MINUTES

SPECIAL COMMITTEE ON COMMERCIAL AND FINANCIAL INSTITUTIONS/INSURANCE

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

Members Present

Senator Sandy Praeger, Chairperson
Representative Bob Tomlinson, Vice Chairperson
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

Members Absent

Senator James A. Barnett
Senator Paul Feleciano, Jr., Ranking Minority Member

Staff Present

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

Conferees

Bill Yanek, Kansas Realtors Association
Karen Hiller, Housing and Credit Counseling, Inc.
Ron Gaches, Associated Credit Bureau

Eric Ellman, The Association of Credit Bureaus
Kathy Olsen, Kansas Bankers Association
Matt Goddard, Heartland Community Bankers Association
Bob Day, Department of Social and Rehabilitation Services
Dr. Robert St. Peter, Kansas Health Institute
Theresa Koehler, Project Manager for HealthWave, Maximus
Robert Lynn, Doral Dental Services of Kansas
Gary Mandernach, Doral Dental Services of Kansas
Bob Alderson, National Association of Public Insurance Adjusters
Leroy Brungardt, Kansas Insurance Department
Steve Rarrick, Attorney General's Office
Melissa Wangemann, Secretary of State's Office
Gary White, Kansas Trial Lawyers Association
Chris Clarke, Division of Legislative Post Audit
Joe Lawhon, Division of Legislative Post Audit
LeAnn Schmitt, Division of Legislative Post Audit
Kyle Wendt, Health Benefits Administrator, State Employees Health Care Benefit Program

August 23, 2001
Morning Session

Chairperson Praeger opened the meeting at approximately 10:00 a.m. and asked the members to introduce themselves.

Dr. Wolff gave an overview of the topics assigned this Committee. Four of the five topics assigned will be heard today. Notebooks contain information on the

- National Insurance Adjusters Association, main sponsors of the Public Adjusters Bill, **SB 181**;

- Prescription drug information card, **SB 182,** a bill before the Senate Committee on Financial Institutions in 2001 (the study may be more expansive in the interim, including a discussion of regulating pharmacy benefit managers);

- Credit scoring, **SB 185** and **HB 2254**, both heard by respective Senate and House committees during the 2001 Session, and selected materials regarding access to credit scores via the Internet;

- Health Partnership study, **HB 2247** and **Senate Sub for HB 2146**, both bills having originated with the Senate in the 2001 Session, and a copy of the statutes creating the Partnership along with a staff summary of the act; and,

- State Employees Health Benefit Program expansion to include city and county employees, **SB 258** heard by the Senate in the 2001 Session; reports of two Legislative Post Audit studies on the State Employees Health Care Commission, and a copy of a study prepared by the Department of Administration Health Benefits Administration entitled "Demographic and Health Insurance Profile of Public Organizations in Kansas."

The agenda for this August meeting includes hearings on credit scoring, the consolidation of public insurance—Medicaid and HealthWave, licensing of public adjusters, and a preliminary hearing on expansion of the State Employee Health Program. The drug information card issue and further testimony on the expansion of the State Employee Health Program will be scheduled for September 17-18, 2001, and the Business Health Partnership issue will be heard on October 15-16, 2001. Final Committee consideration on all issues will take place on November 13, 2001.

The Chairperson opened the hearing on **Fair Credit Score Disclosure.**

Bill Yanek, Kansas Realtors Association, acknowledged that the Association requested introduction of and supported passage of SB 185 and HB 2254 during the last legislative session. Now, the Association is urging the Legislature to continue monitoring the marketplace to ensure the public has access to credit scores without legislative intervention to make disclosure a reality. He noted that the California Legislature determined that the additional protection of a law was needed to force credit reporting agencies and lenders to disclose credit scores. However, at this time a Kansas law may not be necessary. He added that continued voluntary disclosure by the industry is essential to protect consumers from entering into significant financial decisions uninformed (Attachment 1).

Representative McCreary asked if it was correct if he applied for a mortgage, the financial institution would voluntarily report his credit score. Mr. Yanek responded that the lender would not have to disclose the score as a matter of law; however, Congress does have before it proposed legislation that would mandate credit scoring disclosure.

Nancy Artzer, Housing and Credit Counseling, Inc., testified as a proponent for fair credit score disclosure and for passage of legislation that would mandate such disclosure. She stated that persons she works with on a daily basis have the right to know what their credit score is and how they can improve it (Attachment 2).

Senator Teichman asked who verified information on the credit report. Ms. Artzer stated the information on the credit report was collected by the credit bureau and not from the client. By federal law, credit bureaus must correct information they receive from creditors if the client disputes the accuracy of information provided.

Representative McCreary said he saw quite a lot of information about lending institutions raising the interest rate for people who do not have good credit and asked if that

was true. Ms. Artzer replied that, if a person's credit is good, *e.g.*, with a credit score of 620 or more, the interest rate perhaps would be 7 percent, with a down payment of 3 to 5 percent. If a person's credit is not so good, *e.g.*, with a credit score of 500, the person might qualify for a B or C level loan with an interest rate in the range of 10 to 13 percent. A large down payment also would be required. On FHA loans, financial institutions feel more comfortable with lower scores as the federal government is the guarantor of those loans.

