Approved: 2/24/94
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by Chairperson Richard Bond at 9:07 a.m. on February 23, 1994 in Room 529-S of the Capitol.

All members were present.

Committee staff present: William Wolff, Legislative Research Department
Fred Carman, Revisor of Statutes
June Kossover, Committee Secretary

Conferees appearing before the committee: Richard Brock, State Insurance Department
William Sneed, State Farm Insurance Companies
Chip Wheelen, Kansas Medical Society

Others attending: See attached list

Senator Corbin moved to approve the minutes of the meeting of February 22 as submitted. Senator Praeger seconded the motion; the motion carried.

The hearing was opened on **HB 2617** relating to discontinuance of certain accident and sickness insurance contracts. Richard Brock, State Insurance Department, appeared before the committee to explain that this bill is directed toward alleviating the problems insureds encounter when an insurance company introduces a new policy form, markets it for several years or until the claims begin to require upward premium adjustments, then introduces a newer policy and ceases marketing the previous one. Persons with a health condition or who do not otherwise qualify for the new policy may have no choice but to remain under the original policy until the premium level becomes unaffordable. **HB 2617** would impose requirements to address this situation. (Attachment #1.) Mr. Brock also requested an amendment to insert in section (2)(d) "*Unless an insurer presents evidence satisfactory to the commissioner that such a presumption is or would be incorrect, a block of* business shall be presumed closed ....". Mr. Brock also provided further clarification regarding to whom the bill would apply.

William Sneed, State Farm Insurance Companies, also appeared in support of this legislation and to request an amendment to assure that in instances where a block of business, because of market conditions, does not entail any activity, that block of business will not come under the purview of **HB 2617** and further, if such block of business becomes available within two years, the block of business will be open to any contract holder who falls within the purview of this bill. (Attachment #2.) In response to Senator Lee's question of who determines if a new policy will have comparable benefits, Mr. Sneed advised that, under this bill, the Insurance Commissioner would make this determination.

Mr. Carman questioned whether the term "block of business" should be changed to "group of contracts." Mr. Sneed and Mr. Brock agreed that the term "block of business" is used in the industry and is appropriate.

There were no further questions and no other conferees; the hearing was closed. Senator Steffes made a motion to amend **HB 2617** as requested by Mr. Brock and Mr. Sneed. Senator Moran seconded the motion. The motion carried.

Senator Steffes moved to pass **HB 2617** favorably as amended. Senator Praeger seconded the motion; the motion carried.

The chairman opened the hearing on **HB 2618**, relating to "usual, reasonable and customary charges." Mr. Brock explained that this bill would require that any provision in an insurance policy that purports to base payment of benefits on "usual, customary and reasonable charges" must either specifically define this term, or determination of benefits must be developed from a statistically valid sample which recognizes geographic variation, is produced at least every six months, and is collected on the basis developed and maintained by recognized authorities. (Attachment #3.) In response to Senator Lee's questions, Mr. Brock replied that the insurance companies conduct the studies and that the standards that apply to a geographic region are determined by collecting nationwide and regional data and then adjusting the information to apply to a particular geographical area.

Chip Wheelen, Kansas Medical Society, appeared as a proponent of **HB 2618** and stated that, although KMS was not a part of the task force that generated this legislation, his group endorses the concept and feels this bill will create an industry standard. (Attachment #4.)

The hearing on **HB 2618** was closed. Senator Praeger made a motion, seconded by Senator Steffes, to move **HB 2618** favorably, and to place it on the Consent Calendar. The motion carried.

The hearing was opened on **HB 2619**, nonduplication of workers compensation benefits and health and accident insurance benefits. Mr. Brock of the Insurance Department, explained that the intent of this bill is to clarify exclusions of payment of health insurance benefits if workers compensation coverage is available. (Attachment #5.) Benefits must be actually paid or payable by workers compensation for the exclusion to apply. In response to Senator Bond, Mr. Brock stated that the bill would apply to policies already in effect. Mr. Brock also requested an amendment to page 2, line 11, to read, "(b) The restriction in subsection (a) shall not apply when: (1) the claimant enters into a settlement giving up the right to recover past or future medical benefits under a workers compensation law, or (2) the claimant is covered by a workers compensation arrangement which limits benefits if other than specified providers of health services are used and the claimant continues to receive services for the compensable injury from a non-specified provider, except as provided in KSA 44-510 (c) (2). (Attachment #6.)

There were no other conferees; the hearing was closed. Senator Lawrence made a motion, seconded by Senator Steffes, to adopt the conceptual amendment requested by Mr. Brock. The motion carried.

