Approved February 12, 1990
Date

MINUTES OF THE House COMMITTEE ON Insurance.

The meeting was called to order by Dale Sprague at
Chairperson

3:30 xx a.m./p.m. on February 8, 19 89 in room 531-n of the Capitol.

All members were present except:
Representative Helgerson, excused
Representative Hoy, excused

Committee staff present: Emalene Correll, Research Department
Bill Edds, Revisor of Statutes
Patti Kruggel, Committee Secretary

Conferees appearing before the committee:

see attached list

The meeting was called to order at 3:40 p.m.

Rich Huncker, Insurance Department provided information requested by the Committee at the February 7, 1990 meeting: (Attachment 1) premium income for HMO's; (Attachment 2) HMO quality of care reviews; and (Attachment 3) complaint ratios and their uses.
Mr. Huncker also provided testimony (Attachment 4) which explained the procedures for rate filings required by the Insurance Department.

Don Lynn, Blue Cross/Blue Shield provided testimony (Attachment 5) explaining the rating concepts implemented in Non-Group product lines and in the Small Group coverages. Mr. Lynn stated that rating methods have moved toward a more direct reflection of the actual risks of the individuals insured. producing rates lower for those individuals having low medical expenses while increasing the rates for those having medical conditions which require treatment and expense. He also also explained that if consideration was given to going back to a community rating method, where everyone in this risk pool paid the same rate, it would have to be uniform throughout all insurance companies and businesses in the state in order to keep from the better risk individuals being attracted to these methods being employed, with the companies that are required to stay on community rates, still trying to compete for new businesses and maintain the risk pools that they have on strictly a community rates basis.

Next appearing was Don Cooke, Kaiser Permanente. Mr. Cooke testified (Attachment 6) to the utilization of community rating techniques and explained that community rating requires all members of a rating pool to carry an equal share of the risk and of the cost.

Jim Schwartz, Kansas Employer Coalition on Health provided testimony (Attachment 7) as to the rising costs of health care.

Walt Whalen, Pyramid Life provided testimony (Attachment 8) and gave an overview into the history of health care delivery and rating regulations.

There were no others wishing to testify and the briefings were concluded.

The meeting was adjourned at 5:30.

# GUEST LIST

COMMITTEE: Ins Comm DATE: 2/8

| NAME (PLEASE PRINT) | ADDRESS | COMPANY/ORGANIZATION |
|---|---|---|
| | | |
| | Topeka | KMA |
| | | |
| | Topeka | |
| | Topeka | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

# HMO Quality of Care Review

Pursuant to K.S.A. 40-3211(b), health maintenance organizations operating in Kansas must secure from an independent quality review organization a written opinion regarding the overall quality of care provided by the HMO. A copy of the applicable statute is attached.

The review entity must be an organization which has been approved by the Commissioner to conduct such reviews. The following independent quality review organizations have submitted proposals which were reviewed and found acceptable:

1. Quality Quest
   Excelsior, Minnesota

2. Kansas Foundation for Medical Care, Inc.
   Topeka, Kansas

3. Joint Commission on Accreditation of Healthcare Organizations
   Chicago, Illinois

4. National Committee for Quality Assurance
   Washington, D.C.

One of these four, Quality Quest, has ceased performing quality of care reviews as of December, 1989.

For health maintenance organizations which were admitted in Kansas as of the effective date of the statute (July 1, 1987, 1987 House Bill No. 2111), an initial review must be completed and the required written assessment must be submitted to the Insurance Department by July 1, 1990.

In cooperation with the Kansas Health Maintenance Organization Association, the Department developed a set of guidelines to be used by the review organization. These guidelines are intended to be the minimum review and quality of care standards to be considered during any review process. A copy of these guidelines is attached.

If a health maintenance organization desires to amend any contract with its enrollees or desires to change any rate charged therefor it may do so, upon filing with the commissioner any such proposed amendments or change in rates. Any such proposed change is subject to disapproval by the commissioner within thirty (30) days from the date of filing.

History.—L. 1974, ch. 181, § 10.

## § 40-3211. Examinations

(a) The commissioner may make an examination of the affairs of any health maintenance organization and providers with whom such organization has contracts, agreements or other arrangements as often as the commissioner deems it necessary for the protection of the interests of the people of this state but not less frequently than once every three years.

(b) At least once every three years and at such other times as the commissioner may require, a health maintenance organization shall obtain an on-site quality of care assessment by an independent quality review organization acceptable to the commissioner for the purpose of evaluating levels of health care delivery according to industry standards as prevailing from time to time. The findings of said independent quality review organization shall be expressed by it in a written opinion relating to the general quality of care provided by the health maintenance organization and its related contractors of health care services. Failure to obtain such quality of care assessment or the rendering of an unfavorable opinion by the independent quality review organization shall give the commissioner cause to institute action in accordance with K.S.A. 40-3205, 40-3206 or 40-3207, and amendments thereto.

(c) Every health maintenance organization and provider shall submit its books and records relating its operation to such examinations. Medical records of individuals and records of providers under a contract to the health maintenance organization shall be subject to such examination, but the identity of patients shall not be disclosed in any report to the commissioner or the commissioner's agents or representatives. For the purpose of examinations, the commissioner may administer oaths to, and examine the officers and agents of the health maintenance organization and the principals of such providers.

(d) The fees and expenses of examinations under this section shall be assessed against the organization being examined and remitted to the








commissioner. The fees and expenses of the commissioner shall be in accordance with K.S.A. 40-223, and amendments thereto.

(e) In lieu of such examinations, the commissioner may accept the report of an examination made by the appropriate examining agency or official of another state or agency of the federal government.

History.—L. 1974, ch. 181, § 11; L. 1975, ch. 462, § 52; L. 1987, ch. 175, § 1.

## § 40-3212. Filings and reports open to public inspection

Except as provided by K.S.A. 40-3211 and 40-3226, all applications, filings and reports required under this act shall be treated as public documents.

History.—L. 1974, ch. 181, § 12.

## § 40-3213. Fees

(a) Every health maintenance organization subject to this act shall pay to the commissioner the following fees:

(1) For filing an application for a certificate of authority, one hundred fifty dollars ($150);

(2) For filing each annual report, fifty dollars ($50);

(3) For filing an amendment to the certificate of authority, ten dollars ($10).

(b) Every health maintenance organization subject to this act which has operated for a period of three years but not more than five years shall pay annually to the commissioner at the time such organization files its annual report a privilege fee in an amount equal to one-half of one per cent (.005) per annum of the total of all premiums, subscription charges or any other term which may be used to describe the charges made by such organization to enrollees; and after operating for a period of more than five (5) years from the time of organization a health maintenance organization shall pay annually to the commissioner at the time such organization files its annual report, a privilege fee in an amount equal to one percent (1%) per annum of the total of all premiums, subscription charges or any other term which may be used to describe the charges made by such organization to enrollees. In such computations all such organizations shall be entitled to deduct therefrom any premiums or subscription charges returned on account of cancellations and dividends returned to enrollees. If the commissioner

# QUALITY ASSURANCE GUIDELINES

1. A governing body with ultimate responsibility and authority for development of the Quality Assurance Program evidenced by routine and periodic meetings with documentation of ongoing program oversight.

2. A written plan to periodically and systematically monitor and evaluate patient care aimed at problem identification and resolution to include:

   A. Written program objectives

   B. Implementation design

   C. Scope, function and authority

3. A written and ongoing utilization review program designed to objectively monitor and evaluate the adecuacy and appropriateness of patient care provided.

4. A written policy and procedure for a periodic survey and evaluation of patient satisfaction and a mechanism for member grievance.

5. Evidence of appropriate availability and accessibility of after-hours urgent care and/or emergency care services for members.

6. A review of a statistically significant random sampling of medical records to assess the quality of care provided in physicians offices.

7. A written policy identifying the rights and responsibilities of patients which is readily assessible to the member.

8. An ongoing credential and periodic recredential process of providers to verify maintenance of licensure and absence of sanctions.