Representative Loganbill stated the majority of sample credit reports included with her testimony have health related problems and the people are in a real bind. What is recommended in these cases? Ms. Artzer replied that persons in the condition described, probably have no alternative to taking bankruptcy, although she does not recommend that as an option. She noted that lenders tend to be more sympathetic to potential borrowers whose credit is adversely affected by health conditions than those who have spent beyond their means.

A member asked if a person who was the subject of a credit report could dispute the accuracy of the report. Ms. Artzer replied, yes. The federal Fair Credit Reporting Act allows persons to dispute the information contained in a report and requires any response the person makes to be included in the file and provided to any other party requesting a report.

Senator Brungardt asked the conferee if she felt the clients she works with should have access to their credit scores and how the score is going to help the consumer. Ms. Artzer responded yes to the first part of the question, saying all her clients have the right to their credit scores just as the lender has the right to use the credit score in deciding on the credit worthiness of a client. Further access to the score is important as a tool to educate consumers, to let them know just how much their lives are affected by their credit standing. Some of the bills set out in the credit reports contained in the testimony could have been paid, she said, but the clients chose to ignore them. They could have set up repayment schedules. But, they think when they get the summons to go to court, if they do not go to court, nothing will happen to them. In reality, if they do not show up for court, right or wrong, they have a judgment against them. Having access to their score will help them realize the importance of credit, it gives them something to shoot for and this is where we need to be with these people, and what we need to do to help them have a better life.

Senator Teichman asked, are you advocating that all lending institutions use credit scores for loans, and should they be required to use them. Ms. Artzer stated it was fine to use a credit score as long as it was not the only thing the lender used. Lenders need to look at other things, *e.g.*, housing longevity and job longevity. In Topeka, if a consumer is turned down for a home mortgage, Capitol Federal Savings and Loan Association and Commerce Bank assist the consumer through a committee of their staffs to determine if they could make that loan. Ms. Artzer concluded that financial institutions are using credit scores now and scores are the largest factor in determining whether a loan is made. The score is important because, if a financial institution chooses to sell their loans, they have to meet a certain score. Most loans made in Topeka are being sold.

Senator Teichman reminded the conferee that any legislation would affect the entire state. She is not sure loans made in western Kansas are being sold.

Representative Cox asked Ms. Artzer how her organization was funded. Do you get federal grants? Ms. Artzer replied, funding comes through United Way, City of Topeka—we are out scrounging for money all the time. Some money comes to them through federal grants in a roundabout way.

Representative McCreary stated the top three credit score companies do not take into consideration the character of the person applying for a loan. However, he said he was glad to hear some lending organizations do look at such things as job performance. He asked if a credit score would be brought down if, for example, a debtor has a loan with an organization similar to Household Finance (finance company), even if the credit with that organization was excellent. Further, would a credit score be lower if a person has five credit cards rather than two credit cards?

Ms. Artzer stated scores should not be lower as long as the payments were made on time. Credit score would be lower if a person had five credit cards with zero balance than if the person had two credit cards with small amounts of credit.

Ron Gaches, Associated Credit Bureaus, encouraged the Committee to take advantage of this opportunity to debunk the myths about and learn the reality of credit reporting agencies and their role in credit scores reporting. He said credit scores are just a number to access behavior. Credit scores are not fair and not unfair. Credit scores are simply a numeric measurement, a number, a way of accessing a certain kind of human behavior. Credit scores do not speak to a person's character. No assessment is made by a credit reporting agency of a human's character. The credit scores that are used by lenders are an amalgamation of consumer activity. In most cases they are highly accurate. When it is learned they are inaccurate, there is already in place a mechanism for consumers to correct their credit reports. Credit reports are provided free to consumers. There is not a static credit score as it changes with the consumer's credit experiences.

Mr. Gaches introduced Evan Williams, sales manager, TransUnion, a reporting agency that has the lion's share of credit reporting in Kansas; Mike Stewart, Overland Park, who is responsible for managing the business of TransUnion; and Eric Ellman, Washington, D.C., representing the national Associated Credit Bureaus, and who has the responsibility for watching all 50 state legislatures and tracking all kinds of legislation dealing with the credit reporting industry. Mr. Ellman will be giving testimony today.

Mr. Ellman testified the marketplace is working; consumers have plenty of places to go to obtain score disclosures. He said mandating disclosures based on a California experiment that is only seven weeks old risks the flexibility that consumers and businesses need in a rapidly changing marketplace (Attachment 3).

Representative Cox asked, is a fee charged to access information on the internet. Mr. Ellman replied, TransUnion does not charge, Equifax charges $12.95. Representative Cox further asked what information must be provided for a person to obtain a credit score. Mr. Ellman stated a person has to give identifying information and essentially prove who they are so the credit score will not be misdirected to the wrong person. It is a pretty

thorough request process. Reporting companies ask multiple choice questions, the answers to which only that person would know.

Representative Cox asked how long this process took. Mr. Ellman replied, a couple of minutes.

Representative Phelps asked, whether the conferee did not feel credit score reporting needed to be mandated. Why do you not want consumers to know their credit score? Mr. Ellman stated they oppose mandatory reporting required by law. The industry wants consumers to have a full understanding of their credit histories and the credit score system. The credit scores that lenders use can be based on information which the reporting agency knows nothing about and does not provide. For example, Bank of America will give a higher score for someone who has been a consumer for a number of years and a lower score for a consumer who has just shown up on their doorstep. They also could include information they get from the application that we do not get. Representative Phelps stated, the problem seems to be that one size does not fit all. Mr. Ellman stated there are dozens of variables.

