MINUTES

SPECIAL COMMITTEE ON COMMERCIAL AND FINANCIAL INSTITUTIONS/INSURANCE

September 17-18, 2001
Room 231-N—Statehouse

Members Present

Senator Sandy Praeger, Chairperson
Senator Paul Feleciano, Jr., Ranking Minority Member
Senator James A. Barnett
Senator Pete Brungardt
Senator Ruth Teichman
Representative Ray Cox
Representative Stanley Dreher
Representative Joe Humerickhouse
Representative Judith Loganbill
Representative Bill McCreary
Representative Eber Phelps
Representative Sue Storm

Member Absent

Representative Bob Tomlinson, Vice Chairperson

Staff Present

Dr. Bill Wolff, Kansas Legislative Research Department
Kenneth M. Wilke, Revisor of Statutes Office
June Evans, Committee Secretary

Conferees

Bob Williams, Kansas Pharmacists Association
Bob Alderson, Kansas Pharmacists Association
Terry Bradstreet, Dillons Pharmacist
Terry Wilcox, Pharmacist, Round Corner Drug, Lawrence
Bill Sneed, Health Insurance Association of America
Linda DeCoursey, Kansas Insurance Department
Kathy Greenlee, General Counsel, Kansas Insurance Department

Steve Rarrick, Deputy Attorney General, Consumer Protection/Antitrust Division
Larrie Ann Lower, Kansas Association of Health Plans
Brad Smoot, Blue Cross and Blue Shield
Dr.Edwin Fonner, Jr., University of Kansas School of Medicine
Kathleen Sebelius, Kansas Insurance Department
Randy Allen, Executive Director, Kansas Association of Counties
Bill Butler, Commissioner, Miami County
Rich Vargo, Riley County Clerk
Rita Deister, Saline County Administrator
Bob Johnson, Commissioner, Douglas County
Don Moler, League of Kansas Municipalities
John E. Arnold, Chief Administrative Officer, City of Topeka
Gary Shike, City Administrator, Oberlin
Douglas Smith, Kansas Legislative Policy Group
Kyle Wendt, Health Benefits Administrator, State Employee Health Care Commission
Craig Grant, Kansas National Education Association
Bill Curtis, Kansas Association of School Boards
Sharon Bolyard, Advisory Committee to the State Employee Health Care Commission
Larry W. Magill, Jr., Kansas Association of Insurance Agents

September 17, 2001
Morning Session

Chairperson Praeger opened the meeting at approximately 10:00 a.m. *Representative Phelps moved, seconded by Senator Teichman, that the minutes of the August 23 and 24 meeting be approved. The motion carried.*

The Chairperson opened the hearing on Uniform Prescription Drug Information Card and called on Bob Williams, Executive Director, Kansas Pharmacists Association. Mr. Williams commented that 70 percent of prescriptions are paid for by one of many insurance programs, each issuing its own unique drug benefits card. Frequently, these cards lack sufficient data for pharmacists to efficiently process claims for prescriptions. Consequently, pharmacists often have to spend several minutes to locate the provider and process the claim. A uniform prescription information card would eliminate confusion and expedite filling prescriptions (Attachment 1).

Bob Alderson, Kansas Pharmacists Association, addressed one specific aspect of a drug information requirement, its applicability to Pharmacy Benefits Managers (PBM's). There is no government entity that has sufficient jurisdiction over PBM's to enable meaningful enforcement of SB 182, if the bill were to be passed, with respect to them. He proposed that legislation be drafted that would vest regulatory oversight of PBMs with the

Insurance Commissioner. Such a bill should focus principally on two areas: (1) enforceable registration and (2) consumer protection (Attachment 2).

Chairperson Praeger asked what might be involved in a registration statute. Mr. Alderson stated the Insurance Department perhaps could respond better to that question. However, the registration could include a fee of $100 with a $50 renewal fee. He indicated the model bill drafted by the National Community Pharmacists Association (NCPA) and used as a basis for his proposal, has very complicated registration procedures which he has opted not to propose.