Senator Lawrence moved to pass **HB 2619** favorably as amended. The motion was seconded by Senator Praeger. The motion carried. Senator Hensley will carry this bill.

The committee adjourned at 9:52 a.m.

The next meeting is scheduled for February 24, 1994.

GUEST LIST

SENATE

COMMITTEE: FINANCIAL INSTITUTIONS AND INSURANCE DATE: 2/23/94

NAME	ADDRESS	ORGANIZATION
Bill Sneed	Topeka	State Farm
Dick Brock	"	Ins Dept
Sharol Couch	"	Ks Chiropractic Assn
Chip Wheelen	Topeka	Ks Medical Soc
Rich Guthrie	KC	Health Midwest
Ray Schirr	Topeka	Citizen
Brad Smoot	"	BCBS

Testimony on

House Bill No. 2617

by

Dick Brock

Kansas Insurance Department

House Bill No. 2617 is also a product of the task force effort I previously mentioned and addresses a frequent problem encountered by health insurance policyholders and beneficiaries when benefits are to be paid on the basis of usual, reasonable and customary charges. These problems arise from the fact that this language or this term does not mean the insurer will pay whatever the attending health care provider or health care facility charges less any applicable deductible and copayment. Neither does it mean there is one standard amount that is applied to any given procedure in any given situation.

House Bill No. 2617 is directed toward a problem encountered by health insurance consumers when the insurance company that issued their policy stops selling that particular form and begins marketing a new product. This is a tool used by many insurers to maintain competitively priced products and thereby attract new business.

Generally, the way it seems to work is that an insurance company will introduce a new policy form, market it for several years or until the claims experience begins to require upward premium adjustments. When the premium level reaches the point that it is no longer competitive, the company will introduce a new policy, cease marketing the previous one and sell the new product only to persons who meet certain underwriting criteria. This means that persons with a health condition or who do not otherwise qualify for the new policy have little choice but to remain insured under the policy originally purchased until the premium level reaches the point that it is unaffordable. Meanwhile, those insured under the new policy being marketed grow older, experience health problems and their premiums begin to rise. When the premiums under that policy reach the limit of being competitive, that block of business is closed and the process starts over.

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Attachment # 1

House Bill No. 2617 would impose 2 requirements that should alleviate this problem and probably even stop the practice. First, if an insurer stops marketing a particular policy form, it would be required to permit any existing policyholder to purchase any other product being sold by the company that provides comparable benefits, services and terms. Second, the proposal would require the insurer to pool the claims experience developed by a closed block of business with the claims experience of all comparable blocks of business still being marketed for the purpose of determining the premium for contracts within the closed block. As a result, persons can retain coverage under the original contract then purchased yet pay premiums that are based on the combined experience of all those similarly insured.

We believe this bill will effectively address a recurring problem and ask that you give it favorable consideration. I do have an amendment I would like to offer which I failed to incorporate in our original proposal. Specifically, this amendment would make it clear that an insurer will have the opportunity to rebut the accuracy of a presumption described in subsection (d), lines 13-15, page 2.

(c) No block of business shall be closed by a carrier unless:

(1) The carrier permits existing contractholders to purchase a contract from any block of business that is not closed and which provides comparable benefits, services and terms, with no additional underwriting requirement or waiting period; and

(2) the carrier pools the experience of the closed block of business with all appropriate blocks of business that are not closed for the purpose of determining the premium rate of any contract within the closed block, with no rate penalty or surcharge beyond that which reflects the experience of the combined pool.

(d) ~~A~~ Unless an insurer presents evidence satisfactory to the commissioner that such a presumption is or would be incorrect, a block of business shall be presumed closed if either of the following circumstances exist:

(1) There has been an overall reduction in that block of 12% in the number of in-force contracts for a period of 12 months; or

(2) that block has less than 500 in-force contracts in this state.

The presumption that applies in the circumstances of subsection (d)(2) shall not apply to a block of business initiated within the previous 24 months, but notification of that block of business shall be provided to the commissioner pursuant to subsection (e).

The fact that a block of business does not meet one of the presumptions set forth in this subsection shall not preclude a determination that it is closed as defined in paragraph (2) of subsection (b).