Representative Storm asked if part if their opposition was due to the increased possibility of people wanting to appeal, challenge, or react to a credit score that they do not feel is proper. Mr. Ellman said consumers can appeal now. The credit report is a foundation upon which many, if not most, credit scores are built. It is the underlying data, is the support that holds up a lot of credit score information, and when consumers look through their credit reports as they are entitled to do, they can determine what they feel is accurate and inaccurate. If they feel there are inaccuracies, under federal law there is a mechanism to resolve disputes within 30 days. If the dispute cannot be resolved, confirmed, or denied, within 45 days, the consumer's word is taken and items removed from the credit report. There are ample ways the consumers can dispute information that goes into the underlying battery of the credit score.

The Chairperson asked how much subjective evaluation goes into credit reports. Mr. Ellman said there is subjective evaluation in any credit determination made by the lender. There could be two credit reports—one credit report in the hands of two different lenders and one making a subjective determination that this person does not get a loan and another person looking at the exact same credit report would say they could take the risk. A credit score itself is not subjective information, but a credit decision is subjective.

Mr. Stewart stated his objection mandating legislation arises from the fact that reporting credit scores is an evolving process. "We are not against reporting scores," he reiterated, "we are just against having it locked in."

Kathleen Taylor Olsen, Kansas Bankers Association, testified in opposition because credit scores are only one piece of the entire credit puzzle and would be meaningless, misleading, and confusing to consumers (Attachment 4).

Representative Phelps asked what problems arise out of using the credit score. Are consumers denied a loan if the score is low? Ms. Olsen stated the concern that, if a lender looked at a credit score alone, it could look like the consumer might be qualified for a loan.

But there are other factors taken into consideration and a lender who looks at those factors may think they are more important than what the credit score reflects. There are a number of different credit scores and they can change by the moment. It can be very misleading to just look at a credit score. The credit report is more complete.

Matthew Goddard, Heartland Community Bankers Association, testified in opposition, stating the Association does not feel state legislation is warranted in an area already effectively governed by a uniform federal law. The Fair Credit Reporting Act already protects consumer interests when lenders use information provided by a consumer reporting agency (Attachment 5).

There being no further testimony to be given, the Chairperson closed the hearing on the Fair Credit Score Disclosure topic. She stated good information was received today and at a future date the Committee will decide if it wants to make a recommendation. Several possibilities exist including "if it's not broke, don't fix it," and continue to monitor California law. She acknowledged that the credit score can be confusing as there are several different scores out there. What is probably more effective for the consumer is knowing the specific reasons credit is denied. At any rate, the Committee will think about it and discuss the topic at a later meeting.

Representative Phelps asked how this bill was brought forth. Mr. Yanek said the bill was requested by the Kansas Realtors Association.

Afternoon Session

The Chairperson called the meeting to order at 1:30 p.m. and opened the hearing on **Public Insurance Consolidation in SRS—Medicaid and HealthWave.**

Bob Day, Director of Medical Policy/Medicaid, stated it has been the goal from the beginning of the Medical Policy/Medicaid team to create a health insurance program that combines Medicaid and the children's health program, HealthWave, to make family coverage a reality for Kansas citizens. He called the members' attention to the new application for the HealthWave program that is in a simpler form.

For the past two years, he said, the Department has been working to bring HealthWave (State Child Health Insurance Program (SCHIP)), and Medicaid programs together. Twenty-five percent of all children enrolled in HealthWave are likely to have a sibling or another member in the house enrolled in Medicaid. In that case under the old program the family had potentially two different plans and likely two different providers. In addition, there is a substantial amount of churning that seems to go on between the two programs. Families move back and forth because of the different eligibility requirements of the two programs. The Department estimates that approximately 30 percent of the kids that begin their 12-month continuous eligibility in the HealthWave program do not complete it; but many of them move into the Medicaid program.

He indicated steps are being taken to alleviate that situation. Grant funds totaling $250,000 have been spread among the 11 local area offices to be awarded to local entities to do outreach for the HealthWave program. Also, a new health card will be distributed that has the HealthWave logo and a group number much like any other insurance card. There is centralized processing of applications and an expedited process so that people are not waiting to become eligible. The Legislature eliminated the six-month waiting period in the Title XXI program. Once kids are enrolled they are covered. We have finally accomplished what we set out to do two years ago (Attachment 6).

Representative Storm said in the past there has been considerable difficulty at times in some places in securing participating physicians and in particular participating dentists. What is the status of that situation?

Mr. Day replied that was going to be an ongoing struggle. In the dental community, last year the Legislature proposed and the Governor approved an increase in dental rates. We have given those rates out and given them to the Kansas Dental Association to review. They had done that and given their acceptance. He noted that dental services are a problem for everyone and, nationwide, the ratio is getting worse. We are not turning out enough dentists. The average age of a dentist is 50. At the last check, Doral had 209 dentists enrolled in this program and that only handles people in this program. There are more than that enrolled in Medicaid who are eligible for dental services. They continue to work with providers who are not Medicaid providers to get them to just try participation.