Representative Phelps asked Mr. Alderson what was meant by "dividing model authority." Mr. Alderson responded the NCPA model provides for dividing the regulatory authority over PBMs between the State Insurance Regulator and the Board of Pharmacy. He said that does not present a very workable solution in his estimation since the issue is primarily insurance related as opposed to a concern of the Board of Pharmacy.

Senator Barnett asked what the risks were to patients and to the state if a PBM goes belly up. Mr. Alderson replied that, with respect to an HMO or insurer that goes belly up, his impression is the Insurance Department would look to the HMO or insured to make good on claims. In terms of a self-insured employer who contracts with a PBM to administer a program, there is a risk. He suggested that there are ways to get at that risk as well.

Representative Cox stated a PBM without an insurance company does not keep the premiums, they just manage the benefit program. Where there is an insurance company involved, it collects premiums and subcontracts with a PBM as benefits manager. Then, by association isn't liability always with the insurance company? Mr. Alderson discussed a PBM the state contracted directly with to provide pharmacy benefits to state employees. After about ten months, the PBM said it was leaving and the state scurried around to get another PBM. There was some discussion about bringing an action against the PBM, but none was brought.

Representative Cox asked if the state was self insured for pharmacy benefits and the PBM was just handling the arrangements. Mr. Alderson responded that was correct.

Terry Bradstreet, Director of Pharmacy Operations, Dillon's stores, stated they fill in excess of 100,000 prescriptions each week. Of these prescriptions, 84 percent are tied to some type of insurance program. Twenty percent of a pharmacist's time is spent sorting out insurance issues. A uniform prescription drug card would help ensure that the patients receive the correct medication, and understand completely how to administer the medication, including potential problems associated with their therapy so that the therapeutic outcome is maximized (Attachment 3).

Thomas M. Wilcox, Round Corner Drug, Lawrence, testified that 70 percent of his pharmacy's prescription sales were covered by private insurance and Medicaid. Prescriptions are billed and paid electronically, however, the basic information required to transmit an online pharmacy transaction is often lacking from the insured's medical identification card. This results in delays in processing prescriptions and long waits for the

sick and anxious customers. Uniform insurance identification cards would provide the basic information necessary to file timely insurance claims (Attachment 4).

Representative Cox asked how many new clients were served per day. Mr. Wilcox replied there were several each day and it can cause a big backlog if we have to contact many carriers trying to identify the right insurance company. If this information was on the card it would cut down on processing time.

William W. Sneed, Legislative Counsel, Health Insurance Association of America, spoke in opposition to a uniform prescription drug card. He said the card is unnecessary and would place additional administrative costs on an already tight health insurance marketplace (Attachment 5).

Representative Phelps asked if Mr. Sneed did not believe a drug information card could get over the growing pains and develop into something as effective as the ATM cards. Mr. Sneed replied, no, because there are too many variables in the component of these cards, *e.g.*, different coverages and companies. Further, the law would not affect self-insureds.

Representative Cox asked how much the increased cost would be. Mr. Sneed said it was estimated the cost would be $1.65 to $2.00 per card.

Senator Barnett wondered why Mr. Sneed would not want customers to have a card with all of the information that the pharmacy is required to submit so they can be in and out of the pharmacy in a timely fashion. What is your opposition to that? Mr. Sneed replied what one company requires for processing may be different from another. Additionally, the companies he represents oppose mandates.

Linda DeCoursey, Kansas Insurance Department, provided the members with a copy of the testimony presented during the 2001 Session on SB 182. That testimony reflected the Department was neutral on the bill if certain amendments were made (Attachment 6).

Kathy Greenlee, General Counsel, Kansas Insurance Department, spoke in general terms about the regulation of PBMs and pharmaceutical benefit management techniques. The Insurance Department could regulate PBMs, but such regulation would be sweeping and no other state mandates such regulation (Attachment 7).

