.A. 40-2209f(b). It is unfortunate that we cannot complete the circle to require ERISA groups to grant portability but there appears to be little states can do about that until Congress acts.

Finally, we would suggest that if the Legislature really wants to encourage community rating it will make it difficult for small groups to opt out of the community pool through the mechanism of self insurance with stop/loss coverage. This practice currently allows certain groups to avoid the insurance laws (including rate compression and mandates) while carrying little of the risk normally associated with genuine self-insurance. While federal law (ERISA) will not allow the state to prohibit self insurance by small employer groups, state law can restrict the sale of stop/loss insurance to small employers subject to S 612. The bigger the community pool, the more stable and equitable the rates. It is my understanding that a similar provision is being considered as part of Missouri's reform efforts. Language to accomplish this restriction on the sale of stop/loss insurance is attached to my testimony

We appreciate your support for S 612 and your consideration of these proposed changes.

New Section ____. No insurer or health maintenance organization shall sell, issue, or cause to be issued to a small employer as defined in K.S.A. 40-2209d(z) any policy of stop-loss insurance, excess risk insurance or reinsurance of any kind covering losses incurred by such small employer under a benefit plan covering hospital, medical or surgical expense of the employees or dependents of such small employer.

KANSAS COMMISSION ON DISABILITY CONCERNS
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TESTIMONY PRESENTED TO HOUSE FINANCIAL INSTITUTIONS AND INSURANCE

by

Sharon Joseph, Chairperson
March 14, 1994

Senate Bill 612

Mr. Chair, members of the committee, thank you for this opportunity to testify in support of Senate Bill 612.

Kansas Commission on Disability Concerns advocates for the rights of people with disabilities. One right that traditionally has been denied individuals with chronic health conditions is the right to change jobs without the fear of losing health insurance benefits. The current "portability" law prohibits exclusion of preexisting conditions or the imposition of a waiting period for those individuals who were covered by another group sickness or accident policy with no gap in coverage. This is good because it allows persons with health conditions that traditionally have been subject to lengthy waiting periods the opportunity to choose a career path based on their abilities rather than on the type of insurance coverage available.

KCDC supports your proposed amendment to Section 1(A) that would expand the applicability of this law to groups not previously covered.

KCDC proposes that all limitations on preexisting conditions, including the waiting periods allowed by law, be eliminated. A portability law would not be necessary if all insurance carriers were required to provide immediate and comprehensive coverage from the first day of enrollment.

Thank you very much for allowing me to speak before you today. I would be glad to answer any questions you might have at this time.

Attachment 5
March 14, 1994

Kansas Employer Coalition on Health, Inc.
1271 S.W. Harrison • Topeka, Kansas 66612-2302 • (913) 233-0351

Testimony to House Financial Institutions and Insurance Committee

on SB 612

(Expanding small group reforms to ER size 50)

by James P. Schwartz Jr.
Consulting Director
March 14, 1994

The Coalition is a statewide organization of over 100 employers who share concerns about the cost-effectiveness of health care we purchase for our 300,000 employees and dependents. A third of our members are smaller than 50 employees and could be affected by SB 612.

The Kansas Employer Coalition on Health supports the principles of insurance reform, particularly guaranteed issue and rate compression, and applauds their application to groups up to size 50. We also support the guarantees of portability provided in the bill.

While this bill will not achieve the larger aims of health reform (universal coverage and cost containment), it provides an important foundation for those reforms and offers a degree of relief in the interim.

Attachment 6
March 14, 1994

KANSAS AMI
KANSAS ALLIANCE FOR THE MENTALLY ILL
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TESTIMONY

TO: House Financial Institutions and Insurance Committee
FROM: Sheryl Tatroe, Kansas Alliance for the Mentally Ill
Kansas Mental Health Coalition
SUBJECT: SB 622

Our organizations support SB 622 as being an incremental step towards reform; certainly we are still seeking universal coverage and comprehensive benefits.

This testimony is on behalf of the amendment submitted by Chip Wheelen for the Kansas Psychiatric Society. The language in his amendment provides for treatment of mental illness as any other illness, subject to the same co-payments and deductibles.