On the physician side, rates are a huge problem. They have not had a rate increase since the mid 70s. The office rates remain substantially below the Medicaid rate. The way the system is designed in terms of pharmacy, which is the largest single cost, rates automatically go up to the alarm of almost everyone in the Legislature. Pharmacy rates are climbing. For in-patient hospital stays there is a process by which those rates are adjusted. They do not go up much but there is an adjustment. Physicians and dentists have been waiting for more money to be allocated. They are getting squeezed and are not willing to pick up additional patient loads. A real problem for both physicians and dentists is keeping a balance in their patient load the number they have in Medicaid and the number of self pay.

Chairperson Praeger stated one of the reasons she thought it was important this Committee look at the Medicaid/SCHIP program was that they actually are public insurance programs, it is not welfare anymore. She indicated that managed care providers in general are less willing to absorb any kind of a cost shift, and, she added, we have been one of those cost shifters because we would not pay adequate rates. Mr. Day said it is the office visits that are so underpaid. Other states are experiencing a pretty big crisis and we could too.

Chairperson Praeger asked, regarding Representative Storm's question pertaining to dentists, does it mean those 209 dentists mentioned will take any more patients or will they still limit the number of people. When dentists sign up for the program to be a provider, are they willing to take more patients.

Mr. Day said Doral would be in a better position to answer that, but we know there are dentists that participate in the program and physicians that participate in the program that have panels that are full. They have all the Medicaid patients they are going to take. In Salina we have blocked enrolling people except for the HealthWave group because there are no more physicians available. We monitor the number of physicians and make sure they are available before enrolling people in the program. It is an ongoing struggle.

Senator Praeger asked if we are eliminating some of the paperwork. Mr. Day stated most physicians file electronically, and if it is a clean claim, it can go through within a day or two and checks go out within several days of that. We are mailing checks every day. If it is not clean and is kicked out, it does take longer. Senator Praeger asked if the Department looked at the reasons claims get kicked out and worked with business managers so those can be eliminated. Mr. Day stated if a provider calls, Blue Cross-Blue Shield has provider representatives who go out and train office staff; but providers have to call first and say there is a problem.

Representative Cox asked what the budget was and what the state and federal contributions were. What is paid for an office visit? Mr. Day said the health care component of the Medicaid program is about $700 million and it serves around 200,000 clients on a monthly basis. The federal payment portion is 60 percent and the state pays 40 percent. On HealthWave, the cost will be about $40 million and the federal portion is 72 percent and 28 percent to the state. In terms of actual office rates for Medicaid, the state is doing good if it pays about 50 percent of the Medicaid allowable payment.

Representative Storm asked, given the 60/40 percent match, if the state raised its rate, would the federal government match automatically go up. Mr. Day said that is correct. If the rate is raised $10.00, $6.00 of that would be paid by the federal government and the state would pay $4.00.

Robert St. Peter, M.D., President, Kansas Health Institute, an independent, non-profit health policy and research organization, stated the HealthWave program was implemented in 1999, as a separate program from the Medicaid program. Persons are eligible up to 200 percent of poverty through age 19. There is a premium charge for eligible persons who fall between 150 and 200 percent of poverty. He commented that about 1,400 children come into HealthWave every month and about 1,100 children leave every month. On the Medicaid side, it is a much bigger program, and, therefore there are more people coming in and going out. The net gain is relatively small. One out of four are new to HealthWave, but three-fourths of the children coming into HealthWave have been in the Medicaid program at some point in the past (Attachment 7).

Dr. St. Peter explained the churning saying that either the family income changes and makes it ineligible, or the child ages beyond the maximum age, or the family fails to reapply believing it is no longer eligible. A lot of children, he said, currently could be in the program who are not.

Chairperson Praeger asked if Florida had done a random audit of its SCHIP program enrollees to see if there are people staying on that should not be participating. Is Florida

testing to see if pre-enrollment is keeping more kids on that are ineligible? Dr. St Peter said in Florida, unlike the other states, everybody in their SCHIP program pays a premium. If the family stops paying the premium, it is dropped from the program after a 60-day grace period. There is the potential that families could continue to pay the premium and continue on the program unless some auditing is done. But, the fiscal impact would be very little for those remaining.

Representative Cox said, so we are saying in Kansas after 12 months everyone has a lot more money and that is why re-enrollment is down. What is the re-enrollment hang-up? Dr. St. Peter said two things are happening: people reapply and are being told they are not eligible—possibly the child has gotten too old for the program, turns 19, or the family makes more money and is not eligible for the SCHIP program, or the other is that they just do not reapply. Some are unaware that they have to re-apply. Others know it is time to reapply but think they are not going to be eligible even though they might be. There is a lot of information nationally that families end up not applying because they think they are ineligible because of their income and actually would have been eligible if they would have applied. There is a lot of misunderstanding. The big drop in the re-enrollment numbers for Kansas is something we have been talking about to different committees in the Legislature and to SRS about because a lot of children that could be in the program are not.

Chairperson Praeger asked if any physicians had reported patients had come in that had not re-enrolled and had their claim denied. Mr. Day said he had not heard that and that the Department is actively trying to get people to re-enroll. Mailings go out well ahead of their eligibility termination, phone calls are placed and followed up. Some people do not understand that insurance is about before you get sick, not after you get sick. Dr. St. Peter said there was a lot of turnover in private insurance also; this is not unique to public insurance programs.