On a tangential issue, Steven Rarrick, Deputy Attorney General, Consumer Protection/Antitrust Division, provided information regarding the Kansas Discount Card Deceptive Practice Act enacted in the 2000 Session of the Legislature. That act was included in Chapter 50 of the *Kansas Statutes Annotated*, but did not make the act a part of the Kansas Consumer Protection Act. The issue is then, who is responsible for enforcement of the Kansas Discount Card Deceptive Practice Act. He suggested the Discount Card Act be amended to clarify enforcement by the Attorney General (Attachment 8).

Staff called attention to a letter faxed by Susan Charleston, Director of Governmental Affairs, Pharmaceutical Care Management Association. Because of the September 11, 2001, disaster, she was unable to attend the meeting and give testimony in opposition to regulating PBMs. She offered to attend a later meeting if the Committee wished. A copy of the letter that was faxed is in the notebooks.

In discussion, members expressed interest in the effect other states have experienced after enacting prescription drug information card legislation. Mr. Williams replied that most of that legislation may be too recent to know of any effect, but would check to see if any kind of real relief has occurred. Mr. Williams said he also would check on what information other states are requiring on their identification cards.

As requested by the Chairperson, staff provided a memorandum listing the health insurance mandates enacted over the years by the Kansas Legislature (Attachment 9).

Afternoon Session

The Chairperson called the meeting to order at 1:30 p.m. She told the members that the condition of the health insurance marketplace, particularly the rising cost of health care costs, would be of interest given the topics the Committee has been assigned to study.

Larrie Ann Lower, Executive Director of the Kansas Association of Health Plans (KAHP), provided information on increasing costs of health insurance as experienced by the managed care industry in Kansas (Attachment 10).

Brad Smoot, Legislative Counsel, Blue Cross and Blue Shield of Kansas, stated health care expenses are now 14 percent of the U.S. gross domestic product with estimates of 16.2 percent by 2008, and 25 percent by 2030. Already a huge part of the economy, he said such dramatic increases will strain the ability of employers, families, and taxpayers to fund insurance coverage. A recent *Lawrence Journal World* article, citing U.S. Chamber of Commerce sources, indicated a 12 to 14 percent health insurance premium increase for large companies, and even greater increases for small employers (18 to 20 percent). Blue Cross and Blue Shield quoted similar numbers for Kansas. He noted there is no single cause for this dramatic increase, however, new technology and utilization, particularly of prescription drugs, are big cost drivers (Attachment 11).

The Chairperson opened the hearing on allowing cities and counties to opt into the State Employees Health Care Benefit Program and on the status of school district participation in the program.

Dr. Edwin Fonner, Jr., University of Kansas School of Medicine, gave an overview of the demographic and health insurance profile of public organization in Kansas. Cities, counties, townships, instrumentalities, a collection of special districts, and other public organizations were studied with data from the Kansas Public Employee's Retirement System

(KPERS) and a survey sent to administrators in April/June 2000. Almost 80 percent of the survey respondents are interested in the state health plan. Only 21 percent indicated no interest. He said proportionally more cities, instrumentalities, and other public organizations expressed interest. Geographically, there is no clear relationship between the size of the community and the extent to which respondents are interested in the state health plan (Attachments 12 and 12a).

Representative Phelps asked how Kansas University got involved in this survey. Dr. Fonner said that, at the time of the study he was a consultant for the Department of Administration supported by a Robert Wood Johnson Foundation grant. Later, he was employed by the University.

Kathleen Sebelius, Insurance Commissioner, stated one strategy being explored in states around the country, and with the federal employees health plan, is to use the bargaining clout of a state employees purchasing pool to extend coverage to other groups of uninsured or under-insured workers. Current statutes (KSA 75-6506) already provide that the Kansas State Employees Health Care Commission can include employees of a county, township, city, special district or other local governmental entity, and public school district, by rules and regulations. Kansas has begun to explore this strategy, recognizing that insurance is “the law of large numbers” and spreading the risk to a large pool of applicants is one of the most effective ways to contain costs. It is important to resolve the administration issues associated with expanding coverage, *i.e.*, what is the appropriate place to administer the plan, within a state agency or through a stand-alone agency.