9. Evidence that effective corrective action was taken when indicated.

HEALTH MAINTENANCE ORGANIZATIONS AUTHORIZED IN KANSAS
FOR YEAR-ENDING DECEMBER 31, 1988

(000) OMITTED

| | -Kansas- | |
|---|---|---|
| | Net Earned Subscriptions | Costs of Hospital and Medical Benefits |
| CIGNA Health Plan of Kansas City, Inc. | 6,335 | 4,102 |
| Equicor Health Plan, Inc. | 71,228 | 64,149 |
| Family Health Plan | 4,008 | 3,500 |
| Health Plan of Mid-America | 7,151 | 7,142 |
| HMO Kansas, Inc. | 61,323 | 62,380 |
| Humana Health Plan of Kansas, Inc. | 353 | 781 |
| Kaiser Foundation Health Plan of Kansas City, Inc. | 7,452 | 7,870 |
| Kansas City Health Maintenance Organization, Inc. | 529 | 733 |
| Medplan, Inc. | 4,906 | 5,293 |
| MetLife Healthcare Network of Kansas City, Inc. | 269 | 323 |
| Prime Health Kansas City, Inc. d/b/a Prime Health | 9,963 | 10,829 |
| Principal Health Care of Kansas City, Inc. | 0 | 0 |
| Prudential Health Care Plan, Inc. | 749 | 901 |
| Total Health Care | 9,448 | 9,566 |
| TOTAL | 183,714 | 177,569 |

Attachment 2

Pursuant to K.A.R. 40-1-35, each year companies are required to complete the attached forms. Based upon this information complaint ratio summaries are produced for those companies that have had 10 or more complaints (see copy attached).

For companies with a TOTAL COMPLAINTS/PER MILLIONS PREMIUM WRITTEN ratio of 10 or more, companies that have experienced substantial changes over the previous year, etc., we produce a more detailed printout of information such as type of coverage, who complaint originated from, who complaint was against, reason for complaint, disposition of complaint, etc.

Based upon the above, companies are contacted and meetings are set up with company officials. The purpose of each meeting is to identify problems (as it relates to claims) and outline corrective steps to be taken to eliminate such problems.

Companies called in for 1988 were:

American Fidelity Insurance Company
American Integrity Insurance Company
Pioneer Life Insurance Company of Illinois
Ranger Insurance Company
Transport Life Insurance Company
Union Bankers Insurance Company
Western Fidelity Insurance Company

Companies called in for 1987 were:

American Integrity Insurance Company
Globe Life & Accident Insurance Company
Great Plains Mutual Insurance Company
Hartford Fire Insurance Company
Mutual Protective Insurance Company
NN Investors Life Insurance Company
Pioneer Life Insurance Company of Illinois
Republic Insurance Company
Reserve National Insurance Company
Travelers Insurance Company
Union Bankers Insurance Company
Union Insurance Company
United American Insurance Company
Victory Life Insurance Company
West General Insurance Company

Note: We are currently working on 1989 statistics.

LG:crc
1734

SUMMARY OF COMPLAINTS FROM KANSAS POLICYHOLDERS AND CLAIMANTS

COMP NAME _____
(COMPLETE NAME PLEASE)

FORM COMPLETED BY _____
PHONE NUMBER AND EXTENSION _____

87-2

COLUMN A
Function and Reason

COLUMN B
Line of Business

| | AUTO | FIRE | HO/FO | CROP | INLAND MARINE | INDIV. LIFE | GROUP LIFE | ANNUITIES | INDIV. HEALTH | GROUP HEALTH | WORK COMP. | LIAB. INS. | MOBILE HO | MISC. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. Underwriting | | | | | | | | | | | | | | |
| a. Company underwriting | | | | | | | | | | | | | | |
| b. Individuals application underwriting | | | | | | | | | | | | | | |
| Cancellation | | | | | | | | | | | | | | |
| d. Recission | | | | | | | | | | | | | | |
| e. Nonrenewal | | | | | | | | | | | | | | |
| f. Premiums and rating | | | | | | | | | | | | | | |
| g. Delays | | | | | | | | | | | | | | |
| h. Refusal to insure | | | | | | | | | | | | | | |
| i. Miscellaneous (not covered above) | | | | | | | | | | | | | | |
| Total Underwriting Complaints | | | | | | | | | | | | | | |
| 2. Marketing and Sales | | | | | | | | | | | | | | |
| a. General advertising | | | | | | | | | | | | | | |
| b. Mass marketing advertising | | | | | | | | | | | | | | |
| c. Agent handling | | | | | | | | | | | | | | |
| d. Replacement | | | | | | | | | | | | | | |
| e. Dividend illustration | | | | | | | | | | | | | | |
| f. Delays | | | | | | | | | | | | | | |
| Alleged Misrepresentation | | | | | | | | | | | | | | |
| h. Miscellaneous (not covered above) | | | | | | | | | | | | | | |
| Total Marketing and Sales | | | | | | | | | | | | | | |
| 3. Claims | | | | | | | | | | | | | | |
| a. Claims procedure | | | | | | | | | | | | | | |
| b. Delays | | | | | | | | | | | | | | |
| c. Unsatisfactory settlement | | | | | | | | | | | | | | |
| d. Natural disaster adjusting | | | | | | | | | | | | | | |
| e. Unsatisfactory settlement offer | | | | | | | | | | | | | | |
| Denial of claim | | | | | | | | | | | | | | |
| Miscellaneous (not covered above) | | | | | | | | | | | | | | |
| Total Claims Complaints | | | | | | | | | | | | | | |

| COLUMN A<br>Function and Reason | COLUMN B<br>Line of Business | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | AUTO | FIRE | HO/FO | CROP | INLAND MARINE | INDIV. LIFE | GROUP LIFE | ANNUITIES | INDIV. HEALTH | GROUP HEALTH | WORK COMP. | LIAB. INS. | MOBILE HO | MISC. |
| 4. Policyholder Service | | | | | | | | | | | | | | |
| a. Failure to respond | | | | | | | | | | | | | | |
| b. Delays | | | | | | | | | | | | | | |
| c. Miscellaneous (not covered above) | | | | | | | | | | | | | | |
| d. Total Policyholder Service | | | | | | | | | | | | | | |
| 5. Miscellaneous | | | | | | | | | | | | | | |
| Total Company Complaints by Line | | | | | | | | | | | | | | |
| Insurance Department Complaints by Line | | | | | | | | | | | | | | |

CAJM4/TXTFMS

# TOTAL CLOSED CLAIMS BY LINE OF INSURANCE

FORM COMPLETED BY _____ COMPANY NAME _____

PHONE NUMBER AND EXTENSION _____ _____

(PLEASE USE THE COMPLETE COMPANY NAME)

| Auto | Fire | HO/FO | Crop | Inland Marine | Indiv. Life | Group Life | Annuities | Indiv. Health | Group Health | Workmen's Comp. | Liability Insurance | Mobile Homeowners | Miscellaneous |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

*NOTE: This form is asking for Total Closed Claims (not complaints) by line for the appropriate calendar year. Please do not include dollar figures on this form and do not confuse Closed Claims with Complaints. To insure proper compliance, please use this form.

001

MS

KANSAS INSURANCE DEPARTMENT
COMPLAINT STATISTICS
1988

The ratio for Private Passenger Automobile, Homeowners, Other Property and Casualty, Life and Accident & Health insurance contained in the attached report are based upon three categories. No ratio is shown for companies with fewer than ten complaints. Each category is as follows:

1. Total number of claim complaints divided by the total number of closed claims as reported by companies for compliance with K.A.R. 40-1-35.

2. Total number of other complaints, excluding claim complaints, divided by millions of dollars of premiums written in Kansas in 1988.

3. Total number of complaints divided by millions of dollars of premiums written in Kansas in 1988.

The Other Property and Casualty category was added this year. It encompasses those property and casualty lines not included in the Private Passenger Automobile and Homeowners categories.

The total automobile complaints listed for each company may include some complaints involving commercial as well as private passenger vehicles. This department receives very few complaints involving commercial vehicles and the ratios are based on private passenger premiums written, rather than both private passenger and commercial.

Companies that write high-risk drivers are at a disadvantage because they are likely to be subject to more than the usual number of complaints.