Representative Storm asked whether the drop at enrollment time would not also indicate that families have moved from HealthWave back to Medicaid. Dr. St. Peter replied, yes it does.

Theresa A. Koehler, Project Manager for HealthWave, Maximus, testified that over 50,000 children are insured. We are making sure we close cases when people are not eligible. Maximus has sent out 54,000 of the new applications and returned applications are processed within 15 days of receipt. The enrollment also can be done over the telephone (Attachment 8).

Senator Praeger asked, once they are eligible, how do they know who they are going to. Ms. Koehler replied, Maximus sends out packets with eligible physicians and dentists for the client to choose from. If we do not hear back within 15 days, we call to see whether they received the packet and if there are questions.

Robert Lynn, Doral Dental Services of Kansas, testified that Doral has been very successful in Illinois. He acknowledged that Doral did not do a good job in Kansas in the past. Part of the past experience stemmed from the fact that the program was administered through family health partners, not the state directly, and was not funded at an acceptable

level. There were difficulties caused by the secondary communication and little interaction with provider community. At the present time and under the current contract, Doral is administering the HealthWave program directly with the state and that is working well. He said there are 215 providers signed up at 176 locations and, he added, Doral will be successful (Attachment 9).

Gary Mandernach, Doral Dental Services of Kansas, said the company was marketing the program asking Kansas dentists to "Take Two." Information is going out to dentists asking them to take two and so far 215 (previously 29 non-participating dentists), have signed up. He noted, as other conferees have, that there is a shortage of dentists facing every state (Attachment 10).

Chairperson Praeger asked if there were any required numbers of patients the 215 dentists that have signed up for the program were to serve. Mr. Mandernach replied, no.

Chairperson Praeger asked about the reimbursement rate. Mr. Day stated the state pays about 90 percent of the mean reimbursement according to the "American Dental Association Midwest Analysis," (1999), which is close to the average rate paid in 1999. He said reasonable attempts are being made to pay rates that will improve access.

Having reached the end of the day's agenda, the Chairperson recessed the meeting until 9:00 a.m on August 24, 2001.

August 24, 2001
Morning Session

The Chairperson called the meeting to order at 9:00 a.m., and began the hearing on licensing public adjusters.

Bob Alderson, representing the National Association of Public Insurance Adjusters, stated he requested **SB 181** last session. The bill to license public adjusters was heard in the Senate Committee on Financial Institutions and Insurance and recommended for interim study. He noted the Insurance Department's opposition to licensure and understands the position that, since there are so few public adjusters to be licensed, it does not warrant putting in place a licensing scheme. Further, since it probably makes no fiscal sense to license so few adjusters, he said the Association was withdrawing support for the bill bringing forth a Substitute SB 181 which simply would codify and clarify what a public adjuster can do (Attachment 11).

Representative Phelps said he did not get the connection between the *State of Kansas v. Martinez* referenced in Mr. Alderson's testimony to the licensing of adjusters and the Attorney General's Office opposition to licensing. Mr. Alderson explained that the Attorney General did not oppose licensing as originally opposed in SB 181, but did have some amendments to that bill that needed to be made if the Attorney General were to

support the bill. He explained further that the Kansas Court of Appeals finding in *Martinez* has caused confusion in the marketplace as to whether or not a public adjuster can work in Kansas. SB 181 would remove that confusion. Now, however, since there is no regulation of the profession proposed in the substitute bill, he understands that the Attorney General does not support that bill.

Leroy Brungardt, Director, Agents and Brokers Division, Kansas Insurance Department, testified that the Department requested the Senate Committee in the 2001 Session to take no action on the bill, and he confirmed that the Department does not now support SB 181 as the legislation is not needed (Attachment 12).

Vice Chairperson Tomlinson stated that the Department of Insurance in recent years has made a habit of sending representatives into areas that have had natural disasters. He asked how the Department's role at the scene of such disasters is different from the role of a public adjuster.

Mr. Brungardt responded that their assistance at the scene of a disaster is, and has been for many years, standard procedure. The Department is present strictly as a facilitator of claims between the company and the policyholder. A public adjuster would probably work just with a consumer. The number one priority for the Department is to get the company adjuster and the consumer/policyholder together. If the consumer was not satisfied with the company offer for settlement, the consumer could seek the help of a public adjuster.

Vice Chairperson Tomlinson asked if the Insurance Department ever advised a consumer to see a public adjuster. Mr. Brungardt replied, not that he knew of. The normal procedure in a situation like that would be to examine the claim, contact the company, and try to resolve the concerns the insured would have directly with the company.

Vice Chairperson Tomlinson said, under those circumstances, I can see where the public adjuster would want some clarification as to their role. In a situation where the adjuster could be most helpful, it appears the Insurance Department has stepped in and is fishing in the same pond. He said he did not think the Department is incorrect here, but why not clarify or codify roles so everyone understands them. That would be more fair.