The Commissioner also highlighted two other issues associated with expansion of the state plan: criteria for admission, *e.g.*, rules for new groups based on the existing "ramp up" approach, or separate pools in the plan; and the meaning of the criteria some believe controls admission, *i.e.*, that there can be no "adverse impact" on the existing plan for state employees by adding new members.

Colorado, she pointed out, has a stand-alone agency which administers both the pension plan and the health plan. Meredith Williams, who was the Executive Director of KPERS, runs that plan and he would be a good source to provide information on this topic (Attachment 13).

Senator Feleciano asked if the law is all inclusive or who can come into this group. Ms. Sebelius said the State Employee Health Care Commission could designate by rules and regulations the various groups to be included without statutory change. The majority of the Commission would have to move to get that done. She added that the State Health Care Commission was appropriate for the state employees health plan, but if this plan changes to be a public employees health insurance plan, the Legislature probably should revisit the administrative structure of such a plan.

Representative Phelps asked if any persons would be eliminated from inclusion in the state from the outset. Ms. Sebelius replied, no. If a city wants to come into the state health plan, it will need a minimum of 70 percent of its employees to sign up. That is one of the criteria that would then ensure a fairly broad based risk as opposed to individual employees

being able to decide whether to opt in or out. Minimum participation levels and minimum time commitments to the plan are two criteria for a stable plan and guard against adverse selection.

Randy Allen, Executive Director, Kansas Association of Counties, testified supporting counties be allowed to opt-in to the State Employees Health Care Benefits Program. He said Kansas counties employ about 18,700 full-time employees; that there is no evidence of a substantial risk to the state plan from admitting county employees; and county employees and counties are willing to pay their proportionate share of administrative costs of an expanded plan. He pointed out that 19 other states allow county and city employees to participate in state health benefit plans. He further urged that the Legislature consider appropriations to allow the Department of Administration the necessary and appropriate staffing to ensure the program's success (Attachment 14).

Chairperson Praeger asked how counties would feel if participation were mandatory. Mr. Allen responded local officials were not fond of mandates. We urged rather that admission be at the county's option. He agreed that opting in to the state plan should include a minimum period of participation.

Representative Cox asked Mr. Allen how many counties were interested in coming into this system. Mr. Allen said Dr. Fonner's report indicated well over half of the counties were interested, at least interested in receiving more information. At the time of the study, counties did not have the cost factors for health insurance coverage for their employees. In the last budget cycle there were a lot of county commissioners who were very concerned about the tax levies, particularly the tax levies for health insurance premiums.

Representative McCreary asked if health insurance was now being purchased through pools. Mr. Allen replied as far as health insurance plans, no.

Bill Butler, Miami County Board of Commissioners, stated Miami County is interested in having the opportunity to participate in the State of Kansas Employee Health Benefit Plan. Employee benefits are an important aspect of hiring and keeping employees. The cost of providing these benefits, especially health care, is soaring (Attachment 15).

Representative McCreary said Mr. Butler's testimony reflected there were two single mothers employed. Would they be eligible for HealthWave? Chairperson Praeger said for a family of three the income limitation is $27,000 and questioned if counties opt in, would the mothers be eligible for HealthWave, given the federal prohibitions relating to public employees. Staff will check into the question of eligibility.

Rich Vargo, Riley County Clerk/Election Official, stated that allowing counties to participate directly in the current state plan, similar to the way counties participate in KPERS, would create a much larger health insurance pool. This in turn would help control the health insurance premium cost for both state and county governments. He emphasized the importance of increasing participation of younger and healthier employees into the pool (Attachment 16).

Representative Loganbill commented counties are allowed to participate in KPERS but not health insurance. It seems you can be a state employee at one point but not at another.