Dividing the number of complaints by premium volume could put low-cost companies at a disadvantage, and high-cost companies at an advantage.

Publicity about certain companies may affect the number of complaints.

No attempt is made to distinguish justified complaints from unjustified complaints, as this is largely subjective. Also, no factor is used to adjust for the severity of each complaint.

For smaller companies, a small change in the number of complaints can produce a major change in the ratio.

We include as a complaint, each file that is set up by the Department which primarily expresses a written grievance against an insurance company.

LG:jlca
2050

KANSAS INSURANCE DEPARTMENT
CONSUMER ASSISTANCE DIVISION
1988 COMPLAINT RATIOS
AUTO COMPLAINTS

DATE 12/31/88



| COMPANY NAME | TOTAL COMPLAINTS | CLAIMS COMPLAINTS | CLOSED CLAIMS | PREMIUMS WRITTEN | CLAIMS COMPL. / CLOSED CLAIMS | OTHER COMPL. / PER MILLION$ PREM.WRIT. | TOTAL COMPL. / PER MILLION$ PREM.WRIT. |
|---|---|---|---|---|---|---|---|
| AETNA CASUALTY & SURETY COMPANY | 15 | 11 | 887 | 3,904,714 | .01240 | 1.02 | 3.84 |
| ALLIED INSURANCE COMPANY-MUTUAL | 40 | 18 | 6,926 | 14,173,951 | .00260 | 1.55 | 2.82 |
| ALLSTATE INSURANCE COMPANY | 70 | 36 | 16,009 | 22,728,127 | .00225 | 1.50 | 3.08 |
| AMERICAN FAMILY MUTUAL INSURANCE CO. | 128 | 100 | 21,707 | 36,398,634 | .00461 | .77 | 3.52 |
| AMERICAN FIDELITY INSURANCE COMPANY | 10 | 4 | 740 | 983,943 | .00541 | 6.10 | 10.16 |
| AMERICAN STANDARD INSURANCE CO. OF WI | 44 | 28 | 4,469 | 12,022,704 | .00627 | 1.33 | 3.66 |
| AMERICAN STATES INSURANCE COMPANY | 14 | 9 | 3,444 | 9,799,313 | .00261 | .51 | 1.43 |
| AUTOMOBILE CLUB INTER-INS. EXCHANGE | 15 | 10 | 2,881 | 3,422,829 | .00347 | 1.46 | 4.38 |
| CONTINENTAL CASUALTY COMPANY | 13 | 12 | 565 | 3,089,540 | .02124 | .32 | 4.21 |
| CONTINENTAL WESTERN INS. CO. | 10 | 9 | 1,452 | 3,686,104 | .00620 | .27 | 2.71 |
| DAIRYLAND INSURANCE COMPANY | 30 | 25 | 2,985 | 6,251,035 | .00838 | .80 | 4.80 |
| ECONOMY FIRE AND CASUALTY COMPANY | 14 | 9 | 1,682 | 1,771,611 | .00535 | 2.82 | 7.90 |
| FARM BUREAU MUTUAL INS. CO, INC | 121 | 65 | 71,868 | 62,821,082 | .00090 | .89 | 1.93 |
| FARMERS ALLIANCE MUTUAL INS. CO. | 21 | 16 | 4,255 | 9,986,636 | .00376 | .50 | 2.10 |
| FARMERS CASUALTY COMPANY | 13 | 5 | 3,821 | 7,262,418 | .00131 | 1.10 | 1.79 |
| FARMERS INSURANCE COMPANY, INC. | 130 | 76 | 33,451 | 80,859,905 | .00227 | .64 | 1.58 |
| GENERAL CASUALTY COMPANY OF WISCONSIN | 16 | 10 | 2,953 | 4,562,359 | .00339 | 1.32 | 3.51 |
| HAWKEYE-SECURITY INS. CO. | 15 | 11 | 1,939 | 2,550,872 | .00567 | 1.57 | 5.88 |
| HORACE MANN INSURANCE COMPANY | 12 | 7 | 805 | 1,781,972 | .00870 | 2.81 | 6.73 |
| KANSAS FIRE AND CASUALTY COMPANY | 12 | 9 | 2,053 | 3,081,995 | .00438 | .97 | 3.89 |
| KFB INSURANCE COMPANY, INC. | 21 | 16 | 2,892 | 8,228,941 | .00553 | .61 | 2.55 |
| MID-CENTURY INSURANCE COMPANY | 60 | 38 | 13,502 | 27,776,894 | .00281 | .79 | 2.16 |
| NATIONAL FARMERS UNION PROP. & CAS. CO | 10 | 6 | 1,512 | 2,737,764 | .00397 | 1.46 | 3.65 |

DATE 12/31/88

KANSAS INSURANCE DEPARTMENT
CONSUMER ASSISTANCE DIVISION
1988 COMPLAINT RATIOS
AUTO COMPLAINTS



| COMPANY NAME | TOTAL COMPLAINTS | CLAIMS COMPLAINTS | CLOSED CLAIMS | PREMIUMS WRITTEN | CLAIMS COMPL. / CLOSED CLAIMS | OTHER COMPL. / PER MILLION$ PREM.WRIT. | TOTAL COMPL. / PER MILLION$ PREM.WRIT. |
|---|---|---|---|---|---|---|---|
| NATIONWIDE MUTUAL INS. CO. | 11 | 7 | 1,098 | 1,572,642 | .00638 | 2.54 | 7.00 |
| NEW YORK UNDERWRITERS INS. CO. | 18 | 1 | 2,956 | 4,200,394 | .00034 | 4.05 | 4.29 |
| PATRONS MUTUAL INSURANCE ASSOCIATION | 17 | 9 | 2,338 | 4,041,080 | .00385 | 1.98 | 4.21 |
| PROGRESSIVE CASUALTY INSURANCE COMPANY | 10 | 5 | 1,590 | 6,569,630 | .00314 | .76 | 1.52 |
| RANGER INSURANCE COMPANY | 40 | 29 | 2,569 | 4,006,275 | .01129 | 2.75 | 9.98 |
| SAFECO INSURANCE COMPANY OF AMERICA | 21 | 15 | 2,004 | 3,423,125 | .00749 | 1.75 | 6.14 |
| SHELTER MUTUAL INSURANCE COMPANY | 33 | 26 | 7,390 | 12,044,206 | .00352 | .58 | 2.74 |
| STATE FARM FIRE & CASUALTY COMPANY | 10 | 9 | 12,854 | 15,255,103 | .00070 | .07 | .66 |
| STATE FARM MUTUAL AUTOMOBILE INS. CO. | 196 | 166 | 136,509 | 135,659,516 | .00122 | .22 | 1.45 |
| TRAVELERS INDEMNITY COMPANY | 40 | 15 | 1,972 | 7,485,084 | .00761 | 3.34 | 5.34 |
| UNITED STATES FIDELITY & GUARANTY CO. | 19 | 14 | 4,203 | 13,527,567 | .00333 | .37 | 1.41 |
| UNITED STATES FIRE INSURANCE COMPANY | 30 | 7 | 945 | 4,318,172 | .00741 | 5.33 | 6.95 |
| WEST AMERICAN INSURANCE COMPANY | 20 | 9 | 4,078 | 6,335,540 | .00221 | 1.74 | 3.16 |
| WEST GENERAL INSURANCE COMPANY, INC. | 60 | 39 | 2,711 | 7,397,749 | .01439 | 2.84 | 8.11 |