(e) A carrier shall notify the commissioner in writing within 30 days of its decision to close a block of business or, in the absence of an actual decision to close a block of business, within 30 days of its determination that a block of business is within one of the presumptions set forth in subsection (d). When the carrier decides to close a block of business, the written notice shall fully disclose all information required for compliance with subsection (c). When the carrier determines that a block of business is within a presumption of subsection (c), the written notice shall fully disclose all information required for compliance with a presumption of subsection (c). In the case of either notice, the carrier shall provide additional information within 15 business days after a request by the commissioner.

(f) A carrier shall preserve for a period of not less than five years in an identified location which is readily accessible for review by the commissioner, all books and records relating to any action taken by a carrier pursuant to subsection (c).

(g) No carrier shall offer or sell any contract, or provide misleading information about the active or closed status of a block of business, for the purpose of evading this act.

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MEMORANDUM

TO: The Honorable Dick Bond, Chairman
Senate Financial Institutions and Insurance Committee

FROM: William W. Sneed
Legislative Counsel
The State Farm Insurance Companies

DATE: February 23, 1994

RE: H.B. 2617

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I am legislative counsel for The State Farm Insurance Companies. Please accept the following as our testimony in regard to H.B. 2617.

Please be advised that we support the intent found in H.B. 2617. However, there are instances where a block of business simply, because of market conditions, does not entail any activity. Thus, to avoid that situation we would respectfully request that the attached amendment be added. This will assure that in those instances such block of business will not come under the purview of H.B. 2617. Further, if such block of business does become available within two years after said notice, the block of business will be open to any contract holder who falls within the purview of H.B. 2617.

Please be advised that we have presented this amendment to the Kansas Insurance Department, and they have stated they have no opposition to its insertion in the bill.

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Again, we appreciate the opportunity to present this proposed amendment and testimony, and if you have any questions, please feel free to contact me.

Respectfully submitted,

William W. Sneed

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AMENDMENT TO H.B. 2617

On page 2, after line 10, add the following:

(3) If a carrier does not [redacted] offer or sell any block of business which provides comparable benefits, services and terms comparable to the closed block of business, paragraphs (1) and (2) of this subsection shall not apply. If a block of business providing benefits, services and terms comparable to the closed block of business becomes available within 24 months of the notice to the commissioner, such block shall be open to any contract holder in accordance with the provisions of paragraphs (1) and (2) of this subsection. The carrier shall provide notice to the Commissioner in writing within 30 days of its decision to close a block of business or, in the absence of an actual decision to close a block of business, within 30 days of its determination that a block of business is within one of the presumptions set forth in subsection (d).

On page 2, after line 36, add the following:

This subsection shall not apply to a carrier which does not have available a block of business which provides comparable benefits, services and terms comparable to the closed block of business and which has complied with the notice requirements pursuant to subsection (c)(3).

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Testimony on
House Bill No. 2618
by
Dick Brock
Kansas Insurance Department

House Bill No. 2618 is also a product of the task force effort I previously mentioned and addresses a frequent problem encountered by health insurance policyholders and beneficiaries when benefits are to be paid on the basis of usual, reasonable and customary charges. These problems arise from the fact that this language or this term does not mean the insurer will pay whatever the attending health care provider or health care facility charges less any applicable deductible and copayment. Neither does it mean there is one standard amount that is applied to any given procedure in any given situation.

It is, of course, not an issue with respect to services performed pursuant to a pre-arranged contract between the health care provider and third party payor, particularly those that prohibit balance billing. Rather, the difficulties stem from traditional insurance or indemnity products which simply provide for the payment of reasonable, usual and customary charges without further definition or specificity.

Based on the task force discussion of this issue, it appears the predominant basis for quantifying the usual and customary charge in a given situation is the Prevailing Healthcare Charges System (PHCS) established and sold by the Health Insurance Association of America. The schedule is developed by means of a statistical sample of actual claims arranged in percentiles by procedure by geographic area. The documentation and information acquired through the task force review further seemed to confirm that the PHCS was based on a valid statistical base and would produce reliable results by geographic area.

Difficulties arise, however, from the fact that insurers are not required to rely on PHCS or any other recognized array of charge information. In fact,

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Attachment #3

some insurers appear to rely on a unique schedule or schedules the origin of which is unknown. In addition, even insurers utilizing PHCS calculate their actual payments on a percentile basis. Therefore, some insurers may allow benefits for a covered medical service at the 70th percentile of the PHCS schedule while others may pay at the 80th or 90th percentile. This, of course, creates a disparity because different insureds and different providers receive different benefits/payments for the same service based on the same schedule. The issue is further complicated by the argument that payment at the 100% or, for that matter, any standard level of the PHCS would encourage price increases on the part of providers whereas varying allowances at lower amounts makes it difficult to target the upper limit.