Representative Cox asked Mr. Vargo what the state costs would be compared to what the county now pays? Mr. Vargo said the county offers two plans: Premier Blue and Blue Select. Premier Blue is $307.98 and Blue Select is $949. The county pays 100 percent of a single plan.

Rita Deister, Saline County Administrator, told the members Saline County employees will receive a financial shock October 1, 2001, when the county's cost for health insurance coverage increases over 40 percent. The county's monthly premium for health insurance will increase from $210 to $298 for single coverage, and from $452 to $660 for family coverage. The impact for the employee is a $60 monthly increase for family coverage and the Saline County taxpayers will pick up the remaining $148 increase (Attachment 17).

Bob Johnson, Douglas County Commission member, Lawrence, said health insurance is a big issue for Douglas County. In 1996 there were 407 enrollees in a self-funded health insurance program. Today there are 531 enrollees. In 1996 the costs for claims were $967,000 and in 2000 the costs for claims were $2,791,000. That is a huge difference. The largest difference was in the last two years. There has not been a significantly larger number of people covered, but there has been a higher utilization, higher cost of services, and the misfortune of having a couple of catastrophes. Any one of those in a group of our size would not significantly change costs, he said, but all three have changed it significantly. The county is dealing with it and wants to provide insurance. There has been an increase of 3 mills in property tax to cover the rising costs for coverage. He concluded the county would like for the state to provide an option to join the state plan, but he acknowledged that the county would not choose the option unless it is to the county's benefit. Our preference is to be left alone and work it out ourselves.

Senator Brungardt said, to protect the state's interest, we need some minimum level of participation. Do you think we need to mandate 70 percent? Mr. Johnson said if you look at a county or entity you need to have at least 70 percent of those people. He added that the costs that are driving the counties nuts are not going to change because you, the state, pay.

Chairperson Praeger commented on cities and counties being given the option of coming into the state plan, but if the option is chosen, there would be a required period of time that they would have to participate. She speculated that at the end of the time a county had committed to the state plan, it would again shop the market for rates and, if it received a rate lower than the state plan, it would leave the state plan with some potential adverse risk to the plan.

The Chairperson called the meeting to order at 9:00 a.m., and continued the hearing on allowing cities and counties to opt into the state employees health care benefit program, and on the status of school district participation in the program.

Don Moler, League of Kansas Municipalities, testified there is a growing problem for cities in providing health insurance benefits for their employees. Only the larger cities are able to seek competitive rates in the open market because of the greater number of employees. Many health insurance plans are experiencing a 10 to 15 percent rate increase each year (Attachment 18).

Chairperson Praeger asked Mr. Moler if he was saying that if cities and counties are committed to participate for a period of 3-5 years, then the state should also be committed to participating 3-5 years. Mr. Moler said that was correct. Cities understand if they opted into the program they would have to stay with the state health pooling arrangement for at least 3-5 years. He said if cities and counties made that commitment to the state, the state should make that commitment back.

John E. Arnold, Chief Administrative Officer, City of Topeka, testified the City of Topeka is facing rising costs associated with health coverage. The city is self-insured in an attempt to provide the lowest cost service to the employees and for the taxpayer. Our health care costs have been rising about 20 percent a year and continue to go up. We have 1,300 employees and the city pays the employee share in all four levels, for 2001 that number is $3,205 (Attachment 19).

Representative Loganbill asked what the City of Topeka's deductible was. Mr. Arnold said next year, in the basic plan, the single deductible will be $600 and a family plan will be a $20 co-pay. A buy out plan for a single plan would be $300 deductible and $900 family, with a $15 co-pay.

Gary Shike, City Administrator of Oberlin, explained that it is difficult to attract and retain quality employees in a small rural community. Health insurance benefits have always been a key recruiting tool. Oberlin had paid 100 percent of the health insurance premium for all 16 employees of the city and their families. However, in 2001 there was a 22 percent increase in premiums so the city changed to a different plan with higher deductibles and co-pays (Attachment 20).