KANSAS INSURANCE DEPARTMENT
CONSUMER ASSISTANCE DIVISION
1988 COMPLAINT RATIOS
HOMEOWNERS COMPLAINTS

DATE 12/31/88



| COMPANY NAME | TOTAL COMPLAINTS | CLAIMS COMPLAINTS | CLOSED CLAIMS | PREMIUMS WRITTEN | CLAIMS COMPL. / CLOSED CLAIMS | OTHER COMPL. / PER MILLION$ PREM.WRIT. | TOTAL COMPL. / PER MILLION$ PREM.WRIT. |
|---|---|---|---|---|---|---|---|
| ALLSTATE INSURANCE COMPANY | 19 | 12 | 3,257 | 8,673,730 | .00368 | .81 | 2.19 |
| AMCO INSURANCE COMPANY | 12 | 11 | 1,824 | 4,403,810 | .00603 | .23 | 2.73 |
| AMERICAN FAMILY MUTUAL INSURANCE CO. | 25 | 21 | 5,860 | 14,632,194 | .00358 | .27 | 1.71 |
| BREMEN FARMERS MUTUAL INS. CO. | 10 | 9 | 1,840 | 5,293,341 | .00489 | .19 | 1.89 |
| FARM BUREAU MUTUAL INS. CO, INC | 51 | 38 | 6,819 | 27,619,375 | .00557 | .47 | 1.85 |
| FARMERS ALLIANCE MUTUAL INS. CO. | 12 | 11 | 1,665 | 4,931,320 | .00653 | .20 | 2.43 |
| FARMERS INSURANCE COMPANY, INC. | 17 | 10 | 3,586 | 12,383,017 | .00279 | .57 | 1.37 |
| PATRONS MUTUAL INSURANCE ASSOCIATION | 15 | 12 | 983 | 3,000,454 | .01221 | 1.00 | 5.00 |
| SHELTER MUTUAL INSURANCE COMPANY | 17 | 11 | 1,710 | 3,735,302 | .00643 | 1.61 | 4.55 |
| STATE FARM FIRE & CASUALTY COMPANY | 39 | 30 | 17,085 | 43,800,384 | .00176 | .21 | .89 |

KANSAS INSURANCE DEPARTMENT
CONSUMER ASSISTANCE DIVISION
1988 COMPLAINT RATIOS
A&H COMPLAINTS

DATE 12/31/88



| COMPANY NAME | TOTAL COMPLAINTS | CLAIMS COMPLAINTS | CLOSED CLAIMS | PREMIUMS WRITTEN | CLAIMS COMPL. / CLOSED CLAIMS | OTHER COMPL. / PER MILLION$ PREM.WRIT. | TOTAL COMPL. / PER MILLION$ PREM.WRIT. |
|---|---|---|---|---|---|---|---|
| AETNA LIFE INSURANCE COMPANY | 44 | 39 | 283 | 11,669,672 | .13781 | .43 | 3.77 |
| AMERICAN FAMILY LIFE ASSUR.CO.OF COLUM | 17 | 8 | 10,277 | 5,293,993 | .00078 | 1.70 | 3.21 |
| AMERICAN FAMILY MUTUAL INSURANCE CO. | 19 | 14 | 5,835 | 8,399,636 | .00240 | .60 | 2.26 |
| AMERICAN FIDELITY ASSURANCE COMPANY | 14 | 11 | 7,784 | 5,253,924 | .00141 | .57 | 2.67 |
| AMERICAN INTEGRITY INSURANCE COMPANY | 31 | 9 | 1,981 | 572,159 | .00454 | 38.45 | 54.18 |
| AMERICAN REPUBLIC INSURANCE COMPANY | 13 | 8 | 6,144 | 3,230,353 | .00130 | 1.55 | 4.02 |
| BANKERS LIFE AND CASUALTY COMPANY | 30 | 13 | 61,194 | 13,524,744 | .00021 | 1.26 | 2.22 |
| BENEFIT TRUST LIFE INS. CO. | 14 | 9 | 17,284 | 7,094,327 | .00052 | .71 | 1.97 |
| BLUE CROSS & BLUE SHIELD OF KANSAS CTY | 50 | 41 | 191,187 | 29,823,396 | .00021 | .30 | 1.68 |
| CAPITOL AMERICAN LIFE INS. CO. | 17 | 8 | 642 | 5,293,089 | .01246 | 1.70 | 3.21 |
| COMBINED INSURANCE CO. OF AMERICA | 24 | 15 | 12,563 | 5,983,487 | .00119 | 1.50 | 4.01 |
| CONNECTICUT GENERAL LIFE INS. CO. | 24 | 19 | 98,775 | 9,820,214 | .00019 | .51 | 2.44 |
| DELTA DENTAL PLAN OF KANSAS, INC. | 12 | 12 | 79,857 | 5,571,552 | .00015 | .00 | 2.15 |
| EQUICOR HEALTH PLAN | 60 | 45 | 61,474 | 58,532,539 | .00073 | .26 | 1.03 |
| EQUITABLE LIFE ASSUR. SOC. OF THE US | 14 | 13 | 298,761 | 5,537,482 | .00004 | .18 | 2.53 |
| EXECUTIVE FUND LIFE INS. CO. | 17 | 5 | 1,065 | 2,965,421 | .00469 | 4.05 | 5.73 |
| FEDERAL HOME LIFE INSURANCE COMPANY | 12 | 10 | 4,991 | 4,789,554 | .00200 | .42 | 2.51 |
| GLOBE LIFE & ACCIDENT INS. CO. | 17 | 10 | 3,139 | 2,233,234 | .00319 | 3.13 | 7.61 |
| GOLDEN RULE INSURANCE COMPANY | 11 | 5 | 15,401 | 2,937,454 | .00032 | 2.04 | 3.75 |
| HEALTH PLAN OF MID-AMERICA, INC. | 10 | 8 | 132,502 | 18,958,823 | .00006 | .11 | .53 |
| HMO KANSAS, INC. | 25 | 17 | 487,274 | 53,316,835 | .00003 | .15 | .47 |
| KANSAS BLUE CROSS/BLUE SHIELD | 364 | 269 | 6,177,383 | 449,231,089 | .00004 | .21 | .81 |
| LINCOLN NATIONAL LIFE INS. CO. | 10 | 9 | 10,232 | 3,368,059 | .00088 | .30 | 2.97 |

KANSAS INSURANCE DEPARTMENT
CONSUMER ASSISTANCE DIVISION
1988 COMPLAINT RATIOS
A&H COMPLAINTS



| COMPANY NAME | TOTAL COMPLAINTS | CLAIMS COMPLAINTS | CLOSED CLAIMS | PREMIUMS WRITTEN | CLAIMS COMPL. / CLOSED CLAIMS | OTHER COMPL. / PER MILLION$ PREM.WRIT. | TOTAL COMPL. / PER MILLION$ PREM.WRIT. |
|---|---|---|---|---|---|---|---|
| METROPOLITAN LIFE INSURANCE COMPANY | 21 | 19 | 581 | 5,408,284 | .03270 | .36 | 3.83 |
| MUTUAL BENEFIT LIFE INSURANCE COMPANY | 15 | 10 | 1 | 10,327,626 | 10.00000 | .48 | 1.45 |
| MUTUAL OF OMAHA INSURANCE COMPANY | 53 | 27 | 15,299 | 13,290,677 | .00176 | 1.96 | 3.99 |
| MUTUAL PROTECTIVE INSURANCE COMPANY | 28 | 9 | 5,430 | 3,315,900 | .00166 | 5.73 | 8.44 |
| NEW YORK LIFE INS. CO. | 15 | 12 | 603 | 3,735,052 | .01990 | .80 | 4.02 |
| PHYSICIANS MUTUAL INSURANCE COMPANY | 20 | 16 | 11,481 | 3,918,178 | .00139 | 1.02 | 5.10 |
| PIONEER LIFE INS. CO. OF ILLINOIS | 42 | 14 | 7,129 | 2,043,083 | .00196 | 13.71 | 20.56 |
| PRINCIPAL MUTUAL LIFE COMPANY | 39 | 20 | 401,081 | 33,112,754 | .00005 | .57 | 1.18 |
| PRUDENTIAL INSURANCE CO. OF AMERICA | 50 | 43 | 134,873 | 30,299,604 | .00032 | .23 | 1.65 |
| RESERVE NATIONAL INSURANCE COMPANY | 27 | 13 | 14,251 | 3,472,979 | .00091 | 4.03 | 7.77 |
| TIME INSURANCE COMPANY | 33 | 23 | 37,646 | 10,528,903 | .00061 | .95 | 3.13 |
| TOTAL HEALTH CARE | 11 | 8 | 18,479 | 68,410,698 | .00043 | .04 | .16 |
| TRANSPORT LIFE INSURANCE COMPANY | 12 | 2 | 1,955 | 1,141,526 | .00102 | 8.76 | 10.51 |
| TRAVELERS INSURANCE COMPANY | 29 | 24 | 505,710 | 7,856,843 | .00005 | .64 | 3.69 |
| UNION BANKERS INSURANCE COMPANY | 18 | 5 | 4,921 | 1,736,501 | .00102 | 7.49 | 10.37 |
| UNION CENTRAL LIFE INSURANCE COMPANY | 12 | 8 | 11,077 | 2,157,821 | .00072 | 1.85 | 5.56 |
| UNITED AMERICAN INSURANCE COMPANY | 45 | 9 | 30,696 | 6,467,792 | .00029 | 5.57 | 6.96 |
| UNITED OF OMAHA LIFE INSURANCE COMPANY | 11 | 5 | 11,432 | 4,158,085 | .00044 | 1.44 | 2.65 |
| WABASH LIFE INSURANCE COMPANY | 11 | 10 | 877 | 1,224,060 | .01140 | .82 | 8.99 |
| WESTERN FIDELITY INSURANCE COMPANY | 22 | 8 | 325 | 1,200,739 | .02462 | 11.66 | 18.32 |