This does not create a new mandate. Mr. Wheelen's amendment brings Kansans suffering from biologically based brain diseases under the same umbrella that health insurance offers to persons with heart disease or cancer.

Coverage for cancer or diabetes was not considered at the inception of health insurance; science knew very little about them. When they were demonstrated to be physical ailments they were naturally folded into health insurance coverage. No impact statements were required.

We would ask the committee to recognize that science has now found mental illnesses to be biological in nature and treatable medically. Clinical depression is a physical abnormality of the brain chemistry. It, like other mental illnesses, responds to medication. Clinical depression is something totally separate from the "depression" a person may experience following a job loss, a divorce, the death of a loved one.

Other brain diseases such as Parkinson's disease and multiple sclerosis receive equitable insurance coverage. Mr. Wheelen's amendment would remove the discrimination against the severe major mental illnesses and bring insurance coverage up to date with current scientific evidence.

We do support continued coverage for "mental health" treatment and find this amendment does not preclude the current mental health offerings of the small group policies on the market.

Thank you for the opportunity to address the committee and for your consideration in providing coverage for brain diseases equal to that of other physical diseases.

House F.I. & I.
Attachment 7
March 14, 1994

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TOPEKA

COMMITTEE ASSIGNMENTS
CHAIR: PUBLIC HEALTH AND WELFARE
JOINT COMMITTEE HEALTH CARE DECISIONS FOR THE 90's
MEMBER: FEDERAL AND STATE AFFAIRS
FINANCIAL INSTITUTIONS AND INSURANCE
CORPORATION FOR CHANGE
KANSAS HEALTHY KIDS CORPORATION
JOINT COMMITTEE ON CHILDREN AND FAMILIES

SENATE CHAMBER

Testimony On SB 566

By
Senator Sandy Praeger

Mr. Chairman and members of the House Financial Institutions and Insurance Committee:

SB 566 relates to accident and health insurance and would amend K.S.A. 40-2124. The bill would provide that, on and after May 1, 1994, the waiting period for preexisting conditions would be reduced from 12 months to 90 days for persons covered or making application for coverage under the Act. The board of directors of the plan would retain authority to reduce or increase the waiting period; however, the maximum waiting period could not exceed 180 days. This would allow a reasonable waiting period for those who must look to the Uninsurable Health Insurance plan as their only choice of coverage. This plan was originally created to meet the needs of a special population of Kansans who, because of disabilities and illness, cannot find affordable individual coverage.

Thank you for this opportunity to comment on SB 566, and I would be happy to answer any questions.

House FI&I
Attachment 8
March 4, 1994

Testimony on
Senate Bill No. 566
by
Dick Brock
Kansas Insurance Department

Senate Bill No. 566 would reduce the waiting period for preexisting conditions from one year to 90 days for persons insured under the uninsurable health insurance plan created by 1992 House Substitute for House Bill No. 2511. This change would become operative May 1, 1994, which coincides with the date the uninsurable health insurance plan became operational but as currently drafted, it appears the 90 day waiting period would become effective for contracts already in force as well as those issued after May 1, 1994.

The original legislation contained authority for this waiting period to be reduced by administrative action of the Board of Directors of the plan after the plan had been in operation for two years. Senate Bill No. 566 in effect reverses this process by statutorily limiting the waiting period to 90 days for the 1994-95 plan year but authorizing the Board of Directors to change it thereafter. In succeeding years, the waiting period may be increased from 90 days to a maximum of 180 days or may be reduced below the 90 days. It could even be eliminated.