Doug Smith presented the testimony for Gene Schwein, President, Kansas Legislative Policy Group (KPLG), an organization consisting of 35 counties located in western Kansas. The Policy Group supports legislative efforts to relieve county governments and their 1,600 plus employees from the financial burdens they incur while trying to secure affordable health care coverage (Attachment 21).

Representative Cox asked if the organization of 35 counties had tried to pool these counties. Mr. Smith responded they had not done that, but the topic possibly would be addressed at the annual meeting.

Kyle L. Wendt, Health Benefits Administrator, State of Kansas Employee Health Care Commission, provided specific information about the participation of educational entities in the state's group health insurance program (Attachment 22).

Chairperson Praeger said a survey of school districts was completed a couple of years ago which included a look at premiums paid by school districts at that time. She asked whether the ones that now are participating in the state plan are the same ones that just could not afford other insurance. Further, assuming that cost is a driver, is there any evidence that the 70 percent requirement is a deterrent to districts joining the plan? Also, what potential is there in the future? Does the three-year rule apply to school districts?

Mr. Wendt responded he thought cost was a big driver, probably a major factor. He said the 70 percent requirement is a deterrent for some districts. The three-year rule does apply to school districts. When districts sign contracts they are in for at least three years, and if they choose the ramp-up option, they could be in for as long as five years.

Senator Feleciano stated he heard from Bob Day, Department of Social and Rehabilitation Services, that Kansas was not a big enough state to have the buying power to warrant us to negotiate for better rates on prescription drugs. He suggested forming a consortium with other states. Is that something that could be done?

Mr. Wendt said he did not know the answer to that question. Chairperson Praeger noted that some states in the northeast have created such a consortium and they do seem to get better rates.

Representative Cox asked if more staff would be needed if these people were brought into the plan. Mr. Wendt said yes; there are 18 employees now servicing the existing state plan and more will be needed if the plan size increases. He said the Commission staff is ready to bring on the groups.

Senator Feleciano asked what Mr. Wendt thought of including cities and counties. Mr. Wendt said it was alright as long as it was done in an organized manner, and if it does not adversely effect the existing plan. There are 45,000 state employees covered and there would be over 100,000 if cities and counties were added. Since cities and counties are very different from the school districts as they have had very sophisticated experienced managed plans, they do not bring some of the concerns that the USDs did to the operation of the plan.

Chairperson Praeger asked if given the opportunity to come in, would they come in because of better costs and would they leave if they got a better deal in the future. What happens actuarially? It is a good deal for them to be able to opt in and opt out because the state is allowing them to come in when the cost is lower for them and let them out if they can get a better rate elsewhere.

Mr. Wendt responded that is a philosophical question, the best way we can deal with it is setting a 3-5 year time frame which is already in place. We need to look at the new

groups that come on board. USDs have not all come in at the same time so the issue of staying or leaving has not been raised.

Chairperson Praeger said many of these city and county plans, and school districts, too, are in the small group market. Is there anyway we can figure out what kind of an impact there would be on the small group market if many more small groups came into the state plan? Mr. Wendt said he did not know where that information could be found. Overnight our program could be twice the size it is today and we are already the largest group plan in the state.

Craig Grant, Kansas National Education Association, testified that teachers who have switched to the state plan have been extremely pleased with the coverage and the service provided. He said the coming rate increases and change in deductibles in the plan cannot be attributed to school employees. He acknowledged there has not been enough participation in the plan to cover the administrative expenses associated with their participation. Eleven relatively small districts participating do not generate enough administrative fees to cover the workload. This year the number of participants is increasing to about 17 districts. That will help, but still will not generat enough revenue to cover administrative costs.