KANSAS INSURANCE DEPARTMENT
CONSUMER ASSISTANCE DIVISION
1988 COMPLAINT RATIOS
LIFE COMPLAINTS

DATE 12/31/88



| COMPANY NAME | TOTAL COMPLAINTS | CLAIMS COMPLAINTS | CLOSED CLAIMS | PREMIUMS WRITTEN | CLAIMS COMPL. / CLOSED CLAIMS | OTHER COMPL. / PER MILLION$ PREM.WRIT. | TOTAL COMPL. / PER MILLION$ PREM.WRIT. |
|---|---|---|---|---|---|---|---|
| AMERICAN GENERAL LIFE & ACCIDENT INS. | 21 | 6 | 1,522 | 5,194,318 | .00394 | 2.89 | 4.04 |
| AMERICAN NATL INSURANCE COMPANY | 15 | 0 | 1,362 | 4,406,009 | .00000 | 3.40 | 3.40 |
| MASSACHUSETTS INDEMNITY & LIFE INS. CO | 15 | 0 | 3 | 8,076,238 | .00000 | 1.86 | 1.86 |
| METROPOLITAN LIFE INSURANCE COMPANY | 24 | 5 | 3,105 | 25,356,991 | .00161 | .75 | .95 |
| NEW YORK LIFE INS. CO. | 10 | 1 | 764 | 39,870,716 | .00131 | .23 | .25 |
| OZARK NATIONAL LIFE INSURANCE COMPANY | 13 | 2 | 30 | 7,330,414 | .06667 | 1.50 | 1.77 |
| PRUDENTIAL INSURANCE CO. OF AMERICA | 45 | 3 | 5,580 | 36,676,679 | .00054 | 1.15 | 1.23 |
| SECURITY BENEFIT LIFE INSURANCE CO. | 10 | 1 | 3,225 | 21,005,925 | .00031 | .43 | .48 |

KANSAS INSURANCE DEPARTMENT

CONSUMER ASSISTANCE DIVISION

1988 COMPLAINT RATIOS

DATE 12/31/88

PROPERTY OTHER THAN AUTO AND HOME COMPLAINTS

| COMPANY NAME | TOTAL COMPLAINTS | CLAIMS COMPLAINTS | CLOSED CLIAMS | PREMIUMS WRITTEN | CLAIMS COMPL. / CLOSED CLAIMS | OTHER COMPL. / PER MILLIONS PREM.WRIT. | TOTAL COMPL. / PER MILLION$ PREM.WRIT. |
|---|---|---|---|---|---|---|---|
| AETNA CASUALTY & SURITY | 11 | 3 | 149 | 22,618,188 | .0201 | 0.13 | 0.35 |
| FARM BUREAU MUTUAL INS. CO., INC. | 12 | 12 | 2,458 | 18,521,358 | .0049 | 0 | 0.65 |
| UNITED STATES FIDELITY & GUARANTY CO. | 10 | 4 | 1,158 | 28,436,001 | .0035 | 0.21 | 0.35 |

3-12

Kansas Insurance Department

Testimony Before The

House Insurance Committee

Presented by Rich Huncker

February 8, 1990

Health Insurance Rate Authority of the Kansas Insurance Department

Pursuant to Kansas Insurance statutes, the Kansas Insurance Department has direct approval authority of any rate charged to a Kansas subscriber by a Blue Cross and Blue Shield organization (K.S.A. 40-19c07), Health Maintenance Organization (K.S.A. 40-3210), non-profit dental service organization (K.S.A. 40-19a07), and non-profit optometric service organization (K.S.A. 40-19b07). This authority applies to contracts or certificates issued on a group or an individual basis. Other rate filings that are required to be submitted are the rates charged by a commercial insurance company or fraternal benefit society for any individually issued policy form. These rates are filed by the department if it is determined that the rates appear to be reasonable in relation to the benefits provided by the policy. If the policy forms are acceptable for approval and the rates are determined to be reasonable, such rates are "Filed" concurrently with the approval of the form. Disapproval of an original or subsequently revised rate would require the disapproval of the corresponding policy form. Rates used by commercial insurance companies for group accident and health insurance are not required to be

Attachment 4

filed and are not subject to a review and/or approval process. In addition, the rates used with out-of-state single or multiple employer group programs are not required to be approved by this department.

The procedure followed by the Department in determining the reasonableness of rates is to acquire information from the company containing an actuarial memorandum outlining the statistical basis for the rates, the past claims loss experience, if applicable, and the anticipated ratio of claims to premiums. The minimum applicable anticipated loss ratio must comply with K.A.R. 40-4-1, and varies with the type of policy and the average annual premium.

The rates developed by Blue Cross and Blue Shield for use on an individual or group basis are required to be reasonable, not excessive and not unfairly discriminatory. Blue Cross and Blue Shield may establish classes of risks for rating purposes and develop rates adequate to pay for the anticipated claims for each class. At the present time, classes of business that have been established are: Plan 65 and Plan D programs, individual direct enrolled and conversion categories, group business for ten or more employees, and small groups of less than 10 employees category. Each class may contain one or more subclasses as respects subscriber's age, sex, and other valid criteria. In addition, various tiers may be established to group subscribers of the same relative risk as standard, above standard or substandard. The Plan 65, Plan D, individual (including Farm Bureau category) and conversion programs are all rated in a similar manner, using loss experience that has been trended through a future period for each class to determine rates that will be adequate to pay the anticipated claims, premium taxes, administrative expenses and contribute to company reserves in an amount

equal to a percentage of final rate for each class. Adequate contingency reserves are maintained pursuant to statute and should be sufficient to pay catastrophic claims and absorb unexpected claim trends that may be higher than originally anticipated.

Blue Cross and Blue Shield of Kansas Group rates are calculated in much the same manner as the rates for individual classes of business using the total claims experience for all groups state-wide. The rates for any group with ten or more subscribers, as a subclass, are determined using a prospective rating formula. The formula process uses the actual premium income and claims history to develop a groups rates which are then rounded to the nearest rate adjustment factor established by the base rate calculations determined from the experience of all groups.

Small group (less than 10 employees) rates are developed by reviewing the actual premium income and claim expenses for each group. This loss ratio dictates the amount of premium rate adjustment for each group. No consideration is given to the total experience of all groups of 1-9 subscribers as would be the case in developing a community rate.

In the past, the department expressed concerns to Blue Cross and Blue Shield of Kansas that they were subdividing classes of risks into so many categories that the concept of rating for the "community at large" had been compromised. Groups with few subscribers who had chronic health problems were experiencing rate increases they could not afford. The Kansas Supreme Court, however, in a 1980 case, ruled that the Department was not a position to dictate to Blue Cross and Blue Shield how classes of business could or should be established. Furthermore, the court ruled that when a class of business is established, that class should not be

subsidized by, nor have to bear the burden of subsidizing any other class of business. Kansas Blue Cross and Blue Shield has indicated to the department that their reasons for changing the methods of rating groups is in response to competitive forces in the marketplace.