Mr. Brungardt responded that, in the situation at hand, the issue is more for the Attorney General's Office to comment on than for the Insurance Department. He said the public adjuster does not go awry in the adjusting of the claim with the consumer, but runs into trouble when there is a difference of position between the consumer and the company. At that point the activities of the adjuster ends or the adjuster may find the Attorney General scrutinizing the adjuster's activities as the unlawful practice of law. In that same conflict between the consumer and the company, if the consumer came to the Department we would take the consumer's side and say OK, where is the problem. That is what we would do with a public adjuster or any other adjuster.

Vice Chairperson Tomlinson said he would like for the Insurance Department to look at the proposed bill further as it might help in natural disasters. Mr. Brungardt responded, that is a fair suggestion on your part and we will do that.

Chairperson Praeger stated the primary role of the agency is to see that the contractual agreement is upheld. The Insurance Department is a regulatory body. There is no contract between the insured and a public adjuster. At what point does it justify the regulatory body to come in and intervene when there is no contract? Mr. Brungardt said they would look at that. There should be a contract in place for the services of the public adjuster and, I assume Mr. Alderson would support that. If a public adjuster does anything with a consumer, they have their own contract. Our responsibility is the claim itself, not the contract that the insured signed with the public adjuster.

Chairperson Praeger asked which agency is involved, the Department of Insurance or the Attorney General. Mr. Brungardt stated if the consumer is dissatisfied with the settlement offer from the company, it is the responsibility of the Department to set in at the consumer's request.

Steven Rarrick, Deputy Attorney General, Consumer Protection/Antitrust Division, testified in opposition to SB 181 and to the proposed Sub. for SB 181 as it is not necessary. If there is no testing, licensing or bonding to be required in the bill, there is no protection for the consumer (Attachment 13).

Vice Chairperson Tomlinson stated the Department of Insurance did not want to license public adjusters because there were not enough to make it worthwhile. The Attorney General's Office does not wish to have a clarification of their role because clarification does not provide an increase in consumer protection. Mr. Rarrick responded, the Attorney General did not think any clarification was necessary. What public adjusters do and are doing in Kansas is completely authorized and not prohibited by the *Martinez* decision.

Vice Chairperson Tomlinson stated he understood but he heard testimony that in case of natural disaster, some clarification of the role of the adjuster might be necessary because of the role assumed by the Insurance Department. If I were in business as a public adjuster, he said, I might not appreciate the Insurance Department being exactly where they were.

Mr. Rarrick stated he was not sure the Insurance Department believes clarity is necessary. I know the adjusters do. He explained that the Attorney General also sent representatives to Hoisington with the Insurance Department. The Insurance Department had more of a presence there because they had the ability to help the consumer with their insurance company. We went in also because we were concerned about companies other than insurers that may come in after disasters and commit fraud and that could also include public adjusters.

Vice Chairperson Tomlinson stated he was not disputing either the Insurance Department's or Attorney General's Department's need to be in Hoisington. He said he questioned whether or not there is a need for the clarification of the public adjuster's role and would submit to the Attorney General that perhaps we could do something to help consumers of this bill short of licensure, possibly bonding.

Mr. Rarrick said he was not aware of any statute in Kansas that would bond somebody without a licensing requirement. He said the Attorney General did support the licensing, testing, and bonding of public adjusters and added that the role of public adjusters in Kansas has been clarified for adjusters in Kansas by way of a letter to Mr. Alderson on July 23, 2001. That letter stated public adjusters may legally perform adjusting services in Kansas as long as they limit their activities to investigating, appraising, evaluating, and advising their customers as to the amount of the customer's loss, and do not perform any services that constitute the unauthorized practice of law. We just do not think a statute is necessary.

Vice Chairperson Tomlinson stated rather than the Kansas Insurance Department and Attorney General's office saying we cannot do it, maybe it would be prudent to see what should be done. I believe the position of pubic adjusters should be clarified.

Mr. Rarrick responded that the issue has been clarified. The real concern is that further clarification would be similar to us promoting people going to a private attorney on a consumer protection question where we are statutorily authorized to act. The Insurance Department has statutory authorization and does a very good job in assisting insurers when they have disputes with their insurance companies, especially at the consumer level. At the corporate level, when losses are in the hundreds of thousands of dollars, I certainly think the public adjusters have played a very good role and can continue to do so.

Melissa Wangemann, Legal Counsel, Deputy Assistant Secretary of State, testified if the Committee considers the substitute bill, the Secretary of State is not involved (Attachment 14).

Gary D. White, Jr., Kansas Trial Lawyers, opposed SB 181 because it effectively allows a layperson to practice law without the requisite training and safeguards of a license and fails to protect Kansas consumers in the handling of first-party claims (Attachment 15). The substitute bill provides none of the protection to Kansas consumers that was in the original bill.

Chairperson Praeger asked whether he thinks public adjusters are violating our state law now. Mr. White responded, there is a fine line to be walked. When a public adjuster evaluates a loss and prepares an estimate for a consumer, I do not think the adjuster is violating the law. It is when the adjuster takes the next step and presents the claim to the insurance company and negotiates the claim that the activity constitutes the unlawful practice of law. That is the distinction made in the *Martinez* case. On a large claim they prepare an estimate, but then working with an attorney who negotiates the claim.

Mr. Alderson stated there was a typographical error in subsection (d) line 4, of the substitute bill. It should read "insured" not "insurer."

Mr. White said that changed things significantly, at least as his comments relate to the substitute bill.