Inherent in the very concept of an uninsurable risk pool is the fact that most applicants will have some sort of preexisting medical condition that prevents access to affordable coverage in the voluntary market. Of the 269 participants in the plan as of February 1, 245 had a preexisting condition. Of these 94 had the waiting period waived because of prior coverage credit; 22 were waived by action of the Board relating to initial applicants; 130 have a waiting period of 1-12 months; and, 23 had no preexisting condition. Thus, on the surface, there seems to be a significant conflict between the objective of a health risk pool which is to provide guaranteed access to insurance coverage yet exclude, for a period of time, coverage for the very condition that may well be the reason coverage from the pool is necessary. On the other hand, if there is no waiting period whatsoever or if the

Attachment 9

3-14-94

waiting period is too short, people could wait until they are ill or at least not feeling well before purchasing coverage. To do so would leave them vulnerable to accidents or the onset of a serious illness without warning but even then coverage could presumably be acquired in sufficient time to accommodate much of the expense unless some type of exclusion or other limitation was applied. The problem could be compounded by the absence of a waiting period because once an episode of illness is over, there would be no need to continue coverage since, again in the absence of some provision to prevent it, coverage could again be purchased when another illness strikes.

For the insurance mechanism to function even with respect to an uninsurable pool, there has to be some element of risk sharing, covered events have to be unexpected and fortuitous at least to some degree and there must be more risks that in the long run pay more in premiums than they receive in claim payments than the other way around. Admittedly, most health risk pools don't always meet this latter goal and certainly don't often meet it from a pure dollars in-dollars out standpoint. Nevertheless, without some incentive or disincentive to procure insurance prior to a covered event these principles are not only violated, they are ignored. The result would be the equivalent of buying fire insurance on a building that is already on fire.

Senate Bill No. 566 attempts to adhere to these principles by retaining a waiting period but reducing it to 90 days. Whether this is sufficient to prevent excessive abuse is not known. It will certainly require some increase in premium by virtue of the fact that claims for preexisting conditions will enter the system 9 months earlier.

Finally, if the amendment I mentioned earlier is adopted, the uninsurable health insurance plan will have been in effect for a year when the reduced waiting period becomes operable. Therefore, the population of persons with a chronic preexisting condition who were waiting for such a plan to become available because they had no other choice were presumably early applicants. As a result, reducing the waiting period as proposed by Senate Bill 566 should not produce a sudden and significant influx of claims.

Consequently, any rate impact caused by its enactment should not be dramatic or immediate.

The Insurance Department supports Senate Bill 566 but we do so without knowing what the actuarial impact might be.

Committee on Financial Institutions and Insurance

S.B. 566

Testimony by:

Brenda Parker

4303 Harbour View Road

Manhattan, Kansas 66502

Mr. Chairman and members of the Committee:

My name is Brenda Parker, and I am a mother. I appreciate the opportunity to speak to you today in strong support of S.B. 566. Prior to the birth of my daughter Kaci over four years ago, I was a successful professional businesswoman. If success can be measured in terms of nice vacations, new cars, and new homes, then I guess you would say my husband and I had it made.

Now, however, four years later and a veteran of the health care system, I measure success differently. It now means surviving and thriving. Our daughter, Kaci, was born with several physical birth defects. For two years and through thirteen surgeries on her heart, esophagus, intestines, trachea, and more, we watched our daughter fight for her life. The term "code blue" became too familiar, and our lives as we knew them were dramatically changed.

My successful career ended, our household income was cut in half, our savings were depleted, our expenses rose, and we sold our new home in exchange for a much smaller one.

During Kaci's hospitalizations, we took initiative on our own to learn as much as possible about her condition and how to take care of her. This included learning procedures such as suctioning her tracheostomy tube, replacing it, inserting a feeding tube through her nose into her stomach, learning to interpret lung sounds for possible signs of pneumonia and heart failure, changing colostomy bags, maintaining oxygen equipment, etc. We also took our own supplies to the hospital such as diapers, medications, colostomy and tracheostomy supplies and other equipment we used at home so costs

House FI&I
Attachment 10
3-14-94

could be kept to a minimum. Still, Kaci's one million dollar insurance policy was capped in two years, something we never thought possible, and we were faced with a thing called bankruptcy, something we never dreamed two successful people would ever have to even think about.