Mr. Grant emphasized the school districts concern that when the magic number of 1,250 lives covered by the indemnity policy is reached, the Health Care Commission will separate the school groups out and place them in a separate group based on their own experience. While he has heard the Commission explain that separate pools are not likely, still the possibility is a deterrent for many districts giving serious consideration to joining the state plan. He also noted that many districts do not have the resources to pay the employer's share of the premium, even with the ramp-up provision. He indicated that once the school districts are in the state plan, they probably will not leave the program (Attachment 23).

Representative Storm asked how many districts pay nothing toward the health insurance of their employees. Mr. Grant said there were 14 that provide no health insurance opportunity. There are still a number of districts that provide access but pay nothing toward coverage. The employees pay all of the premium.

Representative Storm, assuming districts that do not even have access are small districts, asked how their salaries compare to districts that provide insurance. Do they help people procure health insurance on their own?

Mr. Grant said some negotiating has been done, even among larger districts, about putting all available moneys into salaries. Possibly half of those employees have insurance coverage elsewhere. He suggested that districts and teachers need to get over the learned paradigm that we do not have to provide benefits for school employees because they could usually get them somewhere else. That is not always the case anymore, but once the money is in a salary schedule it gets harder to talk about carving out some of the salary schedule to go to benefits.

Representative Storm said she was not talking about a cash-out option. Do their salaries reflect that they are thinking about health insurance and providing something additional to the salary to allow people to purchase health insurance on their own? Mr. Grant responded, some do and some do not.

Chairperson Praeger asked if any districts that have not fully utilized their LOB are having trouble with the ramp-up. Mr. Grant responded that at least the smaller districts were utilizing the maximum they are allowed without going to the people. Possibly some of them could utilize more property tax dollars to assist in providing health insurance.

Representative McCreary asked if there were still self-insured pools. Mr. Grant said there were a number of pools that went bankrupt. There is one pool in the southwest that covers 16 school districts. The idea of pooling was good for awhile but the lack of administrative knowledge was a detriment to success.

Senator Barnett asked for clarification of Mr. Wendt's testimony stating that full cost increases are passed to the educational entities, and their contribution rate could change each July 1 just like the state plan. How do we protect the state?

Mr. Grant said at some point in time, if it shows USDs adversely affecting the state plan, there would be a problem. However, the actuarial studies that have been done indicate districts will have no adverse affect on the state plan. He reiterated that there is no intent to harm the state plan. School districts are interested in coming in because the state has a plan that has worked. Whether the effect of the districts joining the state plan is validated at 1,250, 2,500, or whatever the right number of lives is, districts that have been in the plan for a period of years will have generated experiences that the plan will take into consideration.

Bill Curtis, Associate Executive Director, Kansas Association of School Boards, testified for insurance to be affordable there must be a large group participating and, within that group, there also must be a large segment of healthy people. He said a group of 1,250 people cannot stand on its own. This is an opportunity for school districts to get involved in a large group. The question about whether rates are going to go up is not a question that ought to be asked. Rates are going to go up. The questions become by how much, what kind of health care are we going to have, and who can afford to participate. The School Board Association, along with the NEA and the school administrators association have encouraged school districts to participate in the state's health plan. He noted the Association was not in opposition to the rules established by the Health Care Commission for district admission into the plan. He commented that districts were willing to go beyond the 70 percent participation level but were assured that level was an actuarially sound figure (Attachment 24).

Senator Feleciano asked if the state plan mandated the level of contribution from the employer. Mr. Curtis said the employer eventually must contribute 90 percent of the cost of a single plan.

Chairperson Praeger noted that if districts contribute less to the cost of coverage, the difference in the premium must be paid by the district employee. Then the issue becomes one of the employees willingness to pay that difference and participate in the state plan. The higher the level of employee contribution to coverage, the more difficult it becomes to get to the 70 percent level of participation.

Mr. Curtis said the issue for him is at what level of participation is the plan actuarially sound. The actuaries have said at 70 percent. If that is not the case, then the level should be raised to whatever level is necessary to maintain a sound plan. But if districts participate at the required level, whatever that is, there must be flexibility in who pays what percentage of the premium of the participants.