In an effort to control the cost of health care services Blue Cross and Blue Shield has established contracting arrangements with providers calling for maximum allowable payments for physicians and reimbursements to hospitals based on DRGs. For a period of time these reimbursement systems lowered costs, however, health care delivery has shifted to an outpatient basis. Laboratory services and other diagnostic aids appear to be used more frequently, increasing the total overall costs of providing health care benefits.

The rates for most health maintenance organizations are generally determined on a true community rate concept, and are determined prospectively. The single and family rates used are based on an anticipated per member per month revenue requirement adjusted for the demographics of each group and/or the demographics of the community at large. The required revenue per month amount, which is reviewed and approved by the department, is the product of the anticipated utilization of the community at large and the anticipated cost of each service, plus adjustments for administrative experience, stop loss coverage, premium taxes and so forth. Only recently have health maintenance orgainizations begun using adjustment factors for subclasses of business, such as the age of the subscriber and industry factors, to adjust individual group rates to reflect above or below average risks.

The rates charged by the underwriters of accident and health insurance in Kansas generally reflects the cost of providing the benefits of the policies that have been issued. Rates which continually spiral upward are only a symptom of underlying problems: the charges made by health care providers despite contractual rates of reimbursement, the manner in which those providers deliver their services, the mandatory coverages that have been required by Kansas statutes to be included in health insurance policies issued or delivered in this state. Rates can be artificially depressed by rate regulatory authority, however, as claim levels increase as they have in recent years, the financial stability of insurers could be placed in jeopardy. To threaten the solvency of insurers and impair the health care financing system in this state would certainly not be in the public interest. The problems of regulating any health insurance rate is that any such rate is almost wholly dependent upon factors beyond the regulatory control of any government agency or private sector force.

JJR:dbah

3471

HOUSE INSURANCE COMMITTEE MEETING
FEBRUARY 8, 1990

TESTIMONY BY DONALD R. LYNN, M.A.A.A.
BLUE CROSS AND BLUE SHIELD OF KANSAS

"RATE REGULATION AND PRICING CONCEPTS"

The methods of rating Non-Group and Small Group health insurance products have changed considerably over the past several years. Rating methods have been moving toward a more direct reflection of the actual risks of the individuals insured. These methods produce rates lower for those individuals that have low medical expenses while increasing the rates for those that have medical conditions which require treatment and expense. This is a change from the previous Community rating concept, where all individuals, regardless of their medical risks, paid the same rates. These rating changes, to reflect more closely the medical risks of the individuals in the premium rates, is an attempt by insurance companies to be more rate competitive for the lower risk individuals. These rating concepts have been implemented in Non-Group product lines and also in the Small Group coverages.

1. Direct-Enrolled - These are individuals who are not enrolled in an employer group but apply for Non-Group coverage. Blue Cross and Blue Shield of Kansas had to change from a Community rating method for our Non-Group products to one that is based on the age of the contract holder.

Under the previous Community rating approach, all Non-Group subscribers paid the same rate regardless of their medical risks. The experience of the entire Non-Group class of business was put into one risk pool and rates were calculated based on the experience of that particular risk pool. As more insurance companies began to adjust rates based on the risks of individuals, Blue Cross was forced to adopt similar rating methods to stay competitive with these commercial carriers. Blue Cross and

Blue Shield now also uses age rating for the Non-Group coverages. These rates are based on the experience of the Non-Group risk pool; but lower rates are charged to the younger contract holders and higher rates are charged to the older contract holders. We use the contract holder's age to vary the rates, as it is an indicator of the medical risks of the individuals.

Blue Cross and Blue Shield of Kansas was forced to make this change because we were losing our younger, lower medical risk subscribers to commercial insurers that were age rating. This left older subscribers in our Non-Group risk pool which caused the rate increases to be that much larger, which in turn drove more of the healthier risks out to competitors' programs. In order to preserve the enrollment in the Non-Group class of business, we had to go to age rating with health statements for new enrollees. The use of health statements for new individuals enrolling in Non-Group was necessary to prevent people with known medical conditions from adversely affecting the risk pool for the existing Non-Group subscribers.

2. Group Coverage - Blue Cross and Blue Shield of Kansas offers health insurance on a Group coverage basis for all sizes of groups. Several years ago, we individually rated groups that had 25 or more contracts in their group. All groups with less than 25 contracts were combined in a small group risk pool. The rates for all small groups of less than 25 were the same if they had the same coverage. These rates were based on the claims experience of all groups of less than 25 contracts. This was known as "Community Rating", where all groups paid the same rate regardless of their own group's claims expenses.

Again, because of competitive pressures from commercial carriers that were recognizing the more favorable risks of the groups with less than average claims expenses, Blue Cross had to adjust our methods of rating our small groups. We rated

individual groups down to groups of ten or more contracts. This left groups of less than ten in our Community pool. This Community pool was then rated based on the claims expenses of all the groups of less than ten contracts. The rates were charged to each individual group based on the average age of the employees in their particular group.

Last year, Blue Cross and Blue Shield replaced the age rating in our groups of less than ten with a review of the group's actual claims expenses. We currently rate our groups of less than ten based on the claims expenses of the risk pool produced by all groups of less than ten contracts. The needed rates are then distributed to the individual groups based on each group's actual claims expenses of the previous year. This allows us to receive the total premiums that are necessary to pay claims and administrative expenses for the entire risk pool. But, we collect more premium from those groups that have had higher than average claims expenses and less premium from those that had more favorable claims expenses.

The current rating methods that are used by insurance companies are beneficial to the individuals and small groups that have low medical expenses. But these rating methods require those individuals and small groups to pay higher rates if they have had more medical expenses than the average of the risk pool.

KAISER PERMANENTE

Testimony By

Donald L. Cooke, Health Plan Manager

Kaiser Permanente
Shawnee Mission, Kansas

Before the House Insurance Committee

February 8, 1990

Kaiser Foundation Health Plan of Kansas City, Inc.
6900 Squibb Road, Suite 201 Shawnee Mission, Kansas 66202 (913) 384-9090

Attachment 6

As I understand your interests today, you are looking for testimony on the possibility of rate regulation, pricing concepts, and rating techniques. In meeting your interests, I will constrain my comments to the rating techniques utilized by Kaiser Permanente, and relate those to more generalized pricing, or rating, concepts.

As I stated in the opening of my testimony to the joint committee on January 30, Kaiser Permanente is the nation's largest and most experienced Health Maintenance Organization. We have over forty years of experience as a Health Maintenance Organization, and were the concept on which Federal legislation was written to expand the concept. As a result, we have a great deal of experience in developing dues (or premium rates for groups and individuals). I am hopeful that the short description I will provide you today will be useful to you.

Historically, Kaiser Permanente has utilized the community rating technique for establishing our monthly membership rates. Community rating is the rate calculation technique in which all of our members pay the same rate, regardless of the size of the group through which they are enrolled, their industry, age, sex, or health status. In our group business, we have utilized no pre-existing condition waivers, or other exclusions to membership.

In our non-group coverage we have used only a health questionnaire to screen applicants. Any applicant accepted is accepted for all medical conditions.

Community rating is the purest form of insurance - all members of the rating pool, our Kansas City members for instance, carry an equal share of the risk, and of the cost.

Community rating has been under constant attack for the last twenty five years. Employer groups that perceive their risk to be lower than the "community" average want their group to be separated for rate development purposes. Specific group rating, and then full experience rating were originally used by commercial insurers to penetrate the market that Blue Cross and Blue Shield had largely to itself. Finally, in order to protect its market share, Blue Cross and Blue Shield plans have gone to experience rating, even to administrative service contracts and minimum premium plans. A number of HMO's have moved this direction, too.

When the market place has been fractured, which is what full experience rating does, any organization that does not participate in experience rating tempts it's own fate.

To community rate when one's competitors experience rate is likely to result in groups with relatively high experience staying with the community rated plan, and groups with low experience moving to

the experience rated plan. The economic incentives cannot be overlooked.