Preliminary Hearing—Allowing Counties to Opt into the State Employees Health Care Benefit Program; and Status of the School District Participation in the Program

Chairperson Praeger asked the Committee to turn its attention to a preliminary hearing on allowing counties to opt into the State Employees Health Care Benefit Program, and status of the school district participation in the Program. She stated two legislative post audit performance audit reports had been prepared on the State Health Benefits Program and called on the Post Auditors to present the results of those audits.

Joe Lawhon and Chris Clarke reviewed Part I and LeAnn Schmitt reviewed Part II. (The reports: " The State Health Benefits Program, Part I: Reviewing Issues Relating to Premium Costs and Management," and "The State Health Benefits Program, Part II: Reviewing the Staffing and Structure of the Current Program," are not attached to these minutes but are available upon request from the Division of Legislative Post Audit.)

Part I disclosed that there are seven medical health care plans offered by the state in calendar year 2001. They include four health maintenance organizations and three conventional plans. Including dependents, about 90,000 lives are covered by these seven plans. Before 1996 all health care plans offered by the state were fully insured. Since 1996, two medical plans have been self-funded. These two plans are Kansas Choice and Kansas Choice Senior. In a self-funded plan, the employer assumes the risk of medical claims rather than passing that risk on to an insurance company. The audit found that current Kansas health care plans are not out of line and generally fall near the middle when compared with others. The audit also determined that Kansas employees pay less for their medical costs than do employees in most comparison groups.

The state's Health Care Commission is responsible for running and administering the Health Care Benefits Program. The Commission is made up of the Secretary of Administration, Commissioner of Insurance, a current state employee, a retired state employee, and a member of the general public. No problems were found in the areas questioned. On the health administrator position, the audit was conducted in April and there has been a change of administrator so the audit refers to the person in the position at the time of the audit. The administrator was well qualified for the position based on a review of the job description. The administrator has two reporting responsibilities: Health Benefits Administrator (reports to Chair of the Health Care Commission), and the Benefits Manager (reports to the Director of Personnel).

Funding for the State Employees Health Care Program comes from state agency contributions, employee contributions, and a reserve fund. All of the funds were held in the State Treasury and all interest on the funds are credited to the state. The moneys are invested by the Pooled Money Investment Board and are audited each year. The reserve fund includes the portion of premiums paid between 1989 and 1995 and held in reserve segregated by year. As the reserve fund grew over the years, those moneys were used to help insure premium increases were not excessive. When the state switched to a funded plan in 1996, reserve funds were $84 million. Those funds have since been used to cover

part of the agency's premium and help pay salaries and other operating expenses for the staff of the Division of Personnel Services who work with the health benefits. No new money has flowed into the reserve fund since 1995 other than interest generated. By the end of the fiscal year 2002, moneys in the reserve fund will not be available to offset premium contributions or pay salaries and operating expenses. At the end of fiscal year 2000 the fund had a balance of about $39 million. The state needs to maintain a balance of about $29 million in this reserve fund as a safety net for the self-funded health care plan. Estimates are the balance will reach the minimum at the end of next year. As a result the state will no longer be able to use the moneys, supplement agencies premiums, or pay operating expenses. The Department of Administration staff told auditors to be prepared for a large increase in premiums in 2003.

Representative Cox asked if Kansas carried a major medical blanket policy (stop loss policy) so the state does not get wiped out. This had been looked at, he was told, but such coverage was not cost effective.

Part II of the audit covered structure of the program. The structure of the Kansas program is typical of state employee programs. Auditors contacted officials in seven states to see how their programs were structured and states having predominately state employees tended to be located in a multi-function state agency and governed by the head of the agency or by the commission. Two states with the highest percentage of non-state employees, Missouri and North Dakota, each had programs located in a separate agency and governed by a commission. One reason for this could be to insure that all participants are adequately represented.

If the State Employee Health Care Commission were to allow other public entities such as cities and counties into the health benefit program, the scope of Kansas programs would be broader than any other state reviewed. Given all this, the program structure may not be appropriate if the Commission decides to expand the program to include other public entities. Most Commission and Advisory Committee officials interviewed by the auditors said, if additional non-state entities were allowed to join the program, the placement and governance would not be logical anymore. If the program is expanded to include cities and counties, the Health Care Commission and Department of Administration should develop estimates of how many additional staff and how much funding will be needed to handle such expansion, and how those new entities will be added. Auditors recommend that this information be provided to the legislature before a decision to expand program eligibility is made.

The Chairperson asked if the state is subsidizing administrative costs associated with the addition of teachers to the program Yes, was the answer.

Representative Storm asked how many Unified School Districts chose to take their insurance with the state plan? How many did you estimate would come into the plan. Currently, eight school districts, two community colleges, and one service center participate in the state plan. At the outset of allowing school districts into the plan, the Commission sent out surveys and 50 percent of the school districts responded and 50 percent of those

were interested in coming into the plan. We would need to insure 5,000-6,000 lives in order to cover the administrative cost.

Kyle Wendt, Health Benefits Administrator, State of Kansas Employee Health Care Commission, stated the Commission governs the Group Health Insurance Plan (GHIP) and negotiates and enters into contracts with qualified insurers, health maintenance organizations, and other contracting parties for the purpose of establishing the State Health Care Benefits Program.