Mr. Wendt said his response to that position is that within the 70 percent participation level there must be a good mix of individuals, healthy and unhealthy. Is the criteria developed with the actuary based upon the plan? The question of who pays is very relevant in determining who participates. The issue is more than just financial.

Sharon Bolyard, President, Employee Advisory Committee to the State Health Care Commission, testified that the Committee would have no problem with city and county employees joining the state plan as long as there would be no adverse impact on the benefit structure or cost of the existing plan. The Committee believes additional staffing would be necessary to meet the needs of the larger group and an integrated data system would be absolutely essential to successfully manage the new membership (Attachment 25).

Senator Feleciano asked how the data base program would be funded. Why not competitive bid a data system? Mr. Wendt stated State General Fund dollars were not used for the data base. About a year ago the Medical Statistical Data System was installed and all the health plans report to that system. Previous to this data system, the Commission had to rely on the health providers to supply information. Going forward the Commission will have much more accessible, reliable data as it enters into the negotiation process with health plans. In the next three years we will have creditable source of data that we have not had available for competitive bids.

Larry W. Magill, Jr., Kansas Association of Insurance Agents, testified as an opponent to opening the state health care benefit plan to local units of government. He stated his opposition to be both philosophical and practical. Practically speaking, in many cases, local governments can obtain some savings by quantity purchasing, but in most cases, the savings are slight and the impact on local business can be significant. [Opposed to state being private enterprise (Attachment 25).]

Representative Cox asked how many individual policies were written in the State of Kansas. Is this big business? Mr. Magill replied he did not know the number of policies written. Most agents would rather not sell health insurance. Individual businesses are going through some difficult times and some carriers have left the state.

In summary, Chairperson Praeger stated the statutes allow the State Employee Health Care Commission to proceed without the Legislature taking any action. She noted

that adding new members to the plan transforms the way the state pool looks. Is that OK or not OK? There are so many variables to the issue including the needs of the cities and counties, the school districts, the state, and the insurance industry. Additionally, there are the cost drivers in the health care marketplace that drive up the cost of health insurance. If there is any specific information Committee members want to have this would be the time to make the requests. She indicated an interest in knowing what criteria is to be put in place if cities and counties come in. Certainly, young, healthy families need to be encouraged to come into the plan.

Senator Feleciano asked if it was the will of the Commission to enter into negotiations with cities and counties. Mr. Wendt said he could not speak for the Health Care Commission, but his understanding is that the Commission feels the Legislature needs to decide the issue.

Representative Storm asked how significant the concern for the small insurance market can be when school districts report to us they cannot even get anybody to give them a bid. Chairperson Praeger said she still would like to get some kind of report next month on the impact on the private insurance market of moving cities and counties into the state plan.

Representative Storm asked Mr. Wendt for some clarity regarding administrative costs associated with operating the state plan. If the cost of administration is figured into the premium paid by the state and employee, would we make the assumption, when bringing in other groups, that some amount would be worked into the premium to cover administrative costs associated with those groups? If that is the case, any impact on the plan would not be from new administrative costs. Mr. Wendt said that was correct. One of the key points is that going forward with expansion of the plan, the Commission would look at all of the costs that are associated with the plan and not lose site of the administration. That has to be a factor.

Representative Storm asked if he thought the increased cost would not have a negative impact on the people already in the plan since that has been one of the conditions the Legislature has placed on including more groups. Mr. Wendt said he could not answer that today, but would bring that information to the next meeting.

The dates for the October meeting were changed to October 22 and 23, 2001.

The following testimony was distributed: Ness City Board of County Commissioners (Attachment 26), Logan County Board of Commissioners (Attachment 27), and Marshall County Commissioners (Attachment 28).

There being no further business before the Committee, the meeting was adjourned at 12:10 p.m.

Prepared by June Evans and Bill Wolff

Approved by Committee on:

October 22, 2001