Kaiser Permanente is not totally immune to these pressures. Employers have been telling us for some time that they want to pay their own way. We face certain extinction, or a future filled with only the most unhealthy groups, if we don't respond. As a result, now that Federal laws regulating HMO's have changed to liberalize rating techniques, we have instituted, for 1990, Adjusted Community Rating, or ACR. In our version of ACR, we still calculate the community rate. However, we also look at an employer group's past history of health care utilization within our program. Then, we apply a factor, increasing or decreasing the group's rate relative to the community rate. At the present time, the adjustment factor is limited to plus or minus 5% variation from the community rate per year.

An example of the use of the ACR rating technique is the State of Kansas employee group, which received a rate increase 5% above our community rate for 1990. This was based strictly on the higher usage of this group.

Within the ACR methodology, we are attempting to protect small employers and non-group members. These two classifications receive the community rate.

We would have vastly preferred staying with Community Rating. Philosophically, we like it. It is simpler, keeps our fixed costs lower, and benefits those people most in need. We cannot however, be the only community rated plan in town.

Thank you. I'd be pleased to answer any questions you may have.

DC/id
2/6/90

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

**Kansas Employer Coalition on Health, Inc.**
**Testimony to House Insurance Committee**
**February 8, 1990**

by James P. Schwartz Jr.
Consulting Director

Mr. Chairman and members of the committee:

I am Jim Schwartz, consulting director for the Kansas Employer Coalition on Health. The coalition is over 100 companies across the state who share a concern about the soaring cost of health care provided to employees.

In an article this month by Princeton economist Uwe Reinhardt (who is probably the most respected academic in the health economics field), he calculates that if current cost trends continue, in 82 years all of America's GNP will go to health care.

For the past decade we purchasers of health care and health insurance have tried to buck the trends through competitive, market-oriented means. The thought has been: if only healthcare could be treated like other commodities we buy, then the ordinary laws of US economics will prevail and give us quality services at sensible costs.

That hasn't worked on a broad scale.

Attachment 7

We've tried HMOs, PPOs, EPOs, IPAs, DRGs, per diems, capitation, utilization review, case management, second opinions and pre-certification. All of these micro-management efforts rightly claim a measure of success, at least compared with what might have happened in their absence. But in the final analysis, as Professor Reinhardt says, the guys in the suits are no match for the guys in the white coats.

For a lot of reasons, competitive pressures alone clearly haven't dealt successfully with the continuing cost spiral, not to mention the disgrace of large numbers of uninsured. Increasingly, and reluctantly, many of us are coming to realize that some kind of regulation is going to be needed to deal with the problems of cost and access.

As I mentioned to you last week, the Coalition has written a proposal for integrating competitive and regulatory forces to deal with these problems. My board wants the paper re-written to better address the concerns that naturally surface when comprehensive reform is proposed. So I ask for your patience while we try tomorrow to revise the document.

The proposal has everything to do with you and with rate regulation in a broad sense. All of us have grown accustomed to a system in which healthcare fees and number of services grow exponentially, with the result of relentless pressure for increased insurance rates. So far, we have tried to relieve this pressure by attacking the myriad sources of increased fees and utilization. Without going into detail at this time, I can tell you that the orientation we are suggesting basically reverses this strategy by attacking the cost problem from the top down. By deciding in advance what we are willing to pay for health care, we force a containment and re-alignment of the whole system. Insurance rates would

no longer be the path of least resistance. Indeed, insurance rates would be the means for directing change.

I hope to have our proposal ready to send to you next week. Please keep in mind when you receive it that it doesn't yet enjoy the endorsement of the whole Coalition and may never. So it goes with bold proposals. For now please know that the private sector increasingly looks to you as a partner in coming to grips with these problems. Let's agree that band-aid approaches are unlikely to restrain the rapidly deteriorating cost and access problems. But if, through some well-conceived regulation, you can put the healthcare system on a budget, you will have performed an enormous service for your constituents.

I'll be happy to reply to your questions.

PYRAMID LIFE SINCE 1913
THE PYRAMID LIFE INSURANCE COMPANY, 6201 JOHNSON DRIVE, SHAWNEE MISSION, KANSAS 66202 (913) 722-1110

February 8, 1990

Testimony of Walter W. Whalen before the House Insurance Committee on Health Insurance Rates and Rate Regulation

Mr. Chairman, Members of the Insurance Committee, I am Walt Whalen speaking today on behalf of Pyramid Life Insurance Company. Pyramid Life is a Kansas Chartered life insurance company domiciled in Mission, Kansas whose principle line of business is individual health insurance. Most of my comments today will be directly in relation to the field of individually underwritten health insurance policies although many of my comments must of necessity also include group health insurance policies.

I have been in the health insurance industry since 1953. The last 33 years I have served as Vice President and member of the Board of Directors of Pyramid Life Insurance Company. In a sense, some might say that I grew up with the industry and watched it develop and become a major force in the American economy. I assure you Mr. Chairman that I will attempt to keep my comments as brief as possible although I will state that it is difficult to condense 40 years of experience and observations in ten minutes or so of testimony.

In a way, I feel very much like the nine year old boy whose parents took him to church one Sunday. As they were leaving the church the pastor stopped him and said, "Well Sonny, what do you want to be when you grow up? The boy looked him straight in the eye and answered "over-sexed". Frankly it is sometimes impossible to tell the truth without shocking some people, and today I feel that I am going to shock just about everybody, the medical providers, the consumer groups, the regulators, the legislators, and especially the insurance industry by pointing out the mistakes all of us have made in our actions and sometimes in our lack of action, mistakes which have contributed mightily to what is now called the health insurance cost crisis. Each one of these five groups has contributed to the existence of this crisis. None of us are without blame.

Since I will be before this committee in future hearings discussing minimum standards, mandated benefits and so on, I will restrict my comments today as much as possible purely to the matters of insurance rates and rate regulation.

Attachment 8

This weeks National Underwriter, a trade publication devoted to the problems of the insurance industry, in its Editorial lists 15 factors which contribute toward the cost of health insurance. The editorial goes on to point out that these 15 are merely some of the factors which contribute to the cost of insurance. It stresses that there are many other factors involved. Since these comments are listed in my written testimony I will not repeat them at this time.

1. Insufficient financial incentives to hold down doctor's fees.
2. Cost of malpractice insurance.
3. Increasing longevity.
4. Cost of new mechanical technologies.
5. AIDS
6. Defensive medicine.
7. Financial incentives that encourage overutilization.
8. Insurance fraud.
9. Insufficient financial incentives to contain hospital charges.
10. Care to the indigent or cost shifting.
11. Redundant inspections of hospitals by state and federal agencies.
12. Unnecessary surgery.
13. Cost of new pharmaceutical technologies.
14. Mandated Insurance coverages.
15. Inefficiency of the health insurance mechanism.

On the whole, the factors that effect the cost of health insurance can be broken into basically three areas taxes, overhead, and claim payments. The companies in the health insurance industry have tried in just about every way to control so far as possible all three of these areas.

Obviously, there is very little that we can do to control taxes and fees. In addition to the regular taxes that apply to all businesses, we have as an industry to pay a number of fees which are peculiar to the insurance industry. We also have to pay premium taxes, and in most states we have to pay retaliatory taxes based on fees and taxes paid to our domiciliary state. Frankly, other than throwing ourselves on the floor screaming, crying and chewing the rug there is very little that the industry can do to control taxes.

Automatically we feel that the industry should have a great control over its overhead or Home Office distribution costs. This is not true. Just like any other business, many of our overhead costs are beyond our control. There is little for example that the industry can do to control the cost of utilities gas and electricity, telephone, etc. Likewise, there is very little that we can do to reduce the costs of services of supplies which we must purchase in order to stay in business. There is even very little that we can do to control wages and commissions in a highly competitve employment market. Yet I assure you that the industry and especially Pyramid Life has increasingly been aware of overhead costs and has done everything possible to reduce them. However, there is a point of no return in the control of overhead costs especially as they relate to the service that we provide our policyholders. If in order to control costs we reduce the services provided below a certain point, we lose policyholders which restricts the base of those covered and in turn increases rates.

Since claim payments constitute the greatest single factor effecting rates, the industry as a whole has attempted to restrict claim payments as much as possible in an effort to keep premium rates down. However, once again the industry does not have total control over what it must pay in benefits.