From an insurance company perspective, the current system is probably satisfactory. However, from a public interest viewpoint, the determination of usual, reasonable and customary charges is, at best, inconsistent and, at worst, a scheme that permits an intentional underpayment of claims. House Bill No. 2618 is at least a first step toward improving this process from the consumers' perspective.

The proposal itself avoids the problems associated with a uniform standard that cannot possibly recognize the innumerable differences between one medical case and another yet assures the "usual, customary and reasonable" charge data is developed on a credible basis. In addition, it provides the Commissioner and insureds a proper foundation for regulatory or legal action when and if the need arises.

As indicated earlier, House Bill No. 2618 may not be the ultimate solution to this problem but we believe it is a good first step.

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February 23, 1994

To: Senate Financial Institutions and Insurance Committee

From: Chip Wheelen, KMS Director of Public Affairs

Subject: House Bill 2618
Payment of Benefits under Health Insurance Policies

The Kansas Medical Society supports the provisions of HB 2618. The amendment to current law would establish an industry standard for determining what is the usual, customary, and reasonable fee or charge for a specific service or procedure.

Oftentimes, an insurer will require that physicians sign a participation agreement (contract) in order to be eligible for assignment of benefits by the patient. This is done primarily for the convenience of patients because otherwise, the patient would need to afford the initial cash expenditure until he or she could obtain a reimbursement from the insurer. The assignment of benefits to the provider of care has become the norm rather than the exception. Frequently, the patient will select his or her provider based upon whether the provider is listed as participating in the insurance plan.

When a physician signs a participation agreement, he or she is normally required to accept either a schedule of fees which stipulates the amount of payment for each service; or agree to accept the usual, customary, and reasonable payment for services. Some agreements stipulate that the insurer will pay only a specified percentile of a survey of usual, customary, and reasonable charges in a geographic region. Because physicians are prohibited by federal anti-trust laws from collectively discussing their fees, it is not possible for them to determine what is in fact usual, customary, and reasonable. The result can be a dispute as to whether the insurer's determination of usual, customary, and reasonable is indeed reasonable. Enactment of HB2618 would preclude such disputes.

The new language in paragraph (8) would require insurers to use statistically sound methods to determine what is the usual, customary, and reasonable payment for a specified service or procedure. The reference to "codes and nomenclature developed and maintained by recognized authorities" is also important for purposes of standardizing health insurance claims payment.

Thank you for considering our concerns regarding this matter. We respectfully request that you recommend passage of HB 2618.

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Attachment #4

Testimony on

House Bill No. 2619

by

Dick Brock

Kansas Insurance Department

House Bill No. 2619 is another product of the individual health insurance task force described in the testimony on House Bill Nos. 2617 and 2618. This proposal relates to the exclusion contained in most, if not all, health insurance contracts which precludes the payment of health insurance benefits if workers compensation coverage is available.

In its policy form approval process, Kansas does not permit the use of vague or indefinite terms in these exclusions such as "eligible for workers compensation", "workers compensation benefits that may be payable" etc. Rather, an effort is made during the policy review to obtain language which makes the exclusion operable only if workers compensation benefits actually are or will be received.

To the extent abuse would otherwise exist, the Department's administrative action is generally sufficient. However, the possibility exists that an insurer may be using an unfiled policy form, the contract may have been issued in another state or for some other reason the exclusionary language is not properly worded.

The difficulty inherent in an exclusion that is too broad usually is revealed in cases involving sole proprietors, partners, agricultural workers and others who are not required to be covered by the Kansas workers compensation law but may elect to come under its provisions. The exclusion used by some insurers presumes that most or all employee/employer work-related injuries fall within the purview of workers compensation but, in Kansas, this is an incorrect presumption. As a result, the exclusion language needs to be more narrowly drawn than is apparently necessary in some states.

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Therefore, House Bill No. 2619 would simply codify the Department's administrative requirement so that even if a given contract contains an objectionable version of the exclusion, the statutory provision would prevail. In addition, insurers would generally be more aware of the Kansas requirement.

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(b) The restriction in subsection (a) shall not apply when: (1) The claimant enters into a settlement giving up the right to recover past or future medical benefits under a workers compensation law, or (2) the claimant is covered by a workers compensation arrangement which limits benefits if other than specified providers of health services are used and the claimant continues to receive services for the compensable injury from a non-specified provider ~~after exhausting workers compensation benefits for such non-specified provider.~~

except as provided in ICSA 44-510(b)(2)(C).

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Attachment # 6