Kaci's pre-existing conditions prevented us from acquiring other insurance for her. Through much effort, Kaci finally received coverage through a federal waiver program designed specifically for technology dependent children called "Kidscreen". When I found out we would be accepted in the "Kidscreen" program, I felt I'd won the Lottery. At that time, Kaci, even though we were able to have her at home, required oxygen 24 hours a day, suction and respiratory machines for a tracheostomy, colostomy bag changes, gastrostomy tube feedings, and numerous medications on a 24 hour schedule. One of our doctors referred to the situation as "our I.C.U. at home".

That was then. Now, Kaci is getting well. She is no longer on oxygen, her colostomy has been reversed, and there are plans to remove the tracheostomy tube this spring. She is healthy, has not been in the hospital for a year and a half, and we're able to concentrate much more on catching up with developmental delays. She is bright, has had numerous excellent cardiac checkups, and her medications are cut substantially. She is our miracle.

She will not be technology dependent for very much longer. While this is what we and many others have prayed for these last four years, it also means we will no longer have access to medical coverage.

The Uninsurable Health Insurance plan was passed and designed, I believe, to spread the risk, and was an effort to provide an incremental health reform solution to a target group of Kansans. Its premise was good and needed. The fact is, however, if you are uninsurable and qualify for the Uninsurable Health Insurance plan, you likely have a pre-existing condition. A plan for uninsurable people with a full year waiting period for coverage of a pre-existing condition defeats the purpose. In our case, that time frame, especially if there were some unforeseen problem, could bring the fear of bankruptcy again to the forefront of our lives.

The bill before you, S.B. 566, provides for a 90 day waiting period, rather than twelve months. While 90 days without any coverage may be a challenge, we understand the need for a reasonable

waiting period, and we believe this is workable for us as well as others who must look to the Uninsurable Health Insurance plan as their only choice of coverage.

We want to continue to be productive, taxpaying Kansans. We want to continue to contribute to Kansas, instead of being threatened with Kansas having to contribute to us. We have fought very hard over the last four years to keep it that way. We are willing to do what it takes to pay the premiums and deductibles necessary. Our daughter Kaci is worth it. She is very special to us, and she has touched and encouraged so many others.

Mr. Chairman and members of the Committee, our daughter's future looks bright. I ask that you approve S.B. 566 so that the future of Kaci's parents, and the future of other families in Kansas like us, may look bright as well. Thank you for your time.

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TESTIMONY PRESENTED TO HOUSE FINANCIAL INSTITUTIONS AND INSURANCE

by

Sharon Joseph, Chairperson
March 14, 1994

Senate Bill 566

Mr. Chair, members of the committee, thank you for this opportunity to testify in support of Senate Bill 566.

Kansas Commission on Disability Concerns advocates for full inclusion of people with disabilities into **all** aspects of life. One arena that has typically and traditionally underserved people with disabilities is health insurance. Nearly two years ago a new law was passed in Kansas that created the Kansas Uninsurable Health Insurance Plan Act. This new Plan gave fresh hope to those who previously had been unable to purchase health insurance because of health conditions.

Unfortunately for those persons whose health condition had manifested itself with the six-month period immediately prior to application for benefits, the very health condition that necessitated their application for benefits will not be a covered expense during the first 12 months of coverage. We applaud the Committee for reducing the waiting period to 90 days after May 1, 1994, but would like to see you take it a step further and eliminate the waiting period altogether.

KCDC proposes that you strike out Section 1(c), lines 24 through 36 of the Bill and allow the persons for whom this Plan was created reap the full benefits of health insurance. According to the figures given to the Senate Committee on Financial Institutions and Insurance by the Insurance Commissioner's office, 245 out of the 269 participants in the Plan had pre-existing conditions. 130 of those 245 had to serve the 1 to 12 month waiting period.

House F.I.&I.
Attachment 11
3-14-94

May I remind the Committee again that many of the individuals who would benefit from this Plan would not be allowed to receive coverage for the very condition that made it necessary for them to enroll in the first place. These are not people who are waiting until the last minute, when they are deathly ill, to purchase health insurance. We are talking about people who have already been denied coverage by at least two other carriers because of health conditions, or have been accepted for health insurance subject to a permanent exclusion of a preexisting disease or medical condition.

Thank you very much for allowing me to speak before you today. I would be happy to answer any questions you might have at this time.