With the prospect of an increasing number of non-state employee groups joining the GHIP being considered, many factors must be noted and considered.

- If eligibility for the GHIP is extended to cities and counties, the Division of Personnel Services will not have the staff, information systems, or budget to handle the increased workload that would result.

- An additional 84,000 potential school employees and another 28,000 city and county employees could join the GHIP if the Commission allowed them to join.

- Revenue generated from educational entities joining the GHIP have been grossly insufficient to cover the additional cost of serving this group.

- The performance audit believes the Health Benefits Program currently has enough resources to handle its responsibilities, largely because it has been able to pull both staffing and funding from other areas of the Department of Administration to help meet its increased responsibilities.

- If the scope of services is expanded, the GHIP does not have the resources to handle the expanded workload. (Attachments16 and 17)

Chairperson Praeger asked if disease management had been studied. She noted that one reason for hospitalization in the Medicaid program is the lack of patient knowledge of their disease. Through education and case management they can keep their disease under control. Are we educating people about their disease? Is that a viable alternative?

Mr. Wendt replied, yes, the Commission has been gathering data and is trying to educate participants. There is agreement that such management can have a long-range effect and is better than a band-aid approach. The Med Stat Reporting System has been purchased and, along with some additional data, identifies what is going on with our clients. People must be educated to the facts of the plans and available options and consequences of choosing those options.

Senator Praeger asked if there had been any red flags raised regarding the implementation of new privacy standards for health information. She indicated there must be some information sharing in order to provide the education of consumers. Mr. Wendt

said there were red flags, but information from the Med Stat Reporting System will help sort out the areas of privacy concern.

Vice Chairperson Tomlinson said the testimony raises a red flag for him. The testimony says there could be an additional 84,000 school employees and another 28,000 city/county employees eligible for the state plan. We have heard before there is not the administrative capacity to handle this. We know we are not going to get anywhere near that amount of people to join. When we get estimates from the Budget Committee, we get staff estimates of 26 or 27 instead of a more reasonable amount. The first red flag we are aware of is the potential number of employees that could join the program, but what would happen if on a voluntary basis we opened the plan to cities, counties, and schools districts. Realistically, how many would join? We could talk about unrealistic staffing problems, but we need to talk about reality. In 1984 the law did in fact allow for setting policy that would put cities, counties, and public school employees in the state plan. The Legislature, having met every year since then, has had ample opportunity to reverse itself if that was its real intent. We have public entities that are in trouble. I submit that the Legislature is quite clear in not saying that is precisely what they want this program to do. Do you foresee a way that we could open the scope to cities, counties, and other municipalities without a drastic overhaul accepting those entities that are in the same situation as the school districts at this point in time? The number of school districts that have come in are at a manageable level. Can we do that?

Mr. Wendt replied it depends. If the number joining can be determined in advance, if staffing and other resources are in place, and administrative start-up costs are provided the process of expanding the plan would be made a lot easier.

Vice Chairperson Tomlinson questioned regarding plans for continued school district participation in the state plan but in a separate pool. Terry Bernatis, Assistant Director, Division of Personnel Services (former Health Benefits Administrator), said 1,200 participants is only meant to be the point at which the Commission starts taking a look at whether there is comparability of school district employees and state employees, particularly relating to claims experience. She said there is absolutely no intent that anyone who has signed up for this plan is going to start receiving huge increases as the result of any type of claims experience. The Health Care Commission is committed to assuring the districts that will not be negatively impacted.

Vice Chairperson Tomlinson asked, if there is not the potentiality for excluding the pool or forming a pool, why do we want to look at it. Ms. Bernatis replied, because we were told to make sure there was no negative impact for employees of the state. Until there were enough people to determine that, the actuary said bringing in 1,200 contracts could not have a negative impact because the state plan is so large. When reaching 1,200, the possibility of a negative impact begins to arise. That is why the 1,200 number is talked about.

Staff asked, if by bringing teachers and city and county employees into the state plan, whether the nature of the plan would not be changed from a state employee plan to a public employee plan as suggested in the audit study. And, if there was to be a public employee plan, is there any continuing logic to the directive the Commission received from the

Legislature that the state employee plan must be held harmless as it is expanded. Mr. Wendt said that remains to be seen. There is value in having the largest number of participants connected with the state program.

Chairperson Praeger said if we are currently subsidizing the state employees plan and have used reserves to help do that, if the plan becomes a public employees plan, how would additional administrative costs be built into the program. Mr. Wendt said the new group would need to help pay the administrative costs.

Staff commented that the Post Audit report, Part II, would seem to envision a new administrative structure to oversee and restructure the program if all these people were to be brought into the plan.

The Chairperson said this subject would be continued at the September meeting. She commented that there did not seem to be a need to do more on the issue of Fair Credit Scoring since the realtors have adopted a wait and see attitude. On the Public Adjusters licensing topic, she asked the advocates of regulating public adjusters to bring the Committee some scenarios where licensure might make a difference so that the Committee will have a better feel for the process. Also, she asked for the Department to review its position on the adjuster issue and provide a cost estimate of implementing a regulatory program. The Committee will return to the topic at a later date.

The next meeting will be September 17-18, 2001. There being no further business, the meeting was adjourned.

Prepared by June Evans and Bill Wolff

Approved by Committee on:

September 17, 2001