We must remember that the insurance company is basically a middleman or a transfer agent collecting money from one group and paying it to another. Obviously, the more that we have to pay to the second group, the more we have to charge in premium rates the first group. Traditionally and historically there were three areas wherein the industry attempted to control medical costs. These areas were first, the benefits covered or provided; second the amounts payable for these benefits; and third risk selection. I would like to touch very briefly on all three of these to show how and why they initially worked and why they are no longer practical methods of cost control.

The first is benefits provided. At its inception, the concept of health insurance was to provide help in paying for expenses incurred as the result of necessary medical treatment resulting from sickness and accident. However, not all types of treatment were covered. In an effort to provide coverage to as many people at as low a price as possible some conditions and some methods of treatment were not covered. For example, in the 50's and early 60's insurance companies, both group and individual, did not cover substance abuse, alcoholism, injuries or expenses resulting from attempted suicide or injuries resulting from participation in a afelony, etc. As a matter of fact, at the inception of health insurance, most policies, both group and individual, did not provide any maternity coverage at all since pregnancy was considered neither a sickness nor an accident. In short, by limiting the types of coverage available, bare bones policies or basic coverage was available to a greater number of people at a lower rate.

The second area of cost control was in amounts payable. Once again, at its inception health insurance developed what were referred to as structured policies. In other words, policies with inside limits. The industry would pay only so much per day for hospital room rates, so much for specific laboratory or diagnostic services, so much for doctors visits or calls and only so much per surgical treatment dependent upon the procedure involved. The amount payable for any type of treatment was usually between 80% and 90% of the going charge or the average charge at that time. This was a very effective cost control procedure. Frankly, since it involved the policyholder or in other words the consumer directly in the payment of medical expenses it encouraged care and caution on the part of the consumer in obtaining these services. Since the consumer had to pay some of the cost involved, it discouraged over-utilization and unnecessary treatment. By the same token it also encouraged the medical providers to keep their charges down in relation to the amount payable by insurance. After all, if there was too great a gap between what was charged and what the insurance companies would pay, not only was the policyholder encouraged to shop around for more reasonable medical treatment, but if the gap became too great, many policyholders just did not pay it at all, or postponed paying until the next time they were sick. In short, by having inside limits both the consumer and the medical provider were encouraged to keep medical costs as low as possible.

The third tool in cost control is the most difficult to justify to the American public. It is risk selection or underwriting standards. Going back to the original concept of health insurance the purpose was to provide coverage to as many people as possible at the lowest rates possible. Since policies were designed and rated for the average risk, it became necessary to deny or restrict coverage to the above average risk. To draw an analogy, you cannot buy homeowners insurance when your kitchen is on fire, nor can you add collision coverage to your automobile insurance when your teenaged driver has just dented the fender. The theory was that the above average risk could not be insured at the same rate as the average risk. Rates were thus kept low for the many at the cost of discriminating against a few. In the beginning people with certain conditions such as cardiovascular conditions, diabetes, blindness, etc. were denied all coverage. Frankly, that was stupid on the part of the industry and it soon realized that it could provide some coverage to these people while excluding all coverage for these pre-existing conditions. Even this was not too wise an approach. Rather than attempting to find ways to provide some coverage for these conditions, either through limits or caps on the benefits available for these conditions or even perhaps through a premium surcharge for these conditions, the companies were adamant in their position that they could provide no coverage for these conditions. As a result, the insurance companies became the "bad guys" and suffered what might well be irreparable damage in the eyes of the American consumers and the regulators and legislators.

At its inception and for many years these three methods of cost containment worked successfully, and insurance companies were able to provide coverage, even though in many cases it was merely basic coverage, to a great many people at a very low rate. However, these conditions no longer are available to the industry.

With reference to the first, limits on benefits covered or provided, the insurance industry is no longer able to specify the conditions or types of treatment which will be covered. Initially, pressure groups on behalf of certain types of providers organized, and working through the regulators and legislators forced the removal of all restrictions on the types of providers covered. The first and most noteworthy were the chiropractors. Eventually the insurance companies were forced to cover services provided by chiropractors, drugless practitioners, podiatrists, and frankly in certain states though not Kansas, even Christian Science readers. As a result, most policies today cover services rendered by any medical practitioner operating within the scope of his license. In other words, there was an extension of benefits. Again the insurance industry is merely a transfer agent and since more money was paid to a greater variety of practitioners, rates had to be increased.

The second cost containment feature, the structured policy or inside limits also went by the road. Here it will seem I am taking pot shots at the group health insurance industry and at the marketing arms of the individual health insurance industry. Specifically, since there was intense competition among the group writers to provide group coverage on a national scale, companies began going away from the idea of structured benefits to reimbursement on the basis of the usual and customary charge. At the same time employers were encouraged to pay the full premium. As a result, we have more than one full generation which has grown up the majority of whom feel that health insurance is something they are entitled to but are not expected to pay for. The industry, the unions, and the employer did little or nothing to educate the consumers that health insurance benefits were part of their salaries. Health insurance benefits were not free, they were paid for by dollars which otherwise would have gone into salary. However, as I stated, the consumer did not realize this, and health insurance became an entitlement not a benefit.

So far as the individual health insurance industry was concerned, it was under constant pressure from its own marketing arms to meet the group carriers in providing 100% benefits for the usual and customary charge. Despite objections from within the industry most companies agreed and the structured policy became almost a thing of the past. The industry felt that market forces will control costs. Quite honestly, there are very few market forces when you are discussing health insurance costs. As I said, despite objections within the industry itself, the structured policy became a thing of the past. In effect, the insurance industry in agreeing almost joyfully to the "usual and customary charge" approach actually gave the medical provider a blank check. This method of payment destroyed one of the most effective cost containment tools available to the industry as such.

Today there is a movement on the part of the insurance industry to return to certain inside limits in its policies in an effort to control costs. These efforts are being met with strenuous objections from the policyholders, in other words, the consumers. Companies are also trying to stress the use of higher deductibles and coinsurance in an effort to keep insurance rates down. These efforts are also being met with tremendous resistance on the part of the American public. Because of its own mistake, the industry has lost much of its ability to control medical costs and medical inflation.

The third item of cost containment was risk selection. As I said before, this is the hardest to justify to the public. But once again we must realize that in an effort to provide coverage at the lowest cost to as many people as possible, the insurance companies had to eliminate or restrict coverage to high risk individuals. Again, I must say that the industry did not try as hard as it should have to provide some coverage to these people. As a result of industry reluctance to provide any coverage, the American people stormed the regulatory bodies and the legislatures demanding more and more restrictions on companies right to risk selection. More and more states by statute or by regulation required companies to provide more and more coverage to the high risk element of our population. In fact, today when companies are subjected to the market conduct examinations referred to yesterday by Mr. Huncker, we must be prepared to justify every time we have declined to issue insurance or everytime that we have limited insurance coverage by waiver or rider. As a result, the final effective cost containment method or measure was eliminated. The insurance industry was now at the mercy of medical inflation. It could do very little to control costs, and rates continued to escalate rapidly. Whether any or all of these three measures can be reinstated, I do not know. All I hope is that in recognizing the causes of the crisis, we do not increase it by repeating the mistakes that we have made in the past.

Finally, I would like to touch on the question of rate regulation. The Insurance Department of the state of Kansas does not have statutory authority to approve rates. However, it very effectively does so because the law states the companies may not use rates which have not been filed with the insurance department. Every time a new policy or a rate increase is submitted to the insurance department, it must be accompanied by an Actuarial statement justifying that the rates that will be charged are commensurate with the benefits provided. If the insurance department does not feel that there is this balance between benefits provided and rates charged, they refuse to file these rates. The companies then cannot use the rates in the state of Kansas. In other words, though in theory there is no statutory basis for rate regulation, in practice, by controlling the filing of rates, the insurance department is in affect approving them. In short, rate regulation does exist in the state of Kansas.

I thank the members of this Committee very much for their attention and for allowing me to present this overview of the rate structure of health insurance policies. I realize again that it is very difficult to condense 40 years of observation into just a few minutes of testimony. If you have any questions, I would be very pleased to attempt to answer them.

Thank you.